A MODEL TO ENHANCE THE EMPOWERMENT OF PROFESSIONAL NURSES TO PROMOTE THE RECOVERY OF PEOPLE WHO HAVE BEEN DIAGNOSED WITH DEPRESSION

SHELLTUNYAN PEARCE

STUDENT NUMBER: 8926620

Thesis submitted in the fulfilment of the requirements

for the degree of

Philosophiae Doctor in the School of Nursing,

Faculty of Community and Health Science,

University of the Western Cape

Supervisor: Prof. W. Kortenbout

September 2010

A MODEL TO ENHANCE THE EMPOWERMENT OF PROFESSIONAL NURSES TO PROMOTE THE RECOVERY OF PEOPLE WHO HAVE BEEN DIAGNOSED WITH DEPRESSION

SHELLTUNYAN PEARCE

School of Nursing

Faculty of Community and Health Science,

University of the Western Cape

KEYWORDS:

Registered Nurses

Empowerment

Attributes

Depression

Model

Recovery

Critical Social Theory

Biomedical Approach

Multifaceted Holistic Approach

ABSTRACT

The purpose of this research study is to develop and describe a model to enhance the empowerment professional nurses to promote the recovery of people who have been diagnosed with depression.

Depression is a prevalent psychiatric disorder that despite its increase worldwide, often goes undetected or inadequately treated. The biomedical model's reductionist and dualistic approach proves to be inadequate for nursing practice to address depression and calls for the examination of a multifaceted holistic approach. A multifaceted holistic approach views disease as having multiple causes that are amenable to multiple therapeutic interventions. Despite research evidence about the effectiveness of such an approach, an in-dept literature search did not reveal the availability of such a model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

The research question that emerged was:

- How can professional nurses in the Western Cape be empowered to promote the recovery of people who have been diagnosed with depression?

The assumption is that this question was necessary to address.

To realise the purpose of this research study, the following objectives were formulated:

- To explore and describe the self reported attributes needed by professional nurses to promote the recovery of people who have been diagnosed with depression.
- To explore and describe how these self reported attributes can be facilitated in the work environment.
- To propose a model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.
- To develop guidelines for the operationalisation of the model.

The theoretical framework for this research study was adopted from the Critical Social Theory.

The research design and method used was qualitative, explorative, descriptive and contextual in nature. The research was done in two phases. In phase one the researcher did semi- structured interviews with a purposive and convenient sample of fourteen (14) professional nurses who were working in the Cape Town Metropolitan area and the West Coast.

Each interview was transcribed from the tape recordings, verbatim and open coding was used to identify and analyse the content

In phase two the model was designed based on the findings of phase one. The six components, namely goals, concepts, definitions, relationships, structure and assumptions as described by Chinn and Jacobs, were used to develop the model. The guidelines for critical reflection as described by Chinn and Kramer were used to evaluate the model. A purposive sample that consisted of a group of psychiatric nurse specialists was asked to validate the model during a group discussion.

As a result of their daily interaction with people who have been diagnosed with depression, professional nurses identified increased workload, lack of professional development and a lack of organizational support as barriers to implement the identified attributes support, positive approach, interpersonal skills and awareness of structure to promote the characteristics of the recovery approach.

After the data analysis an empowerment model that would support professional nurses to promote a recovery approach in their working environments was developed.

To ensure trustworthiness, Lincoln and Guba's model was used throughout the study. Ethical considerations were maintained throughout this qualitative research study.

DECLARATION

I declare that *A MODEL TO ENHANCE EMPOWERMENT OF PROFESSIONAL NURSES TO PROMOTE THE RECOVERY OF PEOPLE WHO HAVE BEEN DIAGNOSED WITH DEPRESSION* is my own work that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Shelltunyan Pearce September 2010

Signed:.....

ACKNOWLEDGEMENTS:

Thanks to my supervisor, Professor Elma Kortenbout, for her valuable comments and encouragement in helping me to complete this thesis. I will always treasure what I have learnt from you during the completion of this thesis.

Thanks to my family for their support and encouragement.

Thanks to Graham Gillard, Ebin Arries, Delarey Fourie, Caroline Balie, Henrietta Beukes (Cloete), Jo Byrne (Hobbs), and Yvonne Harper for their input, use of resources and continuous encouragement.

Thanks to the management teams and staff at Stikland Hospital and Tygerberg Hospital for their permission and participation in the interviews.

Thanks to the Western Cape Department of Health for granting me permission to do the research study in the Western Cape Province.

Thanks to my line managers Aileen Joiner, Simon Chanase and Maurica Legg for their support, encouragement and granting me leave on short notice to fly to South Africa.

Thanks to S. Arunachallam, A. Traut and P. Martin for the valuable comments during the expert validations.

Thanks to everybody at the School of Nursing, University of the Western Cape, for their friendliness and support.

TABLE OF CONTENTS

CHAPTER FIVE

Concept Analysis

CHAPTER SIX

Description of a model to empower professional nurses to promote the recovery of people that have been diagnosed with depression

CHAPTER SEVEN

Validation, Limitations, Recommendations and Conclusion

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE
ORIENTATION TO THE STUDY

1.1 Introduction

Depression is the most prevalent psychiatric disorder in both developed and developing countries and it is acknowledged to be increasing in terms of disease burden. The World Health Organization estimates that up to 340 million people suffer from depression and it is predicted that depression will be the major source of death after heart disease in the future (Murray & Fortinberry, 2004). According to epidemiological studies one in four women, one in ten men, one in fifty children under twelve years and one in twenty teenagers worldwide can expect to develop depression during their lifetime and about ten to fifteen percent of depressed people take their own lives (Organon South Africa, 2005). Only an average of 50% of depressed people are recognised and fewer than 25% receive effective treatments (in some countries such as Sub-Saharan Africa, treatment rates for depression are fewer than 5%) (Saraceno, 2003). The researcher's seventeen years' experience as a psychiatric nurse and discussions with experts and experienced professional nurses in the Western Cape postulated that the same phenomena of poor therapeutic healthcare experiences of depressed people occur locally. The seriousness and pervasive effect of these phenomena therefore supports the appropriateness of this research study that aims to develop a model to enhance

the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

1.2 Background to depression in the Western Cape Province

In South Africa, neuro-psychiatric disorders account for the second highest proportion of the local burden of disease, after HIV/AIDS (Bradshaw, 2003). In the Western Cape Province alone, more than 22% of all disability is due to "emotional" and "intellectual" disability (Statistics South Africa, 2001). According to Corrigall, Ward, Stinson, Struthers, Frantz, Lund, Flisher & Joska (2007), 30% of adults in the Western Cape Province will develop a mental disorder in their life-time. There are approximately 5 356 900 million people living in the Western Cape Province (Statistics South Africa, 2009). A study in Khayelitsha showed a high prevalence rate of depression. Of 99 women, 44% were depressed, and 25% of the 71 men were depressed. The rate in Langa was given as 13% of men and 17% of 101 women for depression (Kale, 1995). The researcher could not find any other source of reliable data on the prevalence of depression in the Western Cape Province. According to Kleintjies, Flisher, Fick, Railon, Lund, Molteno and Robertson (2006) expert consensus suggests that depression, generalised anxiety disorders, post traumatic stress disorders and childhood behavioural disorders are the most common mental disorders in the Western Cape Province. The increase in HIV/AIDS, chronic diseases, unsupported and stressed nuclear families, rapid societal and technological changes, disempowerment and loss of the self, insufficient adult supervision, child

abuse, violence, fragmented or loss of spirituality, poverty, competitiveness, mass society and work as a priority are only a few factors according to some professionals, that cause depression to increase amongst the population in the Western Cape Province.

The current Western Cape Department of Health, in an effort to promote good mental health, adopted several policies and strategies which include the *Mental Health Care Act*(2002), *National Health Act* (2003), Healthcare 2010, The Comprehensive Service Plan, and the Western Cape Burden of Disease Reduction Project. The *Mental Health Care Act* (2002) has three basic tenets which capture its main essence. These are human rights and the protection of people with mental disabilities; an integrated approach to mental health care provision and the safety of the public (Freeman, 2002). *The National Health Act* (2003) provides an overarching framework to regulate and ensure uniform policies and services across the provinces that is in line with the constitutional provisions relating to health care. It reinforces the vision outlined in the White Paper for the transformation of the health care system in South Africa. It also outlines structures and mechanisms for the progressive realisation of the right to health care (South African Human Rights Commission, 2004). Healthcare 2010 is a long-term strategic plan that aims to reshape the public health services in the Western Cape to focus on primary-level services, community based care and preventative care (Western Cape Department of Health, 2006). The Comprehensive Service Plan was adopted by the Western Cape Department of Health to achieve the goals of the Healthcare 2010. The service plan provides a framework that will facilitate the reshaping of the services

that are necessary (Western Cape Department of Health, 2007). Healthcare 2010 and the proposed Service Plan aims to move the primary site of mental health services from institutions to communities and to promote a more comprehensive and integrated approach to mental health care delivery. This goal is based on the growing International evidence and support for community mental health care as the preferred mode of service delivery for the majority of mental disorders (World Health Organization, 2001b). Care in the community as an approach means services, which are close to home including general hospital care for acute admissions and long-term residential facilities in the community; interventions that are related to disabilities as well as symptoms; treatment and care specific to the diagnosis and needs of individuals; a wide range of services to address the needs of people with mental and behavioural disorders; services, which are co-ordinated between mental health professionals and community agencies; ambulatory rather than static services including home-based care; partnerships with carers meeting their needs; supportive legislation; involvement of the local community (building social capital).

Corrigall et al. (2007) in volume four of the document Western Cape Burden of Disease Reduction Project acknowledged that mental-health disorders provide a further, unseen burden of disease, which is not generally reflected in mortality data but results in a major load on health facilities. Rather than being reactive to the pressures placed upon the health system, information was actively sought that would enable the department to act in a manner that would begin to address - and indeed reduce - the burden of disease. This information will also enable resources

to be directed to address diseases that currently cannot be managed because of resource constraints. To address this challenge, the Western Cape Department of Health commissioned a study over a three-year period by a consortium of universities in the Western Cape. A Project Task Team was appointed to delineate the extent of, and identify the main contributors to, the burden of disease in the Western Cape Province. Five disease groups (major infectious diseases, mental disorders, cardio-vascular diseases, childhood diseases and injury) were identified as the largest contributors to the total burden of disease in the Western Cape and five corresponding workgroups were constituted to develop policies for the prevention of these diseases to significantly decrease the burden of disease in the Province. The Mental Health Workgroup was established as a consortium of multi-sectoral and intergovernmental public health and mental health experts. The workgroup was asked to make recommendations with regard to those interventions which might reduce the burden of mental illness in the province. A further consideration was for the group to focus on preventing "common" mental disorders such as: depression, substance abuse, childhood behavioural disorders, and Post-Traumatic Stress Disorder. By implication, the aim was to suggest interventions which might promote and sustain good mental health.

Most mental health care to the depressed person in the Western Cape Province is provided at community level, in clinics and community healthcare settings as part of an integrated service. The service seeks to improve mental health and social well being of individuals and communities. Preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health and

curative care. Although the majority of mental health care is provided at community and clinic level this service is supported by district hospitals. These hospitals provide care for those with severe psychiatric morbidity including evaluation and management of attempted suicide, the management of substance withdrawal and delirium, the admission and initial treatment of patients with psychoses, and referral of medium-term admissions to psychiatric hospitals. Providing in-patient services in general hospital settings is limited by physical infrastructure requirements as well as by the need to separate patients according to age, gender and level of containment required, rather than the optimum level of care (Western Cape Department of Health, 2007).

The professional practice of professional nurses towards patients with a mental illness at the Valkenberg Hospital, Lentegeur Hospital, Stikland, Groote Schuur Hospital, Alexandria Hospital and Non Governmental Organisations is regulated by the South African Nursing Council (SANC) according to the parameters set out in the *Nursing Act* (2005). Continuous professional development is not yet mandatory.

1.3 Rationale for the study

The burden of depression is enormous, not only in terms of costs to health departments, medical aid schemes and loss of working days, but also in terms of the impact it has on members of the family. Sobieraj, Williams, Marley and Ryan (1998) found a significant association with increased physical morbidity in families

where a member was depressed. The recurrent acute episodes of depression cost society worldwide approximately $43 billion annually. Unfortunately, data related to the specific cost of depression in South Africa is not available (Benjamin, 2006). It is the leading cause for short and long-term disability and a poorer quality of life. Depression is also associated with higher rates of physical illness and health care utilization. An estimated 200 million work days are lost globally every year due to depression (Greenberg, Stiglin, Finkelstein & Berndt, 1993; Koenig & Kuchibhatla, 1998).

Despite the increase in depression and the enormous burden it creates worldwide, it often goes undetected or inadequately treated (Ustun, Ayuso-Mateos, Chatterji, Mathers & Murray, 2000). Various reasons for this can be identified by examining patients' and health care workers' variables. Patient variables include lack of awareness that the depressive symptoms constitute an illness, fear of the stigma associated with mental illness, fear of medical aid or employment discrimination, poor insight that depression is treatable, the perception by some patients that depressive symptoms are a natural consequence of aging or a normal reaction to stressful life events, the tendency by patients to describe only the physical symptoms of depression such as fatigue, sleep disturbances and headaches, even though their primary pathology can be psychological, the misconception by patients that health care workers only want to hear about their physical symptoms so they avoid mentioning those symptoms concerned with emotions, patients might consult with a genuine physical symptom, but not disclose the psychological effects of these, even if these are severe and the fact that depression is often seen

as a defect of character rather than as an illness (Armstrong, 1999; Plummer & Gray, 2000).

The provision of care to the depressed patient varies on a continuum from primary health care to highly specialised services in South Africa. In the primary health care settings approximately 5-15% of patients seen, for whatever reasons, are depressed (Sareceno, 2003). Failure of health care practitioners in primary health care settings to detect depression may be due to bias or accuracy. Bias refers to the primary health care professional's tendency to make or avoid making a psychiatric diagnosis of depression and accuracy refers to the correctness of the diagnosis, either in terms of severity or labelling. Physical complaints may distract primary health care professionals from making the diagnosis. Health care professionals may lack the confidence to ask the patient about symptoms specific to mood or may hesitate to raise the subject because of pressure to minimize time spent with a patient or having limited skills to respond to psychological distress. The health care providers' level of competence in interviewing and communicating with patients can also influence the detection of depression. Health care professionals' attitudes and beliefs with regards to depression and the effectiveness of anti – depressant drug therapies and counselling may also influence the likelihood of diagnosis (Hannigan, 1997; Marks, 1979).

In physical care settings (medical wards, maternity units and outpatient departments) despite increased recognition of the link between physical and psychological health, and the potential for health professionals to recognise these

needs, nurses frequently fail to address these areas in clinical practice. According to Black and Shooter (2003) depression is twice as common in medical patients in general hospitals compared to the general population. Some physical illnesses increase the risk of depression, in particular cancer, diabetes, respiratory disease, neurological conditions, stroke and HIV/AIDS (Mayou, 1995). One of the main reasons why the recognition and treatment of depression in general hospital patients is a problem is the increased risk of morbidity and mortality. The coexistence of depression in cardiac disease and following stroke is linked to increased mortality and worse prognosis, often as a result of decreased physical activity and motivation (National Center on Physical Activity and Disability, 2009; Khandelwai, 2001). Bridges (2001) found that although nursing staff are aware of some of the psychological problems experienced by patients, the majority of nurses felt unable to address these needs. Brinn (2000) found that nurses staffing physical care settings are generally fearful of patients who are experiencing mental health problems, while Bridges (2001) identified lack of time and patient communication difficulties as major barriers to psychological care. Hunt (1993, p. 375) states that the problems that many nurses in general hospital settings encounter in meeting the psychological needs of patients are related to the tendency to gravitate towards so-called "real" patients who, more often than not, have concrete physical needs. He feels that addressing psychological needs is less appealing to nurses in these situations because of the anxiety and fear this generates.

In psychiatric care settings (inpatient, outpatient and community mental health care), the psychiatric nurse's role, in providing the most effective care for

depressed patients, has never been uniform because of the variation in roles and the different models of practice. Psychiatric nurses therefore fail to demonstrate how their interventions are effective or that they have made a difference to the quality of clinical outcomes. This makes the provision of care to depressed patients in general 'something of a lottery' (Armstrong, 1999, p. 40-44).

Professional nurses are often impeded by the beliefs, assumptions and conceptual parameters of the biomedical model as a standard system for the assessment, diagnosis and management of people with depression. The biomedical model proceeds on the assumption that depression is caused by neurotransmitter imbalance. This approach to manage depression has to do with a modernistic (positivistic) perspective, which dominates medical science and practice. It is the belief of the researcher that a biomedical model approach tends to alienate patients from their being when their mental, emotional and spiritual realities are seen as having little bearing on disease. Not all aspects of depression, especially the feelings and emotions that accompany depression can be measured. The biomedical model further limits the patient's sense of competence, control and responsibility. It also excludes or displaces the centrality of the nurse's ability in supporting and improving patient resourcefulness and well-being (Horsefall, 1997; Hall, 1996; Adorno, 2004; Pearson, Vaughan & FitzGerald, 2005). According to Parse (1999, p. 1383-1387) it is important for nurses to be informed by medical, biological, pharmacological and other kinds of knowledge, but these forms of knowledge do not and 'cannot in and of themselves define the heart or unique focus of care'.

1.4 Problem Statement

The person suffering from depression therefore cannot be treated solely by a uni-dimensional manner (bio-medical model), but rather from a multifaceted holistic perspective (Van der Merwe & Naude, 2004). Holistic approaches adopt a wholeness or social paradigm of health care, which aims at a non-mechanistic, non-reductionistic understanding of the disease process and management. The holistic paradigm views disease as having multiple causes amenable to multiple therapeutic interventions through a variety of systems of care. In holistic practice, the goal is balance, not only control of symptoms; subjective relief, not merely a favourable and scientifically measurable clinical outcome (Nelson, 2004). Despite research indicating the effectiveness of a multifaceted holistic approach to the management of depression, an in-depth literature search did not reveal the availability of an approach that would enhance the empowerment of professional nurses to promote the recovery of people diagnosed with depression.

The need for a holistic model that will help professional nurses to implement practices (knowledge, skills, attitudes and decision-making attributes) to provide safe (to protect the patient and provide effective care for those with depression at the time they need it), sound (to ensure that patients and consumers have access to a full range of services which they need) and supportive services (working with consumers, their families and carers to build a healthier community), is crucial. The provision of better nursing practices, and making those practices available to nurses and the people who need it, is required. This will not only affect the people

with depression, but will influence the economy positively and empower nurses in primary health care, general hospitals and psychiatric settings in their approach towards people with depression. Ultimately the quality of life of the individual with depression will be improved and it is only then that the model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression will become a reality.

1.5 Purpose of the study

The main purpose of the study is to develop and describe a model to enhance the empowerment of professional nurses in the Western Cape Province to promote the recovery of people who have been diagnosed with depression.

1.6 Research question

How can professional nurses in the Western Cape Province be empowered to promote the recovery of people who have been diagnosed with depression?

1.7 Objectives

- To explore and describe the self reported attributes needed by professional nurses to promote the recovery of people who have been diagnosed with depression.

- To explore and describe how these self reported attributes can be facilitated in the work environment.

- To propose a model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

- To develop guidelines for the operationalisation of the model.

1.8 Definition of key concepts

- Professional Nurse

A professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (*Nursing Act*, 2005). To practice as a registered nurse in South Africa, the individual must be registered with the South African Nursing Council (*Nursing Act*, 2005).

- Empowerment

Empowerment is the external facilitation of an active process to increase the powers; control and authority of professional nurses to influence institutions positively towards the recovery approach in the management of depression, through the development of skills, and capacity development (see Chapter Five for concept analysis).

- Model

A model is a framework through which the application of beliefs, values, goals of practice and the knowledge and skills needed to achieve these goals can be brought to light. It enables professional nurses to make explicit the way in which they work and what they are trying to achieve (Pearson, Vaughan & Fitzgerald, 2005).

- Recovery

Recovery is a personal process for tackling dealing with or managing the adverse impacts of experiencing mental health problems, despite their continuing presence. It involves personal development and change, including acceptance there are problems to face, a sense of involvement and control over one's life, the cultivation of hope and the support of others, and direct collaboration in joint problem solving between consumers, professionals and families. Recovery starts with the individual and works from the inside out. For this reason it is personalised and challenges traditional service approaches (Frak, 2005).

- Depression

Depression is a mental state of low mood that is described differently by people who experience it, and that is characterised by feelings of sadness, despair, discouragement, low self – esteem, guilt, self reproach, withdrawal from interpersonal contact, and physical symptoms such as eating and sleeping

disturbances. Depression ranges on a continuum from normal feelings of the blues through dysthymia to major depression (Whatley, 2006).

- Attributes

Attributes refer to the knowledge, skills, behaviour and values required to perform a job to a desired standard (Saunders, 2002).

1.9 Methodology

1.9.1 Theoretical Framework

The theoretical departure for this research study will be based on the Critical Social Theory (CST) as it has been previously applied to the field of nursing (Wilson – Thomas, 1995; Hendricks – Thomas & Patterson, 1995; Fulton, 1997) and because CST is congruent with a notion of empowerment. The CST seeks to emancipate people through the promotion of critical consciousness and aims to find alternatives for the structures and arrangements which reproduce oppressive ideologies (established order, taken-for-granted conditions and the status quo) that are produced, maintained and reproduced. The CST contests these oppressive ideologies through critical inquiry. Three types of social inquiry within the CST are described for the attainment of knowledge. This includes technical, practical and emancipatory inquiries, which is respectively related to the positivist, interpretivist and critical philosophical approaches (Ngwenyama & Lee, 1997). Technical inquiry focuses on the predicting and controlling of the natural and social world and is associated with the positivist school of which the aim is to control the situation.

Practical inquiry looks at human interaction and the context in which that action takes place. This type of inquiry is associated with the interpretivist school of which the aim is to understand the situation. Emancipatory inquiries focus on the improvement of the human condition and takes place through group discussions. A critical interpretivist approach to this research study will be adopted in an attempt to understand the context of the attributes needed by professional nurses to promote the recovery of people who have been diagnosed with depression, before striving for emancipation and for changes in how these identified attributes can be implemented (Byrne, 2004; Wagner, 2003).

According to Hedin (1986) critical consciousness begins with a question and the use of dialogue to gather data. The critical reflective question will be: "What are the attributes that professional nurses need to promote the recovery of people who have been diagnosed with depression?". What follows will be a process in which problems and contradictions in experience will be identified and reflected on. As a result knowledge (practical-interpretivist) will be produced which gives insight into structures of the oppression. Hedin (1986) stated that this knowledge can include meanings which are hidden from the participants due to their oppression. The interpretation of this will produce knowledge (emancipation knowledge) that will encourage participants to move from being victims of circumstances to a transforming agent in their own situation (Freire, 1972). In addition, a thorough search of theoretical literature on the identified attributes will be done after data analysis for the control of the research results and to identify other theoretical frameworks or insights that can be included in this research study.

1.9.2 Research design and method

In this research study a qualitative, explorative, descriptive, and contextual design was chosen.

Critical theory and specifically critical hermeneutics justify a qualitative approach (Wagner, 2003). According to Hoshmand (1999, p. 21) in his comparison of qualitative research with hermeneutics stated that "[h]ermeneutics is concerned with human ontology, and qualitative research is looked on by many as a means of improving on the quality of our ontological statements about human beings". Researchers that follow a critical hermeneutic approach will thus analyse cultural beliefs in order to better understand and change our social world (Wagner, 2003). The importance of interpretation to qualitative research that is informed by critical theory is also emphasised by Kincheloe and McLaren (2000, p. 286) by their statement "...Thus the quest for understanding is a fundamental feature of human existence, as encounter with the unfamiliar always demands the attempt to make meaning...". Researchers will therefore make attempts to make meaning of the unfamiliar and try to achieve a deeper understanding of the familiar within the boundaries of their world. Furthermore, the importance of interpretation in critical research was also emphasised by Kincheloe and McLaren (2000) who stated that in qualitative research there is only interpretation; no matter how vociferously many researchers may argue that the facts speak for themselves.

Explorative – the goal of an exploratory study is to formulate new facts through the collection of new data and to explore the dimension of a phenomenon so as to

determine new patterns and to provide new insights about its meaning (De Vos, 1998).See full explanation in chapter three.

Descriptive – a descriptive research approach provides an account of a phenomena or situation as it naturally happens. In other words, how things actually are (Mouton, 1996; Burns & Grove, 2001). See full explanation in chapter three.

Contextual - the context, according to Babbie and Mouton (2002), defines and describes the setting in which the research will occur. See full explanation in chapter three. However, sections 1.2 and 1.3 describe the relevant local mental health and geographical features that provide background to the study, while chapter two provides literature on the global situation.

1.9.3 Research method

Wagner (2003) stated there is no unified approach for a critical social theory methodology. Willig (1999, p. 43) encouraged an action research methodology "which allows individuals to reflect upon the grounding of their actions in structure of meaning and to identify alternative ways-of-being afforded by those structures". Muller (2000, p. 10) expressed concerns about action and participatory research approaches that action research promote, when using Shaeffer's (1992) description that it is "a process fraught with difficulties, disappointments and unkept promises". Muller continued that it is arrogant of critical researchers to assume that they are going to educate members of a group about errors of their practice and that this will bring about the desired emancipation. The contributions of research participants in action research will also not diffuse power relationships or

ensure that everyone is an equal partner around the negotiating table because unequal social relationships will always be present. Although some critical social theorists encourage the use of specific methodologies, the researcher does not want to place any limitations on himself by rejecting methods and methodologies that are not consistent with the critical social theory. For example, Fulton (1997) has used individual interviews/focus groups as methods within a CST approach.

The research was done in two phases. In phase one the researcher explored and described the self reported attributes needed to promote the recovery of people who have been diagnosed with depression and how these self reported attributes can be facilitated in the work environment. Empowerment was identified by the researcher based on the participants' responses as important to overcome the lack of a supportive work environment and to ensure application of a recovery approach by professional nurses in health care settings. Due to the concept empowerment being complex, and multidimensional, the researcher first conceptualised a definition of the term empowerment to offer a working definition as applied to this research study. In phase two the model was designed based on the findings of phase one. These phases have been summarised on pages 23 to 25 and will be explained in detail in Chapter Three.

1.10 Trustworthiness

Lincoln and Guba's (1985) model for trustworthiness was used for the purpose of this study. The strategies for credibility, dependability and confirmability were applied. See full explanation in Chapter Three.

1.11 Limitations

It is not the intention of this study to generalise the findings to the South African population due to its qualitative and contextual nature (qualitative studies are generalised to theory not populations). Time, financial restraints and geographical distances will limit the population and sample to certain areas in the Western Cape Province. Language barriers as the researcher can only speak Afrikaans and English fluently – a translator would have to be used where the participants speak a language not known to the researcher (this was not required).

1.12 Ethical statement

Burns and Grove (2001) emphasise the importance of conducting ethically sound research. The researcher ensured that this research study was ethically sound by adhering to the following:

- The quality of the research
- Researcher and respondent relationship

- Maintaining of confidentiality and anonymity
- Informed consent
- Vicarious Trauma

See chapter three for a full explanation of the above.

1.13 Division of chapters

CHAPTER ONE	Overview of the study
CHAPTER TWO	The global context of depression (literature review)
CHAPTER THREE	Research design and method
CHAPTER FOUR	Data analysis
CHAPTER FIVE	Concept analysis
CHAPTER SIX	Description of the model
CHAPTER SEVEN	Conclusion, validations, limitations and recommendations of the study.

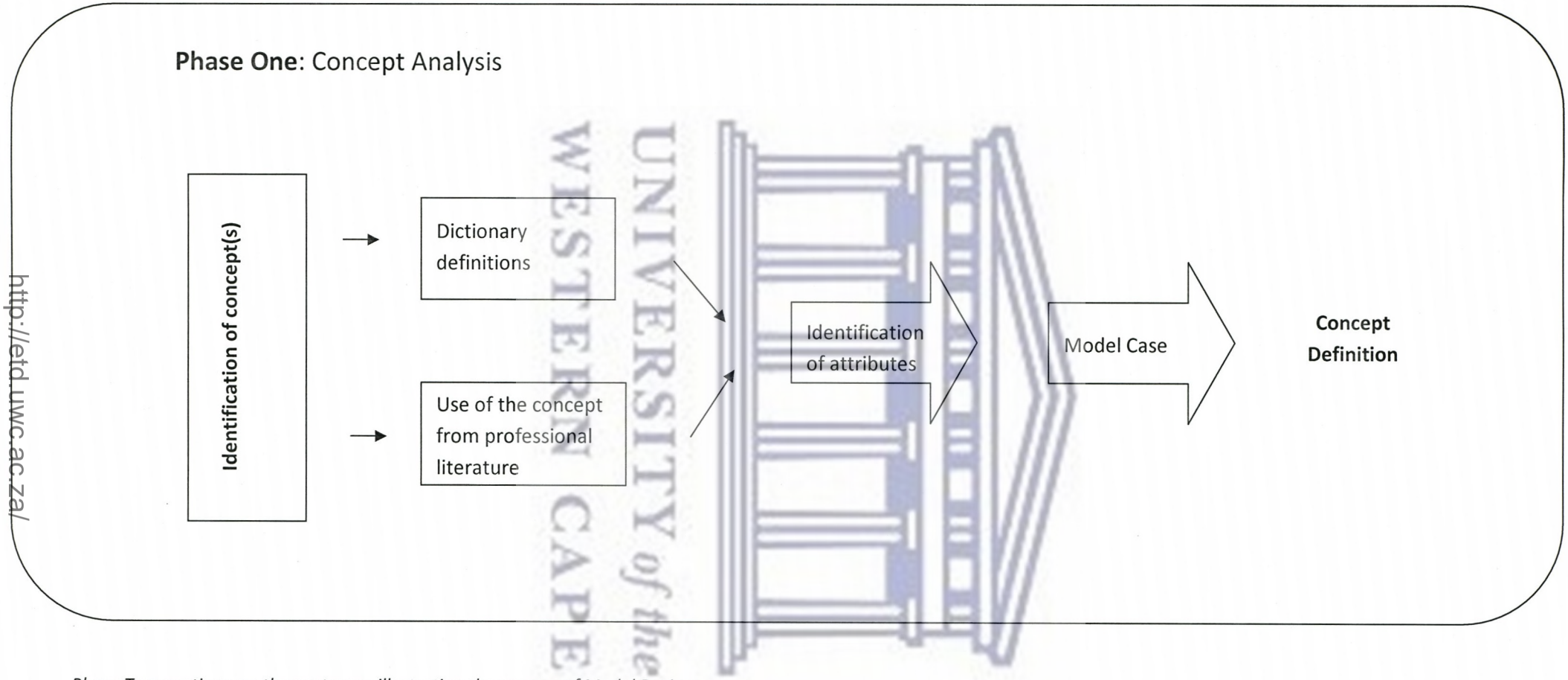
1.14 Summary

In this chapter an overview of the research study was described. It comprised of an introduction, background, literature review, purpose of the study, objectives, definitions of key concepts, methodology, limitations, trustworthiness, ethical statement and division of chapters.

Table 1.1 Summary research methods and methodology

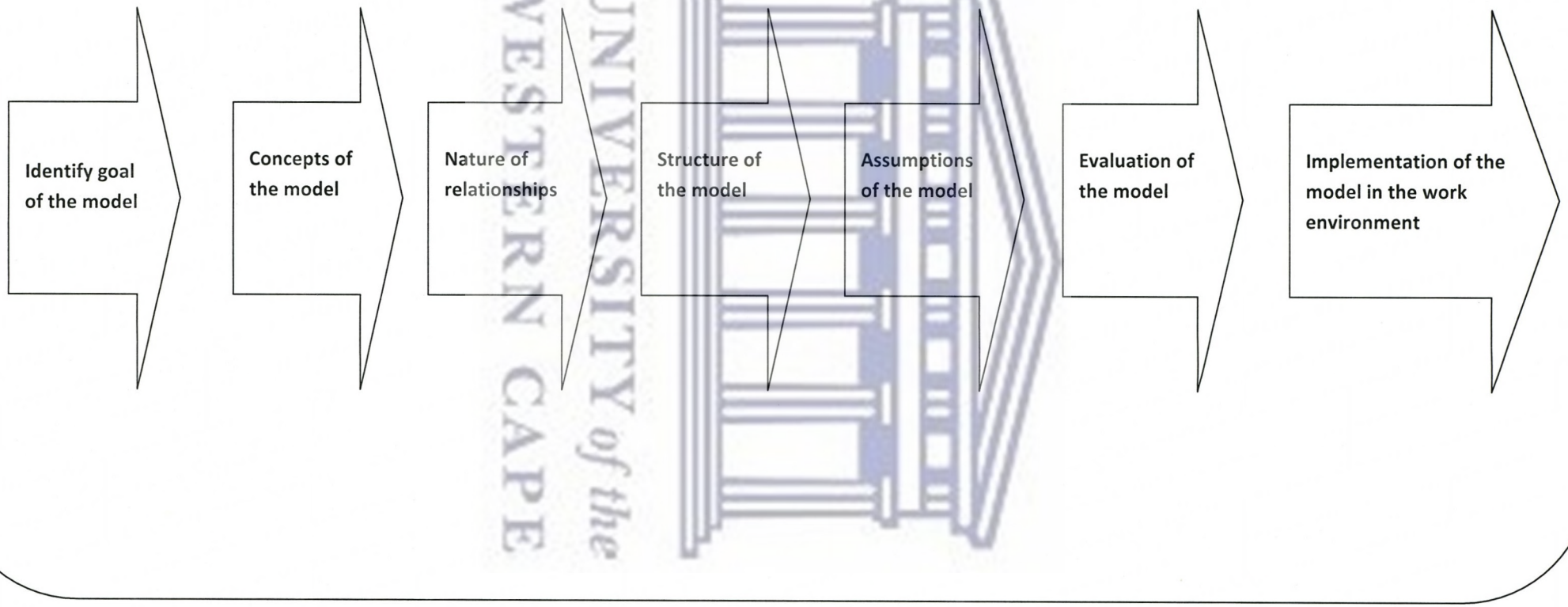
Phase One	Population	Sample	Data Collection	Data Analysis
Attribute identification	Professional nurses who areidentified by their managers after a consultation session with the researcher.	Professional nurses that are registered with the South African Nursing Council, who agree to participate in the study, who have psychiatry as part of their comprehensive qualification or have a general nursing qualification only and who work either in a primary care, general hospital (medical, midwifery, outpatient department) or psychiatric care setting. The researcher will continue to sample until saturation of each new category is reached (Strauss & Corbin, 1990). The researcher will check for saturation after 10 to 15 interviews.	Semi – structured interviews with professional nurses in a quiet room for approximately 30 – 60 minutes. All interviews will be audio tape recorded	Reasoning strategies – analysis, inductive reasoning strategies, and synthesis. Analysis of data will occur concurrently with data gathering and will be an ongoing process (De Vos, 2002). Tesch's (1990) procedure will be used as a method for open coding. Coding will firstly be done independently by the researcher and an external coder. To increase reliability of the recordings the researcher and the external coder will have a consensus discussion to confirm that the identified categories were accurately described and do represent the perceptions of the participants. The researcher and his supervisor will have a follow-up discussion afterwards (Lincoln & Guba, 1985). Literature control. Library searches, journal articles, books, internet accessing, subject dictionaries and electronic mail from various organisations in response to the researcher's electronic request for initial or follow-up information on the identified concepts.

Phase One continue on the next page illustrating the process of Concept Analysis



Phase Two continue on the next page illustrating the process of Model Design

Phase Two: Model Design



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A literature review was conducted by the researcher to contextualise depression globally.

2.2 Aim

The aim of this literature review was to examine and synthesize international literature relating to:

(a) Depression, and

(b) The management of depression according to the recovery approach.

2.3 Method

A review of the literature was conducted by accessing journal articles, books, the World Wide Web search engine Google, subject dictionaries, electronic mail from various organisations in response to the researcher's electronic request for initial or follow–up information, and databases which included My Athens, Medline, EBSCO. All international information was gathered simultaneously.

The search was conducted using the terms: `recovery', depression, `psychosis', `mental illness' and `mental health'. More than 400 literature sources were reviewed. A thematic analysis was conducted. Twelve dominant themes were identified, which included the prevalence of depression, diagnosis of depression, types of depression, other categories of depression, gender and depression, management of depression, background to the recovery approach, what is recovery in mental health, recovery as a process, recovery and the biomedical model, models of recovery and recovery and the Critical Social Theory.

2.4 Note on terminology

People who experience (or have experienced) depression are referred to in this literature review as 'service users' or 'people with mental health problems'. Where a direct quote has been used from international literature they may be referred to as 'consumers' or as 'patients'.

2.5 Diagnosis of depression

Diagnostic criteria and methods of classification of depression illnesses have changed substantially over the years. The clinical diagnosis of depression is made on the basis of a collection of signs and symptoms, also called a syndrome. The most widely used classification system for depressive disorders are the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases. An agreed list of 10 depressive symptoms, which divide the common

form of major depression into four groups: not depressed (fewer than four symptoms), mild (four symptoms), and moderately depressed (five to six symptoms), and severe (seven symptoms or more, with or without various psychotic symptoms) is used by the International Classification of Diseases. The symptoms must be present for at least two weeks. The Diagnostic and Statistical Manual of Mental Disorders system underpins the clinical practice in most of the Western Cape Province. It allows a continuum of severity, but also includes three major depression subtypes: mild, moderate or severe major depression without psychotic symptoms, severe major depression with psychotic symptoms, and melancholia (Retrieved March 20, 2008, from http://depression-webworld.com/icd10.htm).

Depressive symptoms can be measured by a number of self-report inventories and checklists such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961), Hamilton Depression Rating Scale (Hamilton, 1960), and the Zung Self – Rating Depression Scale (Zung, 1965).

The Beck Depression Inventory is a twenty - one multiple choice question self – report inventory that is one of the most widely used instruments for measuring the severity of depression. Each question has a set of at least four possible answer choices, ranging in intensity. It is composed of items that are related to depressive symptoms such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex. When the test is scored, a value of 0-3 is assigned for each

answer. The cut-offs are as follows: 0-13 minimal depression, 14 – 19 mild depression, 20 – 28 moderate depression, and 29 – 63 severe depression. Higher total scores indicate more severe depressive symptoms (Beck, Steer, Ball & Ranieri, 1996).

The Hamilton Depression Rating Scale is a twenty – one multiple choice question questionnaire, that is used to assess the severity of symptoms of patients diagnosed as suffering from depressive states. It rates the symptoms observed in depression such as low mood, insomnia, agitation, anxiety and weight loss. The possible answer to each question is determined by interviewing the person and observing their symptoms. Each question has between 3 – 5 possible responses (Hamilton, 1960).

The Zung Self – Rating Scale was designed to assess the level of depression. It is a short self – administration survey to quantify the depressed status of the patient. The scale consists of 20 items that rate the four common characteristics of depression namely the pervasive effect, the physiological equivalents, other disturbances, and psychomotor activities. Each question is scored on a scale of 1 – 4. The cut – offs are as follows: 25 – 49 Normal Range, 50 – 59 Mildly Depressed, 60 – 69 Moderately Depressed, 70 and over Severely Depressed (Zung, 1965).

The use of these scales depends on the individual approaches of practitioners.

2.5.1 Types of depression

Major Depressive Disorder is specified as either "a single episode" or "recurrent"; periods of depression may occur as discrete events or recur over the lifespan. Where the patient has already had an episode of mania or markedly elevated mood, a diagnosis of bipolar disorder (also called bipolar affective disorder) is usually made instead of major depression; depression without periods of elation or mania is therefore sometimes referred to as unipolar depression because the mood remains on one pole. The diagnosis also usually excludes cases where the symptoms are a normal result of bereavement (Kaplan & Sadock, 1998).

Depression with melancholic features is characterized by a loss of pleasure (anhedonia) in most or all activities, or a lack of response to usually pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, anorexia (excessive weight loss, not to be confused with Anorexia Nervosa), or excessive guilt. The ICD – 10 does not use the term 'melancholic' but calls a similar symptom cluster 'depression with somatic features' (Kaplan & Sadock, 1998).

Depression with atypical features is characterized by mood reactivity (paradoxical anhedonia) and two or more of: significant weight gain or increased appetite, excessive sleep or somnolence (hypersomnia), leaden paralysis, or significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection (preceding mood disorder), causing significant social or occupational

impairment. Contrary to its name, atypical depression is the most common form of depression (Kaplan & Sadock, 1998).

Depression with psychotic features. Depression is accompanied by hallucinations or delusions that are either mood-congruent (content coincident with depressive themes) or non-mood-congruent (content not coincident with depressive themes) (Kaplan & Sadock, 1998).

2.5.2 Other categories of depression

Dysthymia is a long-term, mild depression. There must be persistent depressed mood continuously for at least two years. By definition the symptoms are not as severe as with major depression, although those with dysthymia are vulnerable to co-occurring episodes of major depression. This disorder often begins in adolescence and crosses the lifespan (Kaplan & Sadock, 1998).

Postpartum depression or post-natal depression is clinical depression that occurs within four weeks of childbirth. Owing to physical, mental and emotional exhaustion combined with sleep-deprivation, motherhood can "set women up", so to speak, for clinical depression (Kaplan & Sadock, 1998).

2.6 Gender and depression

Gender refers to both males and females (Hannigan & Coffey, 2003). Most epidemiological studies have shown that depression is twice as common in women as it is in men, regardless of racial and ethnic background or income (Kuehner,

2003). Two worldwide multi-centre studies by the Cross National Collaborative Group and the World Health Organization has shown that this holds true across a variety of cultural settings. In the community-based multi-centre study it was found that while absolute lifetime depression rates varied substantially across centres the gender ratios also varied, with rates for women being consistently higher. The World Health Organization primary care data of a cross-cultural analysis yielded similar evidence (Weissman, Bland & Canino, 1996; Maier, Gansicke, Gater, Rezaki, Tiemens & Urzua, 1999).

Chesler (1972) suggested that women show greater help-seeking behaviour and that women display 'female psychiatric symptoms' such as depression, frigidity, paranoia, psychoneurosis, suicide attempts and anxiety while men display 'male diseases' such as alcoholism, personality disorders and brain diseases. Another artificial influence is that many measures of depression include items that reflect depression responses and expressions that are more likely to be experienced by women, such as crying, appetite and weight changes. These can inflate the scores in women and, if there is a cut off to decide if an individual is depressed or not, women will then be more likely to be depressed than men. Mood amplification has also been demonstrated in many studies. This phenomenon explains that females over time are more likely to remember episodes not previously mentioned when asked, while men are more likely to 'forget' previously reported episodes (Retrieved March 20, 2008, from http://www.blackdoginstitute.org.au/depression/causes/gender.cfm).

'Real' reasons for the differences in rates of depression amongst women and men can be explained according to the Social Role Theory, learned helplessness model and the Life Events Model. The social-role theory is based on the principle that men and women behave differently in social situations and take different roles, due to the expectations that society puts on them. Women have traditionally been regarded as more delicate and compassionate than men. Stereotypes for femininity include expectations to be domestic, warm, pretty, emotional, dependent, physically weak, and passive. By contrast men are thought of as being more competitive and less emotional than women. Masculinity stereotypes include being physically strong, independent, active, aggressive and unemotional. Primary socialisation of these roles occur within the family when boys and girls are treated differently and sex-appropriate behaviour is encouraged and rewarded and transmitted through vicarious learning (parents act as role models and children imitate them). Secondary socialisation continues in schools and workplaces, where behaviour is conditioned through reinforcement and attitudes about what constitutes acceptable male and female behaviour (Nolen-Hoeksema, 1990; Hannigan & Coffey, 2003; http://psychology.jrank.org/pages/575/Sex-Roles.html. Retrieved June 20, 2008).

Women's roles are seen as being more frustrating and less rewarding than men's roles. Illness results from women's dissatisfaction and conflict with their roles. Authors such as Charlotte Perkins Gilman, Adrienne Rich and Betty Friedan have described the frustration, boredom, hard work, isolation and sense of valuelessness of many full-time homemakers or housewives (Nolen-Hoeksema, 1990). These

conditions can cause women to lose self – esteem and motivation and to become depressed. Repetti and Crosby (1984) have referred to this as the noxious nature of the housewife role theory of women's depression. Rosenfield (1980) argued that women who perform traditional roles suffer from more depressive symptoms than women in less traditional roles. According to the paucity of role theory (Repetti & Crosby 1984) women who are not employed outside the home often have only their families as a source of gratification in their lives. As long as all is well in the family, these women will be happy, but when discord occurs, they have nowhere else to turn to for support and gratification. Men on the other hand can turn to their job and co-workers. Belle and Doucet (2003) in their focus on the role of poverty in producing depression in women, made a strong case that poverty contributes to women's greater vulnerability for depression.

2.6.1 Learned helplessness model

Seligman's (1975) theory of learned helplessness postulates that depression results from lack of control over important outcomes in a person's life. The learned helplessness model as an explanation of women's depression, suggest both that women are socialized to be helpless and that they are more likely to be in actual current situations of helplessness than men. Women have been relegated to nurturing tasks and often are forced to decide between both personal growth and development of an intimate relationship with men. According to McGrath, Keith, Stickland and Russo (1990) the rate of sexual and physical abuse is much higher

than previously suspected and is a major factor for the development of depression in women.

2.6.2 Biological

Biologically men and women are obviously different, and there are obvious hormonal differences – women do get depressed pre–menstrually, following childbirth and at the menopause. The impact of sexual hormones on the risk for depression is unclear, but menarche is considered the first time a young woman is at increased risk. Before puberty, the risk for depression is equal, but this changes as a female reaches puberty. A British study evaluated 10 000 citizens for the risk of developing depression. The study found that by the age 16, "the risk for depression was much higher in women and that the difference continued to increase as woman entered young adulthood". The study also found that during menopause and into late adulthood, the rate of depression in both sexes tended to be more alike, but after menopause, women had a lower risk of developing new onset depression (Kuehner, 2003, p. 163 – 174; Gotlib & Hammen, 2002).

It is estimated that as many as 75% of women experience premenstrual emotional and behavioural symptoms, and that the recent inclusion of premenstrual dysphoric disorder (PMDD) in the DSM–IV is based on increasing evidence that show that some women can have significantly disabling depressive symptoms premenstrually. Although the etiology of PMDD is not known, it is hypothesized that normal hormonal fluctuations trigger biochemical events in the central

nervous system and other target tissues that cause premenstrual symptoms in vulnerable women (Rubinow & Schmidt, 1995).

According to O'Hara and Swain (1996) 10-15% of women experience a depressive episode that qualifies for a diagnosis of major depression in the first few weeks after giving birth. This can be due to changes in estrogen and progesterone levels.

There is no evidence to justify a completely separate type of 'male depression', but evidence suggest that some symptoms of depression are more common in men than in women and these include irritability, sudden anger, increased loss of control, greater risk-taking and aggression. Men are also more likely to commit suicide and are 3 times more likely to kill themselves than women, particularly those aged between 16 and 24 years and those between 39 and 54 years. Men are less likely to ask for help and try to deal with their depression by using drugs and alcohol. This might explain the fact why men are diagnosed less with depression than women, but abuse drugs and alcohol more. Compared to women, men tend to be more competitive and concerned with power and success. "Most do not like to admit that they feel fragile or that they need help. They feel that they should rely on themselves, and that it is somehow weak to have to depend on someone else, and are therefore less likely to talk about their feelings and emotions to friends, loved ones and their doctors. Worst is that this traditional view of how men should be – always tough and self-reliant – is also held by some women. Some men worry that if they talk to their partners about their depression they might be

rejected. Even professionals may share this view, and do not spot depression in men as often as they should" (Royal College of Psychiatrists, 2006, p. 1-17).

2.7 Management of depression

Traditionally mental health professionals have tended to focus on symptoms, illness and dysfunction. Influential publications such as The Diagnostic and Statistical Manual of the American Psychiatric Association (APA), and the International Classification of Mental Disorders, have categorised, codified and listed descriptions of a very wide range of emotional or mental problems. These books describe the symptoms and deficits associated with each disorder. For example one symptom of a Major Depressive Episode is a depressed mood, most of the day, nearly every day (American Psychiatric Association, 1994).

It is therefore not surprising that mental health care is thematically built around the signs and symptoms, problems and deficits people might have. It can be argued that the mental health professionals' default mode is to assess around deficits, problems and disabilities. Working in a deficit view is so much a part of professionals' practice that it is almost an unconscious process. Graybeal (2001, p. 233-242) stated that trying to work in any other way than within deficit led models is very difficult because "the exigencies of getting work done, within the dominant paradigm, tend to reduce the attention paid to possible alternatives, leading to a sense of powerlessness in both practitioners and consumers."

In contrast, recovery provides a new rationale for mental health services. It has become the key organising principle underlying mental health services in countries around the world. It provides a framework which, if seriously adopted, will bring a radical transformation of mental health services. In recovery, symptomatic improvement is still important, and may well play a key role in a person's recovery, but quality of life, as judged by the individual, is central.

2.8 Background to the recovery approach

According to Fava, Ruini and Belaise (2007) the term recovery derives from the French word 'recouvrage', which in turn originates from the Latin word 'recuperate'. The concept of 'recovery' was first popularised in regard to recovery from substance abuse and drug addiction. Application of the concept 'recovery' to psychiatric disorders is comparatively recent. The main impetus for the development came from the consumer movement in the United States during the late 1980s and early 1990s. Professional literature began to incorporate the concept from the early 1990s in the United States, and this was followed by several other countries (Shepherd, Boardman & Slade, 2008; Ramon, Healy, & Renouf, 2007; Berzins, 2006).

In the United States (US) the New Freedom Commission on Mental Health (2003) proposed a transformation of the mental health system by shifting the focus of mental health care from the traditional medical psychiatric treatment toward the concept of recover. The document Transforming Mental Health Care in America,

Federal Action Agenda proposed various initiatives to support a recovery movement (Substance Abuse and Mental Health Services Administration, 2005).

In 1998 the New Zealand Mental Health Commission published the Blueprint for Mental Health Services in New Zealand, which was later followed by the publication of the Recovery Competencies for New Zealand Mental Health Workers. The mental health services in New Zealand has therefore been required by the government to use a recovery approach and mental health workers are expected to demonstrate competence in the recovery orientated model.

In Australia, the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003), has identified a recovery orientation that should drive mental health service delivery as one of the major principles.

The National Institute for Mental Health in England (2005) has endorsed a recovery model as the guiding principle of mental health service provision. The Scottish Executive (2005) has included the promotion and support of recovery as one of four key mental health aims and funded a Scottish Recovery Network to facilitate this. A recovery approach as the model for mental health nursing care and intervention was recommended when a review of nursing was done in Scotland (Scottish Executive, 2005).

2.9 What is recovery in mental health?

In mental health, 'recovery' has a range of meanings and does not always refer to the process of complete recovery from a mental illness in the way that somebody may recover from a physical health problem (Repper & Perkins, 2003: 46). It rather means a kind of readaptation to the mental illness that allows for life to go forward in a meaningful way. According to Hatfield and Lefley (1993, p. 184) "the adaptative response is not an end state, it is a process in which the person is continually trying to maximise the fit between his or her needs and the environment". A second reason according to Barton (1998) is because there is not a scientifically rigorous and universally accepted criterion for defining and operationalizing the concept of recovery. According to Anthony (1993, p. 11-23) recovery is a "deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery includes the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". "Recovery is an ongoing, dynamic, interactional process that occurs between a person's strengths, vulnerabilities, resources, and the environment. It involves a personal journey of actively self-managing a psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles"(Retrieved October 15, 2008, from http://pn.psychiatryonline.org/cqi/content/full). Recovery therefore involves the idea that consumers assume responsibility for their lives by making choices and learning from that process as stated by Leete (1994, p. 16-17) "sadly, for years, I had expected someone else to 'fix' me. However, I finally

realized...that no one else could really make me better...for the first time, for the first time I finally felt ready to take responsibility for myself". The emphasis of choice and responsibility is in sharp contrast to much of the traditional professional literature where the strategy is to shape the consumers behaviour through external interventions only (Barton, 1998). The empowerment of consumers to have choices and responsibilities does not mean that service users are solely responsible for their recovery from a mental illness and that professionals can abdicate from responsibility. It also does not mean that consumers can do it by themselves. Responsibility is shared but as outsiders, professionals can only facilitate or enable processes of empowerment. Appropriate external support and intervention, can be important to foster and support the process of recovery. Professionals can ensure that their programmes work to support consumers' individual recovery by encouraging their participation, acquisition of skills, decision-making capacity, and control over resources. Empowerment is demonstrated by the quality of service users' participation in the decisions and processes affecting their lives (Oxfam 1995; Oxaal & Baden, 1997).

Recovery is also about restoring the self. According to Deegan (1996b) recovery involves a transformation of the self wherein one both accepts one's limitations and discovers a new world of possibility. The returning of the consumer "to the realm of being and experience and re-acquainting him or her with the inner dynamics of feelings (like shame or hopelessness), internalizations (like stigma or punitive images) and self representations (identification with the illness)" (Barton, 1998, p. 172). If the consumer in the midst of a disintegrative inner world,

experiences a treatment regime that over-saturates him or her with the notion of chronic illness, he or she may become identified with the illness. Weinberg (1997, p. 217-234) demonstrated that mental disorders can become 'non-human agents' with which consumers learn to interact and manage by attributing various mental states and impulses to the illness. When one attributes everything to the mental illness, one will always be sick. As the consumer descends into powerlessness and identification with the illness, intentionality is affected and being is reduced to mere vegetative existence.

Recovery therefore does not mean that the consumer's mental illness has gone into a complete remission. It means that over time, through what for many is a long and difficult process, individuals come to terms with their illness, learn first to accept it and then move beyond it. They learn to believe in themselves as individuals, learn their strengths as well as their limitations and come to realise that they have the capacity to find purpose and enjoyment in their lives despite their mental illness. The recovery approach focuses upon the potential for growth within the individual. That potential can then be developed by integrating medical, psychological and social interventions. The recovery approach sees individuals with mental illness as active participants in the recovery process.

2.10 Recovery as a process

Recovery is therefore not a step-by-step process but a "series of small beginnings and very small steps. At times our course is erratic and we falter, slide back, re-

group and start again..." (Deegan, 1988, p. 11-19; Anthony, 1993, p. 11-23). Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and a deeply individualised process. There is therefore no right or wrong way to recover (Repper & Perkins, 2003).

Numerous attempts have been made to conceptualize stage models of recovery (Rodgers, Farkas & Anthony cited in Stout and Hayes, 2005). Baxter and Diehl (1998, p. 349-355) proposed three "emotional stages" of recovery. The stages included "crisis," during which consumers attempt to recuperate; "decision," such that consumers decide to rebuild the ability to care for them and to assume normal life roles; and "awakening," in which consumers attempt to rebuild a healthy interdependence. Spaniol, Wewiorski, Gagne and Anthony (2002) categorized the experiences of consumers over a four year interview period, into four phases that included being overwhelmed by the disability, struggling with the disability, living with the disability, and living beyond the disability. Young and Ensing (1999) developed a three-stage model of recovery. The initial phase involves overcoming "stuckness," which includes accepting the illness, finding hope, and having the desire to change. The middle phase entails regaining what was lost and moving forward. The last phase involves improving quality of life by striving for new potentials and achieving a sense of well being.

The findings from the above qualitative studies have been summarized in the form of a five-stage model of recovery. According to Andresen, Caputi and Oades (2006) the five stages includes moratorium (a time of withdrawal characterised by a profound sense of loss and hopelessness); awareness (realisation that all is not lost and that a fulfilling life is possible); preparation (taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovering skills); rebuilding (actively working towards a positive identity, setting meaningful goals and taking control of your life); and growth (living a meaningful life, characterised by self-management of the mental illness, resilience and a positive sense of self). The authors argue that the above five stages must not be seen as a linear progression, but rather as aspects of engagement with the recovery process. Davidson and Roe (2007) explain that many service users are unwilling to engage with recovery because of the severity of their symptoms, their negative experiences of psychiatric care, the side effects of their medication, or the fact that it is sometimes to a painful experience to begin to acknowledge that they need the kind of help that is being offered.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2004) within the United States Department of Health and Human Services the fundamental components of the recovery process include;

Self-Direction: Service users determine their own path of recovery with their autonomy, independence, and control of resources.

Individualized and Person-Centred: There are multiple pathways to recovery based on the service user's unique strengths as well as his or her needs, preferences, experiences, and cultural background.

Empowerment: Service users have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in doing so. They have the ability to join with other service users to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses a service user's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the service user. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for service user access to these supports.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of service users. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Service users encourage and engage other service users in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Eliminating discrimination and stigma are crucial in achieving recovery. Community, systems, and societal acceptance and appreciation of people with a mental illness —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Service users have a personal responsibility for their own self-care and journeys of recovery. Service users identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of community life.

The process of recovery is facilitated when health services enable people to find the right help at the right time, for as long as they need it; give people the best help

available, whoever they are and wherever they are; assist people in the context of their whole lives, not just their illnesses; protect consumers' and carers' rights and treat them with respect and equality; enable people with mental illness to take on competent roles; support people in using mental health services only when necessary; and can look outward and assist people to find and use other community services, supports and resources (Mental Health Commission, 1998).

2.11 Recovery and the biomedical model

The medical model is the traditional approach to recovery from severe mental illness. It considers recovery to be a reduction in symptoms, a reduced need for medication and a reduced need for medical and social care services. In this approach recovery requires a 'cure' for the illness and tends to consider people with mental illness as passive recipients of treatment and services. In contrast the recovery approach does not require people to experience reduced symptoms and reduced needs for medical and social care; but it is about experiencing improved quality of life and higher levels of functioning despite having a mental illness.

The differences in concepts, language and values between the recovery and the traditional biomedical model of mental illness according to the Mental Health Commission Ireland (2005) and Roberts, Davenport, Holloway and Tattan (2005) include:

Recovery Model	Biomedical Model
Distressing experience	Psychopathology

Biography	Pathography
Interest centred on the person	Interest centred on the disorder
Pro-health	Anti-disease
Strengths based	Treatment based
Experts by experience	Doctors and patients
Personal meaning	Diagnosis
Understanding	Recognition
Value centred	(Apparently) value centred
Humanistic	Scientific
Growth and discovery	Treatment
Choice	Compliance
Guiding narratives	Randomised control trials
Transformation	Return to normal
Self-management	Expert care coordinators
Self-control	Bringing under control
Personal responsibility	Professional accountability
Within a social context	Decontextualised

2.12 Models of recovery

Characteristics associated with the recovery approach have been captured in a number of models, and include:

2.12.1 The Tidal Model

The Tidal Model was developed in England between 1995 and 1998, from a series of studies that focused on the 'need for psychiatric nursing' and the discrete nature

of power relationships between nurses and the people in their care (Barker, 2002; Barker, Jackson & Stevenson, 1999). It is a recovery orientated model for the promotion of mental health. The Tidal Model focuses on the continuous process of change that is inherent in all people. It seeks to reveal the meaning of people's experiences, emphasizing the importance of their own voice and wisdom through the power of metaphor. It aims to empower people to lead their own recovery rather than being over powered by professionals (Buchanan-Barker & Barker, 2008).

The philosophy of the model is based on six principles, which are:

(a) A belief in the virtue of curiosity. The nurse knows nothing about the service user and his/her experience. The service user is the expert of their experience and the role of the nurse is to explore the service user's experience with curiosity.

(b) Recognition of the power of resourcefulness, rather than focusing on problems, deficits or weaknesses. Instead of focusing on diagnosis, symptoms or illness, the service user is encouraged to focus on their resources, using a solution focused approach.

(c) Respect for the person's wishes, rather than being paternalistic. The role of the nurse is to take the wishes of the service user seriously.

(d) Acceptance of the paradox of crisis as opportunity. A crisis is seen as an opportunity to change, to rethink the life path and do something differently, rather than seeing a crisis as something to cope with or control.

(e) Think small. Following the solution focused approach, service users are encouraged to take small steps forward and not to set big, less achievable goals.

(f) The virtue of pursuing elegance (the simplest possible means should be sought). Care plans should be 'simple' with 'simple' interventions (Hall, Wren & Kirby, 2008, p. 128).

In order for the practitioner to begin the process of engagement using the Tidal Model, the following needs to be accepted:

- that recovery is possible
- that change is inevitable - nothing lasts
- that ultimately, people know what is best for them
- that the person processes all the resources they need to begin the recovery journey
- that the person is the teacher and the helpers are the pupils
- that the helper needs to be creatively curious, to learn what needs to be done to help the person, now!

The process of engaging with the person in distress takes place in three discrete domains, which includes:

- Self domain is the place, where people maintain their entire 'private' experiences for example thoughts, feelings and aspects of consciousness.

- World domain is where service users bring out some of these 'private' experiences into the world, sharing them, selectively with others.
- Others domain is where people act out their life story with other people; influencing them and being influenced, in turn by them, through an infinite range of social encounters (Buchanan-Barker & Barker, 2008, p. 1-3; Barker & Buchanan-Barker, 2007).

The practice of the Tidal Model is focused upon specific individual and group processes of care, each related to one of the three domains. When a service user enters the service – whether a hospital, clinic or the service user's own home - the focus in the world domain is upon helping them 'tell the story' of how they came to be in mental health care. This story-telling is facilitated through the holistic assessment (an in-depth conversation), aimed at helping the service user explore and describe what has happened, with a view to beginning to discuss what might 'need to be done', to begin to address the identified problems. This leads to further conversations within one-to-one sessions, which focus on helping the service user identify and discuss current issues, problems or difficulties; identifying what he/she might do and what help might be received from others, to begin to address them. If the service user is perceived to be in any way a risk or threat to self or others, in the self domain then in-depth risk assessments are conducted, as preparation for the development of a person-centred personal security plan. This identifies the personal and interpersonal resources the person might use to address current 'risks or threats' (Buchanan-Barker & Barker, 2008, p. 1-3; Barker, 2007).

The above process can be described as the 'beginnings of self-management'. Unlike, other 'recovery models', the Tidal Model emphasises that 'self-management' must be enabled from the point of entry into the service and not at the point of discharge from the service. Through these processes the service user rehearses the kind of decisions and actions, which might be needed as part of everyday living, once he/she returns to ordinary life in the community (Buchanan-Barker, 2008, p. 1-3).

The last three processes in the Tidal Model belong to the others domain and involve specific forms of group work aimed at helping service users reclaim their personal power and identify personal and interpersonal strengths or assets. Service users in psychiatric services are often asked only to talk about what is wrong with them. The discovery group helps service users to discuss aspects of their life experience, which have shaped who and what they are. This life-affirming group aims to help participants appreciate their own diversity through making connections with the diversity of others. The information sharing groups provide information on a topic of the group's own choice. It provides a safe venue for discussion with dedicated 'experts' – chosen for their knowledge, rather than because they are 'authority' figures. The solution groups provides a highly structured setting in which participants can discuss current issues and problems in such a way that the group (rather than a professional) helps them look at problems differently, and begin to think about how they might begin to be resolved (Barker & Buchanan-Barker, 2007, p. 92 – 104).

The values of the Tidal Model can be distilled into Ten Commitments.

- Value the voice - the person's story is paramount
- Respect the language - allow people to use their own language
- Develop genuine curiosity - show interest in the person's story
- Become the apprentice - learn from the person you are helping
- Reveal personal wisdom - people are experts in their own story
- Be transparent - both the person and the helper
- Use the available toolkit - the person's story contains valuable information as to what works and what doesn't
- Craft the step beyond - the helper and the person work together to construct an appreciation of what needs to be done 'now'
- Give the gift of time - time is the midwife of change
- Know that change is constant - this is a common experience for all people (Barker & Buchanan-Barker, 2007, p. 24-27).

2.12.2 Wellness Recovery Action Plan

The Wellness Recovery Action Plan (WRAP) was developed by Mary – Ellen Copeland (Copeland, 2001). It is a self-help tool that helps individuals diagnosed with a mental illness, to identify early warning signs and triggers while encouraging the development of coping strategies and supports. It consists of six stages as indicated in table 2.1.

Stage One	Wellness toolbox	Tools and strategies that I use everyday to stay well.
Stage Two	Daily maintenance plan	What I do each and every day, when I am feeling well?
Stage Three	Dealing with triggers	What are my triggers and what is my response to each one?
Stage Four	Early warning signs	What are my early warning signs for me, and what is my action plan?
Stage Five	When things breaking down	How do I know? Breaking down list and responses/ action plan.
Stage Six	Crisis plan	How do I know when I am unwell, crisis symptoms, supporter's phone list, medication, treatments, treatment facilities and respite care, supporters' roles, and what to do when I am in danger of myself or others?

Table 2.1 Wellness Recovery Action Plan (Copeland, 2001)

As the service user develops their own WRAP it can become a practical support for their recovery which they can refer to daily, as a reminder and guide, and also turn to in times of difficulty. It aids the service user to learn more about themselves, what helps and what does not, and how to progressively move in control of their own lives and experiences. It includes instructions on developing a crisis plan, as a means of guiding others on how best to make decisions for you and take care of you, for the periods when the service user's problems and symptoms have made it difficult to do this for them.

2.12.3 Ohio Model

An influential model was developed by the Ohio Department of Mental Health (2003). Ohio's Recovery Process Model and Emerging Best Practices propose a process of recovery that consists of four stages: ranging from a dependent and unaware; dependent and aware; independent and aware; interdependent and aware stage.

Dependent/Unaware	Dependant/Aware
Independent/Aware	Interdependent/Aware

Table 2.2 Ohio model (Ohio Department of Mental Health, 2003).

The starting point is described as a state of dependency owing to the experience of illness or distress, the impact of the mental health system, traumatic events and the disruption of daily life and relationships. This period of crisis can be characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. The goal and final stage of the recovery process – interdependent and aware - is a state of psychological well-being, defined as personal growth, self-acceptance, autonomy, positive relationships, environmental mastery and purpose in life. Characteristics of this stage are not necessarily the absence of symptoms but the ability to manage the illness and live a meaningful life, show resilience in the face of setbacks and have a positive attitude towards the

future. To proceed from the initial state of crisis towards well- being is a non-linear process. The consumer first has to become aware of their condition as well as the fact that recovery is possible, and start to work on recovery. This early phase in the recovery process (dependent and aware) involves recognising one's values, strengths and weaknesses, beginning to set goals, learning about mental illness and services available, acquiring recovery skills and connecting with peers. The next stage (independent and aware) involves setting and working towards personally valued goals, taking responsibility for managing the illness and taking control of one's life, developing increasing knowledge and skills, and building and maintaining relationships. An important characteristic of this stage is the constant growth in resilience, which requires the opportunity to take risks (to try something new); this requirement is challenging for risk-averse mental health services. The step from being overwhelmed or resigned to gaining awareness, hope and determination is frequently described as a turning point in an individual's life, and may be triggered by an event, a clinician, a role model or a significant other. It can also be a conscious decision arrived at after being ill for a long period (Andresen, Oades and Caputi, 2003; RETHINK, 2005).

2.12.4 The Strengths Model

The Strengths Model grew out of dissatisfaction with traditional models of care, which puts the emphasis on disorders, abnormalities and problems. The strengths model takes the opposite approach to this deficit model. The service user is placed in an equal position as the professional, society and the environment. The

Strengths Model enables professionals to help the service user to recognise and use their strengths, their talents, knowledge, skills and experience, in order to help them achieve their goals and experience an improved quality of life, on their terms (Hall, Wren & Kirby, 2008).

The Strengths Model is based on 6 principles, which includes:

- The focus is on the service user's strengths, and not their diagnoses, weaknesses, problems, or what they are perceived to be lacking. What the service user has learned about themselves, others and their world, as they coped with their lives so far. People learn from their difficulties, disappointments as well as successes, their personal qualities, traits and virtues that people possess. What people know about the world around them, that they have learned through their life experiences? Their talents, their inspirations from cultural and spiritual lives, their ability to survive, and with who they connect in their local communities.
- The community is viewed as an oasis of resources, and not as an obstacle.
- The service user is the director of the support process.
- The service user-practitioner relationship is the foundation of mutual collaboration.
- Pro-active community outreach is the preferred way of working with service users.

- Service users with mental illness can continue to grow and change (Hall, Wren & Kirby, 2008).

2.12.5 Collaborative recovery Model

The Collaborative Recovery Model was developed by Lindsay Oades. In this model, change is initiated by motivating patients with mental health problems to work on their recovery both through techniques such as motivational interviewing and through assessment of their needs. On the basis of the identified needs, goals for change are set in collaboration by the patient and the professional. These are broken down into small, achievable steps and the patient are given homework so that their progress is translated into their natural environment (Oades, Deane, Crowe, Lambert, Kavanagh, & Lloyd, 2005).

2.12.6 Common concepts that are key to the above five models of recovery.

Several concepts are common in the above recovery models. These include hope, personal responsibility, education, self advocacy, and support.

Hope: People who experience mental health difficulties can get better, stay well and go on to meet their life dreams and goals. Personal Responsibility: It is up to the consumer, with the assistance of others, to take action and do what needs to be done to keep well. Education: Consumers need to learn all they can about their experiences so that they can make good decisions about all aspects of their lives. Self Advocacy: Effectively reaching out to others so that you can get what it is that you need, want and deserve to support your wellness and recovery. Support: While

working toward their wellness it is up to the consumer, to receive support from others, and to give support to others.

2.13.7 Strengths about the recovery approach.

From the above mentioned models is the fact that recovery is about whole lives and not just symptoms; it is about taking back control of problems and the way they are treated and of life as a whole; family and other supporters are important partners in facilitating recovery; it is possible for everyone and not unique to certain mental health problems; and it is about discovering a positive sense of personal identity that is separate from illness or disability.

2.13 Recovery and the Critical Social Theory

The aim of the Critical Social Theory is to understand, analyze, criticize and alter social, economic, cultural, technological, and psychological structures and phenomena that have features of oppression, domination, exploitation, injustice and misery. This is done with the goal of changing or eliminating these structures and phenomena and expanding the scope of freedom, justice and happiness. The assumption is that this knowledge will be used in processes of social change by people to whom understanding their situation is crucial for change. (Bentz & Shapiro, 1998).

The premise that recovery from mental illness is a life-long process is confining, restricting and a disempowering belief. Deegan (1992) describes this paradigm as the cycle of disempowerment and despair as illustrated in Figure2.1.

This illustration describes the self-fulfilling characteristics of limiting and restricting beliefs. As people grow to believe in the limitations of their ability and potential, they live and behave accordingly. A negative vision of themselves keeps them trapped in the institutions and their illness.

The recovery approach promotes the idea that recovery is possible when people have the skills, knowledge, supports and attitudes to make changes in their lives. The reality that people can recover from mental illness has the potential to change the way mental illness is perceived, understood, and dealt with in our society. It can free people from the trap of self stigmatization and the accompanying self imposed barriers, limitations, anxieties, fears and hopelessness. People will realize and believe they have choices and can act on them, that they can pursue their dreams and participate fully in life and in society. Secondly, it can release the not yet diagnosed from the fear of mental illness, of overwhelming stigma, losses and hopelessness. This can result in a greater societal acceptance of emotional and mental distress and enhanced availability of resources, services and supports for people experiencing mental health difficulties (Peters, 1999). The notion of recovery in the mental health milieu appears to be consistent with the CST. There is an apparent synergy in the recovery model and research approach underpinned by the CST.

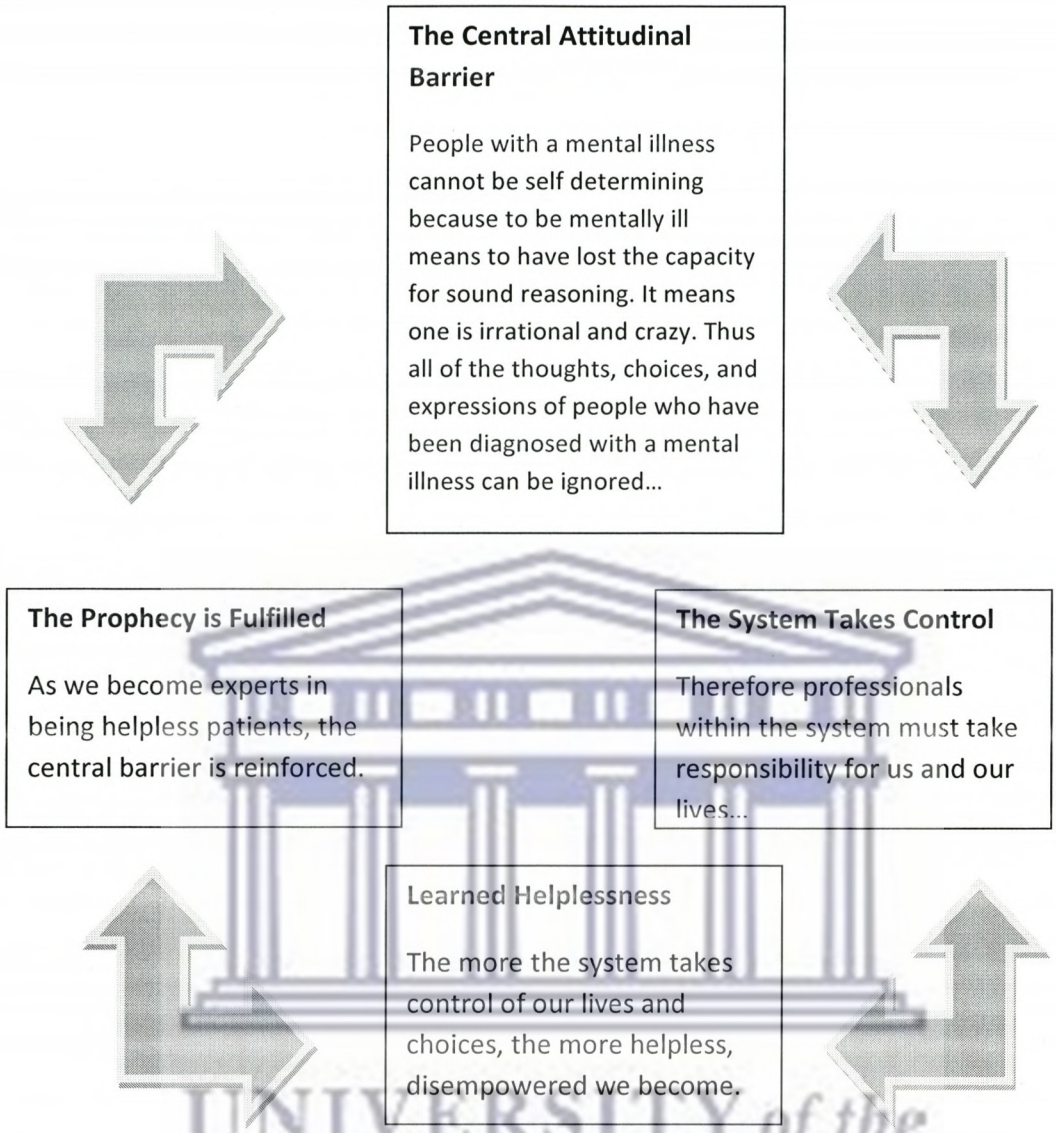


Figure 2.1 Cycle of disempowerment and despair (Deegan, 1992)

2.14 Summary

Depression is a mental state of low mood that is described differently by people who experience it, and that is characterised by feelings of sadness, despair, discouragement, low self – esteem, guilt, self reproach, withdrawal from interpersonal contact, and physical symptoms such as eating and sleeping

disturbances. Depression ranges on a continuum from normal feelings of the blues through dysthymia to major depression.

Recovery provides a new rationale for mental health services to manage depression and has become the key organising principle underlying mental health services in countries around the world. Recovery is a personal process for tackling the adverse impacts of experiencing mental health problems, despite their continuing presence. It involves personal development and change, including acceptance that there are problems to face, a sense of involvement and control over one's life, the cultivation of hope and the support of others, and direct collaboration in joint problem solving between consumers, professionals and families. Recovery starts with the individual and works from the inside out. For this reason it is personalised and challenges traditional service approaches.

Chapter three will describe the research design and methodology.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The purpose of this research study is to develop and describe a model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression. To accomplish this goal, a qualitative, explorative, descriptive and contextual design will be utilized. The study will be conducted in two phases. The research method will include the population and sampling, data collection methods, data analysis, trustworthiness, and ethical considerations. These phases have been summarised on pages 18 to 20 in Chapter One.

3.2 Research design

Burns and Grove (2001) define the research design as a set of guidelines that is used by the researcher to decide how the study will be implemented. A qualitative (Burns & Grove, 2001), explorative (Mouton 1996), descriptive (Mouton, 1996) and contextual approach (Babbie & Mouton, 2001) will be used in this research study.

3.2.1 Qualitative

A qualitative approach can be described as a systematic and subjective approach that "focuses on the way people interpret and make sense of their experiences and the world in which they live" (Holloway, 1997, p. 1). It seeks to explore and describe experiences, feelings and thoughts from the perspective of the participants in their own words rather than simply reducing them to quantifiable categories. The outcomes are in-depth, rich descriptions that provide a holistic meaning of the phenomena. This aids understanding of the intentions, views and experiences of the participants that will create new options for action and new perspectives that can change people's worlds' (Burns & Grove, 2001; Munhall & Boyd, 1999). Patton (1990) describes several characteristics that are unique to qualitative inquiry. Qualitative research is naturalistic, which implies that the researcher does not attempt to manipulate the research setting but seeks to understand "naturally occurring phenomena in their naturally occurring states". Qualitative inquiry uses inductive reasoning because it is "particularly orientated toward exploration, discovery and inductive logic" (Patton, 2002, p. 54). Inductive analysis implies that analysis starts with specific observations and builds towards general patterns. From these open-ended observations, patterns, categories and themes emerge as the researcher begins to understand the phenomena under study (Patton, 2002). The third characteristic described by Patton is the importance of fieldwork in qualitative inquiry, where the researcher has personal and direct contact with those being studied in their environment. The fourth concept is the importance of a holistic perspective, where "researchers and evaluators analyzing

qualitative data strive to understand a phenomenon or program as a whole" (Patton, 2002, p. 59). According to Patton (2002, p. 56) the "holistic approach assumes that the whole is understood as a complex system that is greater than the sum of its parts", thus understanding the entire complexity of what is being studied. Walker and Avant (1995) define qualitative research as descriptive in that the researcher is interested in the process, meaning and understanding gained through narratives.

This study was of a qualitative nature as the researcher intended to develop and propose a model to empower professional nurses to promote the recovery of people that have been diagnosed with depression.

3.2.2 Exploratory

The goal of an exploratory study is to formulate new facts through the collection of new data and to explore the dimension of a phenomenon so as to determine new patterns and to provide new insights about its meaning (De Vos, 1998). Mouton (1996) refers to exploratory research as an attempt to collect new data in areas where little or no previous research has been done. An explorative approach in this study enabled the researcher to obtain actual information on the real and practical situation of what attributes professional nurses require to promote the recovery of people that have been diagnosed with depression.

An explorative strategy was used by the researcher to firstly examine attributes that are used or recommended by professional nurses.

3.2.3 Descriptive

A descriptive research approach provides an account of a phenomena or situation as it naturally happens. In other words, how things actually are (Mouton, 1996; Burns & Grove, 2001). According to Polit and Hungler (1995) descriptive research aims to describe the characteristics of individuals, situations and frequencies with which certain phenomena occur.

The descriptive approach enabled the researcher to describe the various attributes that professional nurses use to manage people diagnosed with depression in selected countries based on literature and in the Western Cape Province as derived from individual interviews.

3.2.4 Context

The context, according to Babbie and Mouton (2001), defines and describes the setting in which the research will occur. The context for this research study was based on the South African professional, ethical and legal health system framework within which the practice of the professional nurse occurs towards people that have been diagnosed with depression. This framework is based on the nursing and health legislation, particularly the *Nursing Act, 1978*, *Nursing Act, 2005* and *the National Health Act, 1993*.

See also 1.2.

3.3 Reasoning strategies

Reasoning strategies used in data analysis contribute to a well - organised chain of evidence that supports the researcher's conclusion after data analysis (De Vos, 2002). In this study the researcher applied the following strategies:

3.3.1 Analysis

According to De Vos (2002) and Walker and Avant (2005) this type of reasoning takes the complex whole and resolves it into its parts for the purpose of clarifying, refining followed by sharpening of concepts, statements and theories. The researcher will afterwards examine the "relationship of each of the parts to each of the other parts and to the whole" (Walker & Avant, 2005, p. 31).

In this research study the researcher applied the strategy to:

- Identify the concepts.
- To place concepts in relationship to one another.

3.3.2 Synthesis

Synthesis is the process of merging isolated pieces of information into a connected whole (Walker & Avant, 2005). In this study the strategy was applied by the researcher to identify the relationships between concepts, which were reconstructed to provide insight into aspects that are studied. A model was then developed.

3.3.3 Derivation

According to Walker and Avant (2005, p. 31) the strategy of derivation requires the researcher to firstly conduct a literature search on the topic of interest. "This approach to theory building can be applied to areas in which no theory base exists".

In this research study the researcher applied the strategy with regard to:

- The literature review on depression and recovery.
- A literature review applicable to the findings from interviews was done at the end of the analysis of the interviews by the researcher to familiarise himself with the existing literature on the identified attributes required by professional nurses to promote the recovery of people that have been diagnosed with depression and how these identified attributes can be implemented in the work environment
- A concept analysis was done to identify ways of looking at 'empowerment'.

3.3.4 Induction

According to Holloway (2004) inductive reasoning means moving from the specific to the general. Mouton and Marais (1990) state that the researcher during inductive reasoning, enters into the field without a clear conceptual framework and after the data has been generated will identify relationships or patterns that results in systematic explanations or a conceptual framework.

In this research study the researcher used inductive reasoning to obtain and analyse data from the interviews conducted.

3.4 Research method and model development

The goal of this research study was to develop a model to enhance the empowerment of professional nurses to promote the recovery of people that have been diagnosed with depression.

The research was done in two phases to develop such a model. In phase one the researcher first explored and described the attributes needed to promote the recovery of people that have been diagnosed with depression and how these identified attributes can be facilitated in the work environment. In phase two the model was designed based on the findings of phase one and it was exposed to a validation process that is consistent with Chinn and Kramer (2004).

3.4.1 Phase One - Attribute identification

Professional nurses identified during interviews the attributes required to promote the recovery of people who have been diagnosed with depression. The identified attributes were then incorporated from the population, sampling, data collection, field notes, data analysis, literature control, and methods used to ensure trustworthiness.

3.4.1.1 Population for interviews

Mouton (1996, p. 134) refers to the term 'population' as a collection of objects, events or individuals having some common characteristics that the researcher is interested in studying. Tudd, Smith and Kidder (1991) state that a population is the aggregate of all the cases that conform to some designated set of specifications. The target population for this phase included:

Professional nurses in the Western Cape Province who work with people who have been diagnosed with depression.

3.4.1.2 Sampling for interviews

A sample is a measured subset of the population and is the selection of a group of people, events or other elements with which to conduct a study (Burns & Grove, 2001). The sampling strategy that was used for this phase was purposive based on the rationale for inclusion of specific participants (Burns & Grove, 2001). Purposive sampling was used to explore and describe the views of professional nurses with regards to:

- what attributes professional nurses require to promote the recovery of people who have been diagnosed with depression in the Western Cape Province,
- how the identified attributes can be facilitated in the work environment.

Appropriateness of the sample was more important, which meant that the sample had to include participants who can best articulate the needs of the study by being a 'good' informant. For the researcher, a good informant was a participant who was able to put into words the meaning or description of their experiences and is willing to reflect and share them with the researcher. Morse (1991, p. 135) stated that "an appropriate sample is guided by informant characteristics and by the type of information needed by the researcher".

In this phase the selection of participants was based on their unique experience as a professional nurse working with people who experience depression. Large sample sizes were not required. The sample size for qualitative studies is usually small, rather than large random samples preferred for quantitative studies, because of the in-depth nature of the research, the resource implications of the data collection methods, and the fact that the researcher controls who are selected to be interviewed by making sure of the appropriateness and adequacy of the sample. Saturation occurs when the researcher is "not hearing anything new" during the interviews or 'informational redundancy' has occurred (Morse, 1991, p. 135; Holloway, 1997, p. 143). Saturation cannot be predicted because it is "achieved at a different stage in each research project" (Holloway, 1997, p. 83). The completeness and amount of information in the data determines when saturation is reached. The researcher checked for saturation after 10 to 15 interviews. According to Gerrish & Lacey (2006) a number of 5 to 12 participants are perceived as reasonable and adequate to provide diversity of perceptions.

Sampling Criteria

According to Burns & Grove (2001) sampling criteria are listed characteristics of subjects that qualify them for selection in the study.

Professional nurses must be registered with the South African Nursing Council, be registered either as a general nurse or community nurse or midwife or psychiatric nurse or comprehensively trained, agree to participate in the research study, work in a primary care, general hospital (medical wards, midwifery, outpatient clinics) or psychiatric care setting.

Psychiatric Nurse Specialists, who will participate in the validation of the model, must have a Masters Degree in psychiatric nursing and must be registered with the South African Nursing Council.

To obtain the sample, the researcher sent letters to the heads of each health facility in the Cape Town Metro and West Coast area expressing a request to conduct the research study at the health facility and seeking permission to do so. After the receipt of written agreement, the researcher used purposive sampling (professional nurses who had cared for persons with depression) and convenient sampling (professional nurses who were available and gave consent to be interviewed). Prospective participants were contacted by the researcher either through a telephone call or a personal meeting. Information sheets and consent forms (Appendices 3 and 4) were then distributed to the prospective participants asking them to read and sign the consent forms and asking them to return these completed forms to the researcher who will address any issues

raised. Their inclusion in the research study was based on the participants' written consent to participate.

3.4.1.3 Data Collection Method

Data collection is the gathering of information through a variety of data sources. Qualitative researchers sometimes reject the term 'collection' in favour of 'generating' data or 'making' data "because researchers do not merely collect and describe data in a neutral and detached manner but are involved in a more creative way: 'the researcher is seen as actively constructing knowledge" (Holloway, 1997, p. 45; Mason, 1996, p. 36).

Data was collected through face- to- face interviews, which was semi-structured. Semi-structured interviews are widely used in qualitative studies and have predetermined open-ended questions or topics that form the basis of an interview guide and not a schedule as in quantitative research (Holloway, 1997). Flexibility to follow issues raised by participants that had not been anticipated is retained. Control and direction of the interview lies with the researcher but there will be capacity to be responsive to the interviewee's agenda and views (Gerrish & Lacey, 2006). According to Poggenpoel in Rossouw (2000) a successful interview will be reliant upon the capacity of the researcher to develop a sense of rapport and trust with the participant. This can be displayed through unconditional acceptance, empathy, respect and honesty. The interviews were conducted in a quiet room for up to 30 – 60 minutes as required and the researcher was the only person present to secure privacy. The interviews started with the question:

"What are the attributes that professional nurses need to promote the recovery of people who have been diagnosed with depression?"

The data was recorded on an audio tape and was transcribed at a later stage. The researcher made field notes during the interviews.

The researcher also made use of non-directive communication techniques that include: active listening, minimal verbal responses, probing, reflection, summarising, silence and clearance.

- Active listening – the researcher's attention to what participants are saying both verbally and non-verbally (posture, facial expressions, tone of voice) (Egan, 1998: 65).
- Minimal verbal responses – these responses indicate to the participant that the researcher is interested and paying attention to what they are saying, and includes responses such as "I understand", "mm-mm" and "yes".
- Probing – it is an open – ended attempt to obtain information through the use of phrases such as "tell me more" and "It is not clear to me which of these four statements you would choose", instead of using what, where or when (Okun, 1992: 75).
- Reflection – it is the ability of the researcher to communicate to the participants' understanding of what has been said and can include feelings and non-verbal behaviour (Cormier & Cormier, 1991: 74).

- Summarising – the researcher repeats what has been said and highlights the main themes to promote clearance, keep a point of interest and to bring the discussion of a specific theme to an end (Perko & Kreigh, 1992: 264).
- Silence – is used by the researcher to give the participant the opportunity to sort out his/her thoughts, to carry over acceptance and insight, to emphasise a point, and to give the participant the opportunity to recover after an emotional moment (Perko & Kreigh, 1992: 263).

Field notes

According to Holloway (2004) field notes are written accounts that help the researcher to remember what he or she heard, experienced, saw and thought of in the course of the interview. It is used by researchers in qualitative studies to remember observations, as well as retrieving and analysing these observations. Observational notes in this study included a description of the events experienced by the researcher through watching and listening (Wilson, 1989).

3.4.1.4 Data Analysis of interviews

Bogdan and Biklen (1982, p. 145) define qualitative data analysis as "working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others". Data analysis methods used in qualitative research will therefore avoid the reduction of data to quantitative categories, in an attempt to

capture and maintain the essence of its form as embedded in the language and behaviours of the participants.

The narrative data from the semi-structured interviews was analysed qualitatively according to Tesch's (1990) method for open coding. It involved the following steps:

- The researcher read through all the transcriptions to test the sense of the whole. Ideas as they come to mind were jotted down in the margin.
- One interview was chosen randomly by the researcher. As he read through it, the following questions were asked: "What is it about? What is the underlying meaning?". The idea was not to think about the content but instead the underlying meaning and to write thoughts down in the margin as it emerges.
- After the researcher has completed the task for all interviews, he made a list of all the themes that emerged and turn them into categories. The themes were categorised as main themes, unique themes and other themes in columns.
- The researcher then took this list and went back to the data. Topics were abbreviated as codes and the codes were written next to the appropriate segment of the text. New categories and codes did emerge.
- The researcher then found the most descriptive wording of topics and turned it into categories. The total list of categories was reduced by

grouping topics that relate to each other together. Lines were drawn between the categories to show interrelationships.

- The researcher then made a final decision about the abbreviation for each category and alphabetises it.
- The data belonging to each category will be assembled in one place and a preliminary analysis will be performed.
- The researcher recoded existing data where it was necessary.

3.4.1.5 Literature Control

Through literature control the researcher was able to search for previous theoretical and empirical work in this field and then related the results with the results of the interviews (Mouton, 1996). The literature control was done to verify the trustworthiness of the study.

3.4.2 Phase One - Concept analysis

According to Walker and Avant (2005), Chinn and Kramer (2004) and Rogers and Knafl (2000), the foundation for model development is the creation of conceptual meaning through concepts. Concept analyses has been valued for its contribution to the production of knowledge (Rodgers, 1989), and it has been seen as a means by which the profession can respond to the obligation for clarifying its phenomena (Sletteboe, 1997). Kemp (1985) Walker and Avant (2005) and Rodgers and Knafl (2000) define concept analysis as a formal, linguistic procedure to determine the essential attributes of a concept as a basis for further development. Morse,

Hupcey, Mitchman and Lenz (1996), define concept analysis as a process of inquiry that explores concepts for their level of development as revealed by their internal structure, use, representativeness and relations to other concepts.

According to Morse et al (1996) concept analysis has the following principles:

- Epistemological principle. Concepts must be clearly defined and well differentiated from other concepts.
- Logical principle. Concepts must be systematically and coherently related to other concepts.
- Pragmatic principle. Concepts should be operationalised so that they are applicable to the world.
- Linguistic principle. Concepts should be appropriate to the use in context.

A number of concept analysis methods are found in the literature, which are based on, or adapted from Wilson's model of concept analysis (Rodgers & Knafl, 2000). The concept analysis method most often found in nursing literature is that of Walker and Avant (2005, p. 64) who believe that concept analysis is useful for a number of reasons, including 'to help clarify overused vague nursing concepts' and 'to produce a ...operational definition'. The approach has also been utilized by Chinn and Kramer (2004). A more radical adaptation to Wilson's model is proposed by Rodgers (1989). Rodgers has developed an approach to concept analysis within which she argues that concepts are abstractions that may be expressed in a discursive or non-discursive way. Then "... through socialization and repeated public

interaction, a concept becomes associated with a particular set of attributes that constitute the definition of a concept" (Rodgers, 1989, p. 332). The goal of concept analysis in the critical paradigm is neither prediction nor control, as in the positivist paradigm, nor understanding, as in the naturalistic paradigm. The goals are critique and transformation (Guba & Lincoln, 1994). "The goal of such critique would not be a singular definition. The goal would be to transform awareness with regard to ideological influences that shape the meanings of concepts and to apply this more complete knowledge to research and practice such that oppression is reduced" (Rodgers & Knafl, 2000, p. 377 – 378). Concept analysis is therefore a dialogic process of concept critique; a questioning and re-examining that develops consciousness and transforms awareness of conceptual awareness of concept meaning. This process is grounded in the critical hermeneutics, a branch of interpretive theory based not only on the assumption that meanings are constituted over time but also that many meanings are socially oppressive, representing the interests of the few (Thompson, 1990: 223 – 280).

The procedure for concept analysis starts with the selection of a concept – a word or phrase that communicates the idea you wish to convey (Walker & Avant, 2005; Rodgers and Knafl, 2000; Chinn & Kramer, 2004). Walker and Avant (2005, p. 26) define a concept as a "mental image of a phenomenon, an idea, or a construct in the mind about a thing or an action". Mouton and Marais (1990) describe concepts as symbolic constructions which people use to make sense of, and give meaning to, their life world. The selection of a concept is a process that involves a great deal of ambiguity and the initial concept may change as meaning evolves (Chinn and

Kramer, 2004). According to Chinn and Kramer (2004) concepts are identified by selecting words or groups of words that represent objects properties, or events within the model development. Chinn and Kramer (2004) continue to recommend that the researcher should make notes of key ideas and tentatively identify how they seem to interrelate. This distinguishing of relationships will then help the researcher to get a clearer perception of the key concepts of the model. As the researcher begins to identify concepts and distinguish their interrelationships, decisions can be made about which concepts are central to the model to be developed.

After the analysis of the interviews the question arose:" how can professional nurses be empowered to promote the identified attributes in their work environment despite the known challenges?" The concept empowerment presented as complex and multidimensional and the researcher thought it important to first conceptualise a definition of the term to offer it as a working definition for the purpose of opening a discussion as to how professional nurses can be empowered to promote the identified attributes in chapter four despite the known challenges. According to Chinn and Kramer (2004) a common word may be selected for a concept or two or more common words can be combined to form a central concept.

The process of concept analysis continued after concept identification by defining the concept(s). Defining concepts starts by firstly identifying as many uses of the concept as can be found. The researcher utilized dictionaries, thesauruses, and

available literature to consider all uses of the term including implicit as well as explicit uses of the concept (Walker and Avant, 1995).

The next step was to determine the defining attributes of the concepts. Walker and Avant (1995; 2005) recommended that the researcher should read through as many instances of the concept at once and make notes of characteristics that appear over and over. These characteristics will form the defining or critical attributes that will assist the researcher to name the occurrence of a specific phenomenon as differentiated from another similar one. The researcher utilized the literature used during the definition of the identified concept(s) in order to establish attributes and not the researcher's own opinions or other literature not mentioned in this research study.

At about the same time the list of attributes were defined, the researcher started to develop a model case (Walker and Avant,2005; Rodgers & Knafl, 2000). According to Walker and Avant (2005) a model case is a "real life" example of the use of the concept(s) that indicate all the defining attributes of the concept(s). Rodgers and Knafl (2000, p. 58) indicate that a model case will help the researcher to see what the "essential features are that allow a person to use the word correctly". In this research study the researcher formulated a model case to illustrate the defining attributes of the identified concept. According to Rodgers and Knafl (2000) the researcher works back and forth until the essential features of the concept become clearer.

The definition of the concept(s) was followed by the next phase of the model development.

3.4.3 Phase two: Model development

The following six components, namely goals, concepts, definitions, relationships, structure and assumptions were used by the researcher to develop the model (Chinn & Jacobs, 1987). Hence these aspects were described in detail. While Chinn and Kramer (2004), Walker and Avant (2005) and Rodgers (1989) have set out the processes that allow theory development, this is equally applicable given the definition of a model in chapter one (Pearson, Vaughan & Fitzgerald, 2005).

3.4.3.1 What is the goal of the model?

This question addresses why the model was formulated and reflects the contexts and situations, to which the model can be applied (Chinn & Jacobs, 1987).

3.4.3.2 What are the concepts of the model and how are they defined?

This question describes the ideas that are structured and related within the model and clarifies the meaning of the concepts within the model (Chinn & Jacobs, 1987).

3.4.3.3 What is the nature of the relationships?

This question explains how the concepts are linked together.

Concepts are not being seen in isolation but in relation to each other during the second stage of theory development. Once the major concepts and their definitions

have been identified and examined the researcher should concentrate on the development of relationship statements. According to Walker and Avant (2005, p. 164) relationship statements "identify the ways concepts relate to each other". According to Chinn and Kramer (2004, p. 98 – 100) relationship statements "provide links among and between concepts".

When a tentative identification of relationships is made, the researcher should ask: "Are there concepts that stand alone, unrelated to others? Are there concepts interrelated with other concepts in several ways and others related in only one or two ways? Are there concepts to which several other concepts relate but that, in turn, are not related to other concepts?" (Chinn & Kramer, 2004, p. 98).

When a relationship can be depicted between two or more concepts it is expressed as a statement. According to Walker and Avant (2005) a statement is an important ingredient in any attempt to develop a scientific body of knowledge and it must be formulated before explanations of predictions can be made.

Relationship statements which create meaning, can therefore link multiple concepts in a loose structure. The researcher can address the nature or character of relationships as links between concepts are identified. The researcher should ask what might be possible relationships if a relationship is unclear, because this can provide clues for further development of theory (in this case the model). According to Chinn and Kramer (2004) the ways in which the relationships develop provide clues to the theory developing purposes and the assumption on which the theory is based. Some concepts may be linked to the theory by assumptions (Chinn and

Kramer, 2004). Chinn and Kramer (2004, p. 103) state that assumptions "are those basic givens or accepted truths that are fundamental to theoretic reasoning". To uncover assumptions, the researcher should ask:" What is the author taking as an accepted truth?" This question can be asked once the purposes are determined, relational statements, structure the concepts and definitions are described.

According to Denzin and Lincoln (1994) the explanation of the emerging model to colleagues and having them ask questions, will refine results and move the researcher forward in his thinking. The more the researcher presents the theory (model), the easier it will be to write, because links will become obvious and it will help the researcher to become more articulate.

3.4.3.4 What is the structure of the model?

The structure emerges from the relationships among concepts. According to Chinn and Kramer (2004) a recognizable structure is essential to theory. Chinn and Kramer (2004) suggest possible structural forms as indicated in Figure 3.1.

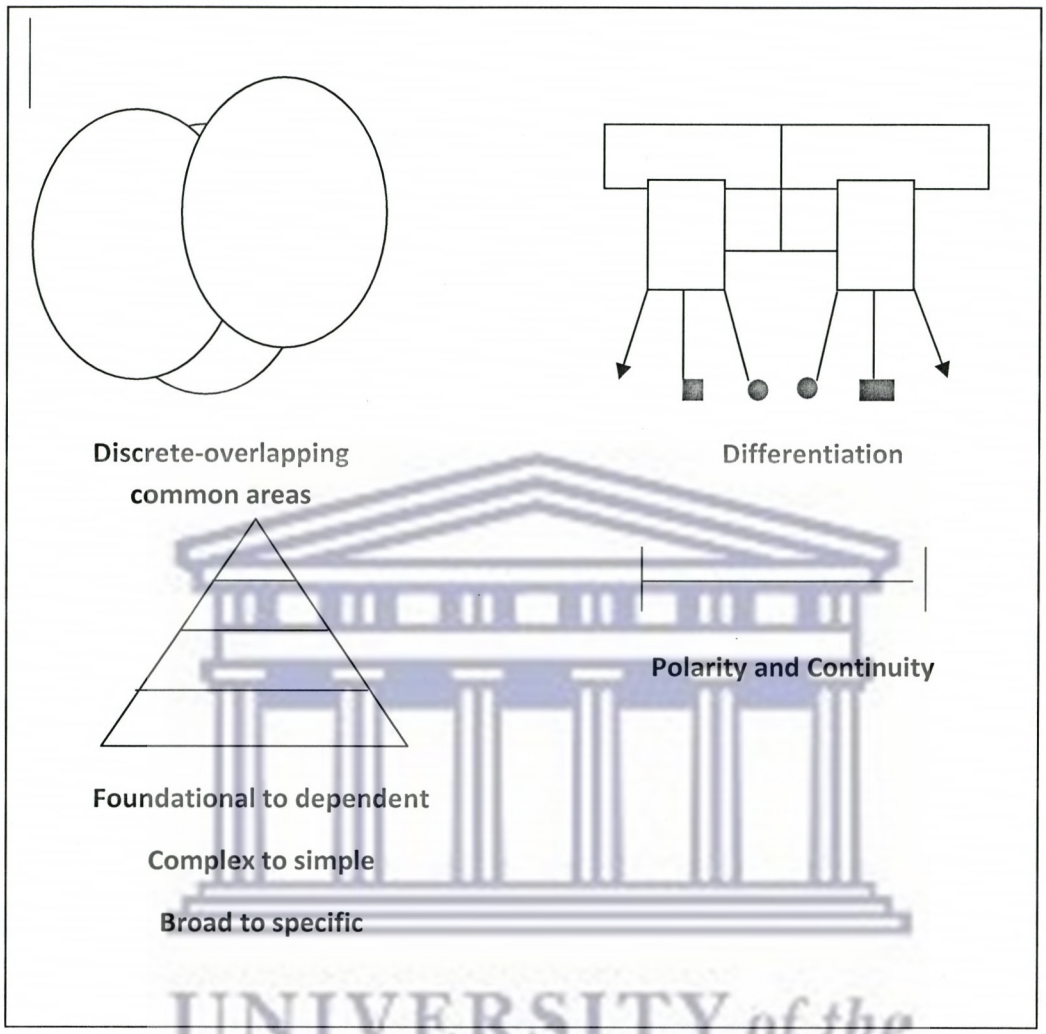


Figure 3.1 Structural forms (Chinn & Kramer, 2004)

According to Chinn and Kramer (2004) the meaning of these structures suggests:

- The triangle suggests a series of related sub concepts that vary in breadth or simplicity. It also suggests the foundational concepts on which other concepts are built;
- The overlapping circles illustrate discrete components with sharing of overlapping areas;

- The horizontal line suggests a continuum; and
- A diagram of differentiation divides major concepts into sub concepts using different shapes.

According to Chinn and Kramer (2004) other aspects of the structure can be described by asking: "How are other structures united with central or core relationships? Can all relationships be structured? Do the structures take multiple forms? Are competing or partial structures suggested? Does the theorist provide diagrams that illustrate aspects of the structure?"

3.4.3.5 On what assumptions is the model build?

This question would address the basic truths that underline theoretical reasoning (Chinn & Jacobs, 1987).

When the model has been described, it would be further critically evaluated by engaging the experts in theory generation. Critical reflection on how well the model relates to research, education and clinical practice would be employed.

According to Chinn and Kramer (2004) the questions related to critical reflection include:

- How clear is the model?

Clarity refers to how well the model can be understood and how consistently the ideas are conceptualised (Chinn & Kramer, 2004). The question of clarity addresses semantic clarity, semantic consistency, structural clarity and structural consistency.

Semantic Clarity

Semantic clarity means that the concepts of the model are used in ways that are consistent with their definitions of concept/s in the model, since these help to establish empirical meaning for concepts within the model. If concepts are not clearly defined, the empirical indicators for the idea are less clear, but if concepts are clearly defined, identification of empirical indicators is relatively easy. Clarity can be vague if terms are borrowed from other disciplines, by using general language terms that carry broad general meanings, when words are used that have no common meaning, when words are invented or fabricated by the researcher to represent some idea, when words with the same meanings are used to represent the central concepts of a model and when excessive narrative is included. However, absolute semantic clarity can never be achieved, nor is it necessarily desirable, because the limitation of language makes it impossible for theoretic meaning to be perceived uniformly by all readers, no matter how clearly the researcher represents it (Chinn & Kramer, 2004).

Semantic Consistency

Semantic consistency means that the concepts of the model are used in ways that are consistent with their definitions. When key words are not explicitly defined, their implied meanings may be inconsistent from one usage to the next.

The consistent use of basic assumptions is important in achieving consistency. The model's purpose, definitions of concepts and relationships need to be consistent with the stated assumptions of the model. The purpose of the model must be

consistent with all other components. Definitions must be examined for consistency with each other and in relation to assumptions (Chinn & Kramer, 2004).

Structural Clarity

Structural clarity refers to how understandable the connections and reasoning within the model are and is closely linked with semantic clarity. The essence of structural clarity is in the descriptive elements of structure and relationships. With structural clarity the concepts are interconnected and organised into a meaningful whole. Structural clarity is enhanced if all the major relationships are included within a single structure. It is vague and lost if there are gaps so that the relationships are not contained within a meaningful structure or when major concepts do not fit into the structure (Chinn & Kramer, 2004).

Structural Consistency

Structural consistency is associated with the use of different structural forms within a model. Whatever the structure, consistency throughout the model with respect to the structure serves as a conceptual "map" that promotes clarity. If the structure of the model is reflected in the relationships as the model develops, then a high level of consistency will be achieved (Chinn & Kramer, 2004, p. 112).

- How simple is the model?

This question seeks to address the number of structural components and relationships within the model. Simplicity implies that the number of elements within each category, particularly concepts, and their relationships, are fewer. The

desirability of simplicity or complexity varies with the stage of model development. Theories reflect various degrees of simplicity, some suggest the need for a relatively simple and broad model that can be used as a general guide for practice, while others suggest the need for a model that is relatively complex, and therefore promotes understanding of extremely complex practice situations (Chinn & Kramer, 2004, p. 113-114).

- How general is the model?

This question addresses the scope of experiences covered by the model. Specificity implies a narrow scope whereas 'generality' implies a wider scope. A model that contains broad concepts will comprise of more ideas in fewer words than one containing very narrow concepts. Whether or not 'generality' is viewed as worthwhile depends on the purpose of the model. A general model organises many ideas and is useful for generating ideas. Nursing theories that address broad concepts like individual, society, health and environment have a high degree of generality and are useful for organising ideas about universal health behaviours. Theories that address a specific human experience like empathy are less general and because of their specificity are useful for guiding practice in a clinical setting (Chinn & Kramer, 2004, p. 114).

- How accessible is the model?

This question addresses the extent to which the concepts within the model are grounded in empirically identifiable phenomena. Concepts can be made empirically accessible by generating and testing relationships, by deliberative application of a

model and by clarifying the conceptual meanings. Only particular dimensions of highly abstract concepts may be empirically accessible. If the concepts of a model do not reflect the empirical dimensions they may be ideas that cannot be explored or understood empirically. Increasing the complexity within theories often increases empiric accessibility because as subconceptual categories are clarified, empiric indicators become more specific. Empirical accessibility of concepts contained within a model is basic to testing theoretic relationships and deliberative application of the model. Empiric accessibility varies according to what the model is developed to do. A model that "provides a conceptual perceptive of clinical practice may not need much empiric accessibility, whereas if a model is to be used to guide research, empiric accessibility is important" (Chinn & Kramer, 2004, p. 114-116).

- How important is this model?

This question addresses the extent to which the model leads to valued nursing goals in research, nursing education and clinical practice. A model is important if it is forward looking, useful and valuable for creating a future. The central question is: "Does the theory create understanding that is important to nursing?" if a model consists of concepts, definitions, purposes and assumptions that are grounded in practice, then it will have practical value for enhancing model-based research. A model that has limited empiric accessibility may not have practical value for research but can stimulate ideas and spark political action (Chinn & Kramer, 2004, p. 116).

3.4.3.6 Description of guidelines for the implementation of the model in the work environment

The guidelines on how to implement the model in practice will be given in Chapter Six.

3.5 Ethical considerations

3.5.1 The quality of the research

The researcher demonstrated accountability and ability to execute the research process by adhering to the highest possible standards of research planning, implementation, evaluation and reporting of research. A research proposal was written, which was submitted to the Faculty of Community and Health Committee and Senate. The research was conducted only after permission has been obtained.

3.5.2 Researcher and Respondent relationship

All attempts were made by the researcher to make the research as transparent as possible. The purpose of the study, type of data to be collected, method of data collection and possible benefits, was explained to the respondents as well as any inconveniences that might arise. Respondents were given an option whether to participate or not to participate in the study. Respondents were given the right to withdraw at any time from the study with no victimization of participants who refuse to participate in the research (Burns & Grove, 2001).

Respondents were made aware that all the collected data was to be kept under lock and key, and that only the researcher and his supervisor will have access to it. The physical address or telephone number of the researcher was given to all respondents in case they want to validate interpretations that were made during the data collection process. The researcher informed the respondents of the intent to publish the findings of the research in an article form.

3.5.3 Maintaining of confidentiality and anonymity

The researcher protected the identity, privacy and dignity of the participants by ensuring that no connection between the participants and the research data can be made. The researcher assigned pseudonyms to respondents. All records were discretely identified to secure the anonymity of the participants although known to the researcher only. All data collection methods were disposed of once the use of their main purpose has been achieved. Privacy was secured by doing the interviews in a quiet and private environment. Procedures were explained to all participants beforehand (Burns & Grove, 2001; Gerrish & Lacey, 2006).

3.5.4 Informed consent

Consent is the prospective subject's agreement to participate in a study, which is reached after the assimilation of essential information (Burns & Grove, 2001). Participants were provided with a written explanation of the purpose of the study, the nature and the procedure of the study and their expected role as participants. The informed consent for this research study was in written form. See appendix Three and Four.

3.5.5 Vicarious Trauma

Vicarious trauma is the cumulative transformative effect experienced by those working directly or indirectly with survivors of trauma. It is a process through which the inner experience of those emphatically engaged with a client's trauma material, is negatively altered (Saakvitne & Pearlman, 1995).

The researcher maintained a healthy balance between the research study, work and rest to offset the physical and emotional fatigue, identified personal coping strategies for reducing stress (time alone, exercise), had regular supervision with his supervisor for debriefing and support, and maintained personal boundaries; to reduce actual and potential vicarious trauma for him.

The researcher conducted the research study in such a way that the participants were protected from any actual or potential vicarious trauma, whether social, emotional, physical or spiritual. The researcher did intend to refer participants for the appropriate support in the event of any discomfort.

3.6 Dissemination of results

The research findings will be disseminated in a wide variety of ways after the completion of the research project, including feedback to the participants, policymakers, and through articles in accredited journals and papers at academic conferences and seminars. The researcher aim to present at three levels – international, national and locally in communities where the research project is

applicable. The full-text thesis will be part of the University of the Western Cape's Electronic Thesis and Dissertation library, which will provide universal, unrestricted free open access. The University of the Western Cape's electronic theses and dissertations library holds full-text theses submitted for degree purposes since 2004, with selected titles prior to 2004. Access to the complete theses (print) collection is available through the online catalogue.

3.7 Trustworthiness

Over the last twenty years, the role of validity and reliability within a qualitative paradigm has been questioned (Kvale, 1995; Holloway, 1997; Sandelowski, 1993). Qualitative research does not seek to be consistent or gain the same results, but rather seeks to elicit the responses of participants at a specific time and place in a specific context. Due to the diversity of the social world it is erroneous to assume the existence of one unequivocal reality to which all findings must respond. Moreover, qualitative research involves subjective interpretations which are often delivered by both participant and the researcher. Sandelowski (1993, p. 2) argued that issues of validity in qualitative approaches should be linked not to 'truth' or 'value' as they are for the positivist, but rather to 'trustworthiness', which 'becomes a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable'. Stenbacka (2001, p. 552) argues that reliability has no relevance to qualitative research as it concerns measurements and if it is used then the "consequences is rather that the study is no good". According

to Tobin and Begley (2004) the introduction of Lincoln and Guba's ideas on trustworthiness provided opportunity for qualitative enquirers to explore new ways of expressing validity and reliability outside the linguistic confines of a quantitative paradigm. Lincoln and Guba (1985, p. 329) recognized that their criterion may be imperfect and that it "stands in marked contrast to that of conventional inquiry [positivist paradigm] which claims to be utterly unassailable". This criterion has been endorsed by other qualitative researchers (Koch, 1994; Sandelowski, 1993), and in this context Lincoln and Guba's model (1985) offered a general framework for assessing trustworthiness of qualitative information, which consists of credibility, transferability, dependability and confirmability, and will be the framework to be used by the researcher in this research study.

Credibility is the evaluation of whether or not the research findings represent a "credible" interpretation of the data from the research participants' original data (Lincoln & Guba, 1985, p. 296). Credibility is shown by prolonged engagement with the participants, persistent observation of those participants, triangulation techniques, peer debriefing and member checks. Transferability is the degree to which the research findings of the research study can apply or transfer beyond the bounds of the research study. Dependability is an assessment of the quality of the integrated process of data collection, data analysis, and theory generation. Confirmability is the measure of how well the study findings are supported by the collection data. In this study trustworthiness will be enhanced through the strategies detailed in sections 3.7.1, 3.7.2, and 3.7.3.

3.7.1 Credibility

Prolonged engagement – the researcher's involvement with the site or phenomena to get acquainted with the culture and values of the target population and to build a trusting relationship with the participants (Lincoln & Guba, 1985).

- The researcher has worked for the last 18 years in psychiatric clinical settings in both South Africa and the United Kingdom.
- The researcher will demonstrate to participants that their confidence will not be betrayed and that pledges of confidentiality will be honoured.
- The researcher will facilitate the interviews.
- The researcher will build rapport with the participants and ensure that the atmosphere during the interviews is relaxed.
- An independent coder will be used during the consensus discussions of the narrative data analysis.
- Specific communication skills will be implemented by the researcher to encourage participants to speak freely and to eliminate misconceptions.

Triangulation – is the use of multiple and different techniques to ensure an accurate representation of the reality (Lincoln & Guba, 1985).

In this study the researcher will employ:

- data collection triangulation (data will be collected through different methods that will include semi – structured interviews and the exposure of the draft and finalised model for validation to psychiatric nurse specialists).

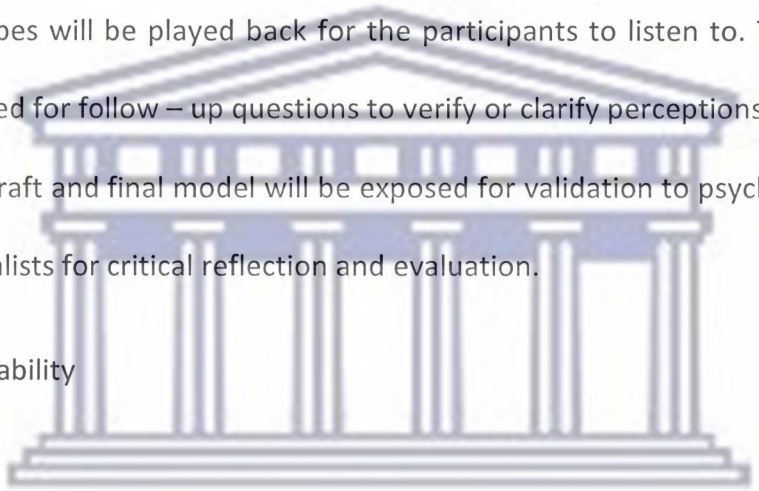
- triangulation of coders (an external coder will do all coding with the researcher).

Member checks – is a vital part of the research study to establish credibility. To establish credibility analytic categories, interpretations and conclusions are checked with the participants from whom data were collected (Lincoln & Guba, 1985).

- All tapes will be played back for the participants to listen to. Time will be allowed for follow – up questions to verify or clarify perceptions.
- The draft and final model will be exposed for validation to psychiatric nurse specialists for critical reflection and evaluation.

3.7.2 Dependability

Audit



- Continuous external evaluation of each step in the research study by the researcher's supervisor.
- Recording of the process for the reader of this report.

Description of each step

- Clear explanation of each step to make the research more process more explicit.

Triangulation

- As described in section 3.7.1.

Coding

- There will be an independent analysis of all narrative data by the researcher and an external coder. The researcher and the external coder will have consensus discussions afterwards.

3.7.3 Confirmability

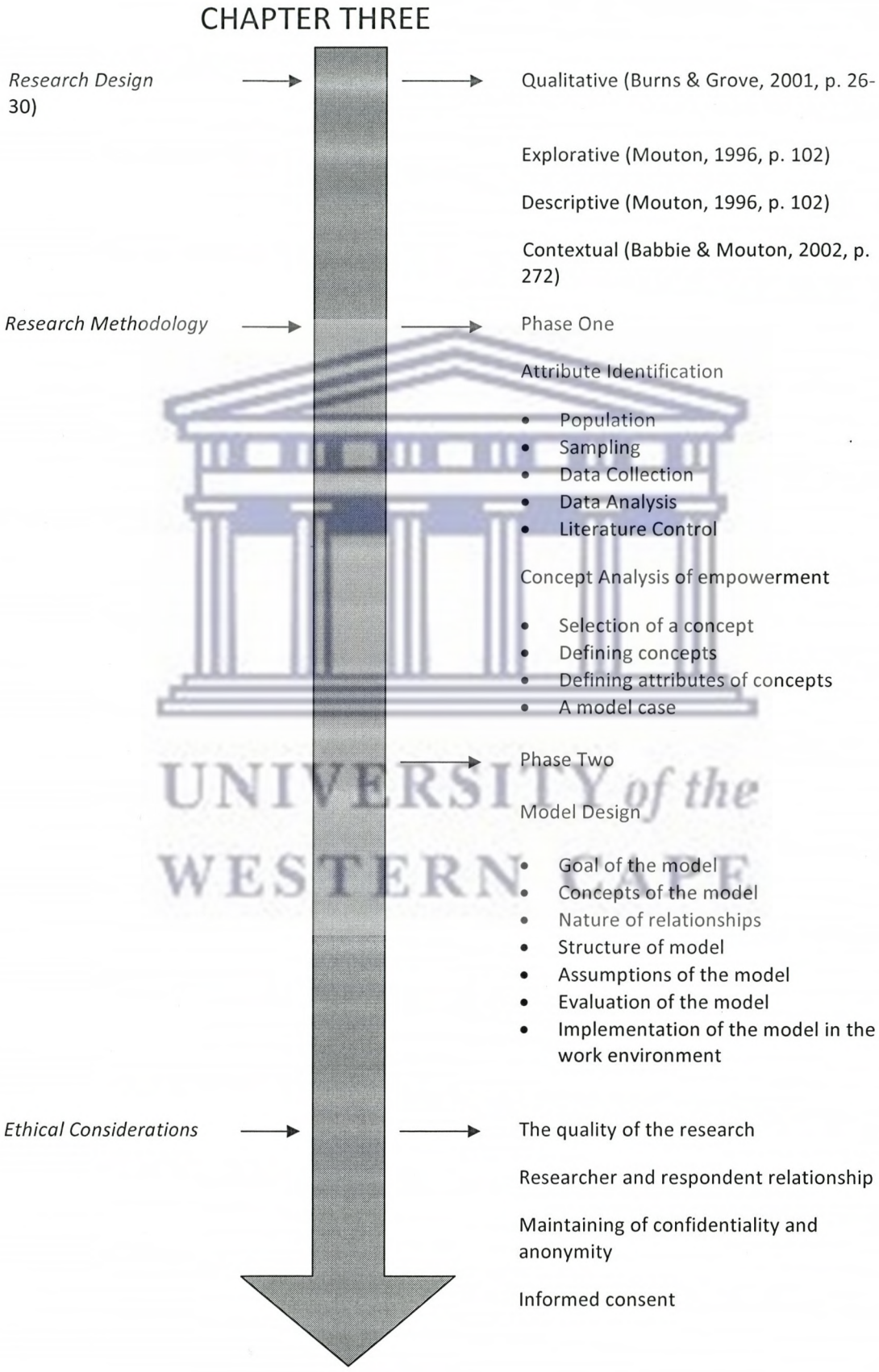
- The researcher will have consensus discussions with his study supervisor, external coder, and validators that will evaluate and critically reflect on the model.

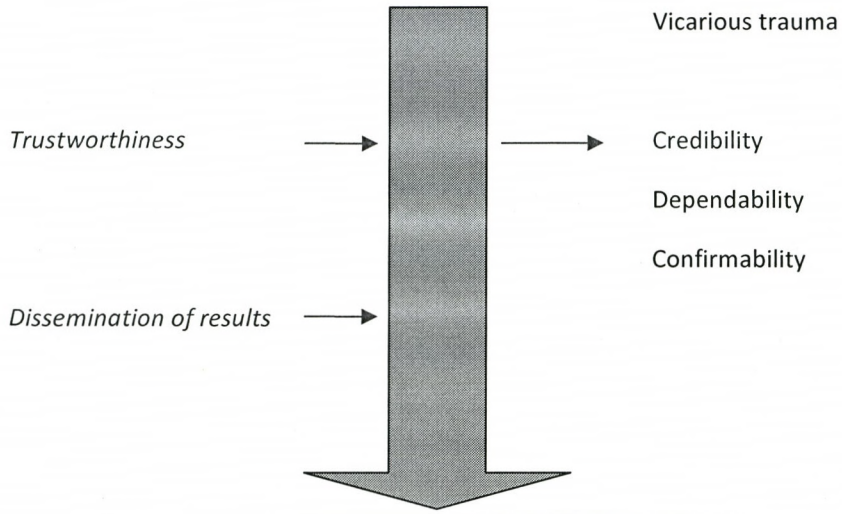
3.8 Summary

This chapter discussed the research design, research methodology, including ethical considerations, dissemination of results and trustworthiness. See page 81 for a graphical illustration of chapter three.

Chapter four will discuss the data analysis and findings from the interviews with registered nurses with reference to the literature reviewed.

Figure 3.3 Summary: The research design and methods





CHAPTER FOUR

CHAPTER FOUR

DATA ANALYSIS

*"...being in the community make me now more aware of the shortcomings of knowledge and sensitivities about psychiatric patients. You see poverty. People live one day to the other. They become depressed. There is a field out there to work with depressed patients..."(***P3***)*

4.1 Introduction

The previous chapter broadly discussed the qualitative research method used in this research study. This chapter will present the results obtained from the analysis of the transcripts of the participants and the data will be presented concurrently with literature reviewed. Field and Morse (1985) states that literature provides a method that assists in demonstrating the usefulness and implications of the findings. This presentation will also include data collection, process of analysing, and the results.

4.2 Data Collection

Permission to conduct the research study in the Western Cape Province was obtained from the Western Cape Department of Health (Appendix 2). The researcher had to obtain further permission from the individual hospitals in the Western Cape Province, which caused further delays. At one institution the Deputy Director did not understand the permission that was granted by the Western Cape Department of Health, and referred all documents back to the research committee.

The researcher did the interviews himself. The sample consisted of professional nurses who were working in the Cape Town Metropolitan area and the West Coast. Purposive sampling (Burns & Grove, 2001) was chosen, as the technique permitted the deliberate inclusion of professional nurses who met the criteria set in 3.4.1.2. The researcher approached the Head of the facility of the different hospitals who referred him to the heads of nursing, who in turn referred him to different assistant directors who suggested professional nurses that could be included in the research. The convenient sample consisted of five participants who worked at a psychiatric hospital, six participants who worked at a general hospital, one participant who was the head of a primary health care service in a rural setting and are now working as an occupational health nurse, one participant who worked in a home based care service, and one participant who worked for a nursing agency in the Western Cape Province that is used by the provincial health department.

Time was taken to explain the purpose of the interviews to each participant prior to conducting the interviews. Formal permission to conduct the interviews was obtained from each participant prior to the interviews (Appendix 3). All 14 interviews were conducted in February 2008. One participant withdrew after the interview was done and the data had been excluded from this report.

Interviews were tape recorded and field notes were written during and after the interviews. Most of the interviews were conducted in English as this was the most accessible language between the researcher and the participants. Two participants found it difficult to express themselves in English and were allowed to speak

Afrikaans. The time spent with the participants ranged from 50 to 60 minutes. The effective interview time was 40 minutes. Due to staff shortages in the different units, the researcher was only allowed to spend more or less than an hour with each participant. Each participant was interviewed once. The ethical standards as set out in section 3.6, were adhered to before, during and after the interviews.

4.3 Process of analysing

Each interview was transcribed from the tape recordings, verbatim. All transcripts were read through and compared with the tapes by the researcher. Open coding was used to identify and analyse the content of the transcripts (Tesch, 1990). The transcripts were read through by the researcher to obtain an overall perception. Notes were made of ideas as they emerged. The first two objectives for this research study - what are the attributes needed by professional nurses to promote the therapeutic healthcare experiences of people with depression and how can these attributes be implemented in the work environment – was used to guide the thoughts of the researcher during the analysis of the content of the transcripts. Similar themes that emerged were clustered together. These themes were then coded. The researcher read through the collected data again and wrote the codes next to the appropriate segments. The researcher made use of different coloured pens to differentiate the emerging topics, which were then categorized into main themes, unique themes and other themes. Saturation emerged after the analysis of the ninth interview; however the researcher did make use of the other interviews.

Figure 4.1 represents the main theme, unique themes and other themes that emerged from the data relating to the attributes that professional nurses require to promote the recovery of people that have been diagnosed with depression.

In order to enhance the trustworthiness of the analysis, the researcher used the four characteristics of credibility, transferability, dependability and confirmability as described by Lincoln and Guba (1985). To ensure credibility, data triangulation from the interviews was done by using narratives to collect the data. A literature review was done by the researcher to clarify the different themes and a second person who was familiar with qualitative research, was asked to scan and interpret the data.

Confirmability was achieved by making use of consensus discussions with the study supervisor and the external coder to confirm that the interpretations were based on actual data. Transcripts could not be given to participants to ensure correct transcription and understanding due to time constraints. A literature control was used to compare the findings with established themes and consensus discussions between the researcher and his supervisor were held to ensure dependability.

MAIN THEME	UNIQUE THEMES	OTHER THEMES
4.3.1 Attributes that registered nurses require to promote the recovery of people who have been diagnosed with depression	4.3.1.1 Support	Build a relationship that create a feeling of hope and inclusion Psychoeducation Family support Awareness of the recovery process
	4.3.1.2 Positive approach/expectations	Assessment and observation skills Knowledge of depression Relapse prevention
	4.3.1.3 Interpersonal skills	Communication skills Listening Empathy
	4.3.1.4 Structure	Application of different therapeutic techniques Person centered approach Holistic nursing Multi-disciplinary teamwork

Table 4.1 Themes that emerged from the data for question one

4.3.1 Research Question One

Research question one enquired about the attributes needed to promote the recovery of people who have been diagnosed with depression. The open ended interview question was designed to elicit descriptions from the participants about the knowledge, skills, attitudes, behaviour and values required to promote the recovery of people who have been diagnosed with depression. Several categories

emerged from the interviews that related to the various facets of the participants' experiences in working with people who have been diagnosed with depression. In their discussion of the attributes, most participants' descriptions centred on an understanding of support, positive approaches and expectations, interpersonal skills, and structure.

4.3.1.1 Support

Support included the efforts made by professional nurses to pay attention to the patient and their families to make them feel comfortable, secure and reduce their anxieties. In their discussion of support, most participants' descriptions centred on an understanding of building relationships that creates a feeling of hope and inclusion, psychoeducation, family support, cultural sensitivity, advocate for the patients, and an awareness of the recovery process.

- Build relationship that creates a feeling of hope and inclusion

Participants emphasised the importance of building"*...a relationship...*" with depressed patients"*...to talk about their thoughts...*" (P1) (P3) and create feelings of "*...hope*" (P8). Another participant stated "*...nurses need to be aware of power relationships and acknowledge that patients are the experts...*"(P6).

In the past the understanding of the relationships between health professionals and patients was based on a paternalistic model. Patients were cast in a passive role, the grateful and uncomplaining recipients of health care, in a system characterised by the almost unrestrained power of the professionals. Professionals were controlling access to the label 'sick' and the role of the patient was to try to

get well and comply with the medical regime, prescribed and accepted without question or debate (Morris & O'Neill, 2006).

Presently patients are looking for different kinds of relationships with health professionals. Patients want more involvement in decision making, more information and more opportunity to express preferences and influence decisions about their care (Coulter, Parsons, & Askham, 2008). According to the Patient's Rights Charter, which is guaranteed by the *Constitution of the Republic of South Africa Act* (1996), patients have the right to participate in decision-making on matters affecting their health. One of the objectives of the White Paper on the Transformation of the Health System of South Africa (1997) was to foster community participation across the health sector by involving communities in various aspects of the planning and provision of health services; establishing mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers; and encourage communities to take greater responsibility for their own health promotion and care.

Participation of the patient is therefore important and indicates a partnership in the service rendering relationship. Partnership implies that patients are equal in the relationship and that service providers are not in a position of authority. The patient is in fact the expert of his or her own situation.

The Batho Pele "People first" principal as highlighted in The White Paper on the Transforming Public Service Delivery (1997) also indicates that patients should be consulted. This consultation should cover the entire range of existing and potential

patients and include views of those previously denied accesses to a department's service.

According to Rapp and Goscha (2006, p. 78-79) hope-inducing practices includes demonstrating care and kindness; communicating belief in the patient and "I am on your side"; asking a patient's opinion/choice about all aspects of the helping process; supporting a patient's decision and helping them to achieve it rather than putting down or minimizing a patient's choices and desires; pointing out achievements/successes; making sure that the goals are actually the patient's goals; promoting integration by using community resources.

- Psychoeducation

Participants acknowledged the importance of improving patients' knowledge and understanding of their mental illness. One participant stated *"...you will try to explain to him what he can do to lessen the effects of the illness so that he can have more knowledge about the illness and can deal better with it. And by showing examples of case studies to show the success rate of the medication that he might be on and let him read about it and get more information about the illness. The more he knows about his illness the lesser the anxiety. So education and information is important"* (P5).

Other participants stated *"...we got small groups in which we talk about depression and how they understand it..."* (P2); *"...information, information. As much as possible information to the patient..."* (P7); *"...teach them about the diagnosis,*

medication, stigmatization, where they must go if they need help outside, support systems in the community..." (P9).

Psychoeducative interventions contain a general set of sessions that cover the same topics with every individual. Psychoeducation is based on a bio psychosocial model and is mainly informative about the condition, pharmacological treatment, and the coping skills that will help with successful community living (Colom, Vieta, Martinez, Jorquera & Gasto, 1998). The specific content can be planned to meet the specific needs of the particular patient (Stuart & Laraia, 1998). The goal is that practitioner and the patient work together to support recovery. Psychoeducation has been associated with a variety of significant gains for the patient, the family and the organization. It helps the patient to build a support network for recovery, provides hope, reduces relapse and hospitalization, improves symptom management, reduces medication dosages, improves social skills and community participation, increases employment, earnings and career options, strengthens family ties, and reduces family conflicts. It provides hope for the family, provides skills to support the recovery of the patient, improves understanding of the illness, improves coping skills, reduces medical illness and enhances medical care utilization, reduces feelings of stigma and isolation, reduces stress, and improves family relationships. For practitioners it improves patient outcomes, community functioning, and satisfaction for patients enhances understanding of severe mental illness and how to treat it, helps to achieve higher rates of recovery for patients, and reduces the need for crisis intervention over time (Family Psychoeducation, 2003).

- Family support

Participants acknowledged that *"...a depressed patient can actually disrupt a whole family functioning and if there is no concern, sympathy or knowledge in that family about the condition there will be no support for the patient which mean the life in the family will be more disrupted and at the end of the day there will be more broken homes"* (P3). Being there for families, listening to them, open communication, maintaining contact, providing information about the disease and how to cope with it, exposure to support groups and involving them in the care process, was identified by participants as important (P1, P2, P3, P4, P6, P7, P9). Listening to the family provided most of the participants with information about the family support structures, their burdens, and the opportunity to develop a trusting relationship (P6). Empowerment of the family was seen as essential to promote "... *acceptance and prevent stigmatization"*(P3).

According to Shephard, Boardman and Slade (2008), mental health problems can have a severe effect not only on the life of the patient who is experiencing it, but also on those close to them. When someone you love is depressed "...you feel lost, afraid, confused, you long for the person who was, you don't recognize who he or she has become, you feel shut out, you feel angry and frustrated, you feel drained, you are desperate for a way to connect, you feel guilty and alone, you will do anything to help, you might wish to push away the whole situation and deny reality, and you might withdraw or feel hopeless and depressed yourself" (Golant & Golant, 1998, p. 3). Family and friends provide most of the patient's support and can have an important role in promoting recovery and facilitating social inclusion. If

they are to do this effectively, they will need the help and support from professionals to understand the situation and the challenges ahead, to help with their own recovery journey. They will also have to re-evaluate their lives, come to terms with what has happened, make adjustments, and discover new resources of value and meaning, both in their own right and in their relationship with their loved one. By supporting families in "...recognising their own reactions and coping mechanisms, nurses can help them to develop a fuller understanding of themselves and through this to evolve a foresight which will help them to prevent, when possible, future recurrences..." (Pearson, Vaughan & FitzGerald, 2005, p. 182). The goal is to help families in a creative, productive and constructive way to develop their own personalities. During this process, the nurse fulfills six roles, which includes counsellor (help the family to realise and resolve their problems through personal interaction), resource (providing information to the family), teacher (Peplau, 1964) distinguishing between instructional work, where the nurse gives information to the family and experiential learning, where the family is encouraged to learn through experience), providing technical expertise (the nurse's ability to use certain interventions to aid recovery), surrogate family member (the family learns to recognise when to be dependent and independent and eventually the balance between the two), and is a leader (the nurse guides the family towards recovery) (Pearson, Vaughan & FitzGerald, 2005).

- Awareness of the recovery process

Participants' knowledge of recovery varied. Statements from participants' that were aligned with a recovery approach, included *"...for the person to live in the community, although still suffering from mental illness..."* (P6) *and "...it is basically a move away from just wanting to get a patient better and discharged. We used to do things for patients, then we were expected to do things with patients (service user involvement), and now with the recovery approach things need to be done by the patient with support from the staff. It is the helping of the patient to be able to function in the community although he/she is still suffering from the mental illness..."*(P8). Participants acknowledged that *"...it starts on the day of admission..."*(P5) *and that "...it is like steps. Nurses are quick fix people. We want to see the problem and fix it, clean the wound, want to dress it nicely and within two weeks see that it is healed. Depression is nothing like that. It is not a quick fix"*(P3).

However, the recovery approach seemed to sit uneasily with professional nurses that worked in a general hospital setting, where the priority is to provide a diagnosis and treatment service. This is evidenced by the following quotes:

"...I do not get the support from my manager and the psychiatric teams, so if a psychiatric patient gets difficult, then I tie him to the bed and give him his medication..."(P10)

"...In trauma the psychiatric patients come in after they harmed themselves. Last year the patient amputated his penis and the one woman sliced off her breast. We do not always know how to interact with these patients..." (P11)

*"...I am a nurse, but if I wanted to work with psychiatric patients, then I would have worked at Lentegeur (Psychiatric Hospital). I do not like to work with psychiatric patients"(*P10*)*

The recovery approach in psychiatry "emphasises the expectation of recovery from mental ill health and promotes both enhanced self-management for mental health service users and the development of services which facilitate the individual's personal journey towards recovery". It does not "deny the neurobiological aspects of the major mental illnesses but promotes balance in terms of seeking a greater recognition that the experience of mental illness is inextricably intertwined with the individual's sense of personhood and experience in the world" (Mental Health Commission Ireland, 2005, p. 4). Anthony (1993) defines recovery as a personal and unique process that causes changes in one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. The common themes underpinning definitions of recovery could therefore be summarised as maintaining hope (believing in you; having a sense of personal agency; being optimistic about the future), re-establishment of a positive identity (finding a new identity that incorporates illness, but retains a core, positive sense of self), building a meaningful life (making sense of illness; finding a meaning in life, despite illness; engaging in life), and taking responsibility and control (feeling in control of illness and in control of life) (Andresen, Oades & Caputi, 2003). Recovery does not mean "cure", and does not mean "going back or regaining a

previous position before the experience of mental health problems" (RETHINK, 2005).

4.3.1.2 Positive approach

It is important that a programme of sensitive but persistent intervention is in place to engage the individual patient, minimize regression and discover and develop potential. In this respect it is important that expectations are high but realistic and based on careful assessment. This will include the strengths and individual needs of the patient, their level of functioning and an assessment of the support they will need. The professional nurse will seek to establish and reinforce self-confidence and self esteem by building on natural strengths, interest and abilities.

It is vital that assessments are made from as wide a perspective as possible and that assumptions are made on the basis of painstaking assessment and not superficial enquiry. These should include a view of the barriers in accessing opportunity.

- Assessment and observational skills

Most participants identified assessment as an important part of the process of care. One participant described it "as the *collection of information about a patient that takes into account the interrelated psychological, biological, social and spiritual needs*". However, a lack of time to spend with service users, lack of human resources and demands of the profession makes this task difficult (P10). Most of the participants were aware of some standardized assessment tools that has been developed to aid the judgement and decision making of nurses, but thought that it

was the role and responsibility of the psychologist to use it (P6). Participants identified experience, instinct, and knowing the patient as equal if not superior to formal assessment tools (P6)(P9)(P4). Participants differentiated between two types of assessment namely the "*assessments of nurses*", and "*assessments with other members of the multidisciplinary team*" (P1)(P6)(P8)(P9). Most of the participants identified the importance of interpersonal skills and engagement with service users as crucial to the assessment process. Participants emphasised the importance of assessments being person centred and holistic. For assessments to be holistic, it should incorporate all aspects of a person's needs - physiological, psychological, social and spiritual. One participant stated that assessment must "*be broadened to the family, how they respond to the patient having depression, and what support they need...*"(P3). Two participants emphasised that nurse assessments must be cultural and gender sensitive, promote equality and diversity. One of the participants was able to elaborate on risk assessments and how important it is in the management of a patient with depression (P7).

Assessment is an integral part of the nursing process (Stuart & Laraia, 1998). Baker (1997) emphasised that nurses cannot offer valid and reliable forms of nursing care without effective assessment. According to Savage (1991) the historic function of nursing assessments was data collection to aid a medical diagnosis. More recently nursing has moved away from the collection of quantifiable data in this fashion, and can be seen as an interactive activity which includes gathering data, interpreting the significance of the data and deciding on whether there is a need for further action from a holistic perspective (Bishop & Ford-Bruins, 2003). Several

nursing theories and models have been developed to emphasise this change. The Tidal Model attempted to give the patient a central role in the assessment and planning of care. The role of the nurse is to collaborate with the patient to explore the identified needs (Baker, 2001).

According to Dossey (1997) the nurse assesses the patient through interaction, observation and measurement. The nurse's interaction with the patient reveals the individual's perceptions, feelings and thoughts. Nursing observations relies on information perceived by the five senses and intuition. Measurement is quantifiable information obtained from standardized assessment tools. For the purposes of depression this will include the Becks Depression Inventory (Beck, Steer, Ball & Ranieri, 1996), Hamilton Depression Rating Scale (Hamilton, 1960) and the Zung Self – Rating Scale (Zung, 1965). During assessment of the patient's holistic patterns, the nurse looks for the overall pattern of interrelationships identify the stages of change and readiness to learn, collects data from previous records and other members of the multidisciplinary team, incorporates new information into the holistic assessment and documents all pertinent data. Important is for the nurse to reflect on the patient's recognised patterns from the assessment and for the nurse to acknowledge his or her personal patterns and what influence it can have on the patient (Dossey, 1997).

Bishop and Ford-Bruins (2003, p. 203-212) identified the "ideal of wanting to spend more time with the client and engage in a more holistic assessment, and the reality of not having enough time" as reasons why nurses cannot do holistic assessments.

Dossey (1997) identifies rigidity in the nurse's beliefs, lack of awareness of personal beliefs and patterns, communication barriers between the patient and the nurse relating to culture, age, gender, or physical limitations as impediments to holistic assessments.

- Knowledge of depression

Nearly all participants identified the importance of having knowledge about depression as evidenced by the following statements:

"Knowledge of what depression is all about..." (P2)(P4)(P7)(P8)(P9)

"...knowledge about the condition will allow you to talk to people about the condition..." (P3)

"...knowledge of depression – how to diagnose patients and how to manage symptoms..." (P6)

"...knowledge about depression...to choose the most suitable strategies and techniques to facilitate growth..." (P8)

According to the Collins English Dictionary (1991, p. 860) knowledge is "...the facts, feelings or experiences known by a person or group of people; the state of knowing; awareness, consciousness, or familiarity gained by experience or learning". Mantzoukas and Jasper (2008) states that knowledge is related to enlightenment, truth, emancipation, power, authority, and professionalism. According to Mavundla (2000) and Lethoba (2005) knowledge can improve self – confidence and can change negative self – perceptions when working with mentally

ill people. The Sainsbury Centre for Mental Health (2001) states that knowledge is the basis of effective practice. According to Mantzoukas and Jasper (2008) nurses use five discrete types of knowledge when interacting with patients, namely personal practice knowledge, theoretical knowledge, procedural knowledge, ward cultural knowledge and reflexive knowledge. This knowledge for nursing can be created through reflective practice, and the study of dialogue and narratives.

- Relapse prevention

Participants agreed that relapsing from depression is serious as the more time patients spend being depressed , their ability to live a productive life decreases, relationships are damaged and they sometimes just do not feel well, even if they are not actively depressed (P3)(P7)(P6)(P9). One participant stated "...*depression is such a sensitive topic and there will be relapses for the first few times until the patient accepts the fact that I have a form of condition that does require some form of treatment. You need to reconfirm and reconfirm all the time this is what you need to do and this is what you need to do and only then will the person develop acceptance"*(P3).

The participant continued *"...yes the patient is now stable and people expect people to just be able to function in the community. People assume that depression is like a cancer or a wound – it is diagnosed, you get your treatment and then you are cured. And people then expect you to get over it and move on and slip back into life. The circumstances outside did not change radically. So aftercare for me is about interpersonal skill development..."*(P3).

Another participant stated *"...you must talk to them about relapse and tell them how important it is to take their medication. They must know where they must be followed up. Not to go when all the tablets are finished"* (P1).

One participant stated"...you must emphasise the importance of medication..." to prevent future relapses (P9).

According to Mwaba and Molamu (1998) a relapse occurs when a patient falls back into a former worse condition. Solombela and Uys (1994) refer to relapse as the discontinuing treatment by the patient without consulting the multidisciplinary team or when the patient experiences increased signs and symptoms of mental illness. According to Fava, Ruini and Belaise (2007, p. 307) "relapse is a return of symptoms satisfying the full syndromal criteria during the period of remission...".

Relapse prevention plans identify early relapse warning signs of patients. The plan should identify what the patients can do for themselves and what the service will do to support the patient. Ideally, each plan should be developed with the involvement of professionals, service users and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the patient's needs. The Wellness Recovery Action Program *(WRAP)* was developed by Mary Ellen Copeland, author of numerous self-help psychology books. *WRAP* is a structured system for monitoring uncomfortable and distressing symptoms and, through planned responses, reducing, modifying or eliminating those symptoms (Devon Partnership for Mental Health Recovery, 2006). The programme helps patients to:

- List their daily maintenance activities – those activities that must be done daily to maintain their wellness. Things like getting a half hour of exercise, drinking eight glasses of water, doing relaxation exercises, take medication and spending time doing things that you like to do.

- List of personal triggers – those events that might cause an increase in symptoms and developing a plan to get through those difficult times.

- List of early warning signs – signs that warn of a possible worsening of symptoms and develop a plan which will help the patient to avoid further difficulties.

- List of symptoms that indicate that the situation is worsening, also known as when things are "breaking down".

- Crisis plan. In this plan patients' write about those symptoms that indicate that they would want others to take over responsibility for care, like being deeply depressed, very agitated, who they want to take responsibility for their care and make decisions for them, and acceptable and unacceptable actions to take on their behalf (Copeland, 2001: 123-147).

Participants emphasised the importance of medication management to prevent future relapses. Participants working in a psychiatric care setting identified the development of skills in motivational interviewing, compliance therapy and management of side effects as essential. One participant stated *"...you must talk to*

them about relapse and tell them how important it is to take their medication. They must know where they must be followed – up. Not to go when all the tablets are finished..." (P1). Other Participants stated that most patients relapse because after six months, they feel better and stop their medication, or they go to a clinic and then there is no anti-depressant medication in stock. Medication will then be changed, and due to them experiencing side effects, patients will become non-compliant and lose trust in the system (P4).

Medication is a central part of treatment for many people with mental health problems and has an important role to play in promoting recovery and/or enhancing the quality of life for people with mental health problems (National Institute for Clinical Excellence, 2003). Medication management is a process of promoting and involving patients in treatment decisions, exchanging information and monitoring, evaluating and providing feedback about treatment (Gray, 2004). Good interpersonal and process skills are the foundation of medication management.

Interpersonal skills include the use of open ended questions, reflective listening and summarising, and eliciting and responding to feedback. Process skills include working collaboratively, agreeing on a clear agenda when meeting with patients about their medication, and emphasising personal choice and responsibility. Exchanging information about medication is another key element of medication management. It involves eliciting from the patients what they already know about the medication, finding out what they want to know about the medication,

providing them with the information that they want and discussing with them how the information you have provided will affect them (National Prescribing Centre, National Institute for Mental Health in England & Department of Health, 2005).

A number of techniques have been shown to be useful in helping service users explore and discuss their medication. These include problem solving (often patients have practical problems with medication), looking back (facilitating a discussion about past experiences of medication, examining what has helped, what has not helped and what can be learnt from previous experiences and incorporated into a new plan), exploring ambivalence (most people have some ambivalence about taking medication. It is helpful to explore the good and not so good aspects of taking or not taking medication), talking about beliefs and concerns, looking forward (for many patients taking medication has very negative connotations. It is helpful to reframe medication as a positive strategy that enables patients to achieve goals and promotes recovery) (National Prescribing Centre, National Institute for Mental Health in England & Department of Health, 2005).

4.3.1.3 Interpersonal skills

Interpersonal skills are all about working with other people and include the ability to support and encourage others, being able to give and receive constructive criticism, being able to negotiate, listening to and valuing others' opinions, and being able to convey your point clearly (University of Reading, 2008).

The characteristics of interpersonal skills as identified by the participants included listening to patients, showing empathy, and being able to communicate with them.

- Communication

Most participants identified communication as a fundamental element of nursing care to the person diagnosed with depression and has regarded it as integral to the provision of quality patient care. According to the participants, communication help them to *"build a relationship..."*with the patient (P1)(P3), *"...identify the stressors and how to address it..."* (P6)(P5), provide *"...one to one support..."* (P5)(P8)(P9), provide the patient *"...with information..."* (P7), *"...motivate..."* the patient (P4), *"...to help the patient to accept the condition"* (P1).

Important was that registered nurses should communicate their *"...thoughts in a way that creates a sense of fairness, respect and reasonableness"* (P8).

Not enough time and shortage of staff were identified as some of the barriers to communicate with patients, as identified by the following participant statement:

"In die praktyk waarin ons nou werk, daar is nie tyd nie, nie baie verpleegpersoneel nie...Jy doen wat jy moet doen. Daar is nie tyd om die ekstra te lewer nie, om by die pasient te gaan sit en met hom of haar te gesels nie" (P11). (*In the current working practice, there is not enough time, and not enough nursing staff. You do what you must do. There is no time to do the extra – to go and sit at the patient's bed and communicate with him or her*)

Successful care of depressed patients relies heavily on communication skills. According to Rondahl, Innala and Carlsson (2006) an important instrument in nursing is dialogue and nursing work may be described as a meeting between two

people, one professional and one patient, to form a relationship. This relationship is a requirement for understanding and participation, and builds on communication. Skilbeck and Payne (2003) argue that communication is the medium in nurse–patient relationships. Good communication may boost patient recovery; whereas poor communication can be distressing for both nurse and patient and might even have tragic consequences (Russell, 1999). Evidence also suggests that effective communication between nurse and patient is a critical factor in the patient's perceived quality of care (Adair, 1994, Young 1995). Communicating with patients has been described as a difficult and potentially stressful aspect of nursing, and many nurses feel they have communication skills training needs. Being too busy and not having enough time to talk with patients is frequently offered as a reason for the low quantity and quality of nurse-patient conversation. The fundamental importance of nurse–patient communication suggests the need for effective pre-service and in-service training to equip nurses with the skills to communicate effectively with the range of patients that they will probably encounter.

According to Rapp and Goscha (2006) professionals should prevent spirit-breaking communication. Examples include speaking to patients as children; taking a parental stance/chastising; being rude to patients; attributing everything to the patient's psychiatric diagnosis and making generalizations; imposing your own standards of living on patients; restricting a patient's choices; making decisions for patients; telling patients that they are not yet ready for the recovery process; and insisting that patients should be forced to take medication.

- Listening

Participants identified the following advantages of listening to patients:

"...to be able to pick up things...knowledge of medication ...to identify the problems they are facing..." (P5).

"...moet die vermoe het om te kan luister na die pasiente. As jy luister dan moet jy die stressore kan identifiseer..." (P6) (Must have the ability to listen to the patients. If you listen then you can identify the stressors).

"Good listening skills because sometimes all the patient wants is just for somebody to listen to him/her because nobody else do in their world. That alone can make him/her feel better and be the catalyst to create an improvement in their mood" (P8).

According to Egan (1998) patients want more than just the physical presence of nurses during human communication; they want the nurse to be present psychologically, socially and emotionally. Complete listening according to Egan (1998: 65-66) involves listening to and understanding the patient's verbal messages, observing and reading the patient's nonverbal behaviour, listening to the context (the whole person in the context of the social settings of his or her life), and listening to things the patient says that might have to be challenged.

Martin (1987) explains good listening as refraining from putting words in other people's mouths and it means not thinking about what the patient is going to say the moment the nurse stops talking. Active listening is also about making space for

the patient, about listening to the verbal content of what is being said as well as noticing the subtext – the music which accompanies the words. It is also about reflecting back to the patient what you is heard – both the verbal and the emotional content. This is not parroting back the same words, but includes understanding of the underlying meaning of what the patient is saying and checking this out with them. In reflecting back what you heard, here may be opportunities to reframe and to focus on possible strengths.

It is important that service users feel heard, valued and acknowledged in their mental pain and that nurses do not simply jump into reframing or offering hope as a means of avoiding or minimising the suffering the patient experiences. To properly hear means to show that understanding of the difficulties, alongside helping patients break these down into manageable chunks.

- Empathy

Participants identified empathy as a core attribute of a helping relationship as identified by the following statements:

"We got small groups in which we talk about depression and how they understand it...some will not participate. Those who cannot talk will have individual sessions during which empathy is shown and to show that it was above their control..." (P2)

"...verpleegkundiges moet goeie empaties wees...om vas te stel wat die pasiente se probleme kan wees en problem oplossings te kan voorstel en te fokus op die behandeling vorentoe en die stressore te kan aanspreek..." (P6)

"...with this go an attitude of empathy...to create a feeling of hope..." (P8)

According to Lenkwane (2001) empathy enables nurses to have a sense of sharing and accepting the patients' emotional point of view. La Monica (1981) explains that empathy signifies a central focus and feeling with and in the patient's world. It involves accurate perception of the patient's world by the nurse, communication of this understanding to the patient, and the patient's perception of the nurse's understanding.

Several nursing studies provided preliminary evidence that the nurse's use of empathy is likely to make a difference to client outcomes (Reynolds & Scott, 1999). La Monica, Madea and Oberst (1987) explored the effect of nurses' empathy on the anxiety, depression, hostility and satisfaction with care of patients with cancer. They found less anxiety, depression and hostility in patients being cared for by nurses who exhibited high levels of empathy.

According to Reynolds and Scott (1999) empathy enables nurses to create a climate of trust and to establish their patients' perception of need; enables nurses to judge the patient's state of readiness to talk; enables nurses to understand the origins and purpose of patients' responses to health problems; enables nurses to facilitate positive health outcomes for patients (reduction in physiological distress, improved self-concept and reduction in anxiety and depression).

4.3.1.4 Structure

Structure is the configuration of items or the collection of inter-related components or services that describes what a recovery approach consist of.

- Application of different therapeutic techniques

Cognitive Behavioural Therapy

When participants were probed about cognitive behavioural therapy (CBT), some answered:

"...what is it?"(P7)

Other participants replied that they learn from other members of the multi professional team when they sit in meetings and than try to apply it in their practice (P6).

"ons leer van ander lede van die multi dissiplinere span waar die sielkundiges insit dan vang ons baie op van CBT en dan probeer ons dit toe te pas"

(We learn from other members of the multidisciplinary team especially the psychologist, than we try to implement it)

Another participant replied: *"Currently there is CBT, problem solving therapy, medication and family therapy strategies that are used by therapists to deal with the recovery of the depressed patient. As a nurse I feel you must have knowledge of all these strategies so that you can make choices and where possible advocate for the patient in multi disciplinary team (MDT) meetings. Not only in team meetings but when you have regular 1:1 sessions with the patient then you can use some of these strategies to create growth"* (P8).

Cognitive Behavioural Therapy (CBT) is a combination of two types of therapy: cognitive therapy, which helps with thinking processes such as unwanted thoughts,

attitudes, and beliefs (called cognitive processes), and behavioural therapy, which focuses on behaviour in response to those thoughts. CBT is based on the belief that most unhealthy ways of thinking and behaving have been learned over a long period of time. The objectives of CBT is to identify irrational or maladaptive thoughts, assumptions and beliefs that are related to debilitating negative emotions and to identify how they are dysfunctional, inaccurate, or simply not helpful. This is done in an effort to reject the distorted cognitions and to replace them with more realistic and self-helping alternatives. The particular therapeutic techniques vary according to the particular kind of client or issue, but commonly include keeping a diary of significant events and associated feelings, thoughts and behaviors; questioning and testing cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation and distraction techniques are also commonly included. It is sometimes used with groups of people as well as individuals, and the techniques are also commonly adapted for self-help manuals and, increasingly, for self-help software packages (Royal College of Psychiatrists, 2005).

- Person centred approach

Participants described person centred care as *"... looking at the patients own specific needs and according to that you develop care plans..."* (P5). Other participants talked about helping people to plan their life after discharge from hospital, organise their supports and what services they will need (P9)(P6).

According to Bradley (2004) person centred care is about rights, independence, choice and strengthening the patient's voice. Innes, Macpherson and McCabe (2006) state that person centred care is about autonomy rather than control. It is about listening to the patient concerned, learning about them and understanding them – their talents, strengths and aspirations. Interdependence is important as person centred care recognises that reliance on one another is essential – a patient is an individual within the context of their family and communities. According to Sanderson (2000, p. 7) person centred care "...is based on learning through shared action, about finding creative solutions rather than fitting people in boxes and about problem solving and working together over time to create change in the person's life, in the community and in organisations". Person centred care is therefore not a 'once and for all event', but an ongoing process that takes account of both the present and the future and the ways in which aspirations change as life changes (Bradley, 2004, p. 23).

The White Paper on Transforming Public Service Delivery or Batho Pele White Paper (1997) introduced an approach to service delivery within the South African Public Service to put the people first, which is supporting a person centred care approach.

- Holistic nursing

A holistic approach was emphasised by most participants.

"For me I think it should not all be about medication. Because if I look at the present situation the most important thing is to change medication if the patient did not improve. It must be comprehensive..." (P2).

Participants in support of the holistic approach also emphasised that one should increase one's understanding of how the bio-psychosocial approach influences the patients' views and behaviours' that are related to health and illness (P6).

Holistic nursing involves caring for a patient as a whole, with awareness of his or her physical, mental, emotional, and spiritual dimensions and needs (Dossey, Keegan and Guzzetta, 2005). This approach originated as far back as Florence Nightingale, the founder of modern nursing. Holistic nursing is underpinned by two assumptions, namely that the individual always responds as a unified whole and that individuals as a whole are different from, and more than the sum of, their parts (Pearson, Vaughan & Fitzgerald, 2005). According to Dossey and Guzzetta (2005) two major challenges have emerged in nursing in the twenty – first century. The first is to integrate the concepts of technology, mind and spirit into nursing practice; the second is to create and integrate models for health care that guide the healing of self and others. Holistic nursing is viewed as the most complete way to conceptualize and practice professional nursing. Caring is central to holistic nursing. Watson (1979, 1988) constructs nursing as a humanistic service with a central notion to caring. Upholding these caring values in daily practice helps transcend the nurse from "just doing the job" to that of a gratifying profession. Watson's caring moment occurs when a nurse and another person come together

with their unique phenomenal fields and a juncture for human caring is created. Phenomenal field refers to the totality of the human experience which includes feelings, thoughts, goals, expectations, meanings, spiritual beliefs, and bodily sensations based on one's past, present and future. The caring moment can influence and affect the cared-for and the caregiver and becomes transpersonal when it allows the presence of the spirit of both. There are ten carative factors that Watson describes. 'Carative' is a word chosen to differentiate nursing care from medical cure. Cure may result or be a part of caring, but this is not necessarily so. Watson's ten factors that form the 'core' of nursing are: the formation of an humanistic – altruistic system of values, the instillation of faith – hope, the cultivation of sensitivity to one's self and to others, the development of a helping – trust relationship, the promotion and acceptance of the expression of positive and negative feelings, the systematic use of the scientific problem-solving method for decision-making, the promotion of interpersonal teaching – learning, the provision for a supportive, protective and (or) corrective mental, physical sociocultural and spiritual environment, assistance with the gratification of human needs, and the allowance for existential – phenomenological forces (Vaughan, Pearson & Fitzgerald, 2005).

Holistic care involves more than just theoretical models and includes comprehensive therapy, alternative treatments, and use of complementary medicines as well as concerns for patients' spiritual and religious needs.

- Discharge planning

Participants emphasised the importance of discharge planning to ensure safe, adequate and continuing care (P3)(P4)(P5)(P6)(P7)(P9). Discharge planning was described by participants as an interdisciplinary process which should include all the relevant professionals as well as the depressed patient and his or her family where possible (P3)(P6). Professionals involved in the discharge planning of a patient should be aware of the available community resources (P1)(P4)(P9), the importance of medication education, the capacity of the patient to self medicate in the community and the management of medication in the community (P1)(P6)(P7)(P9). Community resources can include an advisory, referral, treatment, or a support service. According to participants, communication with the community teams should be timely to ensure support and adequate follow-up in the community.

Discharge planning is a structured and standardised process for ensuring the safe and successful transition of people with a mental illness from inpatient settings to the community. It is part of the continuum of care that commences at the time of admission (Department of Health NSW, 2008). It requires the active involvement of consumers and carers, and close cooperation between all relevant service providers (Simons & Petch, 2002).

- Multi disciplinary team work

Participants identified the importance to *"...have an overall approach. You cannot just treat the patient from a nursing perspective. There must be a social worker, and*

*psychologist involve. You need to have the whole package of service support from a multidisciplinary team"(*P3*).* Different experiences to making a decision, reduction in stress because the group share responsibilities, ability to share alternative ideas, and peer critique were identified as some of the advantages in working with a multi disciplinary team (P6)(P9).

A team may be defined as a set of individuals who work together to achieve common objectives. In contrast to groups that consist of homogenous and interchangeable members, teams have multiple information sources, members with defined roles, and interdependence and co-ordination among members. Teams share valued common goals. Team work is recognized as important to the delivery of quality recovery services. Many studies of effectiveness have been conducted. Reported benefits include improved coordination of care, reduced hospital stay, improved communication, better mental health for team members, improved health outcomes and improved patient experiences (Mickan, 2005; Burton, Brown, Daniels, Norman, Mason & Cunningham, 2006; Chang, Vines, Bertsch, Fraker, Czerniecki, Rosato, Lawton, Conant, Orel, Schuchter, Fox, Zieber, Glick & Solin, 2001; Caplan, Williams, Daly & Abraham, 2004).

4.3.2 Research Question Two

Research question two enquired how the identified attributes can be facilitated in the working environment. Three unique themes emerged from this discussion: workload management, professional development, and organizational support.

MAIN THEME	UNIQUE THEMES	OTHER THEMES
How can the identified attributes be facilitated in the working environment?	Workload Management	
	Professional Development	
	Organizational Support	

Table 4.2 Themes that emerged from the data for question two

4.3.2.1 Workload Management

Participants' complained about the tremendous workload that they encounter on a daily basis, and the shortage of nursing staff to assist with patient care. One participant stated *"...you are sometimes the only professional nurse on a shift; you need to manage the gate, the paperwork, students, patients and sometimes must do the work of the social worker and doctors. It is too much"*(P8*)*. Another participant stated *"...I had two psychiatric patients in the ward. One was manic and the other depress...the one day we were struggling with the manic patient and could not give the depressed patient any attention. The depressed patient then jumped through the window on the eight floor and died. All we got as nurses was a debrief session and we had to continue doing our work..."* (P10*)*. Other comments included*" in the practice where we currently work, there is not enough time and not enough nursing staff. You do what you must do. There is no time to do the extra – to sit with the patient and have a conversation with him or her. You understand?"* (P10*)*.

"Our problem is that there is not enough staff. There is a staff shortage so you must focus on giving out mediaction and doing other things to get through the day. There is not enough time for us to do psychoeducation and therapies. So if we can have more staff – say you are 6 sisters on a daily basis, then 3 can do the other stuff and 2-3 can just focus on Psychoeducation" (P9).

According to the Institute of Medicine "nursing is a critical factor in determining the quality of care in hospitals and the nature of patients' outcomes". However, inadequate staffing in health care settings is reaching crisis proportions in all regions of the world (Baumann, 2007). According to Dr Manto Tshabalala- Msimang (South African Health Minister as quoted in the Nursing Update of August 2003), there are almost 31,000 vacant nursing posts in South Africa. The shortage of nurses causes the workload of professional nurses to increase, leading to greater levels of job dissatisfaction, reduced levels of productivity and increased risks of suffering from burnout. Nurses suffering from burnout become increasingly passive and negative, which in turn has a negative impact on their patients, institutions, employers and on themselves. A shortage of nursing staff often force managers to mandate unsafe nurse overtime, add excess responsibilities to nurses' workloads, and shift nurses from one department to another, all of which compromise the quality of care and decrease a nurse's job satisfaction. Managers must often employ agency nurses, to fill in for unavailable local nurses with specific skills. Nurses who are brought in to fill urgent staffing needs might lack commitment to and engagement with the facility. This makes the regular staff feel they have to 'cover' the agency nurses while they are being paid a lesser wage (HeartMath,

2004: 7-8). Inadequate staffing results in additional costs incurred through high nursing turnover rates and the need to hire temporary staff. The long term investment in fulltime staff will yield cost savings in both recruitment and retention (Baumann & Blythe 2003a; Baumann & Blythe 2003b). Adequate staffing levels has repeatedly been shown to contribute to better patient outcomes, which ultimately manifest in reduced health costs for individuals, families and communities and increased tax revenues as patients return to the active workforce.

The American Federation of Teachers (1995) defines staffing as "an appropriate number of staff with a suitable mix of skill levels . . . available at all times to ensure that patient care needs are met and that hazard-free working conditions are maintained."

4.3.2.2 Professional Development

One participant stated *"Maybe there should be more short courses that nurses can attend to increase their knowledge... Some of the nurses work a long time in one unit and their knowledge is old... We don't move a lot. Our skills are therefore not developed. If you come into psychiatry you should rotate more to develop your skills. There is a need for development"* (P5). Another participant stated *"during the year you get a list of all the in-service training available. When it is time to attend the training session, then you cannot because there is not enough staff in the unit. You cannot go if the ward is not covered"* (P10) (P1).

According to Baumann (2007) an organization becomes a learning organisation when it encourage life long learning by supporting professional development and

the mutual sharing of knowledge. In a climate of learning, employers understand the importance of investing time, effort, and resources to enhance the practice of nurses and improve their knowledge, skills, and judgment. The College of Registered Nurses of British Colombia (2005) set the following indicators for a good learning environment: appropriate orientation is provided for all new positions and practice settings; preceptorship and mentoring programs are available; staff have opportunities for in-service, continuing education and professional development; staff have opportunities for debriefing and reflection on practice, and performance evaluation programs are in place.

According to Inskipp and Proctor (1993) supervision is a working alliance that allows the nurse to reflect on his or her working situation, receiving feedback and where appropriate guidance. The objective is to maximise competence. Participants identified a lack of supervision as a major stumbling block to maintain and improve their practice. Participants stated:

"The idea is to have supervision, but more is expected of nurses and the demands are more. So supervision is not really there in the sense that you want it to be. It is something that needs to be there. The supervision policy needs to change because if you constantly working with people's psychological needs it affects you" (P3).

"That is something that I am actually motivating. I am pushing for supervision. You don't have it that much at management level. It is something that needs to be there. You need to demand time for that in your day" (P3).

"No there are no support systems in place. We have 2 weekly meetings with area manager and try to solve problems" (P1).

"Yes, yes op daai punt – 'n nurse speaking to a nurse that knows what is going on here en wat weet waardeur ons gaan. Dit is nou regtig ere waar nie in plek nie. Ons ASD doen rondtes en vra hoe dit gaan in die saal, maar sal nie soos u se vir 'n uur sit en praat met ons nie. Dit is meer van jy moet gaan as jy probleme het" (P6)

(Yes, yes at that point – a nurse speaking to a nurse that knows what is going on here and understands what we experience. That is not in place. Our Assistant Director will do rounds and will ask how the unit is, but will never sit down with us and talk to us. It is more about you have to go and see them when you have a problem)

One participant said that there were no supervision policies for their organization.

Although there are barriers and resistance to the implementation of clinical supervision, there is an increasing amount of evidence to suggest that the potential benefits can be realized. Jones (1999) stated that clinical supervision offers nurses guidance, support and education, and is fundamentally concerned with quality, safety and protection. According to Berg, Hansson and Hallberg (1994) systematic clinical supervision decreases the negative outcomes of stress felt by nurses and increases their creativity which may enhance patient care. Hallberg and Norberg (1993) found that systematic clinical supervision appeared to improve nurse-patient relationships and also reduced the experience of strain in nurses. Hallberg (1994) found that following systematic clinical supervision nurses felt they had

increased self-confidence and a broader and better base of knowledge. Cutcliffe and Epling (1997) argued that clinical supervision can raise awareness in practitioners, which can help practitioners to understand how supervision contributes to patient care, the supervisees themselves and the organization. Jones (1999) concludes that clinical supervision is a very important concept for nursing because of the potential benefits it can bring to patient care and nurses themselves. As nurses are expected to take on greater responsibilities in their workplaces, an appropriate support network that encourages exploration of practice can only be of benefit.

4.3.2.3 Organizational support

Some participants felt that their organization's policies and practices did not support nurses. Participants reported a lack of mutual respect between nurses and physicians for each other's knowledge and competence. "*...doctors do not listen to nurses when they are asked to refer a patient to psychiatry...after the 10th occasion of asking they will respond...*" (P10).

Nurses uniquely gather, filter, interpret and transform information from patients and the system into the meaningful information required to diagnose, treat and deliver care to a patient. This information management role of nurses is an essential link in the decision making activities of healthcare teams. Failure to recognise the experienced perspective of nurses in clinical and operational decisions may result in costly errors, jeopardize patient safety and threaten the financial viability of healthcare organizations (American Association for Critical –

Care Nurses, 2005). Nurses who are not recognized feel invisible, undervalued, unmotivated and disrespected. This lack of recognition can lead to discontent, poor morale, reduced productivity and suboptimal care outcomes (American Association for Critical – Care Nurses, 2005).

Additionally, participants reported the unresponsiveness of organizations as a source for the generation of stress, which was predictive of their burnout and resignations.

Several participants, who worked in a general hospital, explained that they received little support from the psychiatric department in dealing with mentally ill patients. One participant explained that the increase in workload causes frustration. The consequence is feelings of anxiety, anger. A participant stated *"...I do not get the support from my manager and the psychiatric teams, so if a psychiatric patient gets difficult, then I tie him to the bed and give him his medication..."* (P10). The researcher felt that the participants' frustration resulted because they perceived some mentally ill patients as demanding, taking time away from other patients and because they did not get the proper support. Participants complained of poor policy development in joint working between general wards and the psychiatric departments. *"Hmm. They are so terrified when psychiatry patients come in and they have a psychiatric history, so they are so afraid to handle this patient and even the police. I don't know how to change the system because staff is everywhere a crisis. All staff will have to be trained in how to manage psychiatric patients. It makes the problem available..."*(P1*).*

Innes, Macpherson and McCabe (2006) argues that models of management currently are more concerned with command and control, that is promoting the belief that structures are more important than relationships. Similarly, Foster (2004) notes that practices are undervalued while structures, procedures and management are overemphasised. Boehm and Staples (2002) suggest that managers are under increasing pressures to stick to budgets. According to Jones (2001) a lack of management and social support is one of the difficulties that workers experience. Further consequences can be a lack of understanding of each other's roles, and nurses feeling that their managers do not understand or value their work. Wick, Coppin and Payne (2003) and Penna, Paylor and Soothill (1995) found that good team work and supportive management were key factors in reducing work related stress. The qualities cited as supportive in managers were approachability, willingness to listen and ability to respond in a way that was not perceived as undermining to staff.

Harrison and Hart (2006) argue that little attention is provided to problem – solving methods that will allow nurses to improve their working situation, and that nurses receive little clinical supervision or the acknowledgement that it is necessary, that will give them the opportunity to articulate and work through the anxieties and distress that they experience. Little has been done to provide nurses with the necessary authority to match their levels of responsibility. Few have access to structures to problem- solve, such as shared governance, which engages them in addressing the practical issues they struggle with.

4.3.3 Additional notes from the researcher

Although professional nurses were able to identify the barriers to the implementation of the attributes, there is a body of literature outside their body of knowledge and frame of reference that indicates specific methodologies that can be used to implement the identified attributes.

According to Page (2002) practice development focuses on the improvement of patient care, it incorporates a range of approaches, takes place in real practice settings, is underpinned by the development and active engagement of practitioners, is collaborative and interprofessional, is evolutionary and is transferable rather than generalisable.

Practice development is also underpinned by the theories and methodology of Critical Social theory (Caldwell, in McCormack, Manley & Garbett, 2004). Habermas (1972) identifies three different kinds of knowledge that are all interwoven with human interest, namely technical, practical and emancipatory. Technical interest according to McCormack, Manley and Garbett (2004, p. 37) is about the development of "...technical knowledge that will enable greater skill and mastery over technical work activity". The focus is on the persuasion of staff to use technical knowledge as the mechanism for improving patient care. The goal is therefore known and the aim is on achieving this. The outcome from this approach is rarely sustainable and there is no concern about the process of developing staff ownership. Practical interest is concerned with understanding and the clarification of how others see their world. It develops practical understanding which can

inform and guide practical judgement. In practice development professional nurses can use this approach to develop understanding of how depressed people perceive their world. Although greater understanding of the person's experiences is achieved, this does not necessarily create a change in the way professional nurses practice. Emancipatory interest is concerned with how self-reflection and self-understanding is influenced by the conditions of professional nurses. The resource here is power and according to Carr and Kemmis (1986, p. 136) the science is that of the critical sciences – "a critical social science will provide the kind of self – reflective understanding that will permit individuals to explain why the conditions in which they operate are frustrating and will suggest the sort of action that is required if the sources of these frustrations are to be eliminated". Critical social science therefore goes beyond critique to include actions from the raised awareness. The professional nurse becomes aware of and freed from, taken for granted aspects of their practice and the organizational systems that is constraining them through reflective discussions. Emancipatory interest does not pretend to overcome barriers that is beyond the influence of the professional nurse but instead enables him or her to realise the influence they hold, how to use that influence most appropriately and effectively and to recognise aspects of decision-making that is beyond their direct influence. Enlightenment therefore creates change through raised awareness, recognition of the power of influence and understanding of the limitations on individual power in any organizational context (McCormack, Manley & Garbett, 2004).

Unsworth (2000) identified the critical attributes of practice development as: improvement in patient care based on new ways of working; specific client needs give rise to changes and these changes result in effective services with maintenance or expansion of work/practice. Closely aligned with the critical attributes are the empirical referents for practice development viz. change in the way of working, development that includes client focus and clinically effective service delivery. McCormack and Garbett (2003) point out that change in the context of practice development is understood in the normative re- educative sense where skills and confidence are gained as much for their own sake as for improvement in practice.

Practice development is therefore a collection of improvement processes that aim to increase the effectiveness of patient centred care. This is brought about by helping professional nurses to develop their knowledge and skills and to transform the culture and context of care. It is enabled by external or internal facilitators that are committed to systematic, rigorous continuous process of emancipatory change (changes in practice and ways of working, which will result in an improved patient experience) (Garbett & McCormack, 2002).

4.4 Summary

This chapter discussed the findings from the semi – structured interviews held with participants.

The two main themes from the data analysis included attributes that professional nurses require to promote the recovery of people who have been diagnosed with depression, and how these self reported attributes can be implemented in the work environment. The attributes identified to promote the recovery of people diagnosed with depression included:

1. Support for the person with depression: Support entails building an inclusive relationship that creates hope, provides psychoeducation, encourages family support and facilitates the aim of recovery.
2. A positive approach to the person with depression: This is manifested in assessment and observation skills, based on knowledge of depression and actions towards relapse prevention.
3. Interpersonal skills in this context include communication skills, particularly those for listening and the demonstration of empathy.
4. Awareness of structure: The structure within which the person with depression is found comprises various therapeutic techniques – a person centred approach within holistic nursing and includes the multi-disciplinary team.

The environment conducive to attributes for enhancing recovery from depression should include:

1. Workload management that provides for adequate staffing levels.
2. Professional development entails regular continuing education and supervision as part of a learning environment.
3. Organizational support values the role of the professional nurse providing the context for his or her responsibility with authority to fulfil that role.

These attributes conform to the approaches to recovery that were described in the literature review in chapter two.

Although professional nurses were able to identify the attributes to promote the recovery of people diagnosed with depression, they felt unable to implement the recovery process in their work environments due to the lack of a supportive environment. The question that arises is therefore:

" How can professional nurses be empowered to implement the identified attributes despite experiencing a lack of support with regards to workload management, professional development and organizational support?"

The concept of empowerment is central to this question so chapter five will discuss the concept analysis of the concept empowerment.

CHAPTER FIVE

CONCEPT ANALYSIS

5.1 Introduction

Chapter four dealt with the discussion of the results obtained from the semi-structured interviews and the relationship to literature.

In this chapter, concept analysis will be conducted in order to analyze and generate descriptions, definitions and to further explore the meanings of the identified concept, empowerment. The results from this analysis together with the findings in chapter four will facilitate the development of a tentative model to empower professional nurses to promote the recovery of people who have been diagnosed with depression. Tentative because the model will be "...open and can be changed as new insights and understandings come to light" (Chinn & Kramer, 2004, p. 66).

5.2 Concept analysis

5.2.1 Selection of concept

Despite an increasing number of international policy documents supporting the recovery approach, and nurses being able to identify the attributes needed, professional nurses in this research study identified workload management, professional development and organizational support as considerable challenges to

implementing it in their working environments. The question is therefore:" how can professional nurses be empowered to promote the identified attributes in their work environment despite the known challenges?"

The concept of empowerment has become increasingly important in debates over the nature of nursing practice. This can be seen in empowerment's continued presence as a topic in professional discourse, in the way empowerment features as a declared aim of various health related organizations, and in the research strategies of particular health and welfare foundations (Gilbert, 1995).

The concept empowerment is also important within mental health recovery programs, since these programs often claim that they are promoting independence, autonomy, and other ideas related to empowerment (WHO, 2010).

Nearly every kind of health program claims to "empower", yet in practice there have been a few operational definitions of the term, and it is far from clear that programs that use the term are in any measurable way different from those that do not. Still lacking a definition, the word empowerment has become a common political declamatory, with a flexibility of meaning so broad that it seems to be in danger of losing any inherent meaning at all (Chamberlin, 1997).

The concept empowerment is complex, and multidimensional. The researcher therefore sees it as important to first conceptualise a definition of the term empowerment that is offered as a working definition for the purpose of opening a discussion as to how professional nurses can be empowered to promote the identified attributes in chapter four despite the known challenges.

5.2.2 Defining of concept

It is the purpose of the present concept analysis to build on the question: "how can nurses be empowered to implement the identified attributes despite the known challenges?" and to analyse the concept of 'empowerment' in order to expand the science of nursing, identify what nurses do, and validate the contributions of the nursing profession to the recovery approach.

5.2.2.1 Method

The researcher combined the methods for concept analysis of Walker and Avant (2005), Rodgers (1989) and Chinn and Kramer (2004) and used the steps that were common to all three approaches for analyzing and clarifying the concept 'empowerment'. The method uses a number of steps which interrelate and are circular rather than linear in process. The activities in the method include the selection of concept(s), defining concept(s), defining attributes, and model case.

A description of each step can be found in Chapter Three.

5.2.2.2. Data Sources

According to Chinn and Kramer (1995) data sources provide information about the meanings of the concepts; provide definitions, word usage and professional or existing theoretical definitions. The researcher used three strategies for data collection. The initial source used 'grey' literature such as reports and discussion papers from international agencies from which the use of the term arose. The literature was found using the term 'empowerment' on the World Wide Web

search engine Google. This search was not comprehensive and additional literature was found through cited references in the reports identified. The second source was to examine the use of the concept in nursing, midwifery, health and educational research policy documents and reports through the use of the World Wide Web search engine Google and electronic databases for example My Athens, and EBSCO. The third source used the MEDLINE and CINAHL databases to extract multidisciplinary peer-reviewed literature from the domains of health, nursing and midwifery. Years between 1980 and 2009 were searched and literature sources were placed according to years.

Table 5.1. The sample of 'grey' literature, books and reports

No	Type	Year	Author(s)	Title
1.1	Book	1984	Benner, P.	From novice to expert
1.2	Report	1997	Arai, S.M.	Empowerment from the theoretical to the personal.
1.3	Report	1997	Oxaal, Z. Baden, S.	Gender and empowerment: definitions, approaches and implications for policy
1.4	Book	1997	Sadan, E	Empowerment and community planning
1.5	Report	1999	Page, N Czuba, C.E.	Empowerment: What is it?
1.6	Book	2000	Khosa, M.M.	Empowerment through service delivery
1.7	Report	2001	Saadallah, S.	Empowerment of women in the context of Muslim Societies as a transformative strategy for poverty

				eradication in a globalizing world
1.8	Report	2001	Strandberg, N.	Conceptualising empowerment as a transformative strategy for poverty eradication and the implications for measuring progress
1.9	Book	2003	Adams, R.	Social work and empowerment
1.10	Report	2004	Chambore, V.	Maximising patient power: commercial opportunities for the pharma industry
1.11	Document	2004	Garside, P.	Empowerment: What is it and why should we care?
1.12	Book	2004	Wilde, S.	The three keys to self empowerment
1.13	Book	2005	Ledwith, M.	Community development: A critical approach
1.14	Presentatio	2006	Napier, A.	Empowerment theory
1.15	Book	2006	Rapp, C.A. Goscha, R.J.	The strengths model. Case management with people with psychiatric disabilities (Second Edition)
1.16	Report	2007	Gibson, C. Woolcock, M.	Empowerment, deliberative development and local level politics in Indonesia: Participatory projects as a source of countervailing power
1.17	Document	2007	Great British Equa Support Unit	Empowerment – a guide for development partnerships
1.18	Report	2008	National Empowerment	What is community development?

			Partnership	
1.19	Presentatio	2009	Peters, H.	"Take two"-Empowerment
1.20	Document	2009	World Bank	Empowerment
1.21	Document		Hassan, F.H.	Work empowerment as perceived by nurses and physicians working at a National Heart Institute

Table 5.2. The sample of peer reviewed published research articles and completed thesis's.

No	Year	Author	Title
2.1	1992	Hawks, J.H.	Empowerment in nursing education: concept analysis and application to philosophy, learning and instruction
2.2	1995	Gilbert, T	Nursing: empowerment and the problem of power
2.3	1995	Rowlands, J.	Empowerment examined
2.4	1996	Rodwell, C.M.	An analysis of the concept of Empowerment
2.5	1997	Fulton, Y.	Nurses views on empowerment: a critical social theory perspective
2.6	1997	Jooste, K.	A model for empowerment of nurses: a managerial perspective
2.7	1999	Ryles, S.	A concept analysis of empowerment its relationship to mental health nursing
2.8	2000	Casey, H.	Empowerment: What can nurse leaders do to encourage an

			empowering environment for nurses working in the mental health area
2.9	2000	Kuokkanen, L. Leini-Kilpi, H.	Power and empowerment in nursing: three theoretical approaches
2.10	2000	Laverack, G. Labonte, R.	A planning framework for community empowerment goals within health promotion
2.11	2001	Kuokkanen, L. Leino-Kilpi, H.	The qualities of an empowered nurse and the factors involved
2.12	2002	Nyatanga, L. Dann, K.L.	Empowerment in nursing: the role of philosophical and psychological factors.
2.13	2003	Boog, B.W.M.	The emancipatory character of action research, its history and the present state of the art
2.14	2004	Wittman-Price, R.A.	Emancipation in decision-making in women's health care
2.15	2004	Daiski, I.	Changing nurses' dis-empowering relationship patterns
2.16	2005	Drury, J. Reicher, S.	Explaining enduring empowerment: A comparative study of collective action and psychological outcomes
2.17	2005	Hajbaghery, M.A. Salsali, M.	A model for empowerment of nursing in Iran
2.18	2005	Drury, J. Cocking, C. Beale, J. Hanson, C. Rapley, F.	The phenomenology of empowerment in collective action
2.19	2005	Chitnis, K.S.	Communication for empowerment and Participatory development: A social model of health in Jamkhed,

			India
2.20	2005	Bonisteel, M.	Measuring empowerment: The application of an empowerment model to nursing development in Bosnia and Herzegovina
2.21	2006	Van den Brouke, S. Heunion, W. Vernaillen, N	Planning for empowerment in health promotion with socio-economically disadvantaged communities: Experiences with a small group approach
2.22	2007	Bradbury-Jones, C. Sambrook, S. Irvine, F.	Power and empowerment in nursing: a fourth theoretical approach
2.23	2007	Manojlovich, M.	Power and empowerment in nursing: Looking backward to inform the future
2.24	2007	Gerrish, K. Guilaume, C. Kirshbaum, M. McDonnell, A. Nolan, M. Read, S. Tod, A.	Empowering frontline staff to deliver evidence-based care. The contribution of nurses in advanced practice roles
2.25	2007	Baker, P. Baker-Buehanan, P.	The Tidal Model: Mental health, reclamation and recovery
2.26	2007	Sbongile, M.M.P.	An empowerment programme for nurses working in voluntary counseling and testing services in Swaziland
2.27	2007	Corbally, M.A. Scott, P.A. Matthews, A. Gabhann, L.M. Murphy, C.	Irish nurses' and midwives' understanding and experiences of empowerment
2.28	2009	Chambers, D Thompson, B	Empowerment and its application in health promotion in acute care

			settings: nurses perceptions
2.29	2009	Chamberlin, J.	A working definition of empowerment

5.2.2.3 Results from the literature reviewed (Bold type indicates defining attributes of the concept see also 5.2.3 below)

The Oxford English Dictionary (Simpson & Bradley, 1989) states that the words empowering and impowering were used since the 17th century in administrative letters. The Latin word for empowerment is *'potere'* which means to be able to, or to have the ability to choose (Rodwell, 1996; Thomas, 1995). One of the words used to translate the word empowerment into French is "auto-appropriation"; auto comes from the Greek word 'autos' which means "of oneself", whereas appropriation means "action to make something one's own, to give oneself the means to act" (De Villiers, 2003, p. 105, 137).

The word empowerment is used in many different contexts: community development, psychology, education, economics, nursing, and studies of social movement and organizations, amongst others. According to the Concise Oxford Dictionary (1991) empower is defined as to give **power** to; authority to, make able. The New Merriam - Webster Thesaurus (1989) identify 'authorise', 'entitle' and 'sanction' as synonyms for the word 'empower'. These words all suggest that **power** is given from one person to another rather than individuals having a right to power or developing their own power.

Central to any discussion of empowerment must therefore be its relationship with power (Gilbert, 1995). Power can be understood as operating in a number of different ways:

- Power over: this power involves a relationship of domination or subordination. It is based on socially sanctioned threats of violence and intimidation. It requires constant vigilance to maintain, and it invites active and passive resistance,
- Power to: this power relates to having decision-making authority, power to solve problems and can be creative and enabling,
- Power with: this power involves people organising with a common purpose or common understanding to achieve collective goals,
- Power within: this power refers to self confidence, self awareness and assertiveness. It relates to how individuals can recognise through analysing their experience how power operates in their lives, and gain the confidence to act to influence and change this (Oxaal & Baden, 1997).

The various understandings of power embedded in the concept of empowerment carry through into different approaches to empowerment in practice as illustrated in Table 5.3.

Definitions of power and empowerment in practice	Understanding of power implications in practice
Power over	Conflict and direct confrontation between powerful and powerless interest groups.
Power to	**Capacity building**, supporting individual decision-making, leadership.
Power with	Social mobilization, building alliances and coalitions.
Power within	Increasing self esteem, awareness or consciousness raising, confidence building.

Table 5.3: Various understandings of power (Oxaal & Baden, 1997)

The possibility of empowerment occurring depends on two things. First, empowerment requires that power can change. Second, the concept of empowerment depends on power that can expand. A zero-sum conception of power means that power will remain in the hands of the powerful unless they give it up (Page & Czuba, 1999).

Empowerment is not only about gaining power to open up access, but also include processes that lead people to perceive themselves as able and entitled (Rowlands, 1995). According to Keller and Mbwewe (1991, p. 102) empowerment is "a **process**...to **increase...self-reliance**, to assert the independent right to make **choices** and to control resources which will assist in challenging and **eliminating...subordination**".

According to McWhirter (1991) empowerment is a process by which people, organisations or groups who are powerless become aware of the power dynamics at work in their life context, develop **the skills and capacity** for gaining some reasonable control over their lives, exercise this control without infringing upon the rights of others and support the empowerment of others in the wider community. The process of increasing people's awareness is known as facilitation.

Kieffer (1984) identified four stages in the empowerment process. These are the era of entry, advancement, incorporation, and commitment.

Era of entry: This is the stage where the person explores structures, to reach some critical consciousness of their powerlessness. The participants in Chapter Four indicated that they experience workload management, professional development and organizational support as barriers, which they could not overcome.

Advancement: During this stage, people begin to experience greater understanding and sometimes feel strongly about iniquities.

Incorporation: The development of organisational and political skills by people is some of the characteristics of this stage of empowerment. This includes the acquisition of assertiveness, decision making, organisational and confrontational skills, and lobbying.

Commitment: This is the final stage of the empowerment process, in which the individual incorporate the social action component into their daily and real life situations.

Empowerment is also a key concept within the Critical Social Theory as CST is often associated with the improvement of the living conditions of the underprivileged (Ward & Mullender, 1991; Stevens, 1989). In CST the underprivileged groups are commonly described by the concept of oppressed groups, which can include ethnic groups, homosexuals, immigrants and nurses (as representatives of a female-dominated group of employees). The oppression of these groups is maintained by social institutions and other administrative units. The lack of empowerment is associated with the negative and authoritarian concept of power, which refers to status and the possibility to control people, their actions and economic resources (Freire, 1972, Ward & Mullender, 1991).

"To uncover...constraints that impede free, equal and uncoerced participation in society..." it is important that knowledge must be gained (Stevens, 1989, p. 58; Habermas, 1972). It is Freire (1972) who expands on the concept of gaining knowledge or facilitating understanding (conscientisation) through transformative action. Lewis (1990, p. 469) define transformative action from a Critical Social Theory perspective as "...the development of a critical perspective through which individuals can began to see how social practices are organised to support certain interests, and the process whereby this understanding is then used as the basis for active political intervention directed toward social change with the intent to disempower relations of inequality". Freire (1987) identify 4 stages of transformative action. The first stage, intransitive consciousness is when individuals are pre - occupied with basic survival and have little interest in asking questions about their living situations. The next stage, semi-intransitivity is evident when

there is an absence of critical questioning about "the way things are", a culture of dependency exists, as individuals do not have the confidence or ability to be self-sufficient. The next stage, naive or semi-transitive consciousness is when individuals start to question "the way things are", and will "test the waters" with rebellious acts. The final stage, critical consciousness occurs when consciousness is informed by in-depth questioning, interpretation and analysis.

In both the processes described by Kieffer (1984) and Freire (1987) empowerment is a process during which the individual moves from total ignorance of the need to or the ability to change the way things are, to a level of questioning where people or groups look towards themselves and their own deficiencies to bring about change. Empowerment is therefore a process that cannot be imposed by outsiders, although appropriate external support and intervention can speed up and encourage it (such as by facilitation). It is about individuals being able to maximise the opportunities available to them without or despite constraints. It calls for a facilitative approach and an attitude of complete respect for and confidence in the people being worked with, or accompanied (Rowlands, 1995). As empowerment processes are driven by nurses themselves and different nurses have different needs and goals depending on their location in structures of class, ethnicity, and gender and on personal preferences, the content of empowerment will differ between a nurse and groups of nurses.

Empowerment is therefore **an active process** that enables individuals to become strong enough to participate in, take **control** of, and **influence institutions** and

events that affects their lives (Parsons 1991 in Campton, Galaway and Cournoyer, 2005).

The prevalent elements of empowerment are choices and power. Empowerment is synonymous with **choice**. To be empowered, nurses need to make choices irrespective of the environment that provides a range of options from which to make choices and that ascribes the **authority** to the person to choose. The assumption is therefore that the more choices identified by the person – the greater the contribution to that person's empowerment will be. Authority refers to the nurses' actual power to select from the range of choices that is available (Rapp & Goscha, 2006).

According to Hitchcock, Schubert and Thomas (1999, p. 222) empowerment "provides new ways of being, doing and living".

According to the National Empowerment Partnership (2008) an empowered person is one who is confident, feel inclusive, organised, co-operative, and feel they can be influential. These five dimensions is the result of putting certain development values into action which are learning (recognising the skills, knowledge and expertise that people contribute, building on these and what has gone before), Participation (facilitating democratic involvement by people in the issues which affect their lives based on full citizenship, autonomy and shared power, skills, knowledge and experience), Co-operation (working together to identify and implement action, encouraging networking and connections between communities and organisations), Social justice (enabling people to claim their human rights, meet

their needs and have greater control over the decision-making processes which affect their lives). Table 5.4 summarises aspects of empowerment at an individual level.

An empowered person	Organizations can contribute by...	Negative consequences of ignoring this dimension	Benefits of addressing this dimension
Confident	Working in ways which increase professional nurses' skills, knowledge and confidence, and install in them a belief that they can make a difference.	• People do not contribute to meetings • People do not understand the organization's constraints • People do not believe that change is possible or that they have a role	• Nurses are more confident about taking part, they ask questions and play an active role • Nurses understand the information being discussed • Nurses understand the constraints of the work • Nurses recognize their own and each others' skills, knowledge and expertise
Inclusive	Working in ways which recognize that discrimination exists; promote equality of opportunity and good relations between groups and challenge inequality and exclusion.	• You only hear from the 'usual suspects' or the 'same voices' • Some groups feel isolated in their units • People feel that others gain favors at their expense	• There is a greater understanding and awareness between different units • You hear diverse voices • Nurses are more likely to find common ground • Nurses understand the rationale for the allocation of resources
Organised	Working in ways which bring people together around common issues and concerns, in organizations and groups that are open, democratic and accountable.	• You are not sure that 'representatives' are accountable for speaking on behalf of others • Initiatives or activities are short-term and fizzle out. • 'units' cannot agree on ways forward	• There are thriving nursing groups • Nurses are more likely to work collectively • Nurses work together and understand each other's strengths • Nurses negotiate and identify shared solutions
Co-operative	Working in ways which build positive relationships across groups, identify common messages, develop and maintain links to national bodies and promote partnership working	• Units compete with each other for your time and resources • Work happens in silos or is duplicated • Nurses feel hard done by compared to others	• There is strong unit infrastructure where groups network and support each other • Nurses will understand the needs of other units and the resources allocated to them • Nurses will learn from each other • Nurses see themselves as part of the bigger picture
Influential	Working in ways which encourage and equip professional nurses to take part and influence decisions, services and activities.	• Nurses have consultation fatigue and become cynical • You fail to deliver the most appropriate services • You hit your targets but miss the point!	• Nurses are heard and their contribution makes a difference • Nurses take responsibility for the services and activities provided • Consumers receive appropriate services

Figure5.4 An empowered person (adapted from the National Empowerment Partnership, 2008)

5.2.3 Defining attributes

Walker and Avant (2005, p. 68) describe attributes as "...the heart of concept analysis". According to Rodgers (2000, p. 77 – 102) attributes constitute a 'real' definition of the concept, providing the characteristics, rather than being a nominal expression. The attributes found in the literature defining empowerment in this analysis included power, capacity building, active process, increased self-reliance, eliminating subordination, developing skills, control, influence institutions, choices, and authority.

5.2.3.1 Power

According to Kanter (1977, p. 166) power is the "ability to get things done, to mobilise resources, to get and to use whatever it is that a person needs for the goals he or she is attempting to meet.

5.2.3.2 Capacity building

According to Sekhukhune (2005) capacity building is the mental power to produce capabilities and potential skills for understanding, judgement and imagination.

5.2.3.3 Active process

An active process refers to the strategies and actions used to bring about the transformation.

5.2.3.4 Increase self – reliance

The capacity to manage one's own affairs, make one's own judgements, reliance on one's own powers, and provide for oneself.

5.2.3.5 Eliminating subordination

Eliminating subordination is the development of a critical perspective through which nurses can begin to see how social practices are organised to support certain interests, and the process whereby this understanding is then used as a basis for active political intervention directed toward social change with the intent to disempower relations of inequality (Lewis, 1990).

5.2.3.6 Developing skills

The development of political skills for example lobbying, negotiation and arbitration.

5.2.3.7 Control

Control relates to how nurses perceive their ability to control or change outcomes. Nurses who have an internal locus of control believe that it is their behaviour which influences the outcomes and that they are in control of their own life whereas nurses with an external locus of control believe that it is factors external to them that control their lives or specific outcomes (Weary, Gleicher & Marsh, 1993).

5.2.3.8 Influence institutions

The ability of professional nurses to take part and influence decisions, services and activities (National Empowerment Partnership, 2008).

5.2.3.9 Choices

Choices are the ability of the working environment to provide the nurse with a range of options from which they can make choices and that ascribe the authority to the nurse to choose (Rapp & Goscha, 2006).

5.2.3.10 Authority

Authority refers to the nurses' actual power to select from the range of choices that is available (Rapp & Goscha, 2006).

Each criterion that contributed to the understanding of the concept 'empowerment' was written in bold. See section 5.2.2.3.

5.2.4 The Model Case (defining attributes are in bold type)

According to Walker and Avant (2005) a model case should be developed to exemplify the identified concepts, and should be a 'pure case' that includes all the defining attributes that are indicated in bold.

Mrs. X has been invited by the XYZ University as a visiting lecturer to present the module "the implementation of a recovery approach in mental health" to a group of Masters Degree students in Psychiatric Nursing. The medium of a discussion group was used by Mrs X to generate a mutual exchange of ideas with regards to the aims

of the module, the students' learning needs and the process of how to address the needs. Eight options were identified. The students were allowed to discuss amongst themselves which four options suited them the best and to inform Mrs X about their choice. By enabling the group to identify their own needs and set their own agenda Mrs X encouraged mutual decision making and a sense of freedom to make choices.

During the second contact session Mrs X did a PowerPoint presentation on the historical background and theory of the recovery approach in mental health. Opportunities were created for the students to ask questions based on their understanding and judgements (capacity building). Students were then divided into two groups to discuss four questions. The goal was for the students to reflect on their feelings, thoughts and practice with regards to the recovery approach. During the feedback session 4 major themes were identified, which let to further discussions during which Mrs X used some of her own experiences of recovery practice to increase the students' understanding.

The students were then divided into 3 groups and linked through an email system with three mental health units of which one was in Australia, another in New Zealand and the United Kingdom. The students were to find out how the specific mental health units were using the recovery approach, what models they were using, and what processes they used to implement a recovery approach. The students were then tasked to produce a 20 minute presentation during the third contact session, to explain their findings supported by a minimum of 10 literature

references, and how this can be applied within a South African context. A peer evaluation was done at the end of all three presentations.

During the fourth contact session Mrs X did a video presentation of leadership and the management of change. The students were then given an opportunity to construct a plan of what changes they will make in their working environments to implement a recovery approach and what political skills they will use to bring about the change. This was followed by a presentation of each plan and a group discussion facilitated by Mrs X after each presentation. The students were asked to choose one change they wanted to implement in their working environment. During one to one supervision sessions students were helped by Mrs X to develop a formal project plan that could be presented to each multidisciplinary team where the student was working. With the support of Mrs X, appointments were made with each multidisciplinary team to present the project plans. Mrs X supported each student during the question and answer session after each presentation. During the next 4 weeks Mrs X had weekly one to one supervision sessions with each of the six students to evaluate and monitor progress and to provide support to students. During the third and fourth week Mrs X met with each multidisciplinary team where the students were working to have professional discussions about the progress made and how the teams adjusted to the changes.

The six students at the end of the four weeks were asked to write a reflective essay of 2500 words about how they were empowered through the module "the implementation of a recovery approach in mental health" to enhance the

empowerment of nurses to promote the recovery of people that have been diagnosed with a mental illness. The essays were presented to the rest of the mental health lectures for evaluation.

This model case contains all the defining attributes of empowerment. Mrs X was involved in a helping **process** with the post graduate students. The students used her international experiences as a psychiatric specialist nurse and used her as a resource to gain the **authority** and opportunities needed to develop **their skills**, **control**, **self-reliance** and **power** to **influence the institutions** where they were working to enhance the empowerment of nurses to promote the recovery of people that have been diagnosed with depression. This **eliminated subordination**.

5.2.5 Definition of the main concept empowerment.

Empowerment is the external facilitation of an active process to increase the powers, control and authority of professional nurses to influence institutions positively towards the recovery approach in the management of depression, through the development of skills, and capacity building (by implication positive influence will entail overcoming the three barriers in the environment).

5.3 Summary

In this chapter empowerment was the concept selected for concept analysis. The concept analysis included definitions, defining attributes, development of a model case and definition of the main concept.

Chapter six will describe the development of a model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

CHAPTER SIX

DESCRIPTION OF A MODEL TO ENHANCE THE EMPOWERMENT OF PROFESSIONAL NURSES TO PROMOTE THE RECOVERY OF PEOPLE WHO HAVE BEEN DIAGNOSED WITH DEPRESSION

6.1 Introduction

The identified need for this research study was to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression. For the purpose of this research study, the researcher first did a literature review about recovery in Chapter Two to do a global assessment of the approach. The researcher then did semi - structured interviews with a group of professional nurses working in the Western Cape Province, to gain insight in and knowledge about the attributes (knowledge, skills, attitudes, behaviour and values) required to promote the recovery of people who have been diagnosed with depression, and how these identified attributes can be implemented in the working environment. The data from the interviews then guided the literature control that included information that justified the results of the interviews.

The researcher discovered that workload management, professional development and organizational support were considerable challenges to implement a recovery approach in the working environments of professional nurses, despite an increasing number of international policy documents supporting the recovery approach, and

professional nurses being able to identify the attributes needed to promote the recovery of people who have been diagnosed with depression. The question was therefore:" how can professional nurses despite having problems with workload management, professional development and organizational support be empowered to promote the identified attributes (support, positive approach, interpersonal skills, links with community and structure) in their work environment?"

Empowerment is therefore necessary to overcome the lack of a supportive environment and to ensure the application of a recovery approach by professional nurses in health care settings. Practice development is an approach to improve patient centred care that is consistent with the concept empowerment (Unsworth, 2000; McCormack, Manley & Garbett, 2004).

6.2 Model development

The following six components, namely goals, concepts, definitions, relationships, structure and assumptions were used by the researcher to develop a model to enhance the empowerment of professional nurses to promote the recovery of people that have been diagnosed with depression (Chinn & Jacobs, 1987).

6.2.1 Goal

The goal of the model is to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

6.2.2 The concepts described

The researcher utilized the data gathered that consisted of semi – structured interviews, field notes, analyzed data from the interviews and literature reviews, to identify the concepts of the model. Professional nurses and people who have been diagnosed with depression are included because they are the focus of this study. The concept recovery has been identified by the interviews and literature review. The attributes support, positive approach, interpersonal skills and structure and the barriers workload management, professional development and organizational support has been identified through the interviews. Empowerment was concept analysed, practice development, because it is congruent with empowerment. Facilitator and facilitation as these are congruent with empowerment and practice development.

6.2.2.1 Professional Nurse

According to the *Nursing Act* (2005) a professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice. To practice as a professional nurse in South Africa, the individual must be registered with the South African Nursing Council according to the Nursing Act (2005).

6.2.2.2 The person that have been diagnosed with depression

According to Searle and Pera (1995) a person is a total being - body, mind and spirit - sick or well, who needs support to complement his/her specific ability to accept responsibility for his/her own health. The depressed patient is therefore a whole person and cannot be viewed in reductionist terms, that is, as parts, systems or mind – body split. According to Deegan (2001) whole includes being part of a family, culture, socio – economic class, having friends, a social role, sexuality, values and beliefs and a future that is unknown and ambiguous.

When experiencing a relapse of mental health the depressed patient can find it difficult to cope with their everyday lives. They might have problems in relating—sometimes to themselves and sometimes to other people and they might also have problems in working, playing and having what most of us would call, a 'normal life' (Baker & Buchanan-Baker, 2001, p. 13).

People do not get 'stuck' in states of 'mental illness', but do change (Baker & Buchanan-Baker, 2001, p. 13). To help people grow their awareness of the change process, the professional nurse needs to have knowledge of the characteristics of the patient so that these characteristics can be taken into consideration when activities are planned and implemented to facilitate the recovery process.

6.2.2.3 Empowerment

The process of concept analysis was conducted to identify the characteristics of the concept empowerment.

The concept is defined and described as the facilitation of an active process to increase the powers, control, and authority of professional nurses to influence institutions positively towards the recovery approach in the management of depression, through the development of skills and capacity development.

6.2.2.4 Recovery

Recovery is a personal process for engaging the adverse impacts of experiencing mental health problems, despite their continuing presence. It involves personal development and change, including acceptance that there are problems to face, a sense of involvement and control over one's life, the cultivation of hope and the support of others, and direct collaboration in joint problem solving between consumers, professionals and families. Recovery starts with the individual and works from the inside out. For this reason it is personalised and challenges traditional service approaches (Operational definition).

The attributes to promote a recovery approach according to participants in this research study include:

- Support for the person with depression: Support entails building an inclusive relationship that creates hope, provides Psychoeducation, encourages family support and facilitates the aim of recovery.
- A positive approach to the person with depression: This is manifested in assessment and observation skills, based on knowledge of depression and actions towards relapse prevention.

- Interpersonal skills in this context include communication skills, particularly those for listening and the demonstration of empathy.
- Awareness of structure: The structure within which the person with depression is found comprises various therapeutic techniques – a person centred approach within holistic nursing and includes the multi-disciplinary team.

The barriers to the implementation of a recovery approach according to participants in this research study include:

- Workload management that assumes adequate staffing levels.
- Professional development entails regular continuing education and supervision as part of a learning environment.
- Organizational support values the role of the professional nurse providing the context for his or her responsibility with authority to fulfil that role.

6.2.2.5 Practice Development

Practice development includes a collection of improvement processes that aim to increase the effectiveness of patient centred care. This is brought about by helping care teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled by external or internal facilitators that are committed to systematic, rigorous continuous process of emancipatory change (changes in practice and ways of working, which will result in an improved patient experience) (Garbett & McCormack, 2002).

The new practice may come from the findings of rigorous research; findings of less rigorous research; experience which has not been tested systematically or trying out an idea in practice. The introduction of the development ought to be systematic and be carefully evaluated to ensure that the new practice has achieved the improvements intended (Kitson, 1994). This would depend on the presence of a facilitator who has insight into the process or who is willing to undertake the process alongside professional nurses.

A facilitator is an experienced nurse practitioner such as the ward sister, advanced psychiatric nurse or similar nurse, who is willing and able to share their professional knowledge and skills whilst working in partnership with a practitioner to facilitate learning and development (St Bartholomew School of nursing & Midwifery, 2004). According to Harvey, Loftus Hills, Rycroft-Malone, Titchen, Kitson, McCormack and Seers, (2001) a defining characteristic of the facilitator can be an internal or external role in relation to the organization in which the change is being implemented. McCormack, Manley and Garbett (2004) indicate that facilitators can develop their skills and attributes through an experiential process. The experiential processes can be informal (for example a process of trial and error) or more formal and structured (through models of critical companionship or external/internal facilitation). Kitson, Harvey and McCormack (1998) say the facilitator helps practitioners to understand what they have to change and how they should change it to achieve the desired outcome. A facilitator therefore does not only have a key role to play in affecting the context in which change is taking place but also in working with practitioners to make sense of the 'evidence' being implemented.

Helping practitioners making sense mean that the facilitator accompanies practitioners to discover their own knowledge (Bentley, 1996; Brookfield, 1986). A further distinction can be made between the facilitator's role that is concerned with 'doing for others' and a role whose emphasis is on 'enabling others'. The 'doing' role is likely to be practical and task-driven, with a focus on administrating, supporting and taking on specific tasks where necessary. In contrast an 'enabling' facilitator role is more likely to be developmental in nature, seeking to explore and release the inherent potential of individuals.

Identified personal qualities and attributes of the facilitator according to McCormack, Manley and Garbett (2004) includes being patient-centred, being available, accessible, generous and flexible, being enthusiastic, being self-aware and attuned to others, being a collaborator and a catalyst, having a vision for nursing, being a strategist and demonstrating political leadership.

Facilitation is a strategy most often used within the process of practice development. Kitson, Harvey and McCormack (1998, p. 152) describe facilitation as a 'technique by which one person makes things easier for others'. The definition suggests that facilitation is achieved by one person carrying out a specific role, which enables the development of others and can provide a pathway for individuals to empower themselves.

Facilitation is activated when the facilitator helps the practitioner to examine and question their current practice (Garbett & McCormack, 2002). It involves consciousness-raising (bringing taken-for-granted knowledge embedded in everyday practice to the surface), problematisation (increase awareness of

problems in situations that are perceived as being problem free), self-reflection (increase the practitioners' awareness of aspects of practice that might need to be questioned and changed), and critique (developing new knowledge and critically reviewing it through debate). Facilitation therefore aims to emancipate practitioners, which is consistent with the critical social theory. Critical Social Science is concerned with enabling a process of emancipation, empowerment and enlightenment (Fay, 1987).

Other strategies that the facilitator may use include critical companionship, clinical supervision, and action learning.

Critical companionship is a metaphor for a helping relationship where the critical companion accompanies a less experienced practitioner on a learning journey. The key concepts from the critical companionship framework are mutuality, reciprocity, particularity, graceful care, saliency and temporality (Titchen in McCormack, Manley and Garbett, 2004). Mutuality is when the facilitator and the practitioner work together in a partnership that is carefully negotiated. The facilitator is alert to the practitioners' readiness to learn and make use of opportunities where experiences are shared. The facilitator builds on the practitioners starting point and uses his or her experience and knowledge as a resource for the practitioner to draw on in solving problems and helping them to learn from practice. Reciprocity is the development of reciprocal closeness, giving and receiving feedback, support or challenge in a mutually collaborative way, exchange of knowledge, thoughts,

feelings and actions. Particularity is the process through which the facilitator gets to know the practitioner they are helping as a whole person, as well as a colleague. Once the facilitator has established the level of the practitioner's development, he or she will use this as a starting point from which they can help the practitioner to learn from their experience. Graceful care is the support given to the practitioner by the facilitator through acts of being genuine and expressing self as a person, being generous with self, knowledge and time, giving undivided attention, being physically and emotionally present with the practitioner, dealing with negative and inappropriate emotions, using humour to provide support and valuing the practitioner as person. Saliency is the ability of the facilitator to know what is important in a particular situation. Temporality is the capacity to give time to the relationship and the learning that takes place within it (Titchen in McCormack, Manley and Garbett, 2004; Hanley, Hardy, Titchen, Garbett & McCormack, 2005). The emphasis is therefore on facilitating learning from practice, and the co-creation of new knowledge through the use of critical reflection and dialogue between the practitioner and the experienced facilitator. Learning entails provision of recovery care within the environment and working towards positively influencing workload management, professional development and organizational support.

Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care.

Action learning is a method of developing skills through a support group. It enables a group, under the initial guidance of a facilitator, to discuss matters of contention and the potential methods for resolving these. It offers practitioners a unique opportunity to develop knowledge and skills in a safe, non-threatening environment. The support of peers and a facilitator is a powerful resource that enables individuals to discover opportunities, develop critical thinking skills and become more effective practitioners (Rayner, Chrisholm & Appleby, 2002).

The goal of the facilitator-practitioner relationship during the facilitation process is to move beyond dependent-fostering behaviours and to support the development of interdependence. Interdependence can be defined as operating with a high degree of independence and allowing others to do the same. According to Covey (1989) in collaborating with others the result is win-win. Interdependence supports esteem, problem-solving, risk taking, growth, decision making, autonomy and conflict management.

6.2.3 Assumptions

The following assumptions are made in proposing the model:

As a result of their daily interaction with people who have been diagnosed with depression, the increased workload, lack of professional development and a lack of organizational support, professional nurses are prevented from implementing the identified attributes of support, positive approach, interpersonal skills and awareness of structure to promote the characteristics of the recovery approach.

Due to the impact of an increased workload, lack of professional development and lack of organizational support, the interaction between the professional nurse and the person who has been diagnosed with depression is according to the custodial medical management model which maintains the status quo.

The maintenance of the status quo prevents professional nurses from entering into a dialogue process with facilitators to increase their consciousness.

Professional nurses who do not have opportunities to interact with facilitators are not able to discuss their concerns and expectations, which in turn prevents the facilitation of future practice development opportunities.

The lack of practice development reduces the opportunity for professional nurses to develop their skills and capacity that will allow them to influence organizations to implement a recovery approach to promote the recovery of people diagnosed with depression.

If professional nurses are provided with practice development opportunities and the opportunity to practice what has been learned - they will be able to intervene effectively to promote the recovery of people who have been diagnosed with depression, they come in contact with.

For a model that aims to empower professional nurses to promote the recovery of people that have been diagnosed with depression, to be effective, it needs to be targeted at a wide range of professional nurses that does not only work in a mental health setting.

6.2.4 Relationship statements

The following relationship statements are proposed to illustrate the relational aspects of the concepts of the proposed model.

As a result of their daily interaction with people who have been diagnosed with depression, the increased workload, lack of professional development and a lack of organizational support prevents professional nurses to implement the identified attributes support, positive approach, interpersonal skills and awareness of structure to promote the characteristics of the recovery approach.

To address these barriers professional nurses communicate with a facilitator to share ideas and experiences.

The facilitator makes use of practice development.

Practice development supports the process of empowerment, which includes advancement, incorporation, and commitment.

The professional nurses develop the skills and capacity through practice development including the change and development aspects and a facilitator.

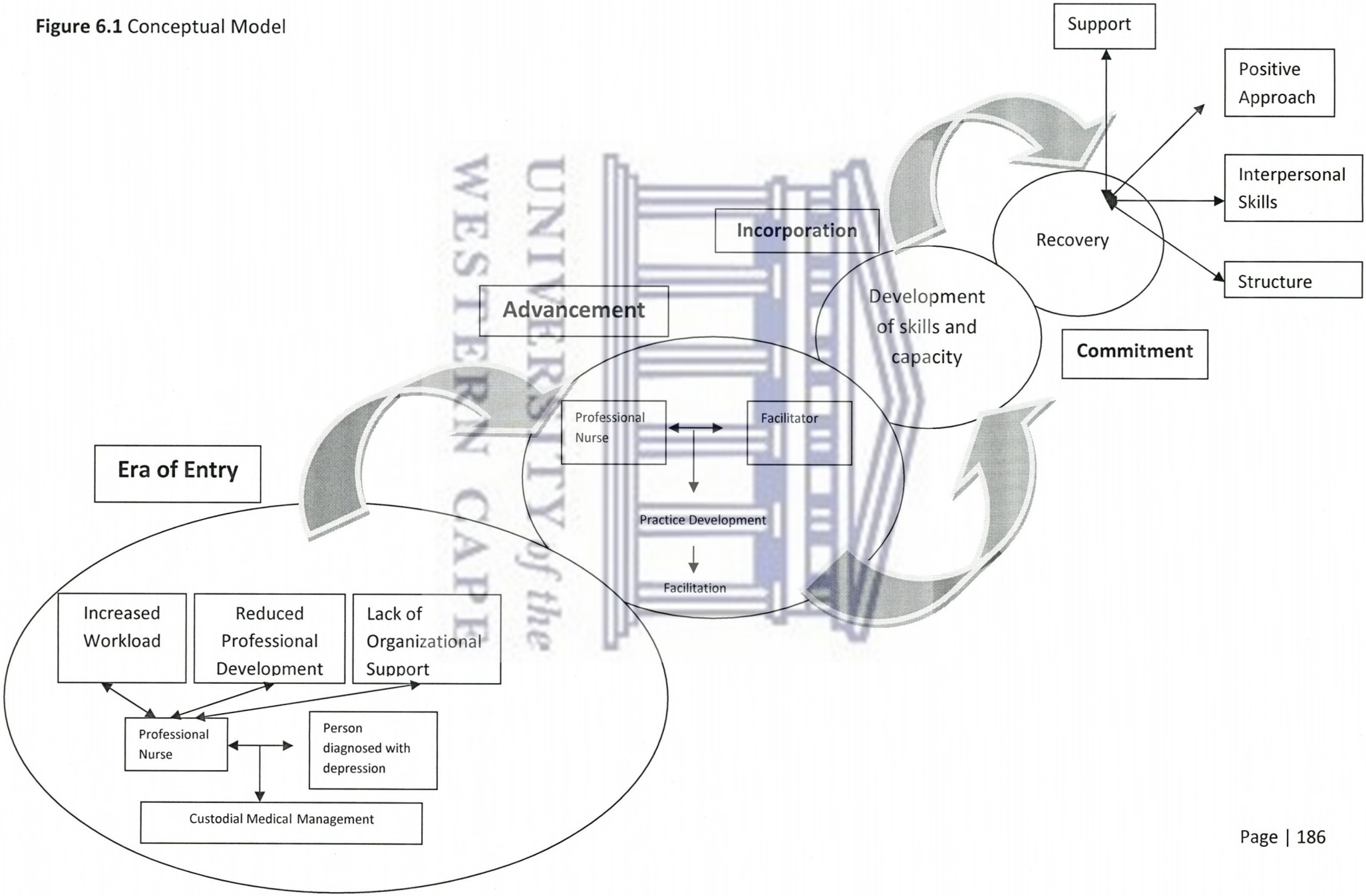
By the application of their new learned skills and capacities, the professional nurses working with people who have been diagnosed with depression, will be able to act on the characteristics of the recovery approach and implement the attributes support, positive approach, interpersonal skills and awareness of structure.

6.2.5 Structure

According to Chinn and Jacobs (1987) the structure gives overall form to the conceptual relationships.

To indicate the structure between the conceptual relationships the researcher used the structural forms as suggested by Chinn and Kramer (2004) in Figure 3.1. This included overlapping circles and horizontal lines.

Figure 6.1 Conceptual Model



6.2.6 Process of the model

Keiffer's (1984) framework was used by the researcher to indicate the process of the model. Keiffer's (1984) work on empowerment is one of the only major studies examining empowerment as a process. He labels empowerment as a developmental process which includes four stages: era of entry, advancement, incorporation, and commitment.

6.2.6.1 Era of Entry

The entry stage is motivated by the participant's experience of some event or condition that is threatening to the self or workplace – an exploration of structures, to reach some critical consciousness of their powerlessness (Keiffer, 1984). Although professional nurses were able to identify the attributes to promote the recovery of people diagnosed with depression, they felt unable to implement the recovery process in their work environments due to workload management, professional development and organizational support. The question that arises is therefore:

" How can professional nurses be empowered to implement the identified attributes despite experiencing a lack of support with regards to workload management, professional development and organizational support?"

6.2.6.2 Advancement

During this stage, people begin to experience greater understanding and sometimes feel strongly about iniquities. There are three major aspects which are important to continuing the empowerment process: supportive peer relationships;

a mentoring relationship; and the development of a more critical understanding (Keiffer, 1984).

This stage involves talking to people – the facilitator and professional nurse start a dialogue process during which they share ideas and experiences and find out relevant information. A plan of action (practice development programme) is formulated which moves from the contradiction of the existing situation towards new practice. This practice development programme includes according to the framework as adopted from McCormack, Dewar, Wright, Garbett, Harvey and Ballantine (2006):

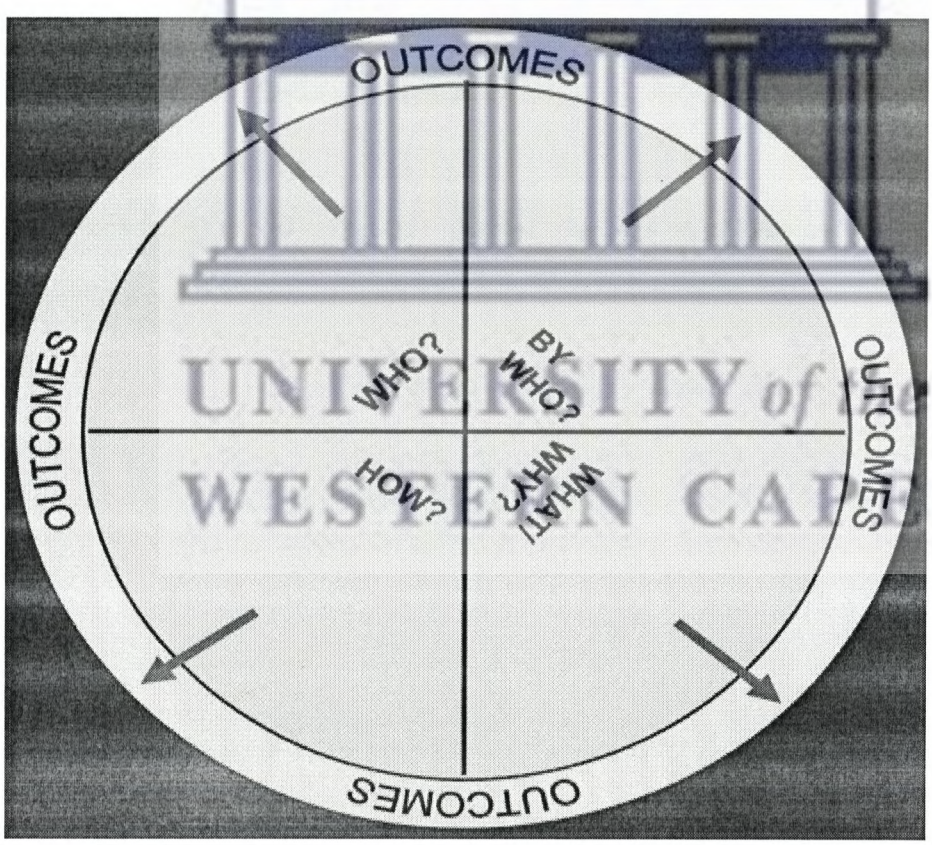


Figure 6.2 Framework as adopted from McCormack, Dewar, Wright, Garbett, Harvey and Ballantine (2006).

- By Who (the person doing the development)
- Who (the person who is the focus of the development)
- What (the impulse to engage in development work, working with ideas around inductive and deductive rationales)
- How (the actual mechanism involved)
- Outcome (What is the result?)

By Who? Facilitator

Who? Professional Nurse

What? Practice Development

How? Facilitation

Outcome? Implementation of the model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

6.2.6.3 Incorporation

The development of organisational and political skills by people is some of the characteristics of this stage of empowerment (Keiffer, 1984). The professional nurses develop the skills and capacity through the practice development approach including the change and development aspects and a facilitator who is identified in the setting such as a ward sister, advanced psychiatric nurse or similar nurse. This stage is flexible and it is possible to flow back and forth, until the parties involved are satisfied with their development.

6.2.6.4 Commitment

This is the final stage of the empowerment process, in which the participants incorporate the social action component into their daily and real life situations.

By the application of the conceptual model (Figure 6.1) the professional nurses working with people who have been diagnosed with depression, will be able to act on the characteristics of the recovery approach and implement the attributes identified through the semi-structured interviews in Chapter Four. They will be able to implement the attributes because the model takes them to empowerment - they develop the skills and capacity through the practice development approach including the change and development aspects and a facilitator who is identified in the setting such as a ward sister, advanced psychiatric nurse or similar. In the conceptual model (Figure 6.1) the arrows indicate this process.

6.2.7 Guidelines for the implementation of the model in the work environment

Awareness of the model will be created through awareness meetings with nurse managers and professional nurses. During these meetings the researcher will present and discuss the model. An open invitation will be given to organisations to participate in the opportunity to implement the model in their organisation/department.

If accepted, then the following guidelines with regards to the implementation are suggested:

Management of change

Any major change in the nursing care environment, such as adoption of a practice model of care, requires ongoing support and reinforcement in order to maintain the benefits of such a change. The process of implementing this model will take time, therefore a strategy of making a few changes, providing training, and then reinforcing the change would afford the most success and buy-in with the staff. Additionally, encouraging individual organisations/departments to use the model in unique ways that meet their needs will encourage nurses to maintain the culture of change.

A facilitator should be in place to drive the implementation process

Information from the literature highlighted the need for a facilitator (who is an expert in the recovery and practice development approach) when implementing the model. The role of the facilitator is to provide leadership to staff, practical support and accompaniment, mentoring, consultation for difficult patient care problems, comment on and make recommendations about the department's transformation process, activities, and progress. The facilitator can also provide objective third-party validation of the organisation's/department's progress toward implementing the model. The second area for the use of an external facilitator can be to design and implement a training module to be used for extensive training of nursing staff by future internal facilitators.

Management support and involvement

Robinson (2003) emphasise the importance of broad-based leadership to improve implementation success and enhance optimal outcomes. Leadership does not only include nurse managers, but also multi-disciplinary team members who have the necessary influence, authority and power.

Development of practice guidelines

Practical guidelines will have to be compiled for each of the identified attributes in the model, based on relevant literature. These guidelines for practice will have to be made available to nursing staff for feedback at regular meetings, and or email correspondence. Once approved, the guidelines should be signed and made available to nursing staff.

Development of new policies and procedures

As the model will be implemented in the work environment, new policies and procedures will evolve and maybe a quest for a new departmental mission, vision and input. Important is that all role players should be involved in any change process to increase ownership.

Monitoring and evaluation

Monitoring and evaluation of the implementation is to be done continuously and can be done during meetings with all role players, checklists based on the guidelines for practice and environmental audits. Important is that any problem highlighted should be followed up immediately and feedback given as soon as possible. Service users should be involved in all monitoring and evaluation processes.

6.3 Evaluation of the model

The guidelines for critical reflection as described by Chinn and Kramer (2004) were used to evaluate the model.

6.3.1 How clear is the model?

The process of concept analysis was used by the researcher to provide definitions of the main concepts to ensure semantic clarity. The researcher combined the methods for concept analysis of Walker and Avant (2005), Rodgers (1989) and Chinn and Kramer (2004) and used the steps that were common to all three approaches for the analysing and clarifying of the concept 'empowerment'. The activities in the method include the selection of concept(s), defining concept(s), defining attributes, and model case.

6.3.2 How simple is the model?

The visual diagram can be used to follow the overall structure of the model. The major concepts of the model were defined, relational statements linked the concepts and the researcher ensured that the assumptions were consistent with each other.

6.3.3 How general is the model?

The model can be applied to any mental health condition and it can also be applied in general nursing, community nursing, midwifery and mental health nursing.

6.3.4 How accessible is the model?

The model would be accessible because it attempted to explain the existing experiences of nurses and also predicted that the implementation of recovery principles will improve the therapeutic experiences of people who have been diagnosed with depression.

6.3.5 How important is the model?

Due to the extent of depression - if applied the model could enhance nursing practice towards the recovery of people that have been diagnosed with depression.

6.4 Summary

In this chapter the conceptual model to empower professional nurses to promote the recovery of people that has been diagnosed with depression was developed. The process for implementing the model was discussed according to the management of change, the need for a facilitator to drive the implementation process, management of support and involvement, the development of practice guidelines, the development of new policies and procedures, and the monitoring and evaluation.

The next chapter will discuss the conclusions, validations, limitations and recommendations.

CHAPTER SEVEN

VALIDATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

7.1 Introduction

The previous chapter dealt with the development of a conceptual model and the process of model functioning. This chapter will focus on whether the objectives of the study have been achieved and validate if the developed model can be applied to nursing practice. The chapter will also discuss the limitations and recommendations for future endeavours and utilization of the model to empower registered nurses to promote the recovery of people diagnosed with depression.

7.2 Validation

According to Chinn and Jacobs (1987) validation is the method for determining the credibility of empirical knowledge in relation to a scientific model or discipline. For this research study the purpose of validation will be to identify the value and potential contributions this model will make to the promotion of recovery of people who have been diagnosed with depression.

7.2.1 Methodology for validation

7.2.1.1 Sampling for the expert group discussion

The researcher made use of purposive sampling to select the participants. The sample consisted of a group of psychiatric nurse specialists who are currently lecturers at the University of the Western Cape and who is well experienced with the process of model development and evaluation.

7.2.1.2 Preparation for data collection

An appointment was made for an expert group discussion with a group of psychiatric nurse specialists. During this expert group discussion session the researcher provided the group with a power point presentation of the model. Time was made afterwards for a question and answer session.

The ethical standards as set out in section 3.6, were adhered to before, during and after the expert discussion session.

7.2.1.3 Data analysis of the expert group discussion

Participants agreed that there is no model in South Africa to enhance the empowerment of professional nurses to promote the recovery of people that have been diagnosed with depression and stated that the model is important in the South African healthcare system, because of the lack of emphasis on rehabilitation and recovery.

Participants agreed that the concepts used in the model were clear and easy to understand, which will make it easy to implement. A suggestion was made to change the concept registered nurse to professional nurse for congruence with the changes made in the new *Nursing Act* (2005). The researcher made the adjustment.

The concept recovery needed more input from the researcher as this concept was confused with rehabilitation by one participant.

Participants agreed that the implementation of the model will challenge existing professional nurses to examine their approaches towards people with depression and ensure that it is truly person centred, seeking to educate and work in partnership with their service users. Consensus amongst the participants was that the implementation of the model will not be without the normal problems, particularly workload related. It will require extensive commitment from services and professionals: at all levels there must be receptiveness to change and a willingness to innovate. The increased service user empowerment and collaborative work can give professional nurses a greater sense of professional competence and improved morale.

Participants agreed that a replication of the model can be conducted in a different context in the Western Cape Province or other province, which can suggest further revision or recommendations for application.

7.3 Limitations

The following limitations were identified during the study:

- Various formats were explored to conduct focus groups with patients, but seemed difficult to synchronize due to patient availability and the schedule of the researcher. An attempt was made with the South African Depression and Anxiety Group, but was unsuccessful. Hence patient views were not included.

- Due to time constraints, the semi-structured interviews only included professional nurses, rather than other stakeholders for example care givers and/or patients who would have provided valuable data. Additional outreach to other professionals, carers and interested members from the community would have been helpful.
- Inherent in a qualitative study is the issue of interpretation of the data. It is necessarily influenced by the background and life experience of the researchers and other people involved in the study. Different interpreters coming from different perspectives might have come to different conclusions.
- A longer time frame would have allowed for further refinement of the model to empower professional nurses to promote the recovery of people who have been diagnosed with depression.
- Again due to time constraints, additional methods of study such as observation and questionnaires might have enhanced the data or provided other insights.
- Familiarity with the topic as the researcher is currently working as a manager in a recovery rehabilitation unit, may have been a limitation in this study. Krueger (1998 in Casey, 2000) describes familiarity as both an asset and a liability. It can assist in the development of meaning from the data collected, but it can also limit one's thinking as assumptions that are made may not be correct.
- This research study was aimed at the level of the individual practitioner and did not set out to address system aspects.

7.4 Recommendations

The following recommendations encompass research practice and education.

There is a need for further research to explore how to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression. Future studies could include the use of carers, interested members of the public and other professionals and additional methods such as observations, focus groups and questionnaires. The researcher recommends the inclusion of these research methods due to the limitations encountered.

Further research is recommended to test the model and the activities and tasks within each of the four phases.

It is recommended that the study should be repeated in other settings, but with a longer time frame to improve the generalisability ability of the model.

It is recommended that the impact of the change (after implementation) in the nursing approach on the multi-disciplinary team, the organisation, the person diagnosed with depression and their families should be investigated.

Recovery is an important new idea which can have major implications for the design and operation of mental health services. There will be barriers such as workload management, professional development and organizational support to the implementation as identified in this research study. To help to overcome them, organizations might consider a recovery – orientated policy implementation guide

to provide guidelines for practice at an individual, team and service level. Such an implementation policy guide can be used as a practice development tool and audit instrument for local practices.

Local universities and colleges should develop characteristics that are empowering such as recovery, and the skills required to deliver this should be included in pre- and post qualification training.

It is recommended that existing educational facilities should include a unit on Practice Development at undergraduate, post registration and masters degree levels. This will ensure that new advanced practitioners and existing senior staff would learn about practice development, together as a means for possibly more successful implementation of the model.

7.5 Conclusion

The goal of the research was to develop a model to empower professional nurses to promote the recovery of people who have been diagnosed with depression. The objectives for the research study were:

- To explore and describe the self reported attributes needed by professional nurses to promote the recovery of people who have been diagnosed with depression.
- To explore and describe how these self reported attributes can be facilitated in the work environment.

- To propose a model to enhance the empowerment of professional nurses to promote the recovery of people who have been diagnosed with depression.

- To develop guidelines for the operationalisation of the model.

The first two objectives were achieved by conducting a study that was exploratory, descriptive, and contextual in nature. Semi-structured interviews were used as a data collection method. The participants described in detail the attributes required by professional nurses to promote the recovery of people who have been diagnosed with depression. The attributes identified to promote the recovery of people diagnosed with depression included support, a positive approach, interpersonal skills, awareness of community links, and the creation of structure. Workload management, professional development and organizational support were identified as major challenges to the implementation of a recovery approach in the working environments of professional nurses. Literature control was used by the researcher to validate the findings from the interviews. The findings indicated that professional nurses needed an empowerment model that would support them to promote a recovery approach in their working environments. Practice development was identified as a concept congruent with empowerment.

The third objective was achieved through the design and development of an empowerment model. The model was developed by using the six components indicated by Chinn and Jacobs (1987: 116) namely goals, concepts, definitions, relationships, structure and assumptions. The process of the model included era of entry, advancement, incorporation, and commitment.

In view of the above it was concluded that these objectives have been achieved.

The theoretical departure for this research study was based on the Critical Social Theory (CST). The CST seeks to emancipate people through the promotion of critical consciousness and aims to find alternatives for the structures and arrangements which reproduce oppressive ideologies (established order, taken-for-granted conditions and the status quo) that are produced, maintained and reproduced. The CST contests these oppressive ideologies through critical inquiry.

Depression is the most prevalent psychiatric disorder in both developed and developing countries and it is acknowledged to be increasing in terms of disease burden. In South Africa, neuro-psychiatric disorders account for the second highest proportion of the local burden of disease, after HIV/AIDS (Bradshaw, 2003). In the Western Cape Province alone, more than 22% of all disability is due to "emotional" and "intellectual" disability (Statistics South Africa, 2001).

As a result of their daily interaction with people who have been diagnosed with depression, professional nurses identified increased workload, lack of professional development and a lack of organizational support as barriers to implement the identified attributes support, positive approach, interpersonal skills and awareness of structure to promote the characteristics of the recovery approach.

Practice development was identified in Chapter Four as a methodology to empower professional nurses. Professional nurses will develop the skills and capacity to bring about transformation, through practice development including

the change and development aspects and a facilitator who is identified in the setting such as a ward sister, advanced psychiatric nurse or similar.

By the application of the conceptual model (Chapter Six) the professional nurses working with people who have been diagnosed with depression, will be able to act on the characteristics of the recovery approach and implement the attributes identified through the semi-structured interviews in Chapter Four. They will be able to implement the attributes because the model takes them to empowerment.

By implementing the attributes in their daily practice professional nurses will be able to change the status quo brought about by the custodial medical management model and they will be able to intervene effectively to promote the recovery of people who have been diagnosed with depression.

REFERENCE LIST

Adair, L. (1994). The patient's agenda. *Nursing Standard*. 9, 20-23.

Adams, R. (2003). *Social work and empowerment* (3rd ed.). New York: Palgrave Macmillan.

Adorno, T. (2004). *The tidal model and the reform of nursing practice*. Birmingham: Solihull Mental Health NHS Trust.

American Association of Critical – Care Nurses. (2005). *AACN standards for establishing and sustaining healthy work environments. A journey to excellence*. Retrieved September 2, 2008, from www.aacn.org/WD/HWE/Docs/HWEStandards.pdf

American Federation of Teachers. (1995). *Definition of "safe staffing."* Retrieved April 11, 2009, from http://www.aft.org/topics/healthcarestaffing/ definition.htm.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders, fourth edition*. Washington. D.C: American Psychiatric Association.

Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*. 16, 11-23.

Andresen, R., Caputi, P. & Oades, L. (2006). Stages of recovery instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry*. 40, 972-980.

Arai, S. (1997). *Empowerment: From the theoretical to the personal.* Retrieved March 20, 2009, from http://lin.ca/resource-details/848.

Armstrong, E. (1999). Role of the community nurse in caring for people with depression. *Nursing Standard*. 13(35), 40-44.

Australian Health Ministers. (2003). *National mental health plan 2003-2008*. Retrieved May 2, 2008, from http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs/$FILE/nmhp0308.pdf.

Babbie, E., & Mouton, J. (2001). *The practice of social research*. South Africa: Oxford University Press.

Baker, P. (1997). *An overview of the assessment process: Bringing life into the light, assessment in psychiatric and mental health nursing in search of the whole person*. Cheltenham: Stanley Thornes Ltd.

Barker, P. (2000). The philosophy of empowerment. *Mental Health Nursing*. 20(9), 8-9.

Baker, P. (2001). The tidal model: developing and empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8, 233-240.

Barker, P. (2002). The tidal model: The healing potential of metaphor within a patient's narrative. *Psychosocial Nursing and Mental health Services*. 40, 42-50.

Barker, P., Jackson, S. & Stevenson, C. (1999). What are psychiatric nurses needed for? Developing a theory of essential nursing practice. *Journal of Psychiatric and Mental health Nursing*. 6, 273-282.

Barker, P. & Buchanan-Barker, P. (2007). *The tidal model: mental health, reclamation and recovery*. Retrieved April 20, 2009, from http://www.tidal-model.com and response to an email request from the researcher.

Barton, R. (1998). The rehabilitation-recovery paradigm: A statement of philosophy for a public mental health system. *Psychiatric Rehabilitation Skills*. 2(2), 171-187.

Baumann, A. & Blythe, J. (2003a). Restructuring, reconsidering, reconstructing: Implications for health human resources. *International Journal of Public Administration, 26*(14), 1561 - 1579.

Baumann, A. & Blythe, J. (2003b). Nursing human resources: Human cost versus human capital in the restructured health care system. *Health Perspectives, 3*(1), 27 - 34.

Baumann, A. (2007). *Positive practice environments: Quality workplaces = quality patient care*. Geneva (Switzerland): International Council of Nurses.

Baxter, E.A. & Diehl, S. (1998). Emotional stages: consumers and family members recovering from the trauma of mental illness. *Psychiatric Rehabilitation Journal*. 21(4), 349-355.

Beck, A.J., Ward, C.H., Mendelson, M., Mock, J. & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*. 4, 53-63.

Beck, A.T., Steer, R.A., Ball, R. & Ranieri, W. (1996). Comparison of Beck Depression inventories –IA and II in psychiatric outpatients. *Journal of Personality Assessment*. 67(3), 588-597.

Belle, D. & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among women. *Psychology of Women Quartely*. 27, 101-113.

Benjamin, J. (2006, June 23). South African steps up the fight against drug abuse. *Pretoria News*, p.5.

Benner, P. (1984). *From novice to expert: excellence and power in clinical nursing practice*. London: Addison-Wesley.

Bentley, T. (1996). *Sharpen your skills in motivating people to perform*. London: The McGraw-Hills Companies.

Bentz, V,V. & Shapiro, J, J. (1998). *Mindful inquiry in social research*. Thousand Oakes, CA: Sage.

Berg, A., Hansson, U.W. Hallberg, I.R. (1994). Nurses' creativity, tedium and burnout during 1 year of clinical supervision and implementation of individually planned nursing care: comparisons between a ward for severely demented patients and a similar control ward. *Journal of Advanced Nursing*, 20, 742-749.

Berzins, K. (2006). *Implementing a recovery approach in policy and practice: a review of the literature*. United Kingdom, Glasgow: Scottish Recovery Network.

Bishop, D. & Ford-Bruins, I. (2003). Nurses perceptions of mental health assessment in an acute inpatient setting in New Zealand: a qualitative study. *International Journal of Mental Health Nursing*, 12, 203-212.

Black, C., & Shooter, M. (2003). *The psychological care of medical patients: A practical guide*. London: Royal College of Physicians and Royal College of Psychiatrists.

Black Dog Institute. (2008). *Gender Differences in depression*. Retrieved March, 20, 2008, from http://www.blackdoginstitute.org.au/depression/causes/gender.cfm.

Boehm, A. & Staples, L. (2002). The functions of the social worker in empowering: the voices of consumers and professionals. *Social Work*, 47, 449-459.

Bogdan, R.C. & Biklen, S.K. (1982). *Qualitative research for education: An introduction to theory and methods.* Boston: Allyn and Bacon, Inc.

Bonisteel, M. (2005). Measuring empowerment: The application of an empowerment model to nursing development in Bosnia and Herzegovina. Retrieved August 3, 2009, from http://awcca.ca/pdf/MB_MeasuringEmpowerment.pdf.

Boog, B.W.M. (2003). The emancipatory character of action research, its history and the present state of the art. *Journal of Community & Applied Social Psychology*. 13, 426-438.

Boscart, V.M. (2009). A communication intervention for nursing staff in chronic care. *Journal of Advanced Nursing*, 65(9), 1823-1832.

Bradley, A. (2004). *Positive approaches to person centred planning*. United Kingdom: Bild.

Bradshaw, D. (2003). *Initial burden of disease estimates for South Africa, 2000*. Cape Town: Medical Research Council.

Branbury-Jones, C., Sambrook, S. & Irvine, F. (2008). Power and empowerment in nursing: A fourth theoretical approach. *Journal of Advanced Nursing*. 62(2), 258-266.

Bridges, J. (2001). Meeting the needs of older people in rehabilitation care. *Nursing Times*. 97(3), 33-34.

Brinn, F. (2000). Patients with mental illness: general nurses' attitudes and expectations. *Nursing Standard*. 14(27), 32-36.

Brookfield, S. D. (1986). *Understanding and facilitating adult learning*. San – Francisco: Jossey-Boss.

Brundage, D., & MacKeracher, D. (1980). *Adult learning principles and their application to program planning*. Toronto, Ontario: Ontario Institute for Studies in Education.

Buchanan-Barker, P. & Barker, P. J. (2008). *The Tidal model of mental health recovery and reclamation*. Retrieved April 20, 2009 – response to an email request from the researcher.

Burns, N., & Grove, S.K. (2001). *The practice of nursing research* (4th Ed). Philadelphia: W.B Saunders.

Burton, S., Brown, G., Daniels, I.R., Norman, A.R., Mason, B. & Cunningham, D. (2006). MRI directed multidisciplinary team preoperative treatment strategy: the way to eliminate positive circumferential margins? *British Journal of Cancer*, 94, 351-357.

Byrne, E. (2004). *A participatory approach to the design of a child-health community-based information system for the care of vulnerable children*. DPhil thesis. University of the Western Cape. Retrieved February 10, 2006, from University of the Western Cape electronic theses and dissertations (ETDs).

Campton, R. B., Galaway, B. & Conmoyer,R.B. (2005). *Social work processes* (7th ed.). Brooks/Cole-Thompson Learning Belmont.

Caplan, G., Williams, A., Daly, B. & Abraham, K. (2004). A randomised controlled trial of comprehensive geriatric assessment and multidisciplinary intervention after discharge of elderly from the

emergency department – the Deed II study. *Journal of American Geriatrics Society*, 52, 1417-1423.

Carr, W. & Kemmis, S. (1986). *Becoming critical: Education, knowledge and action research*. London: The Falmer Press.

Casey, H. (2000). *Empowerment: What can nurse leaders do to encourage an empowering environment for nurses working in the mental health area*? MA thesis. Victoria University of Wellington. Retrieved March, 20, 2009, from Google search engine.

Chamberlin, J. (1997). A working definition of empowerment. *Psychiatric Rehabilitation Journal*. 20(4), 43-46.

Chambers, D. & Thompson, S. (2009). Empowerment and its application in health promotion in acute care settings: Nurses' perceptions. *Journal of Advanced Nursing*. 65(1), 130-138(9).

Chambore, V. (2004). *Maximising patient power: Commercial opportunities for the pharma industry*. Retrieved March 20, 2009, from http://www.pjbpubs.com/pop_report_download.asp?type=toc&subid=386 ...

Chang, J.H., Vines, E., Bertsch, H., Fraker, D.L., Czerniecki, B.J., Rosato, E.F., Lawton, T., Conant, E.F., Orel, S.G., Schuchter, L., Fox, K.R., Zieber, N., Glick, J.H. & Solin, L.J. (2001). The impact of a multidisciplinary breast cancer center on recommendations for patient management. *Cancer*, 91(7), 1231-1237.

Chesler, P. (1972). Women and madness: the mental asylum. In T. Heller, T. Reynolds, R. Gomm, R. Muston and S. Pattison. (1996). *Mental health matters: a reader*. Basingstoke: Macmillen.

Chinn, P.L., & Jacobs, M.K. (1987). *Theory and nursing: A systematic approach*. (2nd Ed.). St. Louis: C.V. Mosby.

Chinn, P.L., & Kramer, M.K. (1995). *Theory and nursing: A systematic approach*. 4th edition. St. Louis: Mosby.

Chinn, P.L. & Kramer, M.K. (2004). Integrated knowledge development in nursing. 6th edition. Mosby.

Chitnis, K.S. (2005). *Communication for empowerment and participatory development: A social model of health in Jamkhed, India*. Phd Thesis, College of Communication of ohio University. Retrieved March 25, 2009, from http:// etd.ohiolink.edu/send-pdf.cgi/chitins%20Ketan%20S.pdf?acc_num...

College of Registered Nurses of British Columbia. (2005). *Guidelines for a quality practice environment for nurses in British Columbia*. Retrieved January 20, 2009, from http://www.crnbc.ca/downloads/409.pdf.

Collins English Dictionary. (1991). (3rd Ed.). Glasgow: HarperCollins.

Colom, F., Vieta, E., Martinez, A., Jorquera, A. & Gasto, C. (1998). What is the role of psychotherapy in the treatment of bipolar disorder? *Psychotherapy and Psychosomatics*, 67(1), 3-9.

Copeland, M.E. (2001). *The depression workbook* (2nd ed.). United States of America: New Harbinger Publications, Inc.

Corbally, M., Scott, P.A., Matthews, A., Gabhann, L.M. & Murphy, C. (2007). Irish nurses' and midwives' understanding and experiences of empowerment. *Journal of Nursing Management*. 15(2), 169-179.

Cormier, W. & Cormier, L. (1991). *Interviewing strategies for helpers.* Brooks-Cole. Pacific Grove.

Corrigall, J., Ward, C., Stinson, K., Struthers, P., Frantz, J., Lund, C., Flisher, A.J. & Joska, J. (2007). *The western cape burden of disease reduction project. Volume 4 of 7: Decreasing the burden of mental illness.* Retrieved March 3, 2009, from http://www.capegateway.gov.za/eng/your-gov/305.

Coulter, A., Parsons, S. & Askham, J. (2008, June 25-27). *Where are the patients in decision – making about their own care?* Policy brief, written for the WHO European Ministerial Conference on Health Systems, Tallin, Estonia. Retrieved June 20, 2009, from http://www.euro.who.int/document/hsm/3_hsc08_ePB_6.pdf.

Covey, S.R. (1989). *The 7 habilts of highly effective people*. Finland: WS Brookwell.

Cutliff, J.R. & Epling, M. (1997). An exploration of the use of John Heron's confronting interventions in clinical supervision: case studies from practice. *Psychiatric Care*, 4, 174-180.

Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*. 48(1), 43 – 50.

Davidson, L. & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*. 16, 459-470.

Davis, M. (1998). *The rocky road to reflection*. In: Transforming nursing through reflective practice (Eds. John, C., & Freshwater, D.). Oxford: Blackwell Science.

Deegan, P.E. (1992). *The independent living movement and people with psychiatric disabilities: taking back control over our own lives*. In L. Spaniol,

C. Cagne, M. Koehler (Ed), Psychological and social aspects of psychiatric disability. Boston University: Centre for Psychiatric Rehabilitation. Boston. Massachusetts.

Deegan, P.E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*. 11(4), 11-19.

Deegan, P. (1996b). Recovery and the conspiracy of hope. *Paper presented to the Sixth annual mental health services conference of Australia and New Zealand, Brisbane, Australia.*

Denzin, N.K. & Lincoln, Y.S. (1994). *Handbook of qualitative research*. Thousand Oakes: Sage.

Department of Health NSW. (2008). Discharge planning policy: Adult mental health inpatient services. Retrieved February 20, 2009, from http://www.health.nsw.gov.au/policies/.

DeVos, A.S. (1998). *Research at grassroots: A premier for the caring professions*. Pretoria: J.L. Van Schaick Academic.

De Vos, A.S. (2002). *Research at grass roots for social sciences and human service professions*. 2nd edition. Pretoria: Van Schaik.

Dickoff, J., James, P., & Weidenbach, E. (1968). Theory in a practice discipline. *Nursing Research*. 17(5), 415-435.

Dossey, B.M. (1997). *Core curriculum for holistic nursing.* American Holistic Nurse's Association. Aspen publishers.

Dossey, B.M., Keegan, L. & Guzzetta, C.E. (2005). *Holistic nursing: a handbook for practice* (4th Ed.). Sudbury, MA: Jones and Bartlett.

Drenhan, D. (1992). *Transforming company culture*. London: McGraw-Hill.

Drury, J., Cocking, C., Beale, J., Hanson, C. & Rapley, F. (2005). The phenomenology of empowerment in collective action. *British Journal of Social Psychology*. 44, 309 – 328.

Drury, J. & Reicher, S. (2005). Explaining enduring empowerment: A comparative study of collective action and psychological outcomes. *European Journal of Social Psychology*. 35, 35-58.

Egan, G. (1998). *The skilled helper. A problem-management approach to helping*. (6th Ed). United States of AmericA: Brooks/Cole Publishing Company.

Family Psychoeducation. (2003). *Implementation tips for public mental health authorities*. Retrieved May 2, 2009, from http://download.ncadi.samhsa.gov/ken/pdf/toolkits/family/10.FamPsy_Tips_Authority.pdf.

Fava, G.A., Ruini, C. & Belaise, C. (2007). The concept of recovery in major depression. *Psychological Medicine*. 37(3), 307-317.

Fay, B. (1987). *The basic schema of critical social science*. In: Critical Social Science: Liberation and its limits (Ed. Fay, B). 27-41. London: Polity Press.

Field, P.A. & Morse, J.M. (1985). *Nursing research: the application of qualitative approaches*. London: Croom Helm.

Foster, G. (2004). Managing front line practice: women and men: the social care workforce. In D. Statham. *Managing front line practice in social care*. London: Jessica Kingsley.

Frack, D. (2005). *A report on the work of the recovery learning sites and other recovery orientated activities and its incorporation into the rethink plan 2004-2008*. RETHINK.

Freeman, M. (2002). New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health. *South African Psychiatry Review*. 5(3(Aug)), 4-6, 8.

Freire, P. (1972). *Pedagogy of the oppressed*. Penguin, Harmondsworth.

Freire, P. (1987). *Education for critical consciousness*. New York: Continuum.

Fulton, Y. (1997). Nurses' views on empowerment: a critical social theory perspective. *Journal of Advanced Nursing*. 26(3), 529-536.

Garbett, R. & McCormack, B. (2002). A concept analysis of practice development. *Nursing Times Research*, 7(2), 87 – 100.

Garside, P. (2004). *Empowerment, what is it and why should we care?* Retrieved July 20, 2009, from http://www.equal-works.com/DPDetail.aspx?ety=8d4f5297-c3f5-485a-9731-0ccf88d64b39.

Gepson, J., Martinko., & Belina, J. (1981) Nominal group techniques: A diagnostic strategy for training needs analysis. *Training and Development Journal*. 35(9), 78-83.

Gerrish, K., & Lacey, A. (2006). *The research process in nursing*. (5th Ed.). Blackwell Publishing.

Gerrish, K., Guillaume, L., Kirshbaum, M., McDonnell, A., Nolan, M., Read, S. & Tod, A. (2007). *Empowering front-line staff to deliver evidence-based care: The contribution of nurses in advanced practice roles*. Retrieved

August 20, 2009, from http://www.shu.ac.uk/research/hsc/sp-kate-gerrish.html.

Gibson, C. & Woolcock, M. (2007). *Empowerment, deliberative development and local level politics in Indonesia: Participatory projects as a source of countervailing power*. Retrieved August 5, 2009, from http://www.bwpi. Manchester.ac.uk/resources/Working-Papers/bwpi-wp-0807.pdf.

Gilbert, T. (1995). Nursing: empowerment and the problem of power. *Journal of Advanced Nursing*, 21(5), 865-871.

Golant, M. & Golant, S.K. (1998). *What to do when someone you love is depressed. A practical, compassionate, and helpful guide for caregivers*. New York: Henry Holt & Company Inc.

Gotlib, I.H., & Hammen, C.L. (1992). *Psychological aspects of depression: Toward a cognitive interpersonal integration*. New York: Wiley.

Gotlib, I.H. & Hammen, C.L. (2002). *Handbook of depression*. United States of America: The Guilford Press.

Gray, R., Wykes, T., Edmonds, M., Leese, M. & Gournay, K. (2004). Effect of a medication management training package for nurses on clinical outcomes for patients with schizophrenia: Cluster randomised controlled trial. *British Journal of Psychiatry*, 185, 157 – 162.

Graybeal, C. (2001). Strengths-based social work assessment: Transforming the dominant paradigm. *Families in Society: The Journal of Contemporary Human Services*. 82(3), 233-242.

Great Britain Equal Support Unit. (2007). *Empowerment – a guide for development partnerships*. Retrieved August 2, 2009, from

http;//www.equal.ecotec.co.uk/resources/.../down_doc.asp?...empowerment...

Greenberg, P.E., Stiglin, L.E., Finkelstein, S. & Berndt, E. (1993). Depression: A neglected major illness. *Journal of Clinical Psychiatry*. 54(11), 419-424.

Guba, E. & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oakes, CA: Sage.

Habermas, J. (1972). *Knowledge and human interests*, trans J.J Shapiro. London: Heinemann.

Hajbaghery, M.A. & Salsali, M. (2005). *A model for empowerment of nursing in Iran*. Retrieved July 20, 2008, from http://www.biomedcentral.com/1472-6963/5/24.

Hall, B. (1996). The psychiatric model: a critical analysis of its undermining effects on nursing in chronic mental illness. *Advances in Nursing Science*. 18(3), 16-26.

Hall, A., Wren, M. & Kirby, S. (2008). *Care planning in mental health. Promoting recovery*. United Kingdom: Blackwell Publishing Ltd.

Hallberg, I.R. (1994). Systematic clinical supervision in a child psychiatric ward: satisfaction with nursing care, tedium, burnout and the nurse's own report on the effects of it. *Archives of Psychiatric Nursing*, 8, 44-52.

Hallberg, I.R. & Norberg, A. (1993). Strain among nurses and their emotional reactions during 1 year of systematic clinical supervision combined with the implementation of individualized care in dementia nursing. *Journal of Advanced Nursing*, 18, 1860-1875.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry*. 23, 56-62.

Hannigan, B. (1997). A challenge for community psychiatric nursing: is there a future in primary health care? *Journal of Advanced Nursing*. 26(4), 751-757.

Hannigan, B. & Coffey, M. (2003). *The handbook of community mental health nursing*. London: Routledge.

Harrison, A. & Hart, C. (2006). *Mental health care for nurses. Applying mental health skills in the general hospital*. United Kingdom: Blackwell Publishing Ltd.

Harvey, G., Loftus-Hills, A., Rycroft-Malone, J., Titchen, A., McCormack, B., & Seers, K. (2002). Getting evidence into practice: the role and function of facilitation. Journal of advanced Nursing. 37(6), 577-588.

Hassan, F.H. (2008). *Work empowerment as perceived by nurses and physicians working at a heart institute*. Retrieved July 20, 2009, from http://unpan1.un.org/intradoc/groups/public/documents/.../unpan020758.pdf.

Hatfield, A.B. & Lefley, H.P. (1993). *Surviving mental illness: Stress, coping and adaptation*. New York: The Gullford Press.

Hawks, J.H. (2006). Empowerment in nursing education: Concept analysis and application to philosophy, learning and instruction. *Journal of Advanced Nursing*. 17(5), 609 – 618.

Health24. (2006). *Millions in SA have mental illness*. Retrieved March 25, 2006, from http://www.health24.com.

HeartMath. (2004). *White paper: New hope for the nurse shortage crisis*. Retrieved September 2, 2008, from www.heartmath.com/company/proom/nurse_white_paper.pdf.

Hedin, B.A. (1986). A case study of oppressed group behaviour in nurses. Image: *Journal of Nursing Scholarship*. 18(2), 53-57.

Hendricks-Thomas, J., & Patterson, E. (1995). A sharing in critical thought by nursing faculty. *Journal of Advanced Nursing*. 22(3), 594-599.

Heron, J. (1990). *Helping the client*. London: Sage.

Heron, J. (1991). *Multi-model learning*. Unplished lecture notes.

Heron, J. (1992). *Feeling and personhood: Psychology in another key*. London: Sage.

Hitchcock, J., Schubert, P. & Thomas, S. (1999). *Community health nursing: caring in action*. New York: Delmar.

Holloway, I. (1997). *Basic concepts for qualitative research*. United Kingdom: Blackwell Science.

Holloway, I. (2004). *Basic concepts for qualitative research*. United Kingdom: Blackwell Science Ltd.

Horsefall, J. (1997). Psychiatric nursing: epistemological contradictions. *Advances in Nursing Science*. 20(1), 56-65.

Hoshmand, L.T. (1999). Locating the qualitative research genre. In M. Kopala & L.A. Suzuki (Eds). *Using qualitative methods in psychology*. Thousand Oakes: Sage.

Hunt, E. (1993). On avoiding 'psych' patients. *Journal of Emergency Nursing*. 19(5), 375-376.

Innes, A., Macpherson, S. & McCabe, L. (2006). Promoting person-centred care at the frontline. York: Joseph Rowntree Foundation.

Inskipp, F. & Proctor, B. (1993). *Making the most of supervision: Professional development for counsellors and trainers*. London: Cascade.

Jonas-Simpson, C., Mitchell, G.J., Fisher, A., Jones, G. & Linscott, J. (2006). The experience of being listened to: a qualitative study of older adults in long-term care settings. *Journal of Gerontological Nursing*, 32(1), 46-53.

Jones, A. (1999). Clinical supervision for professional practice. *Nursing Standard*, 14(9), 42-44.

Jones, C. (2001). Voices from the front line: state social workers and New Labour. *British Journal of Social Work*, 31, 547-562.

Jooste, K. (1997). *A model for empowerment of nurses: A managerial perspective*. D. Litt. Thesis, University of South Africa. Retrieved September 2, 2009, from http://search.ebscohost.com.ezproxy.uwc.ac.za/login.aspx?direct=true&db=c8h&AN=2004110427&site=ehost-live.

Joppe, M. (2000). *The research process*. Retrieved March, 10, 2007, from http://www.ryerson.ca/~mjoppe/rp.htm.

Kale, R. (1995). South Africa's Health: New South Africa's mental health. *British Medical Journal*. 310(6989), 1254-1256.

Kanter, R.M. (1977). *Men and women of the corporation*. New York: Basic Books.

Kaplan, H.I. & Sadock, B.J. (1998). *Synopsis of psychiatry. Behavioral sciences/clinical psychiatry* (8th ed). United States of America: Williams & Wilkins.

Keller, B.R. & Mbwewe, D.C. (1991). Policy and planning for the empowerment of Zambia's women farmers. *Canadian Journal of Development Studies*. 12(1), 75-88.

Kemp, V.H. (1985). Concept analysis as a strategy for promoting critical thinking. *Journal of Nursing Education*, 24(9), 382 – 384.

Khandelwai, S. (2001). *Conquering depression*. Retrieved November12, 2009, from http://www.searo.who.int/LinkFiles/Conquering_Depression_ment-120.pdf.

Khosa, M.M. (2000). *Empowerment through service delivery*. Pretoria: Human Sciences Research Council.

Kieffer, C. (1984). Citizen empowerment: a developmental perspective. *Prevention in Human Services*. 3, 9-36.

Kincheloe, J.L. & McClaren, P. (2000). Rethinking critical theory and qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds), *Handbook of qualitative research* (2nd ed.). Thousand Oakes: Sage.

Kitson , A. (1994). *Clinical Nursing Practice Development and Research Activity in the Oxford Region*. Centre for Practice Development and Research, National Institute for Nursing, Oxford.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence-based practice: a conceptual framework. *Quality in Health Care*. 7, 149-158.

Kleintjes, S., Flisher, A., Fick, M., Railon, A., Lund, C., Molteno, C., & Robertson, B.A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *South African Psychiatric Review, 9,* 157-160.

Klopper, H. (1999). *Nursing education. A reflection*. Lynwood Ridge: Amabhuku.

Knowles, M. (1980). *The modern practice of adult education. From pedagogy to andragogy* (2nd ed.). New York: Cambridge Books.

Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*. 19, 976 – 986.

Koenig, H.G., & Kuchibhatla, M. (1998). Use of health services by hospitalized medically ill depressed elderly patients. *American Journal of Psychiatry*. 155(7), 871-877.

Kuehner, C. (2003). Gender differences in unipolar depression: an update of epidemiological findings and possible explanations. *Acta Psychiatrica Scandinavica*. 108, 163 – 174.

Kuokkanen, L. & Leini-Kilpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. *Journal of Advanced Nursing*. 30(1), 235-241.

Kuokkanen, L. & Leini-Kilpi, H. (2001). The qualities of an empowered nurse and the factors involved. *Journal of Nursing Management*. 9(5), 273-280.

Kvale, S. (1995). The social construct of validity. *Qualitative Inquiry*, 1, 19-40.

LaMonica, E. (1981). Construct validity of an empathy instrument. *Research in Nursing and Health*, 4, 389-400.

LaMonica, E., Madea, A. & Oberst, M. (1987). Empathy and nursing care outcomes. *Scholary Inquiry for Nursing Practice*, 1, 197-213.

Laverack, G. & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning*. 15(3), 255-262.

Lincoln, M. & Guba, E.G. (1985). *Criteria for assessing trustworthiness of naturalistic inquiry*. London: Sage.

Leddy, S.K. (2003). *Integrative health promotion*. SLACK Incorporated.

Ledwith, M. (2005). *Community development: A critical approach*. Great Britain: The Policy Press.

Leete, E. (1994). Stressor, symptom, or sequelae: Remission, recovery, or cure? *The Journal of the California Alliance for the Mentally Ill*. 5, 16-17.

Lenkwane, S.T. (2001). A model for facilitation of continuous assertiveness for the psychiatric nurses in a psychiatric context. In M.J. Manamela, *Nurses interaction with patients who are HIV/AIDS infected*. D.Cur. Thesis. Johannesburg University. Retrieved July 11, 2008, from http://ujdigispace.uj.ac.za:8080/dspace/bitstream/.../Nursesinteraction.pdf.

Lethoba, K.G. (2005). *Professional nurses' perception of nursing mentally ill people in a general hospital setting*. MA dissertation. University of South

Africa. Retrieved July 12, 2008, from http://etd.unisa.ac.za/ETD-db/thesis/available/etd-08242005-132129/unrestricted/oofront.pdf.

Lewis, M. (1990). Interrupting patriarchy: Politics, resistance, and transformation in the feminist classroom. *Harvard Education Review*, 60(4), 467-488.

Maier, W., Gansicke, M., Gater, R., Rezaki, M., Tiemens, B. & Urzua, R.F. (1999). Gender differences in the prevalence of depression: a survey in primary care. *Journal of Affective Disorders*. 53, 241-252.

Manojlovich, M. (2007). *Power and empowerment in nursing: Looking backward to inform the future*. Retrieved August 15, 2009, from http://www.nursingworld.org/.../LookingBackwardtoInformtheFuture.aspx .

Mantzoukas, S. & Jasper, M. (2008). Types of nursing knowledge used to guide the care of hospitilized patients. *Journal of Advanced Nursing*, 62(3), 318-326.

Marks, J.N. (1979). Determinants of the ability of general practitioners to detect psychiatric illness. *Psychological Medicine*. 9, 337-353.

Mason, J. (1996). *Qualitative researching*. London: Sage.

Mavundla, T.R. (2000). Professional nurse's perception of nursing mentally ill people in a general hospital setting. *Journal of Advanced Nursing*, 32(6), 1569-1578.

Mayou, R. (1995). The relationship between physical and psychiatric pathology. In House, A., Mayou, R., & Mallinson, C. (Eds). *Psychiatric aspects of disease*. London: Royal College of Physicians and Royal College of Psychiatrists.

McCormack, B., Dewar, B., Wright, J., Garbett, R., Harvey., Ballantine, K. (2006). A realist synthesis of evidence relating to practice development: final report to NHS education for Scotland and NHS quality improvement Scotland. *http://www.nes.scot.nhs.uk/*

McCormack, B., Manley, K., & Garbett, R. (2004). *Practice development in nursing*. Oxford: Blackwell Publishing.

McGabe, C. (2004). Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing*, 13, 41-49.

McGrath, E., Keith, G.P., Stickland, B.R. & Russo, N.F. (1990). *Women and depression: Risk factors and treatment issues*. Washington D.C: American Psychological Association.

McWirther, E.H. (1991). Empowerment in counselling. *Journal of Counselling and Development*. 69, 222-227.

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Retrieved May 2, 2008, from http://www.mhc.govt.nz/publications/1998/Blueprint1998.pdf.

Mental health Commission. (2005). *A vision for a recovery model in Irish mental health services*. Retrieved January 19, 2009, from http://www.mhcirl.le/.../Discussion%20Paper%20A%20Vision%20for%20a%20Recovery%20Model%202008.pdf.

Mickan, S. (2005). Evaluating the effectiveness of health care teams. *Australian Health Review*, 29(2), 211-217.

Morris, P. & O'Neill, F. (2006). *Preparing for patient-centred practice: Developing the patient voice in health professional learning*. Retrieved August 3, 2009, from

http://www.leeds.ac.uk/medicine/meu/.../P_PennyMorris_FionaO'Neill.pdf.

Morse, J.M. (1991). *Qualitative nursing research, a contemporary dialogue* (revised edition). Londons: Sage.

Morse, J.M. (1994). *Critical issues in qualitative research methods*. London: Sage.

Morse, J.M., & Field, P.A. (1996). Nursing research. The application of qualitative approaches. (2nd Ed). New York: Chapman & Hall.

Morse, J.M., Hupcey, J.E., Mitcham, C. & Lenz, E.R. (1996). Concept analysis in nursing research: a critical appraisal. *Scholarly enquiry for nursing practice: An international Journal*. 10(3), 253-275.

Mouton, J. (1996). *Understanding social research*. Pretoria: J.L. Van Schaik.

Mouton, J.L., & Marais, H.G. (1990). *Basic concepts in the methodology of the social sciences*. Pretoria: Human Sciences Research Council.

Muller, J. (2000). *Reclaiming knowledge: Social theory, curriculum and educational policy*. London: Routledge.

Munhall, P.L. & Boyd, C.O. (1999). *Nursing research. A qualitative perspective*. United States of America: toExcel.

Murray, B. & Fortinberry, A. (2004). *Creating optimism: A proven, seven-step program for overcoming depression*. McGraw-Hills Company.

Mwaba, K. & Molamu, R.B. (1998). Perceived causes of relapse among a sample of recovering psychiatric patients at a Mafikeng Hospital. *Curationis*, 1998, 55-56.

Napier, A. (2006). *Empowerment theory*. Retrieved April 2, 2009, from http://www3.malone.edu/.../Empowerment_Presentation_A_Napier.s06.pdf.

National Center on Physical Activity and Disability. (2009). *Disability/condition: Depression and physical activity*. Retrieved Novem ber10, 2009, from http://www.ncpad.org/disability/fact_sheet.php?sheet=709...all.

National Empowerment Partnership. (2008). *What is community development?* Retrieved July 20, 2009, from http://www.cdx.org.uk.

National Institute for Clinical Excellence. (2003). *Schizophrenia. Full national clinical guideline on core interventions in primary and secondary care*. Royal College of Psychiatrists & British Psychological Society. Retrieved June 20, 2008, from http://pb.rcpsych.org/cgi.content/full/28/9/351.

National Institute for Mental Health in England. (2005). *NIMHE guiding statement on recovery*. United Kingdom: Department of Health.

National Prescribing Centre, National Institute for Mental Health in England & Department of Health. (2005). *Improving mental health services by extending the role of nurses in prescribing and supplying medication*. Retrieved August 20, 2008, from http://www.dh.gov.uk/en/Publicationstatistics/.../DH_4110324.

Nelson, D.A. (2004). *The philosophy and practice of holistic health care*. Phd Thesis. Auckland University of Technology. Retrieved September 15, 2009, from http://aut.researchgateway.ac.nz/bitstream/10292/361/1/NelsonD.pdf.

New Freedom Commission on Mental Health. (2003). *Achieving the promise. Transforming mental health care in America*. Final Report. DHHS. Pub. No. SMA-03-3832. Rockville.

Ngwenyama, O.K., & Lee, A.S. (1997). Communication richness in electronic mail: Critical social theory and contextuality of meaning. *MIS Quarterly*. 21(2), 145-167.

Nolen-Hoeksema, S. (1990). *Sex differences in depression*. Stanford, CA: Stanford University Press.

Nyatanga, L.& Dann, K.L. (2002). Empowerment in nursing: The role of philosophical and psychological factors. *Nursing Philosophy*. 3(3), 234-239.

Oades, L., Deane, F., Crowe, T., Lambert, W. G., Kavanagh, D. & Lloyd, C. (2005). Collaborative recovery: An integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry, 13* (3), p.279-284.

O'Hara, M.W. & Swain, A.M. (1996). Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry*. 8, 37 – 54.

Ohio Department of Mental Health. (2003). *Ohio mental health recovery and consumer outcomes initiative*. Retrieved January 20, 2008, from http://www.mh.state.oh.us/initiatives/outcomes/outcomes.html.

Okun, B.F. (1992). *Effective helping, interviewing, and counselling techniques*. Monterey, California: Brooks/Cole.

ORGANON SOUTH AFRICA. (2005). *Mental health-Your partner in mental healthcare*. Retrieved November 18, 2005, from http://www.organon.co.za/news/index.asp.

Oxaal, Z. & Baden, S. (1997*). Gender and empowerment: definitions, approaches and implications* for policy. Retrieved April 2, 2009, from http://www.ids.ac.uk/bridge/Reports/re40c.pdf.

Oxfam. (1995). *The Oxfam handbook of relief and development*. Oxford: Oxfam Publishing.

Page, S. (2002). The role of practice development in modernising the NHS. *Nursing Times*, 98(11), 34-35.

Page, N. & Czuba, C.E. (1999). *Empowerment what is it?*. Retrieved March 20, 2009, from http://www.joe.org/joe/1999october/comm1.html.

Parse, R.R. (1999). Nursing Science: the transformation of practice. *Journal of Advanced Nursing*. 30(6), 1383-1387.

Patton, M.Q. (1990). Qualitative evaluation and research methods. London: Sage.

Patton, M.Q. (2002). *Qualitative research & evaluation methods*. United States of America: Sage.

Pearson, A., Vaughan, B., & FitzGerald, M. (2005). *Nursing models for practice*. (3th Ed.). Melbourne: Butterworth – Heinemann.

Penna, S., Paylor, I. & Soothill, K. (1995). *Job satisfaction and dissatisfaction amongst residential care workers*. York: Joseph Rowntree Foundation.

Peplau, H.E. (1964). *Basic principles of patient counselling* (2nd ed.). Philadelphia: Smith Kline and French Laboratories.

Perko, J.E. & Kreigh, H. (1992). *Psychiatric mental health nursing: a commitment to care and concern*. Reston, Virginia: Reston.

Peters, H. (1999). *Complete recovery from mental illness. A matter of empowerment*. Retrieved June 9, 2009, from http://www.manitoba.cmha.ca/data/l/rec.../763_hp_complete_recovery.pdf.

Peters, H. (2009). *"Take two"- Empowerment*. Retrieved August 25, 2009, from http://cenpatico.com/2009/06/19/take-two-empowerment/-

Polit, D.F. & Hungler, B.P. (1995). *Essentials of nursing research: methods, appraisal and utilization*. Philadelphia: J.B. Lippincott.

Plummer, S.E., & Gray, R. (2000). Community mental health nurses, primary care and the national service framework for mental health. *Nursing Standard*. 15(7), 47-52.

Ramon, S., Healy, B. & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and Britain. *International Journal of Social Psychiatry*. 53(3), 108 – 122.

Rapp, C.A. & Goscha, R.J. (2006). *The strengths model. Case management with people with psychiatric disabilities* (2nd Ed). United States of America: Oxford University Press.

Rayner, D., Chrisholm, H., & Appleby, H. (2002). Developing leadership through action learning. *Nursing Standard*. 16(29), 37-40.

Repper, J. & Perkins, R. (2003). *Social inclusion and recovery. A model for mental health practice*. Bailliere Tindal, Elsevier Ltd.

Repetti, R.L. & Crosby, F. (1984). Women and depression: Exploring the adult role explanation. *Journal of Social and Clinical Psychology*. 2(1), 57-70.

RETHINK. (2005). A report on the work of the recovery learning sites and other recovery-orientated activities and its incorporation into the RETHINK plan 2004-08. Retrieved June 20, 2008, from http://www.rethink.org/document.rm?id=1042.

Reynolds, W. & Scott, B. (1999). Empathy: a crucial component of the helping relationship. *Journal of Psychiatric and Mental Health Nursing*, 6, 3637-30.

Roberts, G., Davenport, S., Holloway, F. & Tattan, T. (2005). *Enabling recovery*. United Kingdom: Cromwell Press Limited.

Rodgers, B.L. (1989). Concepts, analysis and development of nursing knowledge: the evolutionary cycle. *Journal of Advanced Nursing*, 14, 330 – 335.

Rodgers, B.L. & Knafl, K.A. (2000). *Concept development in nursing. Foundations, techniques and applications.* (2nd Ed). United States of America: Saunders.

Rodwell, C.M. (1996). An analysis of the concept of empowerment. *Journal of Advanced Nursing*. 23(2), 305-313.

Rondahl, G., Innala, S. & Carlsson, M. (2006). Heterosexual assumptions in verbal and non-verbal communication in nursing. *Journal of Advanced Nursing*. 56(4), 373 – 381.

Rosenfield, S. (1980). Sex differences in depression: do women always have higher rates? *Journal of Health and Social Behaviour*. 21, 33-42.

Rossouw, D. (2000). Intellectual tools. Pretoria: Van Schaik.

Rowlands, J. (1995). Empowerment examined. *Development in Practice*, 5(2), 101-107.

Royal College of Psychiatrists. (2005). *Cognitive behavioural therapy (CBT).* Retrieved June 09, 2008, from http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/cognitivebehaviouraltherapy.aspx.

Royal College of Psychiatrists. (2006). Men and depression. Retrieved March, 25, 2008, from http://www.rcpsych.ac.uk.

Rubinow, D.R. & Schmidt, P.J. (1995). The treatment of premenstrual syndrome: Forward into the past. *New England Journal of Medicine*. 332, 1574 – 1575.

Russel, S. (1999). An exploratory study of patients' perceptions, memories, and experiences of an intensive care unit. *Journal of Advanced Nursing*. 29, 783 – 791.

Ryles, S.M. (1999). A concept analysis empowerment: its relationship to mental health nursing. *Journal of Advanced Nursing*. 29(3), 600-607.

Saadallah, S. (2001). *Empowerment of women in the context of muslim societies as a transformative strategy for poverty eradication in a globalizing world*. Retrieved March 25, 2009, from http;//www.un.org/womenwatch/daw/csw/empower/.../Saadallah-EP5.pdf.

Saakvitne, K.W., & Pearlman, C.A. (1995). *Trauma and the therapist: Countertransference and vicarious traumatisation in psychotherapy with incest survivors.* W.W. Norton and Co, New York.

Sadan, E. (1997). *Empowerment and community planning*. Retrieved August 15, 2009, from http://www.mpow.org/elisheva_sadan_empowerment.pdf.

Sainsbury Centre for Mental Health. (2001). *The capable practitioner*. The Practice Development & Training Section: The Sainsbury Centre for Mental Health.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science*. 16(2), 1-8.

Sanderson, H. (2000). *Person-centred planning: Key features and approaches*. York: Joseph Rowntree Foundation.

Saraceno, B. (2003, November 13-15). *The epidemic of Depression: The data and observation of the WHO*. Paper presented at the XVIII International Conference, Citta del Vaticano, Rome. Retrieved March 12, 2006, from http://www.healthpastorol.org/events/18conference/index.html.

Saunders, E. (2002). *Assessing human competence: Practical guidelines for the South African manager*. (2nd Ed.). Johannesburg: Knowres Publishing (Pty) Ltd.

Savage, P. (1991). Patient assessment in psychiatric nursing. *Journal of Advanced Nursing*, 16, 311-316.

Sbongile, M.M.P. (2007). *An empowerment programme for nurses working in voluntary counselling and testing services in Swaziland.* Phd Thesis, University of South Africa. Retrieved July 20, 2009, from http://etd.unisa.ac.za/ETD-db/ETD-desc/describe?urn=etd-09122007-100123.

Scottish Executive. (2005). *Review of mental health nursing in Scotland*. Retrieved May 3, 2008, from http://www.show.scot.nhs.uk/schd/nrmhns/

Sekhukhune, D. (2005). *A model to facilitate a quest for emotional maturity of psychiatric nurses through capacity development in promoting their mental health*. D.Cur Thesis. Johannesburg University. Retrieved March 4, 2009, from http://ujdigispace.uj.ac.za:8080/dspace/bitstream/10210/1698/1/final.pdf.

Seligman, M.E.P. (1975). *Helplessness: On depression, development, and death*. San Francisco: W.H. Freeman.

Shaeffer, S. (1992, January). *Collaborating for change: The participation of government, NGOs, and the community in education and development*. Paper presented at the South African Seminar on Collaboration for Educational Change in Non-Formal Basic Education, Kenya Institute of Education, Nairobi.

Shepherd, G., Boardman, J. & Slade, M. (2008). *Making recovery a reality*. United Kingdom: Sainsbury Centre for Mental Health.

Simmons, M. (2004). 'Facilitation' of practice development: a concept analysis. *Practice Deveopment in Health Care*, 3(1), 36-52.

Simons, L. & Petch, A. (2002). Needs assessment and discharge: a Scottish perspective. *Journal of Psychiatric and Mental Health Nursing*, 9(4), 435-445.

Skilbeck, J. & Payne, S. (2003). Emotional support and the role of clinical nurse specialists in palliative care. *Journal of Advanced Nursing*, 43(5), 521-530.

Slettleboe, A. (1997). Dilemma: A concept analysis. *Journal of Advanced Nursing*. 26, 449-454.

Sobieraj, M., Williams, J., Marley, J., & Ryan, P. (1998). The impact of depression on the physical health of family members. *British Journal of General Practice*. 48(435), 1653-1655.

Solombela, P.W. & Uys, L.R. (1994). Factors influencing the relapse of outpatients with schizophrenia in the Kentani area of Transkei. *Curationis*, 17(3), 24-28.

South African Human Rights Commission. (2004). *5th Economic and Social Rights Report Services, 2002/2003 Financial Year*. Retrieved October, 12, 2008, from http://www.sahrc.org.za/old_website/esr_report_2002_2003.htm

Spaniol, L., Wewiorsk, N.J., Gagne, C. & Anthony. W.A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*. 14(4), 327-336.

Statistics South Africa. (2001). *Census 2001*. StatsSA: Pretoria.

Statistics South Africa. (2009). *Mid-year population estimates, 2009*. StatsSA: Pretoria.

St. Bartholomew School of Nursing and Midwifery. (2004). Mentor guidelines. City University London.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision*, 39(7), 551-555.

Stevens, P.E. (1989). A critical social reconceptualisation of environment in nursing: Implications for methodology. *Advances in Nursing Science*, 11(4), 56-68.

Strandberg, N. (2001). *Conceptualising empowerment as a transformative strategy for poverty eradication and the implications for measuring progress*. Retrieved March 25, 2009, from http://www.un.org/womenwatch/daw/csw/empower/.../Strandberg-EP6.pdf.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures & techniques*. Newbury Park: Sage Publications.

Stuart, G.W. & Laraia, M. (1998). *Principles and practice of psychiatric nursing* (6th Ed.). Missouri: Mosby.

Substance Abuse and Mental Health Services Administration. (2005). *Transforming mental health care in America, federal action agenda*. Retrieved April 20, 2009, from http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx.

Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. New York: Falmer.

The president's new freedom commission on mental health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.

The *White Paper on Transforming the Public Service Delivery (Batho Pele)*. (1997). Government Gazette. Vol. 388. Pretoria: Government Printers.

The *White Paper for the Transformation of the Health System of South Africa*. (1997). Government Gazette. Vol. 832. Pretoria: Government Printers.

The World Bank. (2005). *Empowerment*. Retrieved November 18, 2005, from

http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTEMPOWERMENT.

Thomas,E.J. (1989). Advances in developmental research. *Social Service Review*. December: 578-597.

Thompson, J. (1990). Hermeneutic inquiry. In L.E. Moody (Ed.), *Advancing nursing science through research*, Volume 2, (pp. 223 – 280). Newbury Park, CA: Sage.

Tobin, G.A. & Begley, C.M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396.

Tudd, C.M., Smith, E.R. & Kidder, L.H. (1991). *Research methods in social relations*. Orlando: Harcourt Brace.

University of Reading. (2008). *It graduates need 'people skills'*. Retrieved February 3, 2009, from http://www.e45.co.uk/.../view/886/job-news-and-information/graduate/IT-graduates-need-people-skills.

Unsworth, J. (2000). Practice development: A concept analysis. *Journal of Nursing Management*. 8, 317-326.

Ustun, T.B., Ayuso-Mateos, J.L., Chatterji, S., Mathers, C., & Murray, C.J.L. (2000). Global burden of depressive disorders in the year 2000. *The British Journal of Psychiatry*. 2004(184), 386-392.

Uys, L., & Middleton, L. (2004). *Mental health nursing a South African perspective*. (4th Ed.). Juta & Co. Ltd.

Van den Broucke, S., Hennion, W. & Vernaillen, N. (2006). Planning for empowerment in health promotion with socio-economically disadvantaged

communities: Experiences with a small group approach. *Archives Public Health*. 64, 143-158.

Van der Merwe, I., & Naude, S. (2004). Exercise and depression: a treatment manual. *Health SA Gesondheid*. 9(4), 28-41.

Wagner, C. (2003). *Placing psychology: A critical exploration of research methodology curricula in the social sciences*. DPhil thesis. University of Pretoria. Retrieved March 20, 2006, from University of Pretoria electronic theses and dissertations (ETDs).

Walker, L.O. & Avant, K.C. (1995). Strategy for theory construction in nursing. Conneticut: Appleton – Century Crofts.

Walker, L.O. & Avant, K.C. (2005). *Strategies for theory construction in nursing* (4th Ed). United States of America: Prentice Hall.

Ward, D., & Mullender, A. (1991). Empowerment and oppression: An indissoluble pairing for contemporary social work. *Critical Social Policy*, 11(2), 21-30.

Whatley, W.J. (2006). *Compiled glossary of common medical terms and definitions for student nurse aides*. Retrieved June 18, 2008, from http://www.nursenancy.org/frnatp_glossary.pdf.

Watson, J. (1979). *Nursing: the philosophy and science of caring*. Colorado: Colorado Associated University Press.

Watson, J. (1988). *Nursing: Human science and human care – A theory of nursing*. New York: National League for Nursing.

Weary, G., Gleicher, F., & Marsh, K. (1993). Control motivation and social cognition. New York: Springer-Verlag.

Weinberg, D. (1997). The social construction of no-human agency: The case of mental disorder. *Social Problems*. 44, 217-234.

Weissman, M.M., Bland, R.C. & Canino, G.T. (1996). Cross-national epidemiology of major depression and bipolar disorder. *JAMA*. 276, 293-299.

Western Cape Department of Health. (2007). Comprehensive service plan for the implementation of Healthcare 2010. Retrieved October, 1, 2009, from http://www.capegateway.gov.za/Text/2007/7/may15,2007_csp_2.pdf.

Wick, D., Coppin, R. & Payne, S. (2003). Teamworking in nursing homes. *Journal of Advanced Nursing*, 45, 197-204.

Wilde, S. (2004). *The three keys to self-empowerment*. South Africa: Hay House.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionist work. In D.J. Nightingale & J. Cromby (Eds), *Social constructionist psychology*. Buckhingham: Open University Press.

Wilson, H.S. (1989). Research in nursing. Redwood: Addison Wesley.

Wilson – Thomas, L. (1995). Applying critical social theory in nursing education to bridge the gab between theory, research and practice. *Journal of Advanced Nursing*. 21(3), 568-575.

Wittman-Price, R.A. (2004). Emancipation in decision-making in women's health care. *Journal of Advanced Nursing*. 47(4), 437-445.

Worldbank. (2008). *Empowerment*. Retrieved August 10, 2009, from http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTEMPOWERMENT/O,,contentM[DK:20245753...

World Health Organization (2001b). *The world health report 2001: Mental health: new understanding, new hope*. Geneva: World Health Organization.

World Health Organization. (2010). User empowerment in mental health – a statement by the WHO regional office for Europe. Retrieved February 10, 2010, from http://www.euro.who.int/document/e93430.pdf.

Young, S.L. & Ensing, D.S. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*. 22(3), 219-231.

Zachary, J.L. (2000). The mentor's guide. Facilitating effective learning relationships. John Wiley & Sons, Inc. United States of America.

Zung, W.W. (1965). A self-rating depression scale. *Archives of General Psychiatry*. 12, 63-70.

Acts:

Constitution of the Republic of South Africa 1996 (SA).

National Health Act No 61 of 2003 (SA).

The Mental Health Act No 17 of 2002 (SA).

Appendix One

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/294
Fax: +27 21 959-3170
Website: www.uwc.ac.za

1 June 2007

To Whom It May Concern

I hereby certify that the Senate Research Committee together with the relevant Ethics Committee of the University of the Western Cape has approved the methodology and the ethics of the following project by: Ms S Pearce

Research Project:	A model to enhance empowerment of professional nurses to promote the therapeutic healthcare experiences of people suffering with depression
Registration no:	07/1/9

Peter Pyster
Research Development
University of the Western Cape

Appendix Two

Verwysing
Reference
Isalathiso 2007/RP53

Navrae
Enquiries
Imibuzo Dr. M.M. Makiwane

Telefoon
Telephone
Ifowuni 021 483 9911

Departement van Gesondheid
Department of Health
iSebe lezeMpilo

Ms. Shelltunyan Pearce
77 Kirkstall Place
Old brook
Milton Keynes
MK6 2XF
United Kingdom

Fax: 0944 1908 582371

Dear Ms. Pearce,

A model to enhance the empowerment of professional nurses to promote the therapeutic healthcare experiences of people with depression.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that your research has been approved.

Please contact Dr Virginia Zweigenthal at vzweigen@pgwc.gov.za or 021 460 9257 to assist you with accessing the site and ensuring that the site is adequately prepared for your study.

Please inform us in writing when the research report will be available and quote the reference number above.

Yours sincerely,

DR J CUPIDO
DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMMES
DATE: 10/9/2007

CC: Dr K. Cloete: Chief Director Metro

Dorpstraat 4
Posbus 2060
KAAPSTAD

4 Dorp Street
PO Box 2060
CAPE TOWN

Appendix Three

INVITATION AND INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Dear Sir/Madam

My name is Shelltunyan Pearce, a Phd student at the University of the Western Cape in the Western Cape, South Africa. Presently I am engaged in a research project entitled "A model to enhance the empowerment of professional nurses to promote the recovery of people diagnosed with depression". The study will be conducted under the guidance of Professor Wilhelmina Kortenbout of the Department of Nursing Science.

The purpose of the study is to:

- To explore and describe the attributes that registered nurses need to promote the recovery of people diagnosed with depression.
- To explore and describe how the identified attributes can be facilitated in the work environment.
- To identify and describe a conceptual framework for a model to enhance the empowerment of professional nurses to promote the recovery of people diagnosed with depression.

You are invited to participate in this research project because of your experiences in working with people that experienced or are still experiencing depression. Your participation will mean that I visit you on an agreed date, time and location, for a semi - structured interview that will last for no more than 30 to 60 minutes. During the interview I will be taking notes to keep track of what has been covered. To get every word on paper I will record (audio-tape) the interview. The audio-tape will be analysed by the researcher and an independent coder.

I undertake to ensure anonymity by omitting the use of your name or any other information that might identify you. The transcription of the taped interview will only be accessible to supervisors, the coder who will be assisting in data analysis and me.

Your participation in this research project is totally voluntary. You are therefore under no obligation to participate. You will give your consent but still reserve the right to withdraw from the study at any stage without repercussion or penalty. If you are interested in the findings of the study, they will be communicated to you as soon as they are available.

Inquiries concerning the above matters can be directed to me at the following address and telephone numbers:

S. Pearce

190 Muller Street

Kraaifontein

7570

During the day: 021 9886519

I _____ have discussed the above points with the participant. It is my opinion that the participant understands the risks, benefits and obligations involved in participating in this research project.

_____ _____

SIGNATURE OF THE INTERVIEWER DATE

I _____ understand that my participation is voluntary and that I may refuse to participate or withdraw my consent and stop taking part in this research project at any time without penalty or repercussions.

_____

SIGNATURE OF PARTICIPANT DATE

Appendix Four

INVITATION AND INFORMED CONSENT TO PARTICIPATE IN AN EXPERT DISCUSSION GROUP

Project Title: ***A model to empower registered nurses to promote the recovery of people that have been diagnosed with depression***

What is this study about?

This is a research project being conducted by Shelltunyan Pearce at the University of the Western Cape. I am inviting you to participate in this research project because of your experience as a psychiatric nurse. The purpose of this research project is to develop and describe a model to empower registered nurses to promote the recovery of people who have been diagnosed with depression.

What will I be asked to do if I agree to participate?

You will be asked to identify the value and potential contributions this model will make to the empowerment of registered nurses to promote the recovery of people who have been diagnosed with depression. The validation will take the form of an expert discussion at the boardroom on the 30th September 2009, and will last for no longer than 90 minutes.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. I undertake to ensure anonymity by omitting the use of your name or any other information that might identify you. The evaluation form at the end of the session will only be accessible to my supervisor and me.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

What are the risks of this research?

There are no known risks associated with participating in this expert discussion.

What are the benefits of this research?

The benefits to you include the contribution of your experience to expand the science of nursing, and validate the contributions of the nursing profession to the recovery approach.

We hope that, in the future, other people might benefit from this study through improved understanding of what nurses do and what contributions nurses make to the recovery approach in psychiatric nursing.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Shelltunyan Pearce at the University of the Western Cape. If you have any questions about the research study itself, please contact Shelltunyan Pearce at: pearcegillard@msn.com.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

Appendix Five

Transcript of interview

Interviewer: To help patients recover from depression, what do you think is the attributes that professional nurses need?

Participant: 'n Mens moet weet wat depressie is. Hoe om pasiente te diagnoseer. Simptome en hantering van depressie. Moet empaties kan wees. Moet die vermoe het om te kan luister na die pasiente. As jy luister dan moet jy stressore kan identifiseer en dan as jy die stressore geidentifiseer het, dan moet jy probeer om die stressore aan te spreek, want die baat nie jy behandel die pasient en vermy die stressore en dan kom daarin ook die verwysing buite. Betrek die maatskaplike werker - buite soveel as moontlik ondersteuning sisteme daarbuite. Betrek die familie - as dit 'n problem is met die man verwys na huweliksterapie – maatskaplike werker en sielkundige insette word gelewer. Betrek die arbeidsterapeut as die pasient nog werk om vas te stel wat die werksituasie is – wat is die siekverlof situasie – want dit kan alles die depressie vererger. As die pasient kinders het, sorter uit wat die problem met die kinders is; kyk dit is nou maar alles wat ons nou maar hier doen.

Researcher: What about assessments?

Participant: As daar pasiente in die mediese sale is met depressie soos F1 wat "geoverdose" het, dan kom hulle af na ons toe. Nou ons deursoek die pasiente en dan kom hulle nog met net so 'n klomp pille in hulle sake. Dan voel 'n mens daar waar die toelatings is dat die "assessments" ordentlik gedoen moet word want ek voel pasiente moet daar al deursoek word. Dan moet ons die pille wegvat.

Researcher: What about interview and counselling skills?

Participant: Wat ons doen hier in die saal – elke dag skryf ons 'n verslag en voordat ons 'n verslag skryf voer ons 'n onderhoud met die pasient – stressore – vaardighede om vas te stel wat die pasiente se probleme kan wees en problem oplossings te kan voorstel en te fokus op die behandeling vorentoe en die stressore te kan aanspreek.

Verpleegkundiges moet goeie empatiese luisteraars wees.

Researcher: What do you mean with you need counselling skills with regards to problem solving?

Participant: Oh yes, oh yes. The other thing is the importance of training. Ons het nie training nie, ons leer van ander lede van die multi dissiplinere span waar die sielkundiges insit dan vang ons baie op van CBT en dan probeer ons dit toe te pas.

Researcher: Do you think that it is important for nurses to have some knowledge about CBT?

Participant: Yes, yes. We could do with CBT, because jy hoor van CBT, en as jy nie lank in die rondtes is nie om te weet waaroor CBT gaan dan sal jy die heeltyd wonder waaroor dit gaan.

Researcher: What about treatment and relapse prevention?

Participant: Ons pasiente word nie sommer op medikasie geplaas nie, want ons wil eers vas stel of dit nie miskien 'n annpassingsversteuring is nie, want baie kere kom mense in met overdose en 'n depressiewe gemoed, maar as die stressore uit sie pad uit is, dan verbeter die depressie sommer baie gou en dan is daar nie behandeling nodig nie. So wat ons doen as die pasient inkom is om hulle eerste te observer, hoe hulle aanpassing in die saal is, hoe hulle sosialiseer, hoe hulle slap en eet, negatiewe gedagtes en dood wense of hulle dit uitspreek. As die pasient toegelaat is en se na 'n dag hulle begin sosialiseer, eet goed en het geen negatiewe gedagtes en ons kom agter wat die stressore is en ons spreek die stressore aan en die depressie lig dan begin hulle nie sommer die pasient op medikasie nie. Maar as dit nou gaan na die geskiedenis en dit is 'n langstaande ding wat oor 'n paar maande aankom en hulle het al 'n paar pogings aangewend, miskien "geoverdaose" of gewat ook al, en dan en die pasient is baie emasioneel en kan nie aanpas nie – hulle le wil nie eet nie en dan in die saalrondte waar sielkundige, dokter, verpleegkundiges, arbeidsterapeute, maatskiplike werkers twee keer 'n week bymekaar kom en bespreek die pasient se vorderings en dan as daar 'n gevoel is dat die depressie nie lig nie, dan begin ons die pasient met medikasie. Prozac – die eerste en beste en die goedkoopste. As die pasient na 'n paar weke nie respond nie, dan gaan hulle na iets soos cipramil of venlafaxine, citalopram.

Researcher: Is there any education sessions for patients with regards to their medication?

Participant: Medikasie opvoeding word deur alle lede van die MDT gedoen.

Researcher: Anxiety and depression. Do you think that nurses have the knowledge and skills to manage it?

Participant: Hoe langer jy werk met die pasient en jy kan die simptome van angs assesseer. Dan council ons vir hulle baie vinnig. Die arbeidsterapeut doen dan ontspannings oefeninge.

Researcher: What about person centred care planning?

Participant: What is it?

Researcher: Researcher explained

Participant: Wanneer ons die pasient sien nadat hulle gemoed gelig het, dan vra ons hulle wat wil hulle he van ons? Baie kere is hulle verwagtinge onrealisties dan bring jy hulle terug na die realiteit toe. Baie kom in dan wil hulle ?pensioen he, wat onrealisties is want hulle kan werk en dan word hulle gestuur vir werk evaluasies en sulke goed. Maar ons is baie gefokus op wat hulle wil he. Kyk baie van die pasiente wat depressief is het baie kere 'n persoonlikheidsversteuring ook en as jy nie vir hulle vra wat dink jy – dan gaan hulle die siteem ann mekaar misbruik en manupileer verskriklik.

Researcher: What about the involvement of the family?

Participant: Familie is net so belangrik as die pasient. Want jy kan nie die pasient behabdel en haar beter kry en terug stuur na 'n siek familie. Die familie word gereeld ingebring. Die social worker doen huweliksberading.

Researcher: Does nurses have knowledge of family therapy?

Participant: Ons doen dit want baie kere kom die familie naweke dan is daar niemand anders nie. Dan praat ons met die familie. Kyk ons is die mense wat die kollateraal kry want die familie kom na ons toe. Hulle vra vrae en on sweet presies wat wat om te vra om kollateraal te kry. Wat is die stressore by die huis en wat is daar wat die pasient pla. As ons sit met 'n problem by die huis dan vat ons nie net die man se woord nie, ons probeer soveel as moontlik kollateraal kry om vas te stel wat die pasient pla.

Researcher: What about nurse leadership?

Participant: It is important. Ons gee opleiding sessies en gee ondersteuning vir mekaar.

Researcher: What about supervision from your managers?

Participant: Dit is ons onder mekaar, wat mekaar ondersteuning gee. Hulle kom rondtes doen en vra hoe dit gaan. Ons kan afsprake maak, maar dit is nie set rules nie.

Researcher explained how supervision is working in his work environment.

Participant: Well we do have social workers allocated for staff. They are there for us. Similar like ICAS.

Researcher: But it is still the issue of about a social worker speaking to a nurse and not a nurse speaking to a nurse.

Participant: Yes, yes op daai punt – 'n nurse speaking to a nurse that knows what is going on here en wat weet waardeur ons gaan. Dit is nou regtig ere waar nie in plek nie. Ons ASD doen rondtes en vra hoe dit gaan in die saal, maar sal nie soos u se vir 'n uur sit en praat met ons nie en vra. Dit is meer van jy moet gaan as jy probleme het.

Researcher: What about the discharge of the patient to the community?

Participant: Ons ontslaan nie sommer pasiente in die gemeenskap nie. Ons stuur hulle eers op naweek verlowwe om te sien hoe hulle kan cope buite en terugvoer oor hoe die naweek gegaan het en dan elke keer as dit beter gaan en die familie voel en daar is genoeg ondersteuning buite en die stressore wat depressie veroorsaak het, het verminder. Ons kan nie alles oplos vir die pasiente nie maar gee guidelines, informasie van groepe, 'n contingency plan in place for them.

Researcher: What about follow – up?

Participant: Ek voel follow – up is goed. As ons onseker voel dan word hulle vinniger opgevolg. Hulle word by ons opgevolg totdat die dokter voel die pasient is gereed om na die gemeenskap verwys te word.

Researcher: Do you think the community service is good?

Participant: Yes, Yes. Ons het baie kontak met die gemeenskap.

Researcher: What is your opinion about the new mental health act?

Participant: Ons is redelik op hooghte. Daar is altyd probleme met ander sale. Hulle sertifiseer die pasient daarbo maar daar is altyd probleme met die papier werk.

Researcher: What do you think needs to change in future about depression?

Participant: Baie mense wil nie depressie aanspreek nie. Sisteme in place, bang vir stigma. Bewuswording dat depressie 'n siekte is en behandel kan word.

Researcher: Do you think the knowledge of registered nurses in other wards is up to date?

Participant: Ons is in psigiatrie en nie op hooghte wat aangaan in ander sale nie. Pasiente word nie holisties behandel nie. Daar is probleme met joint working.

Participant spoke about what recovery is after the interview. Said that recovery approach is good. Described it as the patient being able to live in the community but still suffering from the mental illness. Did not see it as the recovery from a physical illness. Said that nurses need to be aware of power relationships and acknowledge that the patient is the expert and that we should listen to the patient.

Participant also spoke about how it is important for nurses to be reflective about their practice.