



The
University
Of
Sheffield.

**The impact of a Continuing Professional Education degree programme in
Mental Health Nursing: a phenomenological study**

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Abstract

The aim of this study was to explore the lived experiences of general trained nurses who went on to undertake a post qualification BSc in Mental Health Nursing and to establish how they perceive and experience their current role and the ways in which undertaking the degree may have impacted how they practice and deliver care.

Focus groups and in-depth interviews were conducted with purposely selected participants and their narratives were analysed using Interpretative Phenomenological Analysis. Four superordinate themes emerged from the interpretative analysis. In the first theme of 'coming into the fold' the modes by which the participants were deployed to the hospital were discussed in relation to their impact on the participants present day role. In the second theme, 'constructions of a psychiatric nurse', the participants conceptions of their role and the reality of their working lives pointed to a divergence from the contemporary descriptions of the role and practices of psychiatric nursing found within the literature. The third theme was 'positioning the nurse within the practice environment' in which the nurses accounts highlighted several obstacles which they feel impact their working practices, not least a sharply defined hierarchical culture of structure and control and impaired professional relationships. In the final theme - 'the path to greater knowledge', motivations for undertaking the course were generally established as being a means of personal improvement and in some instances for financial gain. Overall none of the participants were able to identify any tangible effects on patient care giving practices that could be ascribed to them having completed the course.

The implications of this study are that the influences exerted by a strong bureaucratic organisational culture within a healthcare organisation should not be underestimated for their potential to obstruct change. These findings led to recommendations for action by both the academic body responsible for nurse education and the organisation's management. Future research was suggested to widen understanding of the complex array of interrelated factors affecting the working practices of psychiatric nurses who have undertaken a diploma to degree BSc in Mental Health Nursing.

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This thesis reports a study which explored the lived experiences of general trained nurses who went on to undertake a post qualification BSc in Mental Health Nursing and to establish how they perceive and experience their current role and the ways in which undertaking the degree may have impacted how they practice and deliver care.

This chapter begins with a brief overview of the context of the study. The research aims and the significance of the study are outlined. A brief description of issues related to conducting insider research is presented, followed by a discussion of positionality and the factors which led to the conception and organisation of the study. Finally an overview of the structure and content of the thesis is presented.

1.1 Research context

The ability of health care systems to respond to ever evolving needs and advances is dependent on appropriately trained and supported healthcare professionals (World Health Organisation [WHO], 2002). The importance and relevance of continuing professional education (CPE) for nurses is not a new topic and has been well discussed in the literature (Barriball & White, 1996). However the availability, features and provision of CPE varies considerably from country to country. Participation in continuing education has been correlated to improved nursing practice and better patient outcomes and resulted in higher productivity, reduction in occupational accidents, an enhanced organisational climate and greater work satisfaction (Pena Flores & Alonso Castillo, 2006). Factors affecting uptake of CPE are wide ranging

and complex and include (but are not limited to), financial aspects related to both purchasers and providers: whether it is voluntary or mandatory for re-registration; availability of courses; limited course choice; nurse shortages; administrative difficulties (Woodruff, 1987). Although the literature asserts that CPE correlates with improved patient care there is scant evidence of research that measures cause and effect and thus such an improvement is not clearly established (Burrow et al., 2016), generally relying on perceptions of change (which, as Gristi & Jacono (2006) noted, by no means equates to improvement in patient care). And in Malta specifically, there appears to be no available, recorded research based studies which report the effectiveness of CPE on psychiatric / mental health nursing¹.

Around half of the registered nurses employed within the hospital where the present study was conducted hold a BSc in mental health nursing, all of these having been attained post initial nursing qualification and within approximately the last ten years.

Tertiary education in nursing started later in Malta than in other countries such as the UK and the USA. The first Bachelor's degree in (general) nursing was introduced by the University of Malta in 1988 (Sammut, 2012) but it was not until 1992 that a full time diploma in psychiatric nursing became available, thus it appears that it took some time to acknowledge that psychiatric nursing warranted specific nurse education programmes. The first postgraduate degree programme to convert diploma psychiatric or general diploma nurses to degree level mental health nurses began in 2004 (Ward, 2010) and in 2009 the University of Malta offered the first direct entry BSc

¹ The terms psychiatric nurse and mental health nurse are used interchangeably in this study – as they are in practice.

Mental Health course. Malta has one psychiatric hospital employing approximately 110 registered nurses. Over half of these are now psychiatric nurses. The part time Bachelors' degree (BSc) in Mental Health Nursing is open to nurses of any cognate discipline (i.e. they can hail from a general nursing background or psychiatric background). There was a very positive response to this conversion degree, both from within the psychiatric hospital and to some extent from nurses working in other areas, since according to the course director, around 10% of students worked in other hospitals in Malta (Ward, 2010). To date around 80 nurses in total have completed or are completing the BSc course. Such courses are funded totally by the government and nurses are given substantial amounts of study leave to attend lectures on a part time basis (one day per week) plus a fixed number of additional study days per year for attending other courses and writing up of dissertations. Since the course began, three of the nurses who have achieved the BSc in psychiatric nursing have transferred back to general nursing at the state general hospital.

This study seeks to establish how psychiatric nurses perceive and experience their current role, asks why they undertook the conversion degree course and examines what factors are felt to impact their working practices after having completed the conversion course.

1.2 Research aims and questions

The aim of this study is to explore the stories and experiences of a small group of nurses who have successfully completed a post qualification degree in mental health nursing, with the intent of establishing how they experience and interpret their current role, determine the factors that influenced them to

undertake the degree and ascertain the ways in which undertaking the degree may have contributed to changes in how they practice and deliver care. The method of analysis employed in this study is Interpretative Phenomenological Analysis (IPA), which is a systematic qualitative research approach concerned with exploring in detail how people make sense of their lived experiences (Smith, et al., 2009).

In order to meet the study aim, three main questions were posed:

- How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
- What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
- What do psychiatric nurses' perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

1.3 Significance of the study

This study addresses gaps in the literature related to CPE in hospital-based Diploma to BSc programmes for mental health nurses in Malta. Additionally the findings will be relevant and timely for the Maltese healthcare sector more generally, which is currently in the midst of significant changes in the way patient-care is delivered (for example through the new Mental Health Act [Malta] 2012). Furthermore, this study contributes to empirical knowledge about the cultural geography of present day psychiatric healthcare.

1.4 Insider researcher

Insider research is described by Greene (2014) as being “*research which is conducted within a social group, organisation or culture of which the researcher is also a member*” (p.1). Insider researchers often base their choice of project on their years of experience of the issues under investigation in their workplace and workplace research is most usually small scale, not least in terms of number of participants (Drake, 2010).

Greene (2014) presented a balanced account of the value of insider research. Advantages may be briefly summarised as being related to knowledge, interaction and access; insider researchers have the advantage of already being orientated to the research participants and the environment, they have prior knowledge of the context of the research and are able to ask meaningful questions, providing a more authentic understanding. In terms of interaction, the researcher is in a position to approach colleagues with a level of familiarity and finally, access to the participants may be more intimate. On the other hand, Greene (2014) cautioned about the potential drawbacks of insider research, namely subjectivity and bias. Greater familiarity with participants may lead to a decrease in objectivity and carry the risk of the researcher making assumptions about meanings and events that are not based on the current data but rather on the researcher’s prior knowledge and experience. Participants may also make assumptions that the researcher already knows the issues and therefore their descriptions may be weaker. Drake (2010) noted that, furthermore, since researchers may often remain in their workplace after the completion of the study, then they are faced with living with the consequences of their work.

1.5 Positionality

This study draws on Interpretative Phenomenological Analysis (IPA). This is a research method that is dependent upon the researcher's ability to accurately interpret the reported experiences of the participants, or as Smith et al., (2009) put it: *"the researcher is trying to make sense of the participant trying to make sense of ..."* (p.3). Within an IPA study, therefore, the researcher has an active and iterative participatory role. Shaw (2010) noted:

IPA recognises the significance of the researcher's, presuppositions and that they can hinder and enhance the interpretation of another's lived experience. (p.235)

In this study, nurses who have successfully completed a post qualification degree in mental health nursing were asked to describe their experiences of their daily work and their studies; my role as researcher was to make sense of the verbal account which each participant offered. In the same way as any other researcher, it is inevitable that I drew upon my own worldview as I attempted to make sense of the participants' experiences; thus my worldview is inextricably linked to that of the study's participants and the whole is conceived as characteristically insider research.

Shaw (2010) suggested that:

Through making ourselves aware of our own feelings about the expectations of the research, we can begin to fully appreciate the nature of our investigation, its relationship to us personally and professionally and our relationship as a researcher and

experiencer in the world to those with whom we wish to gather experiential data. (p.235)

According to Drake (2010) an IPA account should go beyond the requirements of a written methodology which aims to reveal the workings within a study, and should strive to lay bare the bones of the study. Such a level of scrutiny is not without risk, since as Drake (2010) noted, such openness is not always well received by reviewers but nonetheless, Drake contended that a doctoral degree “*may depend on a higher degree of reflexivity for novice researchers to engage critically in small scale local projects involving colleagues.*” (p.87). Indeed Unluer (2012) saw this process as a positive virtue, maintaining that elucidating one’s role in the research lends credibility to the study. However, Brocki and Weardon (2006) acknowledged that putting a spotlight on the characteristics of the researcher themselves “*may not necessarily benefit reader’s interpretations of an analysis and might perhaps even represent a misleading diversion.*” (p.92). They went on to state, however, that in cases where the researcher’s role in the process might be argued to have a significant impact on the analysis, such a focus may actually exemplify best practice. Thus, later in the study, reflexive notes will be provided in distinct sections at the end of key chapters, with the aim of providing the reader with an insight into my mind set and awareness of my own influence on the study. Since my positionality influenced the study *sine qua non* from the very first moment the concept was conceived - and even before the research questions were formed - I feel that it is important at this point that the reader gains an initial understanding of my personal and professional positioning, along with the reasons why this

particular research topic was chosen. These are addressed at the end of this chapter.

1.6 Structure of the thesis

Following on from this introductory chapter, the next chapter illustrates in brief, the background and development of the social, cultural, political and environmental milieu in which this study is conducted. Chapter 3 introduces and interprets the major issues that surround the study topic, providing a reference point from which to conceptualise, organise collection of, and critically interpret the data. It also establishes which areas of the literature make a significant contribution to the understanding of the topic and indicates gaps that exist within the literature. Chapter 4 discusses and justifies the philosophical, theoretical and methodological issues which inform the actual design of the research methods I employed and Chapter 5 provides a detailed description of the research methods adopted in this study in order to meet the research aim. The findings of the study as well as the process of data analysis are presented in Chapter 6. The analytical discussion in Chapter 7 presents the interpretation of these findings and their relation and relevance to the existing literature as well as to the local situation. The final chapter, Chapter 8, provides a synopsis of the main findings, drawing together the major features of the previous chapter and highlighting the implications of these for nursing practice, nurse educators, patients, organisational stakeholders. Based on the implications, practical and research recommendations are made. Consideration of the originality and contribution of the study leads to an exploration of its strengths and limitations. Finally, the chapter concludes with some closing reflections,

based on the central finding of the study which has revealed that a complex array of interrelated factors, mainly linked to the prevailing organisational culture, have in combination been detrimental to the possibility of a post qualification degree positively impacting the care provided by psychiatric nurses.

Reflexive box: 1

I have been a nurse for around 34 years, initially qualifying in England as a diploma level nurse for people with learning disabilities. At that time, care for that particular patient group was generally restricted to large institutions and it was in one such facility that I spent the greatest number of years before working for a relatively short period in a community based environment following the closure of such institutions in the late 1980's. During these years the focus of care shifted dramatically from harsh, custodial care within closed environments to more patient centred facilities situated in local communities. In my experience, nurses themselves were often the drivers of change and actively pursued autonomy and professionalism in their daily roles. The rights of the patients were very much the focus of changes in care delivery and nurses seemed to have an enormous amount of pride in their role. In the 1990's I immigrated to Malta and worked for a short time in a respite care home, a service which was run by a non-governmental, non-profit organisation. The level and standard of care delivery was comparable with my experiences in England, albeit based on a very much more philanthropic and less client enabling approach. It quickly became apparent that people with disabilities of any kind in Malta, were highly stigmatised by society in general, and – in some cases - by the people who cared for them. In the year 2000 I took up post as a staff nurse in the Island's only psychiatric hospital. With an inpatient population of around 600 patients, the hospital cared for people with all types of mental illness and learning disabilities.

To say that my first day at the hospital was a culture shock is an understatement. The environment was old, grim and dilapidated and care delivery was custodial and task orientated. The hospital operated a top down management style, with no policies or procedures at all, where consultant psychiatrists were like demigods, the union ran the hospital by prescribing what nurses would and wouldn't do and patients were treated dispassionately.

continued

The following years saw various changes both in the environment and the approach to care, but these were minor improvements and it wasn't until the first wave of diploma psychiatric nurses began to enter the system that the first glimmer of any positive changes, from a nursing perspective, started to emerge. The advent of the first diploma to degree in mental health nursing seemed to offer a possibility of radically improving nursing care of patients, by creating critical practitioners and injecting research based theory that would hopefully navigate the gap, or chasm, to actual practice. After several years as a staff nurse I was then promoted to nurse in charge of an acute ward which I ran for around 7 years. I have at times studied with and worked alongside all of the participants in my study to varying degrees. My current role is that of Senior Practice Development Nurse and I am faced with what seems at times like an unsurmountable task of improving nursing practice. Within the organisation where the study was conducted there seemed to be a general good feeling that a significant number of nurses held a BSc in Mental Health Nursing and yet subjectively, there was no evidence to suggest that this had had any significant impact on nurses' practice or patient care. This led me to question why the mass undertaking of the Diploma to Degree course apparently failed to directly impact patient care and it was from this starting point that my study developed.

2.1 Introduction

This chapter briefly illustrates the background and development of the social, cultural, political and environmental milieu in which this study is conducted.

2.2 Malta

The Maltese archipelago consists of three small islands – Malta, Gozo and Comino. Collectively covering just 122 square miles, the largest island of the three is Malta from which the archipelago takes its name. Described in *The Lancet* as “*a few sun-baked specks in a narrow stretch of the Mediterranean sea*” (Pincock, 2005) it occupies a strategic geographic position that has in the past, made it very attractive to any power that wished to control the Mediterranean (Azzopardi Muscat and Dixon, 1999) and consequently Malta’s history is marked by conquest and colonisers. Its position as a central naval platform resulted in multiple occupations by various nations and peoples, including but not limited to, the Romans, Arabs, and the French. Sovereign State (Briguglio & Busuttil, 2018). A decade later Malta was declared a Republic and then five years later on 31st March, 1979, Malta was given its Freedom. A quarter of a century later, in May 2004, Malta acceded to the European Union.

2.3 The people

Malta’s population numbered just over .43 million in 2015 (National Statistics Office (NSO), 2016) which makes it the lowest populated country in the European Union though, conversely, it is also one of the most densely

populated due to its small geographic footprint. Nearly 5% of the total population are non-Maltese nationals which is slightly lower than the average in other European countries. The national language is Maltese although English is also recognised as an official language. The family is often held up as a paradigm and in the past was characteristically extended, patriarchal and influenced by Roman Catholic teachings. Inhabitants of villages were closely related through familial ties and most people never left their village, except those that married someone from another area.

Although largely socially homogenous due to its small size, it is acknowledged that Maltese society is undergoing a rapid change in terms of structure, attitude and values. Factors such as land development, mass tourism (almost 1.8 million inbound tourists visited Malta in 2015 – NSO, 2016), increased overseas travel, advances in information technology, new work and leisure patterns and a rapid extension of higher education are permeating the traditional Catholic society (Briguglio, 2002) leading to an erosion of both family and church discipline.

2.4 The church and religion

Religion is an integral part of Maltese culture both historically and still pervasively, if less hegemonically, in the present day. Nationally reported statistics routinely claim that up to 98% of the population is Roman Catholic although this figure is based on the number of individuals baptized as babies and so may be a gross over representation of the actual number of practicing Roman Catholics.

Dutch social anthropologist Jeremy Boissevain immersed himself in Maltese society on and off for a period of forty years. In his recent works (Boissevain, 2013) he provided an illuminating and in-depth description of life in Malta, illustrating the essential culture that characterised local society over the years. Boissevain (2013) described Malta as a collection of villages or parishes. Each parish was relatively homogenous, each having a parish church and a patron saint, or sometimes two. The parish church was until the 1960's, the geographical centre of the village, and would be elaborately decorated and adorned, this generally being paid for by the villagers themselves and thus a way of displaying the wealth of the parish. The parish priests were the village leaders of both religious and secular affairs up until 1993 when legislation provided for local government in the form of councils. Proximity to the church, either of residences or commercial enterprises indicated greater wealth and prosperity. Each patron saint had an affiliated (marching) band club associated with it and the feast days (Maltese: *festi*) that marked the celebration of the saint would be a grand affair with visiting bands from other areas and extravagant firework displays. Although each village presented a united front to outsiders, internal divisions and rivalry ran deep. It is popularly held that Maltese people are inclined to partisanship, so if there were two village saints they supported one or the other (usually according to whom their family supported), (Boissevain, 2013).

Malta has been slow to separate the secular from the religious. In the early days of Maltese politics (circa 1921), the Catholic Church automatically controlled a number of seats in parliament and proclaimed itself as the 'moral torchbearer' for the islands. Opposition to this state of affairs was dealt with by excommunication from the Church, and the situation progressed to such

an extent that in the early 1960's the Church, declared that it was a mortal sin to vote for a particular political party, read, distribute or advertise the party owned newspapers or attend their party political meetings (Vassallo, 2009). The party in question was advocating a separation of the Church from the State. This blatant show of clericalism may be less pronounced today but is still very much evident to differing degrees. The Church regularly comments and attempts to influence the running of the Maltese State and competes for public policy which then affects all citizens, regardless of their religious sentiments. Many institutions in Malta are run as if all the citizens were Catholic, and in fact it may be said that the Catholic Church is one of the most powerful political organisations in the country (NION, n.d.). Despite the high number of church-goers, church schools, baptised people and other supposed indicators of practicing Catholicism, the high rise of marital separation, the increase in domestic violence and drug trafficking and use and the recent legalisation of divorce and civil unions, to name just a few social issues in Malta, would suggest that there is a "*blooming anti-religious secularist society over which the Church has no control*" (Micallef, 2011) which is becoming increasingly more evident.

2.5 The political system

The political system in Malta is essentially a parliamentary democracy, based on the British model and the executive power is held by the Council of Ministers which is headed by the Prime Minister. The Parliament is constituted of the House of Representatives and has 65 members. General elections are held every 5 years. Local government in the form of 67 elected local councils, was established in 1993. Malta has one of the highest voter

turnout averages in the world, a fact which may be attributed to the near two party system in which success is sometimes achieved by small margins. The two major political parties are the Nationalist Party and the Labour Party. Allegiance is often seemingly inherited at birth, a fact which makes the 'floating voter' extremely influential in the electoral system. Political rivalry can be traced back to the second decade of the twentieth century (Montebello, 2007) and till the present day political polarisation represents the severest social division. This division was discussed at length by Boissevain (2013). He reported that in the 1960's people either supported the Malta Labour Party or the church. Labour party supporters were denied absolution by the church, a highly significant matter in a predominantly Roman Catholic country. This rivalry continued until the 1981 general elections when an unprecedented state of affairs led to the Nationalist Party gaining an absolute majority of votes, but yet had only 31 seats in parliament to the Labour Party's 34. This led to a political crisis, often resulting in incidents of politically motivated violence. Although a change in Malta's Constitution prevented the recurrence of such a situation, political rivalry was, from then on, firmly between the Nationalist Party and the Labour Party (Boissevain, 2013). In a key study, Boissevain coined a phrase that is very much in use in modern parlance in Malta today; the term is '*friends of friends*' and in his 1974 book of the same name, Boissevain started from the premise that the commonly held view that's people's behaviour is based on culturally defined directives, or sanctioned and accepted norms, fails to account for the reality that humans are first and foremost self-interested beings and not predominantly a member of a group or institution. Boissevain maintains that a person's social network, (or network of relations) which s/he is partly born

into and is partly self-constructed, is constantly manipulated with the aim of reaping personal benefit and meeting personal goals. This social network can be represented more or less as a circle, with the person at the centre surrounded by a ring or zone that contains those people with whom s/he is connected. Surrounding this is another circle, containing people known to those in the first zone, with whom the person may come into contact. These people are referred to by Boissevain as *friends of friends* and the term is a much used part of everyday parlance in Malta (Boissevain, 1974).

Of particular relevance to this study is Boissevain's consideration of these networks in relation to the people of Malta, and more specifically to healthcare in the island. Because Malta is small, access to politicians is as simple as a telephone call and politics is extremely personal. An example might be when someone is unhappy with a decision by their doctor they will ring directly the Minister for Health or other high ranked civil servant who may directly intervene in individual cases, even in banal situations such as a person asking for their relative to be allowed to contravene ward rules whilst in hospital. Another example would be when politicians become involved in recruitment for public service posts, using their influence to secure jobs for people, most often in a kind of 'favour for votes' system. Many seemingly mid to low level civil service and managerial posts are political influenced appointments and around the time of elections public institutions undergo staff movement and changes based on political affiliation. This was seen in the most recent general election (June, 2017) when one of the leading newspapers in the Island reported that between September 2016 up until the election, the number of public service employees increased by 3,000 and that in one instance a particular Minister recruited 150 workers, mainly from

his own electoral district, to join the national Water Services Corporation in the weeks leading up to the election. This figure represented a 15% increase in the total workforce of the corporation (Camilleri, 2017). Boissevain (2013) seemed to sum up this cultural aspect well when he said that small islands and communities, such as Malta, are subject to a:

Pervasive system of patronage, clientalism, nepotism and a real or imagined network of friends of friends. (p.249)

2.6 The education system

Education in Malta is compulsory from age five to sixteen years. There are three providers, these being the state, the church and the private sector. Around 70% of children receive free education at State schools. Those attending church schools may be required to give an annual contribution to fund school projects, and as one would expect, those students attending privately run schools are charged an annual fee (Cutajar, 2007). At the end of the compulsory education period there are three options available: to continue into the post-secondary academic route, to embark upon vocational education or enter into the labour market. The post-secondary academic route, known as Sixth Form, lasts for two years. Upon completion students may take the Matriculation Certificate Examination (MATSEC) to progress to higher education (National Commission for Higher Education, 2009; Ministry for Education & Employment, 2014). Sixth Forms are the 'stepping stone' to higher education. Students can choose to enrol in public and private Sixth Forms or Church Sixth Forms. As with compulsory education facilities, State and Church sixth forms are free of charge, although students attending Church sixth forms make donations to the school while private sixth forms

charge fees. Those students who attend approved sixth forms are eligible for students' maintenance grants or a stipend as, somewhat controversially, are Maltese students at the tertiary level of education. Malta is one of only three EU countries who provide university education that is both free and covered by a grant (Camilleri, 2012). Full time undergraduate courses are free-of-charge to citizens of Malta and the European Union. Fees are charged in the case of higher degree courses and to nationals from non-EU states.

2.7 The healthcare system

Healthcare in Malta is primarily funded by the tax system and operates by means of an integrated health services system that is organised at a national level (Azzopardi Muscat & Dixon, 1999). Access to the health care system is largely equitable, but like many other developed countries Malta is facing a chronic lack of funds (Pincock, 2005) and is feeling the effects of a global recession. Factors such as demographic and epidemiological transitions, technological developments and the increasing expectations of the population, are all working together to exert pressure on an area where, as in many countries, spending is growing faster than inflation. The health sector is one of the largest employers in Malta, with a total workforce of over 11,000 people (Price Waterhouse Cooper, 2012). Due to the Island's small size, services tend to be centralised and favour a bureaucratic top down management approach. Industrial relations are turbulent and the workforce is highly unionised, with around 80% of workers being covered by collective bargaining and there are frequent occurrences of industrial disputes with threats of industrial action. Salaries and other incentives for health care professionals are lower than those of their European counterparts. Hospital

based care forms the core of the state health care system at the present time and the field of psychiatry is no exception (Azzopardi Muscat et al., 2017).

2.8 Mental health

Mount Carmel Hospital is Malta's only psychiatric hospital and currently provides around 420 in-patient psychiatric beds, having seen a reduction in bed state over the last few years. Arton (1988) noted that the history of mental health nursing is poorly recorded and neglected, suggesting that this is due the fact that it lacks 'glamour', and indeed the history of mental health nursing in Malta is scarcely reported. Fortunately however, in 2004 the Association for the Study of Maltese Medical History published a comprehensive account of the history of "*mental disease*" in Malta. The author, C. Savona-Ventura provided a detailed and descriptive picture of psychiatric care through the ages (Savona-Ventura, 2004). By combining this with a published account of the local history of the care of the mentally ill, written by Maltese staff nurse Joseph Muscat (Muscat, 1973), it is possible to assemble a detailed narrative of the development of psychiatric care on the island and the following paragraphs represent an assimilation of these two works.

The first hospital providing psychiatric care was in the country's capital city of Valletta, and was opened by the Knights of the Order of St. John of Jerusalem. Named the Sacra Infermeria (Holy Infirmary), this general hospital opened its doors in the late 1500's and in a dedicated ward for psychiatric patients, occupancy averaged around 18 male patients per month. Generally reflecting the progression of psychiatric care elsewhere in

Europe, 'treatment' consisted of manageable patients being bound and chained to their beds or if they became unmanageable, chained to the walls in the hospitals basement. The basement windows reached street level and passers-by were able to observe the patients in a manner similar to people nowadays watching a reality TV entertainment programme. The care of the patients was the responsibility of a warden, who was supervised by the chaplains. Patients who were deemed incurable were transferred to another facility in the next town - Floriana, called the Ospizio. In the 18th century provision was for the first time made for female patients, in the form of two rooms for "*mad women*" (Muscat, 1973, p.43), at the Hospital for Incurable Women, Valletta and it was later still, in the 19th century before all patients, both males and females, were moved to the Ospizio where, along with the elderly, tramps and prostitutes, they were still shackled, chained and beaten by the wardens. In 1835 increasing patient numbers led to an old mansion, called Villa Franconi, being converted into a 80 bedded "*mad house*" (Muscat, 1973, p.44), that served to separate these patients from the general hospital population. Treatment and conditions were still at best very poor, and more often than not inhumane and barbaric.

A rapid increase in the number of patients and problems with nursing such patients in a densely populated residential area led to the building of a purpose built asylum. Designed to provide around 200 beds and set in ample agricultural land where the patients could work, the 'Asylum for Imbeciles' (or 'Asylum for the Insane') opened in 1861. The plans for the hospital were designed by F. Cianciolo, an Italian immigrant posing as an architect, and it was later found that the architectural design had been plagiarised from a hospital in Britain (the Wakefield Asylum), which itself had already been

demolished after having been found inappropriate for its intended use (Savona-Ventura, 2004). In Malta, the patients were transferred to their new accommodation by a plain-clothes police escort, under the cover of darkness in July of that year. From the very beginning numerous structural defects were apparent and it became clear that the number of beds in the new asylum was inadequate. There were eight large wards, four for men and four for women. Over the following thirty years the hospital population grew to over 650 patients, but it took 50 years to build an additional 7 wards.

During this era, care staff were reportedly completely untrained, generally illiterate and were either ex-agricultural workers or ex-patients of the Ospizio. Many were elderly and physically infirm. The ratio of attendants to patients was around 6:150. Desirable qualities for the attendants were strength, tallness, courage and intelligence. In the late 1800's nuns joined the female nursing staff and the very first lecture on basic nursing care was delivered to the attendants (though records state without any apparent irony that there was no noticeable improvement in nursing care as a result of this solitary lecture).

Over this period of time, there was never any suggestion of actual therapeutic treatment being given to the patients. Described by one of the hospital's medical superintendent's as "*a store for lunatics*" (Savona-Ventura, 2004), the hospital only ever provided containment in various forms, although many of the patients were gainfully employed in industrial and agricultural work within the hospital. In the late 19th century various types of medicinal sedation were employed to control the patients but it was not until the 20th century that European advances in pharmacotherapy started to impact patient care and treatment. Some of these therapies required an intensive

level of nursing care, for example caring for a comatose patient receiving insulin coma therapy, yet the nurses remained largely untrained and there were in fact inevitable fatalities related to lack of nursing knowledge and care.

Along with the 'advances' in psychiatric treatment, came a realisation that the title of the hospital could influence people's perceptions of the services it delivered. Having changed from its original name of Asylum for the Insane to the Hospital for Mental Diseases in 1928, a new title was sought, in an attempt to mark the changes in therapeutic approaches. To this end, the hospital was renamed Mount Carmel Hospital in 1967 and retains this title until the present day.

An extensive search of available literature reveals that very little information has been published about mental health care or services in Malta over the decades, perhaps reflecting the low priority of mental illness on the country's agenda. However by 1994 the government acknowledged the burden that mental ill health was arguably placing on society and recognised that the mental health sector required radical reform (Department of Health Policy & Planning, 1995). In a comprehensive situational analysis conducted at that time, several deficiencies were identified as contributing to what was clearly a less than favourable situation. Amongst these were noted the poorly developed community psychiatric services, inefficient management structure and use of resources, custodial (rather than rehabilitative) patient care and a critical shortage of adequately trained professional staff (ibid). This emerging acknowledgment of issues that needed addressing was validated in the country's targets for achievement by the year 2000. In the strategic priority setting document, Health Vision 2000, mental health was deemed a growing

problem and designated as a priority area for attention. Amongst other issues, the document made specific reference to implementing changes in managerial approaches, transforming the custodial approach and improved rehabilitative and community services (Department of Health Policy & Practice, 1995).

Some 15 years later in 2010 the government published the Strategy for Non-Communicable Diseases in which it outlined developments that had occurred since the 1995 strategy document (Department for the Prevention and Control of Non-communicable Disease in Malta, 2010). It is clear from this document that a definite shift in policy planning had occurred but it is also apparent that very little headway had been made on achieving the targets set out in the 1995 strategic planning document.

More recently, in 2011 a practical guide outlining the menu of services available for people with mental illness in Malta was published. It describes the psychiatric hospital as a dynamic system and talks of a “quantum leap” in the quality of care over the last 150 years. In this brochure descriptions and information related to the hospitals wards are presented under sub-speciality headings which describe the services offered in each area (Mental Health Services, 2011); these significantly include the provision of community mental health services, which were largely non-existent up until 10 years ago

Of course, it should be acknowledged that the barriers to improving mental health services in Malta are commonly shared with other low and middle income countries and include the low priority of mental health on public health agendas; the low numbers of specially trained staff in mental health

care; and a general (and often generic) resistance to change (Saraceno, et al., 2007).

2.9 Legislation related to mental health

Legislation governing the care and treatment of people with mental ill health in Malta was non-existent prior to the development of the country's 1976 Mental Health Act; before this practice and policy were effectively regulated by custom and reinforced by local tradition. The 1976 legislation was enacted in September, 1981 and was essentially derived from the UK's 1959 Mental Health Act. The Maltese statute dealt only with the confinement of patients and neglected the fact that mentally ill patients are not necessarily only found within the Island's only psychiatric hospital. Unsurprisingly, since no community services existed, it neither provided for community based mental health services nor recognised the rights of people with mental ill health, the latter point perhaps indicating the general attitude of the State and the general public towards people with mental illness. In fact it could be said that it was the omissions of the Act, as opposed to the content, which constituted a breach of human rights. Despite its shortcomings, the Act remained in place until December 2012, when the new Mental Health Act (2012) was approved by Parliament.

2.10 History of nursing in Malta

The early nursing body consisted of a very small number of female 'lay' nurses and nuns and education was haphazard to say the least and it wasn't until the twentieth century that any formal mental health training was delivered to nurses. (Savona-Ventura, 2004). In the mid-1940s, nursing

standards were raised to those of British nursing schools and by the early 1950's Maltese trained nurses were recognised by the General Nursing Council (GNC) of the United Kingdom (UK), (Savona-Ventura, 2004). The modern School of Nursing opened in the 1960's and was fully funded by the Ministry of Health. In 1977, a 10-year doctors' dispute was initiated when the government at the time amended legislation governing medical licensing. One of the consequences of the strike was the suspension of Maltese doctors' medical qualifications by the General Medical Council (UK) and in addition the GNC suspended recognition of nurses' qualifications (Sharples, 2017).

In 1987 the Institute of Health Care was established within the University of Malta, replacing the School of Nursing and still subsidised financially by the Ministry of Health. Later nurse education in Malta went from being mainly organised by the Medical and Health Department to being delivered at a tertiary level of education, through programmes organised by the Faculty of Health Science, at the University of Malta. Apart from being a significant institutional reform in the education of health care professionals, this measure was noteworthy as it elevated the status of nurse education (Azzopardi Muscat & Grech, Malta, 2006).

The first Bachelor's degree in (general) nursing was introduced by the University in 1988 (Sammut, 2012) but it was much later, in 1992 that a full time diploma in psychiatric nursing became available (Gafa, 2016). The first postgraduate degree programme to convert diploma psychiatric or general nurses to degree level psychiatric / mental health nurses followed twelve years later in 2004 (Ward, 2010) and in 2009 the University offered the first direct entry BSc Mental Health course. In 1993 post registration educational

opportunities were introduced for the first time for nurses in general (Fenech Adami & Kliger, 2005). Until the present day, in stark contrast to other European countries, the uptake of continuing education is not mandatory for nurses in Malta and once a nurse is registered with the Maltese Council for Nurses and Midwives, they are registered for life. The development of psychiatric nursing in Malta is illustrated in the following timeline.

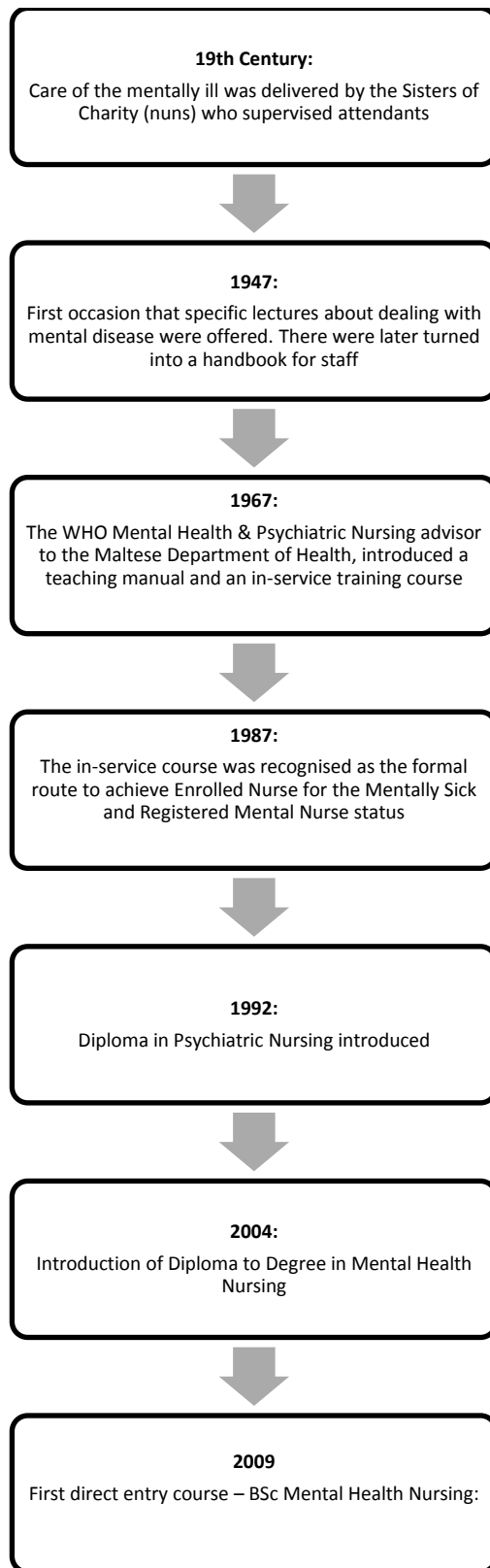


Figure 1: Development of Psychiatric Nursing in Malta

2.11 Conclusion

In any analysis of Maltese policy, the importance of religion and local politics cannot be underestimated, as they are core issues that permeate every aspect of life in Malta. Reform in any area is slow partly because of administrative, political and cultural obstacles (WHO, 2006). Of particular note for this study is that the cultural context in which healthcare operates is one of the most difficult barriers to overcome when implementing reforms in health care (Azzopardi Muscat & Dixon, 1999). It is of no small significance that resistance to change is illustrated in the fact that patients, health care professionals and even the general public still refer to Mount Carmel Hospital as 'Franconi' (pronounced fran-kuni), referring to Villa Franconi, which was the Island's "*mad house*" in 1835 (Muscat, 1973, p.44).

The slow evolution of reform locally is also evident in the development of nurse education. European policies generally emphasise that the training and education of health professionals are a major means of improving mental health services (Nolan & Brimblecombe, 2007). Horatio, which is the representative body of approximately 300,000 European psychiatric nurses, stated that in the highly specialised area of mental health nursing, the level of preparation is a crucial indicator of the ability of services to deliver an appropriately high quality of care (Ward, 2010). Since the introduction of the conversion course from diploma to BSc (Mental Health Nursing) over a decade ago, there has been a steady flow of nurses undertaking the course, but scant appraisal of how effective the programme has been in improving care and services in the sector. Thus this study seeks to establish how psychiatric nurses perceive and experience their current role, asks why they undertook the conversion degree course and examines what factors are felt

to impact their working practices after having completed the conversion course.

Reflexive box: 2

I first wrote this chapter very early on in the development of the study. I was very conscious of the fact that my thesis was going to be read by people from another country, who may have little or no insight into Malta as a country or of the culture and way of life and even less knowledge or experience of its mental health care. I recall that whenever I spoke to people from outside Malta about the issues I wanted to look at in my study, my perception was that they thought I was exaggerating or being overly critical, when I thought that in many instances I was probably giving a sanitised version of how things really were. Therefore I set about writing a brief overview of the country and certain key elements of its structure to paint a picture for the reader - giving an overview of the milieu in which the study was going to be conducted.

3.1 Introduction

This study aims to establish how a group of nurses who have successfully completed a post qualification degree in mental health nursing perceive and experience their current role and the ways in which undertaking the degree may have contributed to changes in how they practice and deliver care. In order to address this issue three main questions are posed:

- How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
- What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
- What do psychiatric nurses' perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

This chapter explores core issues directly related to the central topics of psychiatric nursing and continuing professional education (CPE). However since psychiatric nursing does not exist within a vacuum, there are other key influential elements that are synonymous with psychiatric care in general which cannot be excluded, and as such they are also discussed within this review, namely stigma, institutionalisation and culture.

In preparation for the empirical elements of this study, this chapter has the following objectives; it will:

- Introduce and interpret the major issues that surround the study topic providing a reference point from which to conceptualise, organise collection of and critically interpret the data;
- Establish which areas of the literature make a significant contribution to the understanding of the topic; and
- Critically indicate gaps that exist in the literature.

3.2 Psychiatric nursing

In considering psychiatric nursing in a current context, it is pertinent to reflect and comment on key aspects both of, and related to, the role. Therefore the following sections will consider the development of psychiatric nursing, consider the scope, professionalisation and identity of this specialist nursing group, and finally the subject of outcomes in psychiatric nursing is explored.

3.2.1 Development of psychiatric nursing

Throughout the course of examined history the care and treatment of people with mental illness has developed fairly consistently in westernised countries; indivisibly linked to a chequered past of untrained carers delivering often inhumane and at times, barbaric care, psychiatric nursing developed due to the shift from uneducated carer to trained nurse which coincided with the medicalisation of the treatment of mentally ill people (Lakeman, 1995). In the Victorian era, large and imposing institutions, then called 'lunatic asylums' were controlled and run by medical superintendents who were later called psychiatrists, and according to Barker (1990) it was as a result of the

patronage and beneficence of the medical profession that psychiatric nursing emerged. In describing nursing at that time, Clarke (1999) wrote:

This was a nursing comprised of [sic] hierarchies, rules and uniforms, the omnipotence of doctors, an obsession with illness and especially, the death by boredom of shift systems. There existed a slavish obedience ... whereby patients simply withered on the vine of concepts of chronic illness. In far too many cases these attitudes led to a slippage into abuse and neglect. (p.2)

As a function of medicine more generally, nurses were created – both practically and culturally - in a servile role, an extension of the doctor. Rolfe and Cutcliffe (2005) noted that in the past psychiatric nurses were “*poorly trained foot soldiers of the psychiatric system*” (p.254) and there is no doubt that as Barker (1990) has it, psychiatric nursing remains firmly in the “*ideological shadow*” of psychiatric medicine, not least because biological explanations and treatments underpin the medical model of care delivery that dominates psychiatric nursing activity (Lakeman, 1995; Santos and Amaral, 2011).

The twentieth century was characterised by significant changes in medical knowledge and theory, advances in pharmacology, shifting health care policy trends and a rise in service users’ expectations. It was in this shifting era that an American nurse, Hildegard Peplau, developed what became the foundation or theoretical base for psychiatric nursing (Forchuk and Brown, 1989; Callaway, 2002). Peplau (1992) asserted that mentally ill patients, whether they recognise or accept it, require help to identify, understand and resolve those problems that have interfered with their living productive lives

and that the central aim of the psychiatric nurse is to pursue these goals with the patient. The therapeutic relationship is a series of interactions in which the nurse works with the patient to achieve positive behavioural changes and this occurs over a series of phases, which are commonly referred to as orientation; identification; exploitation; termination. The relationship is goal orientated, focused solely on the patient's needs, time limited and professional and rests on several basic elements including: trust, rapport, unconditional positive regard, empathy, limit setting, therapeutic communication and the therapeutic use of self (nurse). Although Peplau was not the first person to advocate interpersonal relationships as an underlying framework for psychiatric nursing, she was the one who made it widely known and she is commonly acknowledged as a major architect of the field of psychiatric nursing (Olson, 1996). Adams (2017) discussed Peplau's contribution to psychiatric nursing, which she described as the biggest influence on the development of the speciality. Adams contended that Peplau's interpersonal theory "*led psychiatric nursing out of the confinement of custodial care into a theory driven professional practice*" (p.12). It was at this point in nursing history, largely due to Peplau's influence, that psychiatric nursing was established as a distinct speciality within the nursing professions (Sills, 1988; Haber, 2000).

3.2.2 Professionalisation of psychiatric nursing

Nursing is an honorable, a remunerative, a noble calling, but efforts to exalt it into a profession or to rank it with the higher branches of learning and culture are the apotheosis of the absurd.

(Messer, 1914, p.122)

Definitions of a profession abound in the literature and generally include the following key characteristics:

- extensive theoretical knowledge base emanating from higher education;
- legitimate expertise based on a body of knowledge and theory in a specified field;
- an altruistic commitment to providing a service that benefits individuals and the wider community;
- possessing autonomy, control and accountability;
- self-control through standards and a code of ethics
- conduct overseen by a body of representatives within the field itself
- a personal identity that stems from the professionals occupation

(Boling, 2003; Yam, 2004).

Thus a merely distinct speciality is differentiated from recognition as a profession. In fact, nursing is generally considered rather as a practice-based discipline, but it also has a long tradition of being identified as a vocation, with aspirations to become a profession. The sense of vocation originates from its strong roots in caring and altruistic service to others, often within a religious context. The positive associations of vocation are offset by the more negative impressions of subservience and obedience to others (Brown and Gobbi, 2006).

Within the turbulence of change and development of role identity in the twentieth century outlined above, psychiatric nursing began what was to be an enduring struggle to evolve from being recognised as a vocation to being accepted as a profession. Yam (2004) described it as a hard fought battle as

nurses in general tried to shed the image of a role that was perceived as an extension of the physical and emotional work of wives and mothers with roots that were firmly based in religious contexts. Wynd (2003), concurred when stating that the question of the professional status of psychiatric nurses is open to debate, and the literature offers a number of partial explanations as a starting point. In its relatively short history, psychiatric nursing was always a low status, predominantly female occupation in an area where male dominated (medical) attributes were valued (Wynd, 2003) and this inhibited the development of any privileged place in society such as the professions typically enjoy. Furthermore psychiatric nurses rarely “*own the rights to the end product*” (Andrew, 2012, p.848), meaning that when a patient ‘gets better’ it is never attributed to nursing care and interventions but rather to the input from the psychiatrist. Similarly, increased income, status and prestige were never associated with a career in psychiatric nursing. The mass media tends to depict nurses, and specifically psychiatric nurses, in a negative light, portraying them at best as obedient, motherly care givers who assist doctors or conversely, as stern, power-mad dictators; as Heyman (2012) noted “*mental health nurses are often viewed by the public as corrupt, evil and mentally abnormal.*” (p.16). An appropriate example from popular culture is Nurse Ratched in the iconic film *One Flew over the Cuckoo’s Nest* – a nurse portrayed as a cold and heartless tyrant (Forman, et al., 1975). Although a fictional example, perspectives such as these, lend themselves to perpetuation of the low status-image of psychiatric nursing but also have more far reaching implications. Yam (2004) illustrated potential consequences when he pointed out that since politicians are preoccupied with healthcare financing, such a low status can justify the low pay of the

largest group of employees in the health sector. Diversity of psychiatric nursing activities means that pinning down an exact description of the job or role of a psychiatric nurse is elusive and it is not easy to pinpoint its 'unique' contribution. The 'holism' of nursing is a concept of which psychiatric nurses are very concerned (Clarke, 2003), but as Ruddy (1998) pointed out, this holism becomes vague and perplexing and results in a failure to distinguish nurses from other professions.

Evidence based, scientific foundation was slow to develop in this specialised area and emerging research based evidence about best and most effective practice was, as Hafferty and Castellani (2010) put it: "*held captive by the tradition based practice of psychiatric nurses trained in another era and under a different value system.*" (p.289). This is an opinion supported by Allen (2007) who noted that the established values, beliefs and assumptions about psychiatric nursing make it difficult to see how things may be any different.

Concurrent with shifting patient populations, the changing focus of care (from hospital to community) and the competing models of care which underpinned them, came the arrival of nurse education which emerged in many countries as a recognised element in the higher education system. This shift was pivotal in the pursuit of professionalisation as formally recognised knowledge is considered essential to the validation of the theoretical knowledge base that characterises any given profession and hence closes all other avenues of entry into it. Moreover this gatekeeping should permit the professional's autonomy by encouraging members to assume control and policing of a body of knowledge, and to participate in decisions.

Boling (2003) in reference to psychiatric nursing in the United States of America (USA), stated that professionalisation actually became a reality through the development of theory, advanced education, research, publications and explication of standards; Boling thus implied that the process of professionalisation in that country (USA) is complete but this is not an opinion shared elsewhere regarding the status of psychiatric nurses. Examples of a differing opinion being that of Yam (2004) who claimed that more often than not, the label 'semi-profession' is applied to nursing, a position that Andrew (2012) described as "*the grey margins that exist between vocational and professional status.*" (p.846).

3.2.3 Scope of psychiatric nursing

Barker and Buchanan-Barker (2011) claimed that psychiatric nurses are uniquely indispensable in the sense that mental health services can function without other therapeutic disciplines but not without nurses. Jackson and Stevenson (2000) went further by asserting that nurses are the cement that holds everything together. However, according to Clarke (1999), the question of just what *is* psychiatric nursing is one that has "*bewitched, bothered and bewildered*" academics for a long time (p.x). The American Nurses Association (2010) considered psychiatric nursing to have two major components: a science component, referring to the application of theories of human behaviour and an art component which relates to the purposeful use of self within the therapeutic relationship. Barker and Buchanan-Barker (2004) discussed the values inherent in psychiatric nursing and appeared to lament the declining popularity of caring. They stressed that the role of the nurse is to be of service to the patient, helping them to identify what is

important to them and why. Whilst they extol the human connection between nurse and patient, where the nurse nourishes and nurtures but does not find solutions, they deride the ever present question of whether psychiatric nursing is an art or a science; their own conclusion is that it is distinctively a *craft*, whereby nurses use skills and knowledge to achieve their aims, and that this may be invisible but is yet transformative. Wilkin (2003) is in agreement when he defined psychiatric nursing as:

... primarily being and becoming with people who are suffering the effects of mental disease and distress. (p.26)

Generally the literature may be seen as representing positions between two polarised characterisations of psychiatric nursing, these being the prescriptive (what they *should* do) and the descriptive (what they *actually* do in practice). Barker (2002b) suggested that the principles of the prescriptive are well understood but that this understanding does not translate into practice. Alarming, this latter point seems to be the case, as research has shown that in reality nurses on the whole, tend not to interact with patients in any meaningful therapeutic manner (Molin et al., 2016; Whittington & McLaughlin, 2000) but are more concerned with the smooth and efficient running of the ward and concentrating on activities that promote what Porter (1993) described as 'occupational comfort'. Several authors defend the apparent shortfall of nurses in not engaging in what research has clearly purported to be the central aim of the nurse i.e. the use of self within the context of a therapeutic relationship. Cleary (2004) suggested that the pursuit of the ideal is confounded by such issues as organisational pressures, diversity in the nurse's role and ever increasing competing workplace demands. Delaney and Fergusson (2011) concurred, and defend

the elusiveness of the interpersonal connectivity inherent in the therapeutic relationship, in environments that are characterised by time and role pressures and a turbulent work life. Other authors maintain that the issue is not that nurses do not carry out the requirements or duties of their role, but rather that they fail to articulate their uniqueness and the nature of their work (Michael, 1994; Lakeman, 1995; Olson, 1996; Barker, 2002a; Deacon, et al., 2006). This is an issue that has been referred to often by Barker who was the UK's first Professor of Psychiatric Nursing Practice. In an ongoing study (Barker and Buchanan-Barker, 2008), he asked 200 psychiatric nurses, leaders, researchers, and educators to provide a brief and concise definitions of what psychiatric nurses do, in terms that could be understood by a lay person. The results were remarkable, many respondents were either unable to answer, or else asked for time to think about it, whilst some even said it cannot be defined.

3.2.4 Professional identity

Barker and Buchanan-Barker's (2011), study raises concerns about the professional identity of psychiatric nurses. The findings of a small qualitative study by Crawford et al., (2008) which included issues related to the professional identity of a group of psychiatric nurses working in the community, reiterated a theme commonly found in the literature: that psychiatric nurses struggle to develop a professional identity because they fall under the shadow of doctors and are furthermore unable to articulate their diverse and unique contribution, thus adding to their invisibility. The participants of a small scale study carried out by Rungapadiachy et al., (2006), who were themselves recently qualified psychiatric nurses, perceived

the role of psychiatric nurses to be ambiguous and dependent upon individual nurses, individual patients and the environment. They described their role as multifaceted and diffuse. The literature is replete with the assertion that the central role of the psychiatric nurse is the development of a therapeutic relationship; however in Rungapadiachy's 2006 study some participants described the main roles of the psychiatric nurse as being administration of medication and the management of aggressive patients. Rungapadiachy et al., (2006) noted that both of these tasks imply a controlling role and it is this paradox between control and therapeutic involvement, in addition to the diversity of the quotidian roles of the psychiatric nurse, which causes ambiguity.

Neary (2013) discussed the concept of professional identity, which she defined as being "*how we perceive ourselves within our occupational context and how we communicate this to others.*" (p.14). In considering the construction of professional identity Caza and Creary (2016) reflected on the question of why professional identity really matters. These authors said that professional identity shapes a person's attitude towards work and their decision making choices thus guiding their behaviour and practice. Johnson et al., (2012) pointed out that nurses' professional identities are not fixed but rather develop through the course of their lifetimes - before they enter nurse training, through their years of education and clinical experience, and so on - and evolve perpetually during their careers. Furthermore, Johnson et al., (2012) contended that professional identities are strongly influenced by a person's self-image, beliefs and role expectations; perceptions of how others perceive nurses and how nurses are regarded by the general public and society.

The issue of professional identity, as highlighted by these authors, relates directly to the future of psychiatric nursing and hence to the recruitment of psychiatric nurses. In 2007, the World Health Organisation predicted that the number of people with mental illness would continue to grow, and its acknowledgement that psychiatric nurses play an essential role in their care (WHO, 2007) included a call for urgent investigation into how psychiatric nurses make sense of their role and professional identity. More recently, it has been argued that a well-defined representation of the role of psychiatric nurses might positively influence recruitment and retention (Hercelinskyj et al., 2014). Hercelinskyj and colleagues, undertook a small scale study which investigated psychiatric nurses' understanding of their role and the impact of that understanding on their professional identity. Amongst other issues, the respondents expressed concern about the future of psychiatric nursing. Holmes (2006) addressed that particular concern in an evocatively entitled article: 'The slow death of psychiatric nursing: what next?' which noted that even though recruitment of psychiatric nursing has always been marked by shortages, nowadays it is in a more precarious position than ever. Holmes (2006) provided a comprehensive list of factors which, he argued, were contributing to recruitment problems in nursing in general:

- a failure to attract high academic achievers;
- a reputation for being a demanding profession;
- an inability to compete with more attractive professions;
- unattractive pay and status;
- a change in the underlying attitudes and values which lead people to choose nursing which are being eroded due to a greater requirement for job security and career development;

- a dislike for the environment where nursing takes place.

Holmes (2006) went on to describe a number of additional issues, which are particular within the psychiatric context where he argued that recruitment is further hampered by:

- the “*appalling*” (p.404), state of mental health services which reinforce the poor image of psychiatry;
- sensationalized media reporting of violence and aggression by mentally ill people; media revelations of poor care practices;
- scarce resources;
- widespread stigma towards people with mental health issues and the people who care for them.

3.2.5 Professional scope and standards in psychiatric nursing

A central element of professionalisation is establishing and maintaining professional psychiatric nursing standards. This involves the development of statements about what the members feel is imperative in order to guide their practice, to establish control over practice, and to influence the quality of that practice. Nursing standards, which are “*authoritative statements defined and promoted by the profession by which the quality of practice, service, or education can be evaluated*” (ANA, 2010, p.67), are critical to guiding safe, quality patient care. Halcomb et al., (2017) offered three key purposes for developing standards: in order to articulate the role and scope of nurses; as a basis for development of nurse education curricula and as tools for measuring outcomes. According to the Canadian Federation for Psychiatric-Mental Health Nurses (CFPMHN), (2014), “*professional standards reflect the current state of knowledge and understanding of a discipline and are therefore contextual and dynamic*” (p.5). In referring to the absence of a

definitive international list of tasks that psychiatric nurses engage in, and which could be used as a checklist to define the role, Santos and Amaral (2011), lamented that it is this lack of what they refer to as formal vocabularies or producing a shared culture of nomenclature, that has contributed to the lack of a unique identity for the nursing profession. This is however a challenge that has been addressed at a national level in many countries and some westernised countries (or regions within countries) have nursing organisations which have developed country specific professional scope and standard documents. These will be the focus of the next section.

3.2.6 International practice scope and standards

In 2010 the Australian College of Mental Health Nurses (ACMHN) developed 9 practice standards that addressed the attitudes, knowledge and skills which were considered essential for psychiatric nurses across a range of clinical environments. They specify the minimum level of performance required for a registered nurse practising in any mental health setting.

Elsewhere, the fourth edition of *Canadian Standards for Psychiatric-Mental Health Nursing* were published in 2014 by the Canadian Federation of Mental Health Nurses (CFPMHN), providing direction to nurses and the public on acceptable practices of a psychiatric-nurse. Expanding on earlier editions and incorporating stakeholder views from a survey open to CFPMHN members which had asked for input regarding potential standards, the standards consist of seven domains. The primary aim of the standards is to provide direction for professional practice so as to promote competent, safe and ethical care. The standards further express the desired and achievable level of performance for psychiatric nurses (CFPMHN, 2014). In

2008, the Health Regulation Department in Dubai produced competency criteria for psychiatric nurses which stress individual accountability of nurses and decision making in line with competency standards. They subscribed to the view that the scope of practice may be more specifically defined in reference to an individual nurse rather than defining a scope of practice for an entire profession. The standards are organised into five domains. Each domain identifies the related competencies, indicators, sub indicators and evidence guide examples. A similar New Zealand document (*Standards of Practice for Mental Health Nursing in Aotearoa New Zealand, 2012*), acknowledges the importance of national and individual culture in the development of standards of practice for psychiatric nurses. Their stance when developing standards was that psychiatric nursing is a speciality which is built on a foundation of general nursing competencies and standards. In 2012 they produced six standards, each of which clearly defines expected outcomes, and attributes (knowledge, skill and attitudes) required of each psychiatric nurse. The standards are applicable to all psychiatric nurses in New Zealand.

In the USA, the American Psychiatric Nurses Association (APNA) stressed the importance of developing scope and standards of practice in order to define boundaries and furthermore inform society about the parameters of nursing practice (APNA, 2014). A comprehensive consultative process resulted in a document outlining standards which are divided into two sections: those related to practice (6) and those related to professional performance (10). Each standard is accompanied by related competencies, each providing a rationale and a list of actions and behaviours expected of each nurse.

The 2014 *Standards for Competence* produced by the Nursing and Midwifery Council (NMC) in the UK apply to all registered nurses and are based on four central domains (professional values; communication and interpersonal skills; nursing practice and decision making; leadership, management and team working). In addition to more generalised competencies which are applicable to all nurses, they also provide four comprehensive speciality related standards and competencies related to psychiatric nurses.

In a paper expressing a collection of generalised views from a loose community of European states, the European Psychiatric Nurses Association, officially named Horatio, acknowledged a lack of uniformity and continuity between European psychiatric nurses concerning (amongst other things) core competencies and clinical practice (Ward, 2012). They stated that this is a situation that has never been fully addressed by either national representative organisations nor by the EU legislative bodies. With this in mind they developed the 'Turku Declaration' (Ward, 2012) which is a document containing 66 items divided into sections outlining the requirements of educational preparation for psychiatric nurses, the essentials of clinical practice and responsibilities in respect of research and development (Horatio European Psychiatric Nurses Association, 2011). It is to be noted that this document is not officially adopted by any European national or state organisation.

Table 1 displays the seven country specific documents, the year they were released and the issuing body.

Country:	Year:	Issuing body:	Title:
Australia	2013	Australian College of Mental Health Nursing (ACMHN)	Standards of Practice in Mental Health Nursing
Canada	2014	Canadian Federation for Psychiatric- Mental Health Nurses (CFPMHN).	Canadian Standards for Psychiatric-Mental Health Nursing 4th Edition March 2014 Standards of Practice
Dubai	2008	Health Regulation Department. Dubai Health Authority	Scope of Practice for the Mental Health Nurse
New Zealand	2012	New Zealand College of Mental Health Nurses	Standards of Practice for Mental Health Nursing in Aotearoa New Zealand
USA	2014	American Psychiatric Nurses Association	Psychiatric-Mental Health Nursing: Scope and Standards of Practice, 2 nd Edition
UK	2014	Nursing & Midwifery Council (NMC)	Standards for competence for registered nurses
Europe	2011	European Psychiatric Nurses Association – Horatio	The Turku Declaration

Table 1: International standards for psychiatric nurses

Although differing in content, each country document states the specific standard required and then in most cases goes on to provide an explanation of indicators or measurement criteria (behaviour, knowledge, skills and attitudes) which each nurse is expected to have. Table 2 provides an illustration of commonalities in the central themes found amongst the different country standards.

Developing & maintaining a therapeutic relationship	Maintaining a therapeutic environment	Therapeutic interventions	Patient focused care
Care planning process	Dealing with psychiatric emergencies	Respecting cultural diversity	Works within a legal & ethical framework
Recovery focused practice	Professional responsibility & accountability	Continuing professional development	Research based practice
Stakeholder collaboration	Act as patient advocate	Teaching & coaching	Mental health promotion

Table 2: Common themes in international standards for psychiatric nurses

This review suggests that irrespective of the lack of a joint or shared taxonomy, the vision of what a psychiatric nurse should know and do is fairly constant internationally.

3.2.7 Outcomes in psychiatric nursing

Changes in healthcare policy through the 1980's and 90's resulted in an increased emphasis on accountability (Santos and Amaral, 2011) and psychiatric nurses, like all healthcare professionals, have faced a growing pressure to provide evidence that the care and treatment they give is effective (Doerfler, et al., 2002; Santos and Amaral, 2011). Generally, outcome measurement in healthcare tends to be related to tangible aspects such as mortality rates, post intervention performance and function assessment, quality of life measurement and patient satisfaction surveys. However, the measurement of outcomes in psychiatric nursing care is a challenging undertaking. Chambers (1998) emphasised this point stating that in essence the work of the psychiatric nurse is a creative human enterprise and that as such *measurement* of the therapeutic value of the role is not

attainable. Rolfe and Cutcliffe (2005) concurred, asking what would count as measurable evidence. Frequently cited work from the 1970s, described psychiatric nursing as comprising high and low visibility functions (Brown and Fowler, 1971). High visibility functions pertain to tasks such as giving injections and medications and these, Brown and Fowler argue, are the functions that are most valued by management as they are tangible and can be measured. Low visibility functions, such as building interpersonal relationships (warmth and empathy), are not quantifiable and, thus defying measurement, resists effective management (and is of course consequently undervalued by managers). Ironically however, as Hamblet (2000) pointed out, it is only when these low visibility functions are absent that they receive any attention at all, usually as a result of a patient's complaints. Montgomery, et al.; (2009) also discussed patient health outcomes in psychiatric nursing. They stated that the reasons psychiatric nurses have lagged behind other health fields in critically valorising interventions include a lack of reliable outcome measures and a "*reticence (sic) to let go of a professional attitude of knowing what is best for the patient*" (p.32). They suggested that psychiatric nursing interventions have been strongly influenced by generally held practices and beliefs as opposed to systematic empirical support. Buccheri et al., (2010) promoted the use of objective outcomes measurement tools, not least so that psychiatric nurses can illustrate the complexity of their skills and the effect of their interventions on patient outcomes. (Such tools would include patient self-assessment scales, nursing observation scales and so on). They stated that employing measurement tools can explain what psychiatric nurses do, defining their role and contribution to the treatment team as well as demonstrating the effect on

patient outcomes. Buccheri et al., (2010) claimed that when nurses can provide objective data that a nursing intervention has improved patients' symptoms or illness, the general credibility and perceived value of nurses' interventions are more evident. The lack of published material related to outcomes in psychiatric nursing was noted by Santos and Amaral (2011) in a discussion paper regarding identity and effectiveness of psychiatric nurses, in what they identify as an "*era of accountability*" (p.330). Although these authors stressed that evidence on effectiveness may not necessarily directly influence how psychiatric nurses are valued and respected they, like Buccheri et al., (2010), suggested that such evidence does so indirectly by improving the quality of care and highlighting the necessity for psychiatric nurses.

Despite the significance of evaluating patient outcomes in relation to psychiatric nursing being acknowledged within the literature for over a quarter of a decade, there is little evidence that there has been any widespread headway towards developing outcome instruments which are sensitive to psychiatric nursing interventions. In an integrative literature review, Montgomery et al., (2009) reviewed 25 studies which had evaluated outcome instruments specific to psychiatric nursing. They concluded that ambiguous links between nursing processes and patient outcomes created doubt as to whether the tools used to measure a connection were reliable indicators of nursing's effect.

3.3 Continuing professional education in nursing

Having considered central themes related to the development and professionalisation of psychiatric nursing, this section now looks to introduce

the major second issue that surround the study topic, which is Continuing Professional Education (CPE). The background to CPE, motivation, barriers and opportunities and issues related to outcomes of CPE will be discussed.

3.3.1 Background

Zander (1985) recalled that Florence Nightingale said “*nursing is a progressive art, in which to stand still is to go back*” (p.179) and this illustrates that the importance of continuing nurse education has been recognised, at least by some, since the beginning of the profession. In the second half of the twentieth century there was a marked shift in perspective worldwide (Bahn, 2007); nursing was struggling within a social context which, according to Donner and Wheeler (2001), devalued nurses’ work as being unskilled and totally dependent upon the medical profession. It was against this backdrop that Francke, et al., (1995) described the “*storm of professional education sweeping across the nursing profession*” (p.371), which characterised the response to the paucity of professional education.

Continuing, and more specifically Higher, Education was seen as vital in promoting nursing as a profession, responding to the changing needs of society and reforming archaic health care systems (Sibandaze, 2018). A central part of this move was linking nurse education programmes to higher education institutions (Smeby, 2015). As Yam (2004) noted, formal knowledge is regarded as the central characteristic of professionalisation. Furthermore, it was envisaged that upgrading the status of the profession would reflexively attract better candidates, provide a higher level of teaching and lead to the development of research based scientific knowledge (Spitzer & Perrenoud, 2006).

Woodruff (1987) recollected that it was once estimated that the 'half-life' of a nurse's basic education was about 5 years (borrowing 'half-life' from pharmacology and referring to the period of time required for the concentration or amount of drug in the body to be reduced by one-half); it was perhaps the realisation of this metaphor which led to the growing awareness that basic professional preparation for nursing was no longer sufficient, as it could not effectively meet the changing and complex needs of modern health care (Pena Flores & Alonso Castillo, 2006; Altmann, 2011; Urbano and Jahns, 1988). In the last decade or so this awareness has continued to grow, largely as a result of changing service user expectations, an increasingly litigious society and the evolution of the traditional role of the nurse which is ever expanding and becoming more diverse (Presho, 2006).

Over a century and a half after Nightingale's observation (above), CPE is still acknowledged as crucial for both advancing professional competence and in preventing obsolescence (Gallagher, 2007). Of particular relevance to this study, is the work of Furze and Pearce (1999) which pointed out that CPE does not stand in a vacuum, but rather is influenced by culture and policies both internal and external to nursing. Osterman et al., (2009) further reminded that the nursing workforce is composed of practitioners with a variety of entry level credentials and Finn et al., (2010) maintained that as pre-registration nursing was becoming a degree programme, post registration (or post qualification) degree courses were necessary in order equitably to align the many levels of nurses.

3.3.2 Motivations, barriers and opportunities

Nugent (1990) claimed that some nurse's feel that their work experience renders the need for further academic study redundant. However, in keeping with a global recognition that rapid scientific and technological change requires constant updating of skills in all professional activity, CPE is no less essential for nursing to prevent obsolescence (and not least because of the increased expectations of patients and employers). Griscti and Jacono (2006) assumed that the growing numbers of registered nurses who go on to undertake a degree later in their career indicates that a "*thirst for knowledge is apparent within the nursing profession*" (p.454) though Bahn (2007) preferred to acknowledge a variety of complex reasons which influence a person's decision to continue learning and Kovner et al., (2012) held that these reasons are a combination of intrinsic and extrinsic motivating factors. Such motivational factors tend to be well documented in the literature, identified from both the USA and European practitioner and research communities, and include (though are by no means limited to), professional advancement, increased self-worth and enthusiasm and the ability to influence and change practice (Hogston, 1995; Clodagh Cooley, 2008). Other authors offer more tangible contributory factors such as tuition costs, flexibility, location and duration of the programme, maintaining a balance between work and personal life, finances, age, employer support, role obligations and academic stressors, all either acting to encourage or block uptake of CPE (Zuzelo, 2001; Griscti and Jacono, 2006; Evans et al. 2007; Gallagher, 2007; Kovner et al., 2012; McEwen et al., 2012).

Kovner et al., (2012) noted that the individual's decision to re-enter education is marked by an evaluation of the benefits and barriers presented (a 'what's in it for me' approach) rather than the thirst for knowledge referred to by Griscti and Jacono, 2006) and these authors held that it is this question which is the main force in prompting their participation in CPE. Gopee (2003) found that nurses perceived compulsory CPE as ineffective, and if compelled to study, nurses would pay only lip-service to their development. Therefore understanding the motivations of nurses to undertake CPE is relevant since they are influential on whether they translate theory into practice.

3.3.3 Outcomes of CPE

In a systematic literature review, which formed part of a larger national review in Ireland investigating the impact of post registration nurse education on practice, Gijbels et al., (2010) looked at 61 generally small scale studies that focussed on those education programmes which led to a recognised academic award and reported the perceived impact as described by various stakeholders (nurses, patients, carers, education and health service providers). Gijbels et al., (2010) found that a significant amount of work carried out internationally to evaluate the impact of CPE on practice, reported consistent findings even in different settings and contexts. They state that in the main, CPE programmes have been evaluated from the perspective of the student, whilst reports of the perspectives of course leaders, employers and - significantly - patients themselves, were few and far between. Gijbels et al., (2010) concluded that the most commonly reported outcomes of CPE are changes in the attitude and perceptions of those that take part and the acquisition of skills and knowledge. There was, according to these authors,

less reported evidence that the acquisition of skills and knowledge had any direct impact on the organisation or on service delivery and scant evidence of any direct benefits to patients or carers.

Draper and Clark (2007) speculated as to whether the lack of articulation (or evidence) about the value that CPE adds to direct patient care, may result in healthcare organisations no longer being willing to invest in it. But the quandary is: how is the impact or outcomes of continuing education to be evaluated in an area as complex, as sensitive and – above all – as essentially hominine as psychiatric nursing? For measuring any kind of outcomes at all in psychiatry is contestable, problematic and fraught with ethical issues. Holloway (2002) appreciated the predicament of attempts to measure outcomes in psychiatry when he discussed the complex social interventions that occur within mental health services. Some authors point to the usefulness of patient surveys in general health care environments, whilst cautioning that no matter how much the patient is assured anonymity the likelihood is that s/he may still be concerned that they will be identifiable (Griscti and Jacono, 2006). This must surely be much more significant in the case of psychiatric care, where very possibly the patient may, amongst other issues, need to have recurrent contact with services and thus be even more reluctant to respond frankly and honestly. In fact no studies could be located which addressed this issue in relation to psychiatric nurses practicing within a psychiatric hospital. The only published study concerning continuing nurse education in Malta (Fenech Adami and Kiger, 2005), which sought to explore the views and opinions of the Maltese nurse population towards specialised and continuing education, excluded psychiatric nurses as the authors felt that they represented “*a special and different case*” (p.80) although the authors

did not expand upon how they arrived at this assessment. The exclusion from this local study would seem to confirm the hesitancy of researchers to investigate populations related to psychiatry.

As stated at the beginning of this chapter, this review aims to introduce the major issues that surround the study topic, and the following sections relate to three topics that are often discussed in association with psychiatry and in particular in-patient psychiatric care: stigma, institutionalisation and culture.

3.4 Stigma

According to Ahmedani (2011) most conceptualisations of stigma do not focus specifically on mental illness and it is relevant in other contexts such as race, gender, and sexual orientation. However for the purposes of this study stigma in relation to three key areas will be discussed: mental illness; stigmatisation of psychiatric nurses and stigmatisation by psychiatric nurses. Lastly, to bring the subject to a local level, stigma and psychiatric care in Malta will be discussed.

3.4.1 Mental illness

Goffman (1963), noted that it was the ancient Greeks who coined the term *stigma*, referring to bodily signs depicting something uncommon and bad about the status of the bearer. The signs were cut or burnt into the body as a means of recognition that the bearer was for example a slave or a criminal, or a person tarnished in some way, and as such the person was to be avoided. Nowadays the term is more often applied to less literal characteristics. Goffman (1963) offered a brief definition of stigma: “*the*

situation of the individual who is disqualified from full social acceptance” (p.9) and more recent definitions barely deviate from this early description; for instance Byrne (2000), in discussing stigma and mental illness, identified stigma “...as a sign of disgrace or discredit, which sets a person apart from others. The stigma of mental illness (is) more often related to context than to a person's appearance” (p.65), and Davey (2013) similarly found stigma to be “...characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given”. Ebrahimi et al., (2012) described stigma as having three components: stereotypes, the cognitive element; prejudice, the emotional element and discrimination, the behavioural element. They continued:

When a person believes in the stereotypes of a mental illness, he/she will have negative emotional reactions toward it, which shows social prejudice in the form of attitudes and values, and causes discrimination against and isolation of the patient, which places the person with mental illness in an unfavourable social situation. (p.534)

Ward (2012) pointed out that the number of people suffering from mental illnesses worldwide is estimated to rise to affect 15% of the world's population by the year 2020. Byrne (2000) observed that despite all the educational advances of the last few centuries, mental illness is still perceived as a sign of weakness. Gaebel et al., (2017) concurred when they claimed that despite the growing number of people with mental illness, stigma has not dissipated over the years and wondered whether it is so deep

rooted in mankind, that efforts to change it may be in vain. Rössler (2016) too reflected the scale of the problem when he said:

The stigma attached to mental illness is ubiquitous. There is no country, society or culture where people with mental illness have the same societal value as people without a mental illness.

(p.1251)

In discussing the actors in the perpetuation of stigma, Rössler (2016) described three levels of at which stigma occurs. The first of these he called the macro level, which comprises of society as a whole and includes the mass media; secondly the intermediate level, in which he included healthcare professionals; and finally the micro level, which includes the person with a mental illness, who themselves contribute by self-stigmatization (Rössler, 2016). According to Byrne, stigma is indivisibly linked with shame and it is this that has arguably the greatest effect on people with mental illness in terms of concealing their illness or seeking professional help (Byrne, 2000; Halter, 2008). Gaebel et al., (2017) similarly noted that although it is a commonly reported fact that around one in four people may suffer from mental illness at some point in their lives, only around a third or one half of this number ever receive treatment. In fact the literature overall has determined that those people who experience mental illness are “*among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society*”. (Johnstone, 2001, p. 201). In a review of the literature regarding stigma towards mental illness as it relates to the nursing profession, Ross and Goldner (2009) concluded that healthcare workers may be categorised as being both the stigmatiser and the stigmatised.

3.4.2 Stigmatising of psychiatric nurses

Halter (2008) conducted a study which focussed on stigma by association as it relates to psychiatric nurses. She asked 122 nurses to rate preferred areas of speciality and psychiatric nursing was the least preferred of ten possible areas; furthermore they reported that psychiatric nurses were least likely to be thought of as skilled, logical, dynamic and respected. Heyman (2012) claimed that psychiatric nurses are subject to many of the same misconceptions as the patients whom they nurse and that such misconceptions can be found amongst both the general public and other strands of nursing. This is a view also expressed by Ben Natan et al., (2015), who asserted that negative stereotypes commonly held about people with mental problems, such as that they are dangerous and unpredictable, have led to a negative perception of psychiatric nurses, who in turn are perceived as being neurotic, inefficient, and unskilled, and as having mental problems of their own.

3.4.3 Stigmatising by psychiatric nurses

Goffman in 1961, noted the tendency of both patients and staff of institutions *“to conceive of the other in terms of narrow hostile stereotypes,”* with *“staff often seeing inmates as bitter, secretive, and untrustworthy”* (Goffman, 1961, p.18). More than 50 years later it appears stigma emanating from staff towards mentally ill patients is still an issue. Hansson et al., (2013) noted that people with mental illness feel demeaned, degraded and penalised by mental health service providers and moreover that the negative opinions held by the general public towards people with mental health problems are also

found in the people who are caring for them. Ebrahimi et al., (2012) suggested that it may be commonly assumed that healthcare professionals, with a university degree and in regular direct contact with mentally ill people would have fewer stereotypes, prejudices, and tendencies to prejudice. However they noted that the literature points to the inaccuracy of such an assumption and recognised that in some instances, psychiatric nurses themselves may realise significant stigmatising attitudes and behaviours towards the patients they nurse. This view is also expressed by Halter (2008) who held that whilst health care professionals in the field will possess at least a basic level of understanding about mental illness and an element of altruism generally, it would be mistaken to assume that they are necessarily supportive of people with mental illness and show less tolerance to negative stereotypes. In reality, however, Halter (2008) suggested that even health care professionals are subject to societal acculturation - which includes negative stereotypes of people with mental illness - and so they too exhibit stigmatizing attitudes and discriminatory behaviour. The impact of such stigmatisation was reinforced by Hansson et al., (2013), who noted that some people with mental illness feel demeaned, degraded and penalised by mental health service providers in whom they find the same negative opinions held by the general public towards people with mental health problems.

3.4.4 Stigma and psychiatric care in Malta

Very few published texts could be located that refer directly to stigma within psychiatry locally, in Malta, in the present day. However Sammut (2008), in an unpublished BSc dissertation, reported on a survey which he conducted

amongst 116 psychiatric and general trained nurses employed within mental health services. He found that nurses were well informed about the nature of mental illness and about trends in the care and treatment of the mentally ill. According to Sammut, psychiatric nurses had a better mental health literacy, resulting from their more detailed theoretical knowledge which he ascribed to their specialist training. On the other hand, Sammut's (2008) study seemed to support the findings of Halter (2008), Hansson et al., (2013) and Ebrahimi et al., (2012) in that they also showed that the participants in general held what may be considered less than favourable views about the patients they cared for, where nurses described perceiving patients as 'slightly' rude, immature, pessimistic and dirty. In a discussion paper presented at a special interest group of psychiatrists, Agius et al., (2016) offered an opinion on the development of stigma towards the mentally ill in Malta, tying it to the lack of State policies and a low commitment to improve services. They argued that the ingrained national Maltese culture of forming part of a group - whether this be political loyalties, spiritual allegiances (through supporting the local village saint), or the supporting of football teams - is one reason why people who are inherently different are not accepted by the larger society. The mentally ill then are perceived as a 'group' formed involuntarily, who live in often bleak and inhumane care conditions; the perception being that requiring psychiatric inpatient care meant that, once admitted, patients may remain in hospital for life. These authors are not describing a time far removed from the present. In fact as they noted in their paper, prior to the 1980's, all admissions to the hospital were involuntary and it was not until 1981 that some wards became 'open' (i.e. not locked), and patients were permitted to access the hospital grounds, and even potentially return to their

own homes. Agius et al., (2016) noted a number of positive developments in the ensuing 36 years, mainly related to a greater public awareness and acknowledgement of issues related to mental ill health. Nonetheless they held that generally Maltese people tend to avoid talking about mental illness, much less acknowledging that there is mental illness within their family and they conclude that “*stigma against mental health problems continue to exist in Maltese Society (sic)*”. (p.78).

3.5 Institutionalisation

Throughout Western Europe, from the 1950's onwards, the poor standards of care and quality of life within mental institutions prompted a political and social drive to close down the Victorian era asylums, a process referred to as de-institutionalisation. Large asylums have been closed or down-sized, and the total number of psychiatric hospital beds has fallen dramatically. Mental health services have been established in the community, although there is substantial variation between countries in the provision of community services (Priebe, 2004; Killaspy, 2006). However, in the country where this study was conducted, in-patient hospital care remains the mainstay of care and treatment for people with mental illness. As such, the issue of institutionalisation remains significant until the present day.

Shen and Snowden (2014) defined institutionalisation as:

... a social process by which structures, policies, practices, and programs are instilled with enough value such that they first acquire social legitimacy, are normatively and cognitively held in

place by members of the world society, become taken-for-granted by the collective, and ultimately achieve a “rule-like” status. (p. 1)

In this section, the concept of institutionalisation will be discussed with reference to the influential work of Erving Goffman and then considered in reference to the local context.

3.5.1 Goffman’s asylums

Erving Goffman’s (1961) seminal work on institutions remains one of the most widely referenced explorations of closed communities (such as psychiatric hospitals) and has been in print continuously since it was first published (Suibhne, 2011). One of the key concepts of his ethnographic work was that of *total institutions*, which he defines as:

... a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. (Goffman, 1961, p.11)

Goffman provides a vivid portrayal of institutional life and although he drew comparisons between different types of total institutions the main emphasis of his work was related to psychiatric hospitals. (Therefore although Goffman’s text refers to *inmates and staff*, to situate his work in the current context the terms *patient and nurse* will be substituted in this text). In delineating the characteristics of a psychiatric hospital Goffman describes a setting where all activities of daily living occur in the same place. Patients’ are treated ‘en bloc’ and their day is characterised by rigid schedules and strict rules that are imposed by a higher authority. The people charged with

supervising the day to day running of the institution (i.e. nurses) are necessarily preoccupied with surveillance in order to ensure compliance from the patients who generally outnumber the nurses. From the point of admission, patients undergo a process of what Goffman calls being “*mortified*” (p.24) as a result of series of degradations and humiliations. At this time staff make judgements as to how obedient the patient is. Very often they are stripped of their possessions, and sometimes even their clothes. Personal and intimate details are written in a file that everyone has access to and there is an expectation of discussion of these details in front of groups of strangers e.g. at weekly review. During their stay, staff are unable or fail to provide a safe environment, and the patient may suffer verbal or even physical abuse from other patients. Even basic requests, such as cigarettes or a glass of water or to use the telephone, must be framed in a humble way to avoid being perceived as demanding. Privacy and dignity are compromised, as open door toilets and/or showers and collective sleeping arrangements are the norm. Communication is controlled by the nurses, who tend to shout when talking to the patients, as if all of them are hearing impaired. The patient’s access to visitors is controlled by the nurses, who also act as gatekeepers for access to the doctor. Highly prescriptive nursing routines limit nurse-patient interaction. This chasm between the nurse and the patient is, according to Goffman, a key repercussion of organisational management of large blocks of people.

In describing how the two groups, in this case nurses and patients, regard each other, Goffman said:

Each grouping tends to conceive of each other in terms of narrow hostiles stereotypes, staff often seeing inmates as

bitter, secretive and untrustworthy, while inmates often see staff as condescending, highhanded and mean. (p.18)

While his work emphasised the patients' situation within these historical institutions, Goffman also provided invaluable insights into the contemporary psychiatric hospital environment and dedicated some attention to what he describes as 'the staff world'. Goffman notes the uniqueness of the work of staff within a total institution. Although the work is with people, it differs from the work that is involved in the service industries and has certain characteristics reminiscent of manufacturing industries. Patients become akin to inanimate objects, being processed through a production line. A paper trail accompanies them from beginning to end, stating what has been done and by whom. Staff may perceive the patients as posing a threat, either to themselves or to their colleagues or other patients and often attempt to mitigate perceived risks with over cautionary behaviour, often to the detriment of the patients. Individualised care is a luxury that cannot be achieved if the smooth running of the ward is to be maintained. Examples might include having a stock of communal clothes which patients are obliged to wear, or keeping all of the doors locked just because some patients may pose a risk of absconding. Staff are obligated to maintain the *status quo* of the total institution and in order to do this, they operate a highly subjective system of threats, rewards and persuasion. Since the system is only effective if everyone is treated in the same way, staff have to maintain a certain amount of distance from the patients, avoiding any emotional involvement, and subscribing to the overall doctrine of control. Failure to do this can have very negative consequences for the staff who may face the wrath of their colleagues.

3.5.2 Present day institutionalisation

In the fifty plus years since Goffman published his work, the focus of psychiatric care in the developed world and in related contemporary literature has shifted towards providing care and treatment in the community. Loukidou et al., (2010) stated that changes in patterns of care have led to a redefinition of the role, behaviours and attitudes of nurses within psychiatric care.

However such changes are by no means generalizable from country to country. Muijen (2008), acknowledged the considerable diversity in national provision of psychiatric services within Europe. Although there is a general move towards community based services, Muijen noted that in some countries, psychiatric hospitals remain the central point of care and treatment. Loukidou et al., (2010) claimed that the recent reality of the daily work of nurses in institutions and it is not dissimilar to that described by Goffman in 1961. Institutions operate as a top down bureaucracy. Nurses' work is demanding and their role unclear. Interaction with patients is limited, partly due to organisational constraints such as paperwork, or too many patients and not enough staff. The nurses hold negative attitudes towards the patients and this creates a barrier to interaction on an interpersonal level. Completion of daily tasks and routines is the predominant goal reinforced by bureaucratic rules. It is these rigid rules and regulations that determine the behaviour of the nurses. The focus of hospital care continues to be based on containment and nurses are the custodians.

The notion of psychiatric institutionalisation in Malta has received scarce direct attention within local literature. The work of one Maltese author, Joseph Muscat (1973), which was discussed in Chapter Two of this study,

provides an indication of the continued prevalence of institutionalisation up to the 1970's. Muscat described a style of nursing care which mirrors that described by Goffman, which is care based on inherited, traditional practices, delivered in a gloomy and custodial environment, characterised by rigid adherence to routines. Muscat noted that the nursing care provided at the time lagged behind that being delivered in similar facilities in Europe. He did however observe that positive reformations were taking place, i.e. one particular ward which offered day time activities and offered more flexibility than the other wards. More recently another Maltese researcher, in an unpublished thesis which presented an analysis of the therapeutic alliance within mental health services, offered her personal view that mental health services locally have generally improved over the last 15 years (Grech, 2014). She credits a number of factors as being instrumental in this improvement, including: better media representation of mental illness, commitment to professional development, changes in legislation, EU membership and cultural changes. However even whilst acknowledging a positive shift, Grech also identified that many of the indicators of institutional care persist locally up to the present day. Grech (2014) observed that the psychiatric hospital is still perceived as inferior amongst the wider state health services. A number of professionals work within the hospital because they had no other choice and were transferred there against their will. The hierarchical management style persists and an enduring failure to engage and consult with frontline staff and patients has a negative impact on implementing much needed change. Most alarming is Grech's observation that patients are still very often not afforded even basic respect by care givers.

3.6 Culture

Looking outside of the environments where the care and treatment of mentally ill people takes place enables a better understanding of what happens inside. The Office of the Surgeon General [OSG], (US), (2001) stated that recognising the diverse effects of culture and society on mental illness and mental health services is important because it bears upon what *all* people bring to the clinical setting. It is, according to the OSG, all too easy to lose sight of the importance of culture. The following sections will consider notions of culture, the part it plays in healthcare and finally, culture within psychiatric healthcare in Malta.

3.6.1 Notions of culture

The notion of culture is a complex and dynamic construct with its definitions varying according to perspective or disciplinary approach from which they emanate. The word itself is often loosely used to denote lifestyles with particular socioeconomic characteristics such as the culture of poverty and also as a description of groups of people who participate in socially marginal or undesirable behaviours such as drug culture or gang culture. Kreuter and McClure (2004) remarked that despite these examples including some components of culture, such as values and behaviour, it is limiting and misleading to think of culture as something that is simple and fixed as it is a complex, dynamic and adaptive construct.

Despite the lack of a universal specific definition, there is general consensus amongst social scientists as regards common threads that are incorporated in the notion: culture is learned, shared and transmitted inter-generationally.

It is not inherited, being derived from one's social environment, not from one's genes (Spencer-Oatey, 2012). It reflects the knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, roles, way of life, symbols acquired by a group of people (Smircich, 1983; Kreuter and McClure, 2004). The shared values or beliefs of members are manifested by symbolic devices such as myths, rituals, stories and specialised language which have special and specific meanings for the group. Collectively these provide a sense of identity, generate commitment to something larger than oneself and guide and shape behaviour (Smircich, 1983). Hofstede (1991), stated that there are four such manifestations that encapsulate the concept, these being symbols, heroes, rituals and values. He employed the representative imagery of an onion to illustrate his concept. Each manifestation can be imagined as the skins of the onion, with symbols representing the most superficial outer layer, followed by heroes and rituals and finally the inner layer are values which make up the deepest layers of culture. Table 3 shows Hofstede's explanations of the meaning of each manifestation and possible examples of each one within a psychiatric nursing are provided.

Symbols	Words, gestures, pictures or objects which carry a particular meaning, only recognized as such by those who share the culture. New symbols are easily developed and old ones disappear; symbols from one cultural group are regularly copied by others. This is why symbols represent the outer, most superficial layer of culture.	Pass keys – usually collected in a large bunch and carried by all staff Nurses uniforms – colour coded to indicate grade of staff Use of nursing abbreviations in conversations (e.g. PRN / stat)
Heroes	People, alive or dead, real or imaginary, who possess characteristics that are highly prized in a culture, and thus serve as models for behaviour.	Nurses who have dealt with aggressive patients Tall, large framed men Nurses who are willing to bend the rules to help other nurses
Rituals	Collective activities, technically superfluous to reach desired ends, but within a culture considered socially essential: they are therefore carried out for their own sake. Ways of greeting and paying respect to others, social and religious ceremonies are examples.	Handover – nurses meeting at beginning of shift Stripping of patients before secluding Mealtimes / bath times within a very limited time period
Values	Strong emotions with polar opposites such as evil versus good; abnormal versus normal; etc ugly versus beautiful, dangerous versus safe, immoral versus moral, indecent versus decent, unnatural versus natural, dirty versus clean, paradoxical versus logical, irrational versus rational.	Them and us – patients Them and us – other professionals / management All patients are potentially dangerous or problematic

Table 3: Manifestations of culture (adapted from Hofstede, 1991, pp.7-10)

Hofstede (1991) explained that symbols, heroes and rituals can collectively be labelled as ‘practices’. Although such practices are visible to an outside observer, their cultural meaning is not necessarily evident. Values, the inner layer, are somewhat different. Since they are, according to Hofstede, largely

acquired in childhood, many values remain outside the consciousness of those who hold them. Therefore they can rarely be directly observed by outsiders but rather are inferred from the way people act in various situations.

Critically, to appreciate the culture of Malta's psychiatric hospital, it is necessary to review and summarise the cascade of culture which provides the empirical focus for this study. With this in mind, the next section deals with the three different realisations of culture: national and organisational culture; culture in healthcare generically and the specific culture of psychiatric care.

3.6.2 National and organisational culture

The concept of national culture is based on the premise that within countries, individuals identify with others as members of the same nation or state, and that there are certain shared aspects of context. These include feelings of identity, underlying values, norms and traditions and institutions, as well as history, language, religion and education, through which a 'national culture' can develop (Taras, et al., 2011). Hofstede (2011a) stated that the values which are an inherent part of national culture are learned in childhood and that they are taught to children by their parents who themselves acquired them in their own childhood. This generational transmission results in stable and relatively fixed values that can take generations to be changed. The impact of national culture on how individuals and groups think and behave is substantial and impacts the way that individuals approach problem solving and day-to-day work (Smale, 2016). After many years of studying the notion of culture, Gerhart (2008) was emphatic in his belief that there is a strong

relationship between national culture and organisational culture. Hofstede, one of the most renowned authors on the topic, developed what is perhaps the most well-known framework illustrating how values in the workplace are influenced by culture (Taras et al., 2011). Centred on an extensive large scale multi-national study using attitude surveys as a data collection method, his original framework was based on 4 major cultural dimensions, set out in Table 4:

<i>Individualism –collectivism</i>	The relationship between the individual and the group. Related to the emphasis placed on either individualism, (looking after one’s own interests) as opposed to collectivism, (group effort, a sense of community responsibility).
<i>Power distance</i>	The relationship between managers and subordinates. In a culture of high power distance, subordinates do not express disagreement with supervisors and supervisors do not consult with subordinates when making decisions. In lower power distance cultures, employees’ are encouraged to be autonomous and flexible and supervisors are supportive and helpful.
<i>Uncertainty avoidance</i>	Ways of dealing with uncertainty. In high uncertainty avoidance cultures, uncertainty is avoided by sticking to rigid and strict codes of behaviour. Alternatively in low uncertainty avoidance cultures there are fewer rules and guidelines.
<i>Masculinity – Femininity</i>	Related to the aggressiveness or nurturing aspects of a culture. Masculine values such as career progression, assertiveness and pay are set against what are referred to as feminine values whereby physical conditions, friendliness, safety of position are valued.

Table 4: Major cultural dimensions (adapted from Hofstede, 2011a)

Organisations, Gerhart stated, mirror the countries in which they are found (Gerhart, 2008). Organisational culture is widely described within the literature as ‘social glue’ which binds an organisation together (Smircich,

1983; Tsai, 2011) and Devaraja (2012) stated that culture creates the identity of an organisation and in as much as an individual is known through his personality, organisational culture is the personality of the organisation.

3.6.3 Culture in healthcare

Kreuter and McClure (2004) noted an increasing recognition of the important role of culture in healthcare. Mannion et al., (2005) conducted a study which compared cultural characteristics of hospitals and they defined culture in the healthcare context as:

the deep seated assumptions, values and working practices that have been affirmed over decades and woven into the fabric of health care delivery. (p.432)

This may also be referred to in everyday parlance as “*the way that things are done around here*” (Kreuter and McClure, 2004; Middleton, 2002).

Johansson et al., (2014) stated:

Healthcare organisations incorporate cultural features such as special language, rules, myths, artefacts, stories, behaviours, thoughts and beliefs that the members in a group have in common. (p.157).

Goopy (2005) in discussing the importance of national culture as it effects the day to day practices of nurses, stated that there is a universal image of a nurse, a standardised notion, but in reality what nurses actually practice is best explained in relation to local culture as their behaviour arises from their experiences.

3.6.4 Culture and psychiatric health care

It is noteworthy that the recognition of the importance of culture in healthcare is not a new subject. A culture related study, generally acknowledged as seminal in its field, was that of Erving Goffman (1961), whose publication 'Asylums: Essays on the social situation of mental patients and other inmates' described the point where institutional culture meets hospital based psychiatric care. This extensive ethnographic study conducted within a large psychiatric facility in the United States in the mid 1950's painted a graphic picture of a what he referred to as a '*total institution*', a place set apart from society, where 'care' was custodial and task orientated and characterised by routines and a stripping away of all individual identity and social roles (Goffman, 1961; Chow and Priebe, 2013). Goffman also considered the staff world in such institutions, or as he called them, "*socially crazy places*" (Goffman, 1961, p.121). He observed that patients are quickly seen as inanimate objects to the staff. The work typically involved a lot of paperwork, since a "*paper shadow*" (p.73) was required to show who had done what, to whom, given that a responsibility trail is an organisational necessity. He found that staff grouped patients together out of administrative necessity or institutional efficiency and this was observable by the removal of personal possessions or the complete disregard of individual need. They also meted out punishments and privileges in order to maintain the status quo, and perhaps more disturbingly, ceased to see the patients as human, because there is no place for emotions in such a system.

Half a century after Goffman's revealing research, Walton (2000) presented an extremely relevant paper which discussed the aims, methods, quality and

outcomes of hospital based psychiatry. Entitled '*Psychiatric hospital care – a case of the more things change, the more they remain the same*', the paper is an expression of Walton's exasperation with psychiatric in-patient care at that time (2000). Over approximately a ten year period, visiting social workers had recorded their observations of life within psychiatric wards within one UK hospital. Essentially they reported that despite philosophical, geographical and administrative changes within the services, very little had actually changed since Goffman's earlier descriptions. Walton found that there was a lack of attention to human and civil rights, excessive administrative work, a culture of staff watching and not interacting with patients, but yet socialising with each other, devaluing, disempowering professional attitudes, a herding together of patients and a reliance on drugs (medications) as a means of control. Walton (2000) contended that these factors were in sharp contrast to the image portrayed by the UK national health services at the time, of an effective, non-abusive, non-stigmatising service.

Ten years later, Loukidou et al., (2010) also presented a paper which looked at what they described as the contradiction between current trends and demands which called for a new face of psychiatric nursing, and the actual practice of psychiatric nursing in Greece. These authors contend that the institutionalised mode of psychiatric care is the outcome of social, political and medical factors. Furthermore, they postulated that psychiatric nursing within this context is task orientated and characterised by organisational constraints and bureaucratic demands which call for obedience to rules and procedures. This in turn leads to high rates of nurse dissatisfaction, lack of autonomy, lack of role clarity and boredom, idleness and role conflict.

Loukidou et al., (2010) emphasised: *“The institution has played a major role in the definition and actual practice of psychiatric nursing”*. (p.833).

In this respect, individual practitioners can become uncritically saturated with the culture in which they work so that, as Brislin (1993) noted people seldom examine the influence of their own cultural background on their behaviour, because within a group of similar individuals, rarely does the question arise as to why we do the things we do; a consequence of this is that people are poorly prepared to discuss and describe (and one might add, to challenge) their culture.

3.6.5 The cascading culture in psychiatric healthcare in Malta

Chapter two of this study provided an exposition of the background and development of the social, cultural, political and environmental milieu in which this study is conducted, which in its entirety provides a global overview of the national culture and to some extent a description of the culture that exists within its psychiatric healthcare facility. Hofstede’s (1991) model is one of several which aim to define patterns of basic issues that may have consequences for the functioning of groups and individuals, such as relation to authority; the conception of self, including ego identity and dealing with conflict (de Mooij & Hofstede, 2011). By employing Hofstede’s framework (as described in section 3.6.2 of this chapter), it is possible to gain a formalised more structured assessment of Maltese national and organisational culture, an exercise that Hofstede carried out in 2011. Further, in the 1980s, he added a fifth dimension to his model - ‘Long-Term versus Short-Term Orientation’ and in the 2000s, a further (6th) dimension, was added to include

- indulgence vs restraint (Hofstede, 2011a). Figure 5 illustrates Hofstede's findings.

Dimension: Power distance	
Description:	
The extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally.	
Hofstede's score for Malta as assessed in 2011:	56/100
Hofstede's comments:	
Score indicates a hierarchical society. This means that people accept a hierarchical order in which everybody has a place and which needs no further justification. Hierarchy in an organisation is seen as reflecting inherent inequalities, centralisation is popular, subordinates expect to be told what to do and the ideal boss is a benevolent autocrat.	
Dimension: Individualism vs Collectivism	
Description:	
The degree of interdependence a society maintains among its members.	
Hofstede's score for Malta as assessed in 2011:	59/100
Hofstede's comments:	
Malta, with a score of 59 is an individualistic society. This means there is a high preference for a loosely-knit social framework in which individuals are expected to take care of themselves and their immediate families only. In Individualist societies offence causes guilt and a loss of self-esteem, the employer/employee relationship is a contract based on mutual advantage, hiring and promotion decisions are supposed to be based on merit only, management is the management of individuals.	
Dimension: Masculinity vs Femininity	
Description:	
Masculinity indicates that the society will be driven by competition, achievement and success, with success being defined by the winner/best in field – a value system that starts in school and continues throughout organisational life. Femininity dimension means that the dominant values in society are caring for others and quality of life. A feminine society is one where quality of life is the sign of success and standing out from the crowd is not admirable.	
Hofstede's score for Malta as assessed in 2011:	47/100
Hofstede's comments:	
The fundamental issue here is what motivates people, wanting to be the best (masculine) or liking what you do (feminine). Malta scores 47 on this dimension, as this is an intermediate score no clear cultural tendency is shown.	
<i>continued</i>	

Dimension: Uncertainty - Avoidance	
Description:	
The extent to which the members of a culture feel threatened by ambiguous or unknown situations and have created beliefs and institutions that try to avoid these.	
Hofstede's score for Malta as assessed in 2011:	96/100
Hofstede's comments:	
Malta scores 96 on this dimension and thus has a preference for avoiding uncertainty. Countries exhibiting high uncertainty avoidance maintain rigid codes of belief and behaviour and are intolerant of unorthodox behaviour and ideas. In these cultures there is an emotional need for rules (even if the rules never seem to work) time is money, people have an inner urge to be busy and work hard, precision and punctuality are the norm, innovation may be resisted, security is an important element in individual motivation.	
Dimension: Long Term vs Short Term Orientation	
Description:	
This dimension describes how every society has to maintain some links with its own past while dealing with the challenges of the present and future, and societies prioritise these two existential goals differently.	
Hofstede's score for Malta as assessed in 2011:	47/100
Hofstede's comments:	
Societies which score low on this dimension, for example, prefer to maintain time-honoured traditions and norms while viewing societal change with suspicion. Those with a culture which scores high, on the other hand, take a more pragmatic approach: they encourage thrift and efforts in modern education as a way to prepare for the future. With an intermediate score of 47, a cultural tendency cannot be determined for this dimension.	
Dimension: Indulgence vs Restraint	
Description:	
This dimension is defined as <i>the extent to which people try to control their desires and impulses</i> , based on the way they were raised. Relatively weak control is called "Indulgence" and relatively strong control is called "Restraint". Cultures can, therefore, be described as indulgent or restrained.	
Hofstede's score for Malta as assessed in 2011:	66/100
Hofstede's comments:	
The high score of 66 shows that Malta's culture is one of Indulgence. People in societies classified by a high score in Indulgence generally exhibit a willingness to realise their impulses and desires with regard to enjoying life and having fun. They possess a positive attitude and have a tendency towards optimism. In addition, they place a higher degree of importance on leisure time, act as they please and spend money as they wish.	

Figure 2: Hofstede's country comparison: Malta, 2011b

In the absence of any direct confirming or contradictory published evidence, Hofstede's assessment of Malta's cultural aspects and tendencies remains uncontested within local literature. That said, his findings do appear to be corroborated at least in part, by other works referred to in this study such as that of Boissevain (1974, 2013) who after many years of research also concluded that Maltese people are accepting of inequalities (political, social and organisational), and also of hierarchical power systems with an expectation of benevolence based on a system of favours. Boissevain also remarked upon a pervasive '*what's in it for me*' attitude among the population, maintaining that a person's social network is constantly manipulated with the aim of reaping personal benefit and meeting personal goals. Furthermore, an example of uncertainty avoidance, which scored high in Hofstede's framework, may be seen in the nation's continued commitment to depict an impression of being a predominantly Roman Catholic nation. Despite evidence pointing to the contrary, such as the breakdown of church control on politics and family life and the increase in marital separation, domestic violence and drug trafficking and substance misuse, along with other social issues in Malta (Micallef, 2011), people seem to still cling to the doctrine and rules of the church as being their moral compass which guides their everyday life, at least that is the image they outwardly portray. Hofstede failed to establish a clear picture as to how two of his cultural dimensions manifest in Malta: masculinity vs femininity and long term vs short term orientation. Taking the *masculinity vs femininity* dimension and applying it to psychiatric nursing this chapter has shown that the development of healthcare in Malta has generally leaned towards an orientation of femininity, whereby nurses have been seen, or one might say relegated, as nurturing,

motherly type figures. This image is still representative, albeit to much less of an extent, of modern day Maltese society where traditional gender roles are very much alive, with women taking on the roles of caretakers and homemakers (Grimsdottir, 2016).

Turning to *long term vs short term* orientation, Hofstede could also not determine a Maltese cultural tendency in this dimension. However he explains that societies which score low on this dimension prefer to maintain time-honoured traditions and norms while viewing societal change with suspicion as opposed to those with a culture which scores high who take a more pragmatic approach, encouraging thrift and efforts in modern education as a way to prepare for the future. Again, several studies already discussed in this literature review have shed some light on where Maltese tendencies fall. As described previously, despite an acknowledgement that Maltese society is undergoing changes at multiple levels (Briguglio, 2002), the State, the church, other organisations and the general population have, in general, been slow to respond. One example of this is the role of the Church in State matters. It was not until 1971, when the general election brought to power the Malta Labour Party and the newly elected prime minister Dom Mintoff, that the separation of Church and State was realised (Ellul, 2009). This was not a state of affairs that occurred peacefully as it heralded one of the most tumultuous times in recent Maltese history, characterised by violence and suppression of Church involvement in education and care of the elderly (ibid). Some commentators argue that even today, many institutions in Malta are still run as if all the citizens were Catholic, and that the Catholic Church remains one of the most powerful political organisations in the country (NION, n.d.). Another example which relates more specifically to psychiatric

healthcare is the lack of action to change, despite acknowledging that change is indicated. The Maltese government publicly acknowledged as early as 1994 that radical reform was called for in the mental health sector (Department of Health Policy & Planning, 1995), and validated these needs in its long term strategic planning process. By 2010, little headway had been achieved in meeting the government's own objectives (Department for the Prevention & Control of Non-Communicable Diseases in Malta, 2010). Since barely any reference to mental health services in subsequent years exists, it seems acceptable to conclude that in light of all the other cultural indicators that have been documented, society and organisations were not ready to accept the proposed changes in the type of services available and the way in which they were delivered. Further we can conclude that time-honoured traditions and norms in psychiatric health care were more favoured than embracing what might have been considered innovative new approaches. Aspects of this will be a point of focus in this thesis.

Culture is a concept about which much has been written. The heterogeneity of the construct of culture amongst different researchers cannot be ignored. In this critical literature review I have considered notions related to culture in general and have focussed on national through to organisational culture and gone on to focus on specifically local concerns. Anticipating the empirical element of my research, I feel that it is necessary to provide a definition of culture for this thesis which identifies my stance on culture in the thesis context. Therefore for the purpose of this study, Spencer-Oatey (2012) captured the essence of culture as it applies within the local research area, she said:

Culture is a fuzzy set of attitudes, beliefs, behavioural conventions and basic assumptions and values that are shared by a group of people, and that influence each member's behaviour and each member's interpretations of the "meaning" of other people's behaviour (Spencer Oatley, 2012. p.4).

3.7 Conclusion

This chapter has situated the research reported in this thesis within its historical and current research landscapes and provided a comprehensive background for understanding current knowledge. Specifically it has provided a critical discussion of previous research and studies that can be located in the extant literature related to the (i) role of psychiatric nurses, (ii) aspects which may influence the uptake of post qualification education, and (iii) influences that may impact practice.

The development of psychiatric nursing as a discipline has followed a fairly uniform trajectory across the western world. From less than salubrious beginnings as uneducated handmaidens delivering the most basic care to what were considered the dregs of society, psychiatric nurses are emerging as an educated, theory led, skilled professional group within a healthcare workforce that purports to be seeking greater acceptance and respect towards its service users. Nevertheless, this chapter, in reviewing the relevant literature shows that there are apparent contradictions between what is actually practiced by psychiatric nurses and current mental health ideology (Cleary et al., 2012). It could be reasonably construed that once Hildegard Peplau defined the scope of a psychiatric nurse in the early 1990's, the concept became immortalised but practice did not emulate the

ideal. Although hailed as the cornerstone of psychiatric nursing, theories about the therapeutic use of self, remained generalized and the scope, indeed the concept, of psychiatric nursing became progressively more obscure (Barker 1990, Olson, 1996). What is more, it seems that the discipline cannot agree on a title, cannot articulate what they do and seemingly possess invisible skills that are largely unmeasurable which in turn leads to negligible outcome measurement. Although originally referring to a slightly different context, Barker and Buchanan-Barker (2011) in their paper 'Myth of mental health nursing and the challenge of recovery' sum up the evidence succinctly:

[Psychiatric nursing] is a discipline with no obvious purpose and the nurse's primary functions remain much the same as a century ago: to keep people safe; to express medical treatment and in hospital settings, to manage the physical and social environment: the stereotype of the 'housekeeper'. (p.337).

Post-registration nurses have been shown to have personal and professional motives for engaging in continuing professional education programmes and as Pena Flores and Alonso Castillo (2006) noted, it is important to recognise the reasons which influence participation, be they personal or professional, as CPE is crucial to a field of nursing that is seeking to elevate its status and come out from under the shadow of other more venerated professional groups within the field. The literature suggests that CPE improves the quality of nursing care, but outcome measures in other fields of nursing are generally related to tangible evidence, and there is little empirical confirmation to support this within psychiatric nursing, where the craft of nursing depends largely on what are described as *invisible skills* (Chambers,

1998; Rolfe & Cutcliffe, 2005). Some countries have attempted to develop measures based on professional standards, which apart from providing a much needed catalogue of which skills, knowledge and attitudes are required of psychiatric nurses, also serve as mechanisms against which to assess outcomes. But developing nursing standards may not be a panacea to the problem of outcome measurement, since within psychiatric nursing the 'evidence' is less than subjective, emanating in most instances from either the nurses themselves or the patients they care for. In spite of the literature indicating that developing outcome measures is an apparent unsurmountable task of it also acknowledges the importance of measuring the amount and type of human capital (individuals' knowledge and skills) within an organisation so as to be able to best utilise it for improved patient outcomes (Covell, 2008) .

Whilst some disagreement is evident within the literature regarding the role of the psychiatric nurse in contemporary psychiatric care, there is consensus that both national and organisational culture and stigma (and psychiatric institutionalisation as a manifestation of these), historically and even up to the present day, represent an ever present influence on many aspects of psychiatric nursing. As such any exploration into aspects of psychiatric nursing cannot occur without taking these into consideration in terms of their influence and impact.

This chapter has demonstrated that there appear to be gaps in the literature on psychiatric nursing in general and specifically in relation to continuing education, and its outcomes, of this group of specialist nurses. More specifically there is a dearth of empirical or even anecdotal material available about really any aspect of psychiatric nursing in Malta, implying that

politically, socially and within local healthcare contexts, psychiatric nursing remains the Cinderella of the nursing profession, or as stated by local researchers: “*a special and different case*” (Fenech Adami & Kiger, 2005 p.80).

In light of the findings of this literature review, this study will be guided by the following questions:

- How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
- What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
- What do psychiatric nurses’ perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

The next two chapters concentrate on how the answers to these questions are to be obtained. Chapter 4 will outline the decision-making processes used to inform the selection of a research strategy and Chapter 5 will provide a detailed description of the steps taken to conduct the study presented in this thesis.

4.1 Introduction

So far, Chapter 3 has confirmed the paucity of existing research related to diploma level general nurses who have followed a post registration conversion to degree course in psychiatric nursing and the effects of undertaking this particular course on their work practices. The aim of this study is to shed light on the subject by exploring the experiences and stories of a group of diploma level nurses who had undertaken a post qualification degree in psychiatric nursing and to understand how they perceived their role, what factors led them to undertake the course and how their completion of the course may have affected their working practices.

As this study seeks to understand the lived experiences of psychiatric nurses, and the meanings that they attach to them, the use of quantitative methodology was rejected because quantitative data cannot provide in-depth information on individual experiences specifically related to the topics under study. Instead naturalistic inquiry as a paradigm and a qualitative descriptive research design were selected to investigate the phenomena of interest.

Clough and Nutbrown (2002) stated that the purpose of a methodology is not just to illustrate what was the best method available for a research study but rather to *justify* how and why the chosen method or methods were selected.

They stated that:

Methods mediate between research questions and the answers which data partially provide to them; methodology justifies and

guarantees that process of mediation. (Clough & Nutbrown, 2002, p.38).

Therefore, this chapter presents an account of why Interpretative Phenomenological Analysis (IPA) was selected for this research and the reasons for its selection. I will begin by restating the research questions and then move on to describe my own position in relation to the research. I then explain the process of selecting the research paradigm, approach, and methodology, which informed the study design. I conclude by highlighting the issue of reflexivity and considering the limitations of an IPA study.

4.2 Research questions

The aim of this study is to address a central question: *What are the effects of a Continuing Professional Education degree programme in Mental Health Nursing?* which is answered by addressing three supporting questions:

- How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
- What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
- What do psychiatric nurses' perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

4.3 Ontology and epistemology

The design of any inquiry starts with the researcher's underlying philosophical assumptions (Creswell, 2007). Selection of a research approach is dependent upon the central features of the ontological,

epistemological and axiological stance of the researcher, because these factors shape and define the inquiry and are activated or expressed in research designs and judgments (Mason, 2002; Bryman, 2012). The articulation of researcher positionality is not a simple task, because it necessitates an understanding of positional possibilities and the adoption and articulation of a positional stance alongside a clear rationale for the rejection of positions which do not fit with the researchers own position. In this section I discuss and justify the position I adopted during the study and in this thesis, including my reasons for rejection of other positions.

Ontology is defined by Blaikie (2010) as being claims of knowing accurately what exists, what it looks like, what elements it is composed of and how these elements interact with each other. Epistemology concerns the search for knowledge and questions what is (or should be) regarded as acceptable knowledge in a discipline (Bryman, 2012). Principally there are two opposing stances with regard to ontology and epistemology that are often portrayed as two ends of a spectrum. These are often reflected in the different or contrasting research traditions: positivism and interpretivism.

Positivism developed from the empiricist tradition of natural science and contends that it is possible to research social sciences with similar approaches and methods as the natural sciences. As in natural science research, in a positivistic inquiry, theory is used to generate a hypothesis, which can be tested by direct observation or experimentation. The aim of positivistic inquiry is to find general laws and causal statements about social phenomena, thus implying the possibility of objectivity. Essentially positivism assumes that human behaviour is a reaction to external stimuli and that it is possible to observe and measure social phenomena and therefore establish

a reliable and valid body of knowledge. Positivistic studies seek an explanation of behaviour which is disconnected from the meaning of situations that the people studied find themselves in, because meaning cannot be measured in a scientific and objective manner (Bowling, 2009). Within a positivist ontology, reality is believed to be independent of human perception and cognition and social phenomena and their meanings have an existence that is independent of people or groups, or as Cohen et al., (2007) stated: "*it regards human behaviour as passive, essentially determined and controlled, thereby ignoring intention, individualism and freedom*" (p.18) and this, these authors stated, renders positivism as less efficacious in the study of human behaviour where the vast complexity of human nature and the elusive and intangible quality of social phenomena contrast strikingly with the order and regularity of the natural world (Cohen et al., 2007).

The opposite position is adopted by an interpretivist paradigm which developed as a critique of the application of positivism in the social sciences. Interpretivism is associated with the sociologist, Max Weber (1864-1920), who contended that the human sciences are concerned with *Verstehen* (understanding) in comparison to *Erklaren* (explaining) (Crotty, 1998). An interpretivist stance to social science inquiry sees social reality as the product of its inhabitants, the direct experience of individuals within specific contexts, whereby a social world is interpreted according to the meanings participants produce and reproduce as a necessary part of everyday activities together (Blaikie, 2010). This interest in the *nature of subjective experience* from the perspective of research participants themselves is maintained by interpretivists to be the only way that reality can only be fully understood, rejecting the belief that human behaviour is governed by

general, universal laws as positivistic inquiry assumes (Cohen et al., 2007), and moreover interpretivists hold that social reality is seen by multiple people, and each of these interprets events differently, resulting in multiple perspectives of any given phenomenon (Mack, 2010).

Gray (2013), pointed out that very often the discussion regarding research approaches tends to be offered as a dichotomy i.e. a study must be either positivistic *or* interpretivistic. However Gray pointed out that it is often the case that multiple methods will be employed within a study. One reason for this is that research projects usually include a number of different research questions, so a research method appropriate for one question may be inappropriate for another, leading to studies moving between the broad approaches of either objectivity or subjectivity, with researchers selecting the most appropriate approach for each part of the study (Clough & Nutbrown, 2002).

Part of the challenge in understanding the philosophy of research is that although there is little dispute about the concepts themselves, the terms employed are not always used consistently (Crotty, 1998). For example, where Bryman (1984) used 'constructionism' as an ontological term, other authors use 'social constructionism' to refer to a set of approaches used to study of human behaviour (an epistemological use). In this thesis, the term 'social constructionism' is used in an ontological context, to refer to the way that our perceptions and experiences are brought into existence and take the form that they do (Burr, 2003).

My study is ontologically situated in a constructionist viewpoint because this reflects my personal position: that all knowledge is constructed and has a

unique story of origin which ties it to a specific social context. Had my study been conducted in another hospital, in another country, at another point in time, the findings would be different. Social constructionism is based on the notion that knowledge, truth and reality can never be fully known because an objective world that can be discovered, measured and quantified does not exist. Reality exists regardless of consciousness, however without consciousness there is no meaning, therefore reality is seen as an interaction between the objective and subjective (Crotty, 1998).

Social constructionism holds that reality is interpreted through interactions, symbols or joint social activities and that a reality is constructed socially, historically, culturally and linguistically by those who share it, and thus can never be seen as definitive (Bryman, 2012). That is, what is perceived and experienced must be understood as a specific construing of these conditions. It is a position that emphasises the hold that history and culture has on us and urges us to explore ways in which people engage together (Crotty, 1988; Burr, 2003). Gergen (1985) argued that social constructionist inquiry is:

Principally concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live. (p.266)

The study reported in this thesis seeks to gain an insight into the personal, lived, experiences of psychiatric nurses, within a particular health care system in a particular country, who have undertaken a BSc in Psychiatric Nursing. It seeks to describe how they interpret and perceive their role and working practices and, as such, it does not lend itself to a positivistic methodology and so, in keeping with the aim of my study, I reject an

objective epistemological stance in favour of a relativist and interpretive approach. I subscribe to an interpretivist position that social phenomena must be understood within the social contexts in which they are constructed and reproduced through activities. Thus, the understanding of social action of psychiatric nursing must include the meaning that the social actors (the psychiatric nurses) give to their performance and actions.

4.4 Axiology

In the context of research philosophy, axiological assumption relates to the role of values. Axiological consideration can be located between 'value free' and 'value laden' approaches, and supports the idea that the personal values and experience of the researcher cannot be separated from the investigation. Consequently consideration must be given to how these may play out at each stage of the study. It is generally acknowledged that a researcher's own values will influence the selection of research topic; the way in which the research is conducted; and the way findings are interpreted and reported. Positivists lean towards the position that the process of research, once the topic has been chosen, can be free of values. Conversely, interpretivists take the position that the researcher has values that help her/him determine what is considered to be evidence and that those values are brought to bear on the interpretation of that evidence (Hussey, 2009; Chilisa & Kawulich, 2012).

4.4.1 Personal axiological position

The subject of values is intrinsic to my study because of the nature of the central phenomenon itself, which is psychiatric nursing. My axiological position leans more towards the research being value laden and subjective in

nature from my position as a researcher, as a psychiatric nurse, and my beliefs about the nature of the phenomena I am studying. My own values regarding psychiatric nursing are that it ideally should be practiced within a professional culture where respect, dignity, confidentiality, empathy, patient participation and collaboration, advocacy and equitability underpin nursing acts. However my own work experience in the field leads me also to acknowledge the findings of a study conducted by Maben, et al., (2006), who concluded that nurses emerge from training with a strong set of '*nursing values*' (p.101), which are later sabotaged by a number of professional and organisational factors, thus distorting or inhibiting their implementation in practice. Maben et al., (2007) described this '*professional sabotage*' (p.103) as issues such as obeying covert rules, lack of support and poor nursing role models whereas '*organisational sabotage*' (p.104) includes structural and organisational constraints such as time pressures, role constraints, staff shortages and workload. Likewise, based on my own work experience as a psychiatric nurse, I also strongly agree with Chmielewski (2004), who speculated that although everyone's intrinsic values are different, when people work closely together (in this case as part of a nursing team within an institution), individuals tend to take on the core values and perspectives of the group even if it compromises their own values. Furthermore, individual values define culture and provide social guidelines that prescribe desirable standards. Since I am employed within the research area and know to some extent, all of the participants professionally and personally, I am aware that my own subjective values will undoubtedly come into play during the overlapping processes of data collection, analysis and representation and

this subjectivity will be acknowledged and addressed through a process of reflexivity which will be described later in this chapter.

4.5 Methodological orientation

Phenomenology served as the preferred paradigm for this study and interpretative phenomenological analysis (IPA) was selected as the research method. In the following sections I outline the philosophy behind the methodology selected for this research and the reasons for its selection explained. I position my choice of IPA over other qualitative methodologies by exploring potential research strategies that could have been employed, along with reasons why they were not chosen. The elements inherent in the IPA approach: phenomenology, the hermeneutic circle and idiography will be described. Lastly, I discuss reflexivity and outline my own reflexive process while working with the methodology of this study,

4.5.1 Quantitative and qualitative methodologies

Since the 1950s, quantitative or positivist research had been the dominant approach in health and social research, especially nursing (Rolfe, 1995; Burns & Grove, 2001). Often seen as the most intellectually and methodologically rigorous approach, the goal of quantitative research is to produce objective knowledge, referring to understanding that is impartial and unbiased, based on an external view, without personal involvement or vested interests on the part of the researcher (Willig, 2001). The historical dominance of quantitative research within psychiatric nursing in particular is discussed by Cutcliffe and Ward (2003), who suggested that psychiatric nursing as a separate nursing speciality has a relatively short history of

around a hundred years. In the early years, the training, education and practice of psychiatric nurses was mostly influenced by the scientific medical community which stimulated a preponderance of what was considered critically sound, quantitative research. In the late 1990's came the growing recognition that many aspects of psychiatric nursing inquiry may not be susceptible to quantitative methods. However not all researchers in the field of psychiatric nursing embraced the notion and even when psychiatric nursing began to develop its own professional research community, there were still at times strong condemnations of straying away from quantitative research methodologies. In 1997, Professor Kevin Gournay, a renowned psychiatric nurse and a specialist in research in the field, contributed to an article in the *Journal of Psychiatric and Mental Health Nursing* which might be considered as a denunciation of non-quantitative research methods. In the article, Gournay and Ritter (1997) alluded to a shift away from the scientific rigour of quantitative research and condemned what the authors called "*anecdotal accounts ... low in quality ... topics that are of little interest to other professionals and of no benefit to mental health services*" (Gournay and Ritter, 1997, p.441). The authors summarised their article by stating that there is a place for qualitative inquiry within psychiatric nursing research, but that it should invariably be linked to quantitative methods if it is to have any meaning.

Gournay and Ritter's 1997 paper provoked a considerable reaction, for example, Parsons (1997), responded by stating that quantitative enquiry does not address fundamental questions related to psychiatric nursing, such as what it feels like to experience mental illness or what it is that psychiatric nurses do. Further, Beech (1998), argued that within psychiatric nursing, it is

impossible for positivist approaches adequately to research psychiatric nursing interventions, and Clarke (1999), commented on the interest in what he referred to as the prevalence of “*experimental science type of research*” (p.4) in psychiatric nursing. Clarke stated that this ‘scientism’ disputes findings derived from qualitative means, and maintained that this effectively took psychiatric nursing away from a place where everyone’s voice was valuable and placed it in a situation where only that which could be measured was given value. So, such a strong response to Gournay and Ritter’s (1997) article showed that despite some opposition, the movement towards more pluralistic research approaches had begun. Cutcliffe and Ward (2003) summarised the two main arguments that led to this shift in ideology, suggesting firstly that quantitative research aims to examine and enumerate known phenomena and qualitative (nursing) researchers postulated that the article or object has first to be placed within a context, which can only be achieved through qualitative study. Secondly, they suggested that some phenomena are just not susceptible to the processes of quantitative research and in order to understand the nature and complexities of intangible phenomena such as belief systems, perceptions and interactions, qualitative methods are necessary.

More recently, Zauszniewski et al., (2012), conducted a literature review which reviewed data based intervention studies published in five psychiatric nursing journals between January 2006 and December 2010. (Zauszniewski et al., defined intervention studies as those that “*evaluated strategies, procedures or practices that promote mental health or prevent mental illness*” p.8). From the 553 data based articles they found, 83 tested or evaluated nursing interventions. Zauszniewski et al., (2012) identified that 10% of the

studies collected only qualitative data and 6% used both quantitative and qualitative data. The remaining 84% of studies used only quantitative data. These findings suggest that researchers in this specialist field have yet fully to embrace qualitative approaches to research.

With regard to the selection of quantitative or qualitative methodologies, Welman (2006), put forward the view that the nature of the research questions will determine the methodology to be used and consequently the choice of methodology is not a question of 'either / or' but rather that the choice between research methods rests fundamentally on a set of decisions about the questions a researcher wants to answer. Creswell (2007), explained that the qualitative approach is best suited when it is important to understand several individuals' common or shared experiences of a phenomenon and when understanding their common experiences will lead to developing practice and policies, or indeed to develop a deeper understanding of the features of the phenomenon (p.60). Creswell's explanation aptly aligns to the study reported in this thesis, where my aim was to understand the common experiences of a group of psychiatric nurses who had undertaken specialist education, and where the focus of this study is such that a broad, inclusive perspective on methodology is required. More pointedly, in discussing research methods employed within nursing research, Stevenson (2005), suggested that the concept of caring within the context of nursing is complex and abstract and as such it is not readily exposed by quantitative research methods. He argued that nurses have rejected findings from quantitative studies and that psychiatric nurses in particular want to understand more about the complex dynamics of their work, something which, Stevenson stated, cannot be achieved through positivistic inquiry.

It is my view that psychiatric nurses often relate to the qualitative approach as it values individual experience and is essentially searching for meaning through the eyes of another person in much the same way as a nurse seeks to understand a patient's individual experience of mental illness so as to enable them to embark upon the recovery process. This view seems to be in line with that of Cutcliffe and Goward (2000), who postulated that this synchronicity is best explained by the fact that there are commonalities between qualitative research and skills inherent in psychiatric nursing. These are the purposeful use of self, the creation of an interpersonal relationship and the ability to accept and embrace ambiguity and uncertainty (Cutcliffe & Goward, 2000, p.594). Whilst quantitative research might provide answers to some of the questions my study addresses, such methods would fail to provide the rich and in-depth data I am seeking. Thus this study adopted a qualitative approach because it was congruent with my research aims and the exploratory intent of the project.

4.5.2 Reflection on different qualitative methodologies

Having reflected on the aims of my study, identified my own position, and positioned this research within the qualitative paradigm, I then explored the various positions within this approach. There are several qualitative approaches, which differ in their assumptions about what types of knowledge are important and in the type of analysis they employ, as Creswell (2007), stated "*Those undertaking qualitative studies have a baffling number of choices of approaches*". (p.6). Within the range of different qualitative methods available some concentrate on description and others focus on interpretation. Kim et al., (2017) described qualitative descriptive

approaches, such as content analysis and thematic analysis, as being suitable when a straight forward description of a phenomenon is sought and this view supports that of Sandelowski (2000) who claimed that descriptive approaches do not require researchers to move far from or into their data.

The aim of this study is to establish the effects of a Continuing Professional Education degree programme in Mental Health Nursing. It sought to achieve this aim by asking how psychiatric nurses interpret their role, what were the factors that influenced them to undertake a post qualification degree in psychiatric nursing and what do they perceive to be the factors that impact their working practices after having completed a BSc in Psychiatric Nursing, therefore calling for interpretative approach as opposed to a descriptive one.

Therefore, a number of interpretive methodological approaches were considered when designing the study reported in this thesis. Ethnography, grounded theory, case study, discourse analysis, and narrative analysis were examined and eventually excluded for different reasons. These are discussed in the next section.

4.5.2.1 Ethnography

Ethnographic research aims to establish how a cultural group works, by seeking a deeper understanding or description of a specific group.

Ethnography requires the researcher to spend significant amounts of time immersed in the social world of the participants, allowing detailed observation to gain understanding (Denzin & Lincoln, 2011). Data sources can include: participant observation, conducting interviews, gathering oral histories and examining, cultural documents and artefacts. An ethnographer seeks to describe the unique processes or rules of behaviour of the group

with the primary aim of promoting better understanding and communication (Driessnack et al., 2007). The findings are then *“transformed, translated or represented into a written document”* (Thorne, 2000, p.69). Ethnography was rejected as a methodology for this study on the grounds of time and access restrictions, my presence may have been intrusive and influenced their behaviours. However, primarily I rejected an ethnographic approach because the phenomena under study must be observable and I feel that observation (as the main method of data collection) would not reveal the essence of the participants’ experiences which I was seeking.

4.5.2.2 Grounded Theory

The grounded theory approach was first described by Glaser and Strauss in 1967. Their aim was to create a method and a methodology that would offer new theories which would be ‘grounded’ in, or shaped by, contextual data provided by the participants and in order to achieve this they developed a rigorous step-by-step process of coding data that would result in the discovery of a new theory (Creswell, 2007; Willig, 2008). In grounded theory, data collection and analysis occur at the same time and each piece of new data is constantly compared and contrasted with previously identified concepts. When compared to other qualitative designs, in grounded theory, sample sizes are likely to be larger because of the need for theoretical sampling - the selection of participants which involves starting the study with a focused sample and identifying, additional participants as different concepts arise (Driessnack et al., 2007). Given that the purpose of this study was not to provide a new theory but rather to offer an in-depth exploration of

nurses' sense-making of the phenomenon under study, grounded theory was rejected.

4.5.2.3 Case study / thematic analysis

Case studies investigate and report the complex dynamic and unfolding interactions of events, human relationships and other factors in a unique instance (Cohen et al., 2007, p.253). Case study research involves the study of an issue explored through one or more cases within a particular setting or context, through detailed and in-depth data collection, often involving multiple sources of information (such as observations, interviews, documents and reports). One analytic strategy often used in case study research is thematic analysis, which identifies issues within each case and then looks for common themes that transcend the cases (Yin, 2003). A typical format is to first provide a detailed description of each case and themes within the case, called a within-case analysis, followed by a thematic analysis across the cases, called a cross-case analysis (Creswell, 2007). I initially considered a methodology based on case studies and thematic analysis, however whilst this approach offers flexibility, was a potential fit to my value position, and could have provided a rich and detailed account of data, I felt that what would result would be summaries of frequency of the content and a potentially limited outcome, where I was seeking an in-depth approach (Biggerstaff, 2012). According to Rowley (2002), the most challenging aspect of case study research is to lift the investigation from a descriptive account of 'what happens' to a piece of research that can claim to be a worthwhile addition to knowledge. For this reason, and the decision to focus on the

expressed decisions and beliefs of individuals, I decided to reject this method.

4.5.2.4 Discourse Analysis

Discourse Analysis can take many forms, all of which are associated by an interest in how language is used to construct reality. One version, discursive psychology, is concerned with how people use language to deal with their social environment and “*achieve interpersonal objectives*” (Willig, 2008, p.91). Another version, Foucauldian discourse analysis, was influenced by the work of Michel Foucault who explored the role of language in the composition of social and psychological life. Foucault worked out his concept of discourse and discursive practice in his 1972 work *The Archaeology of Knowledge* (Foucault, 1972). Rather than exploring the rules that govern meaning-making, Foucault focused on the power inherent in language and sought to understand how historically and socially instituted sources of power construct the wider social world through language (Given, 2008). For the purposes of this thesis, ‘discourse analysis’ is an analysis of the ways in which a topic has been constructed within a society (Willig, 2008; Morgan, 2010). The array of options and a general lack of explicit techniques for researchers to follow, have often been cited as a hindrance or limitation of discourse analysis (Morgan, 2010). In relation to the study reported in this thesis, language is important - this is especially the case for psychiatric nursing where spoken communication is arguably the single most important tool with which we work. However, in order to answer the questions of this inquiry, I needed to focus on overall experiences and meanings themselves rather than specifically on linguistics. Additionally all the participants taking

part in the study are Maltese by nationality, and fluent in spoken English, their second language. I am English, and although I am able to speak and understand Maltese, I do not have the standard of communicative competence in Maltese that would be required to proficiently undertake discourse analysis.

4.5.2.5 Narrative Analysis

In narrative analysis, the researcher studies the lives and experiences of a purposive sample of a small group of individuals or small groups by asking them to talk about or story their experiences. The stories are reconstructions of the person's experiences as they remember them, and are told to a particular researcher, for a particular purpose. The researcher collects highly detailed accounts of experiences from the participants and the resultant narratives are analysed within and across individuals and then re-told or '*re-storied*' by the researcher in a way that preserves their integrity, often being reshaped into chronological order (Creswell, 2007; Driessnack, et al., 2007). Narrative analysis was a valid option for my study since the notion of presenting the participants experiences in a re-storied form appealed very much to me, especially since it would have added to the potential for concealing identities and places and also allow me to present my findings in a creative manner. However, I rejected this approach since the method I decided to use gives a greater emphasis to openly expressed reflexivity throughout the process, and I was keen to incorporate this aspect into the report of my study.

4.6 Phenomenological analysis

Phenomenology is both a philosophic attitude and a qualitative research approach (Flood, 2010). According to Lester (1999), the scope of a phenomenological research study is to illuminate the specific and to identify phenomena through how they are perceived by the actors in a situation. Similarly, Creswell (2007) described phenomenological analysis as being a method of analysis which describes the meaning for several participants, of their lived experiences of a phenomenon. This is achieved by gathering in-depth information and perceptions through inductive, qualitative methods such as interviews, discussions and participant observation, and representing the phenomenon from the perspective of the research study participants. This approach focuses on those experiences the participants have in common and the researcher then reduces individual experiences to develop a description of the '*universal essence*' – or the very nature of the phenomenon (Creswell, 2007, p.58). Epistemologically, phenomenological approaches are grounded in a paradigm of personal knowledge and subjectivity, and underline the importance of individual perspective and interpretation. As such these approaches are well-matched for understanding subjective experience and gaining insights into people's motivations and actions. Within phenomenology there are many different stances, including: Descriptive Phenomenology (Giorgi, 1985; Giorgi & Giorgi, 2008), Hermeneutic Phenomenology (van Manen, 2007) and Interpretative Phenomenological Analysis (Smith et al., 2009). The aims of this research led me to consider Interpretative Phenomenological Analysis (IPA) which is "*... a qualitative research approach committed to the examination of how people make sense of their major life experiences*" (Smith, et.al., 2009, p.1).

The deciding factor for considering IPA rested on the fact that it appeared consistent with the aims of this study, since as Smith and Osborne (2003) stated:

IPA is a suitable approach when one is trying to find out how individuals are perceiving the particular situations they are facing – how they are making sense of their personal and social world.

(p.27)

Moreover IPA acknowledges the researcher's centrality to the analysis and her ability to reflect on and analyse the accounts that the participants provide (Brocki & Weardon, 2006). In an IPA study the researcher's previous understandings, background, past experiences, and place in the world are all influential in the interpretation of the study. To acknowledge and then make use of these seems to be a more useful approach to data collection and analysis. The following sections will provide an overview of IPA and discuss the theoretical basis of this approach.

4.7 Interpretative Phenomenological Analysis (IPA)

IPA is a branch of phenomenology first developed by Jonathon Smith, Professor of Psychology at Birkbeck University of London, in 1996 as a research approach for use in the field of psychology. For Smith (2009), this was as a response to his belief that psychology would benefit from experiential research as well as the more traditionally employed experimental methods. However, Smith et al., (2009) contended that its origins do not limit or reduce IPA's applicability in other disciplines since analysis should be informed by a general psychological interest, and that researchers who employ this method are those that are "... *concerned with the human*

predicament". (p.5). Smith's assertion of IPA's suitability as a method in a variety of other areas is borne out by the fact that in the years that have followed its inception, IPA has grown in momentum and popularity amongst other disciplines, to the point that it has been referred to as "*a fashionable qualitative method*" by Heffron and Gil-Rodriguez (2011, p.756).

Smith & Osborn (2015) explained that the focus of IPA is the detailed exploration of personal meaning and lived experience and how people perceive, ascribe meaning to, and make sense of their experiences. The notion behind this principle is that people are actively engaged in the world and are constantly reflecting on their experiences in order to understand them (Smith et al., 2009). According to Smith and Osborn (2015), the "*main currency*" for an IPA study is the meaning that certain life experiences have for participants (p.25). In an IPA study data are collected from a purposive, homogenous sample. The most frequently utilised data collection method has been semi structured interviews however other methods are also employed (Biggerstaff & Thompson, 2008). Generally focusing on a specific event, or behaviour, the IPA researcher gathers detailed personal accounts or perceptions from participants. These personal accounts are then subject to intensive and detailed analysis (Larkin et al., 2006) and are presented, discussing the exposed broad experiential themes. This latter phase is paired with the researchers own active interpretation (Pietkiewicz & Smith, 2014), hence a two-stage interpretation process, or a *double hermeneutic*, is invoked (p.361), a process described by Smith & Osborn (2015) as: "*the researcher is trying to make sense of the participants trying to make sense of their world*". (p.26). Smith (2017) stated that idiographic commitment to the detailed analysis of each participant's personal experience is a distinctive

feature of IPA, resulting in a final report where each individual participant has a presence and there is expression of both convergence and divergence within the study sample.

Smith et al., (2009) pointed out that although IPA has a relatively short history as a qualitative approach in its own right, it is informed by much older concepts and debates related to the philosophy of knowledge. Smith (2017) stated that IPA: “has three primary theoretical underpinnings: *phenomenology, hermeneutics and idiography*” (p.303). These are represented in Figure 3:

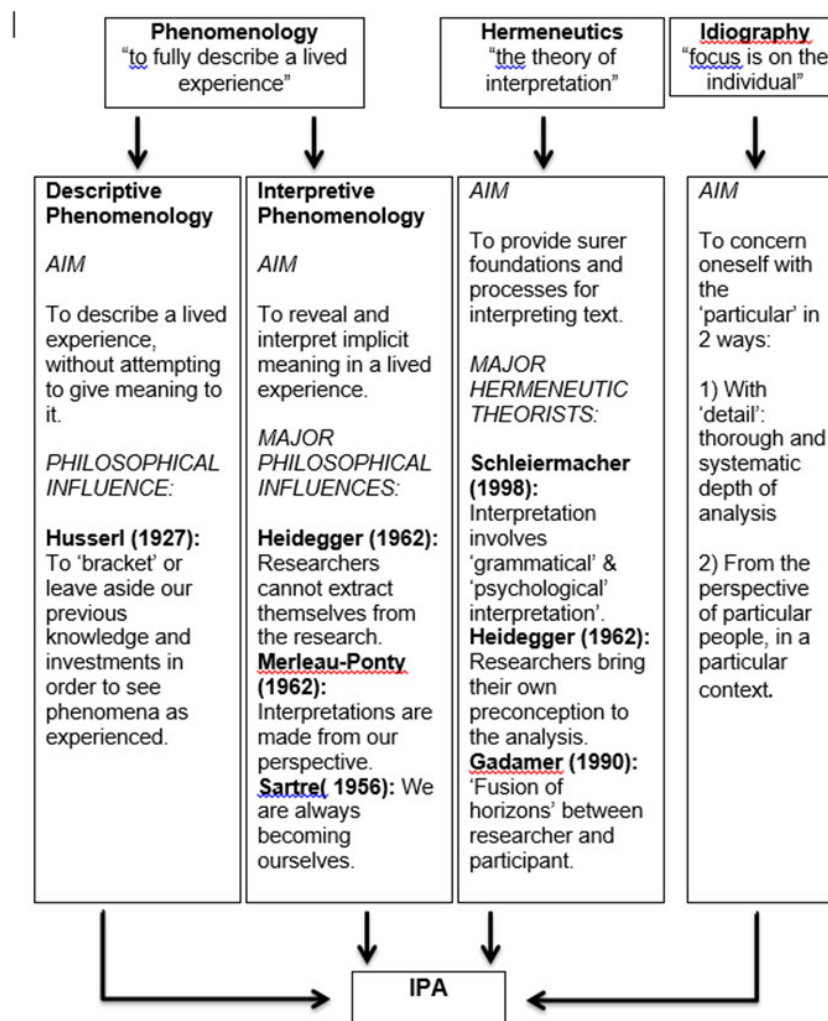


Figure 3: Theoretical underpinnings of IPA. From Charlick et al., 2016, p.207)

Lopez and Willis (2004) cautioned that:

Implementing a method without an examination of its philosophical basis can result in research which is ambiguous in its purpose, structure and findings. (p.726)

Therefore to recognise the influences of IPA on my study it is necessary to understand IPA's theoretical underpinnings, and the following section outlines the key ideas from each of these theories and how they are relevant to this research.

4.7.1 Phenomenology

Phenomenologists share an interest in thinking about what the experience of being human is like, and how we might come to better understand our lived world. There are two main phenomenological approaches: descriptive (eidetic) and interpretive (hermeneutic) and they differ in how findings are generated and used to enhance professional knowledge (Flood, 2010).

German philosopher Edmund Husserl (1859-1938) is generally recognised as developing phenomenology as a philosophical tradition (Ashworth, 2003; LeVasseur, 2003). Husserl argued that the positivist modes of inquiry prevalent at that time, did not address fundamental questions regarding the meaning of human existence, he wrote:

... this science has nothing to say to us. It excludes in principle the questions which man, given over in our unhappy times to the most portentous upheavals, finds the most burning: questions of the

meaning or meaningless of the whole of this human existence

(Husserl, 1970 [1954]:6).

Husserl's philosophical ideas gave rise to the descriptive phenomenological approach to enquiry. Dowling (2007) explained that:

For Husserl, the aim of phenomenology is the rigorous and unbiased study of things as they appear in order to arrive at an essential understanding of human consciousness and experience". (p.132).

Husserl held that subjective information should be important to researchers seeking to understand human motivation because human actions are influenced by what people perceive to be real. He maintained that the things in the world do not speak for themselves but rather are articulated, or made possible by the person experiencing the phenomenon (Husserl, 1970 [1954]). Therefore, to bring out the essential components of the lived experiences specific to a group of people, Husserl contended that a scientific approach is needed in order to bring understanding of the relation between human beings and their world (LoBiondo-Woods & Haber, 2005). Husserl was drawn to finding a way that a person may come to accurately know their own experience of a given phenomenon, and how that may be done with sufficient depth and rigour that they could then identify the essential qualities of that experience. He postulated that if this could be done, these essential features of an experience or phenomenon would transcend the particular circumstances of their appearance and may then also illuminate the given experience for others (Smith et al., 2009). A central component within Husserl's concept was *intentionality*, defined by Spinelli (2005) as: "*the*

*relationship between the process occurring in consciousness and the object of attention for that process*² (p.13), Husserl maintained that the way in which we react within the world is demonstrated through our consciousness or awareness.

He said that when we are conscious, we are conscious of some *thing* and our consciousness is directed by objects or things. McIntyre and Woodrow Smith (1989) offered a more simplistic explanation of Husserl's notion, suggesting that:

Many, perhaps most, of the events that make up our mental life – our perceptions, thoughts, beliefs, hopes, fears, and so on – have this characteristic feature of being “of” or “about” something.

(p.156)

Further, they write:

When I see a tree, for example, my perception is a perception of a tree; when I think that $3 + 2 = 5$, I am thinking of or about certain numbers and a relation among them; when I hope that nuclear war will never take place, my hope is about a possible future state of the world; and so on. (p.161)

McIntyre and Woodrow Smith (1989) explained that each mental state or experience is therefore a representation of something other than itself and so gives a person a sense of something. “*It is this representational character of mind or consciousness – it being ‘of’ or ‘about’ something – (which) is intentionality*”. (p.2). Husserl considered intentionality to be determined by the relationship between the *noema* and *noesis*; noema, referring to the object or what is experienced, and noesis referring the way in which it is

experienced by the subject. The noema is the starting point for most phenomenologists, it calls for the subject to describe their experience of the phenomena, and the noesis relates to understanding the way in which the phenomenon is experienced, and requires the person to reflect on their experience and what it means (Spinelli, 2005).

Husserl was of the opinion that all too often we try to fit things within our own pre-existing categorisation systems, and that this should be avoided by “*going back to the things themselves*” (Husserl, 1970 [1954]: 252). Smith et al., (2009) explained that the notion of the ‘*things themselves*’ refers to the experiential content of consciousness and that Husserl is referring to putting aside various obstacles that can prevent the pursuit of this. Husserl advocated stepping outside of, or disengaging with, our everyday experience, or our *natural attitude*, so as to be able to examine that experience or phenomenon. By adopting a phenomenological attitude, it is possible to stop looking at the experience or phenomenon and direct our gaze towards our perception of these instead.

A Husserlian descriptive phenomenological study incorporates four major processes: *intuiting, bracketing, analysing, and describing*, which Parse (2001) contended, occur simultaneously during a study. Foundational to Husserl’s beliefs was the proposition that “*we can only know what we experience by attending to perceptions and meanings that awaken our conscious awareness*” (Patton, 2002, pp.104-105). An integral principle of Husserl’s approach was the notion that the meaning of lived experience can only be unravelled through one to one relations between the researcher and the participant, involving attentive listening, interaction and observation, so as to come up with a deeper representation of reality than previous

understandings (Wojnar & Swanson, 2007). *Intuiting* occurs through deep contemplation of the meaning of the phenomenon described by participants. After bracketing out personal biases, the researcher must dwell on the phenomenon until pure meaning surfaces (Parse, 2001). Husserl used the terms phenomenological reduction, epoché, and *bracketing* interchangeably in reference to the reflective process by which all ontological assumptions surrounding the nature and essence of the phenomenon are suspended, while the researcher focuses on the individual's perceptions of the phenomena (Tufford & Newman, 2010). Husserl believed that bracketing was necessary in order for the researcher to understand the phenomena without prejudice (LeVasseur, 2003). Kleiman (2004) explained that bracketing, or withholding prior knowledge of the phenomenon under study, is done so that the researcher may take the experience precisely as it is described and assume an attentive and ingenuous openness to descriptions of phenomena, an uncertainty about what is to come and a curiosity about the experiences being brought forth in the descriptions of the participants. Kleiman (2004) stated that theorising, conceptualising, labelling and categorising based on what is already known provokes a sense of complacency and comfort, and these then deprive the researcher of eagerness to discover the unknown about the lived experiences being studied. *Analysing* refers to looking for distinguishing characteristics and common connections within the lived experience. The analysis phase involves extracting significant statements from participant accounts, categorising them and making sense of the essential meanings of the phenomenon (Polit & Beck, 2010). *Describing* is the final phase which necessitates that the researcher focus on the manifestations of the

phenomenon, come to a point of understanding and specify the meaning of a lived experience / phenomenon (Parse, 2001; Polit & Beck, 2010). Husserl's focus then, is on describing human experience. It is a description of ordinary experience of everyday life, of people's beliefs, feelings, actions, what they see and hear (LoBiondo-Wood and Haber, 2005). According to Smith et al., (2009), Husserl's work set the agenda for the "*attentive and systematic examination of the content of consciousness, our lived experience ...*" (p.16), and over time, successors to Husserl modified, critiqued and developed his approach.

German philosopher Martin Heidegger (1889 – 1976) a one-time student of Husserl's work, moved away from Husserl's (1927) notion of 'bracketing' and diverged significantly from descriptive phenomenology when he stressed the importance of knowing *how* people come to experience phenomena in the way that they do (Parahoo, 2006) and rejected the concept that context is peripheral, rather giving context central importance in research. In his work *Being and Time* (1962/1927), Heidegger is concerned with *Dasien* (literally, 'there-being' - the situated meaning of a human in the world), which relates to human qualities such as consciousness, perception and awareness and implies that instead of focusing on people or phenomena, the focus should be on the exploration of the lived experience or 'dasein'. Heidegger (1962 [1927]) contended that understanding cannot occur in isolation of a person's culture, social context or historical context, or in other words, as Parahoo (2006) explained, "*Heidegger sought to discover how a socially and historically conditioned individual interprets his or her world within a given context*". (p.69).

French philosophers Maurice Merleau-Ponty (1908-1961) and Jean-Paul Sartre (1905 – 1980) both expanded upon the works of Husserl and Heidegger, each adding more to the concept that our involvement in the world is linked to relationships both with *it* and with *others*. Merleau-Ponty (2012[1945]) stressed the importance of understanding experience and focused on the way in which experiences are always ‘embodied’ (Merleau-Ponty, 2012[1945]). He emphasised the impossibility of sharing another person’s experience, believing that we can observe and empathise with another person but we can never truly share this experience because the other person’s experience is personal to their embodied position in a particular context. Merleau-Ponty’s view was therefore that we can only interpret rather than *know* the participant’s experience (Smith, et al., 2009).

Sarte (1956) proposed the notion that individual accounts are partial, contextual understandings of experiences and are dependent upon the presence or absence of people’s interpersonal and social relationships. He favoured the view that the self is not a pre-existing unity to be discovered, but is rather a continuing project of always becoming ourselves.

Consequently our engagement with the world is always unfolding, suggesting that meaning-making is equally unfolding for both the researcher and the researched; the story is being developed as it is being interpreted by both the participant and the researcher (Charlick et al., 2016). The influences of Merleau-Ponty and Sartre are reflected in the IPA stance that people are embodied and embedded in the world in a particular historical, social and cultural context (Shinebourne, 2011b).

4.7.2 Hermeneutics

According to Clark (2008), hermeneutics is:

... a process which helps interpretation and understanding things from someone else's perspective. It can be applied to situations where we encounter meanings that are not easily understood but require some effort to interpret. (p.58)

As already noted, Heideggerian or interpretive phenomenology, rejects descriptive phenomenology in favour of studying the concept of *being in the world* as opposed to *knowing the world*. (Reiners, 2012, p.2), hence going beyond mere description of core concepts to look for meanings embedded in life practices – what people *experience* rather than what they *consciously know* (Lopez & Willis, 2004). Heidegger (1962[1927]), used the term '*life-world*' to express the notion that individuals' realities are invariably influenced by the world in which they live, and thus the understanding of individuals cannot occur in isolation of their social context, culture or the historical era in which they live (Wojnar & Swanson, 2007). Heidegger (1962 [1927]) emphasized that presuppositions or expert knowledge held by the researcher are valuable guides to inquiry. He stressed that it is impossible to clear one's mind of the background of understandings that has led to the initial decision that a topic is worthy of research; thus personal knowledge is useful and necessary to phenomenological research (Lopez & Willis, 2004). Moreover, Heidegger proposed the concept of co-constitutionality, in which the meanings reached in interpretive research encompass a blend of those articulated by both participants and researcher (ibid). Wojnar and Swanson (2007) provided a straightforward description of this process. They say:

The goal of hermeneutic inquiry is to identify the participants' meanings from the blend of the researcher's understanding of the phenomenon, participant-generated information, and data obtained from other relevant sources (p.175).

The IPA approach is in accord with Heidegger, since it considers phenomenological inquiry as an interpretative process (Shinebourne, 2011 a).

Influenced by the work Heidegger (1927), Hans-Georg Gadamer (1900-2002) and Paul Ricoeur (1913-2005) are recognised as contributing towards the hermeneutic tradition. Gadamer (1996 [1975]), maintained that understanding of the world can be achieved through language and that conversation, by promoting shared understanding, is the mechanism at the core of understanding (Langdridge, 2007). Gadamer (1996 [1975]), like Heidegger, also considered it impossible to bracket our judgements in relation to a phenomenon and instead emphasised the need for researchers to understand themselves before attempting to understand others. When hermeneutics is applied to the human process of interpretation, Gadamer speaks of a 'horizon' as a way to conceptualise understanding – ones horizon is as far as one can see or understand (Clark, 2008). Within the research process, Gadamer asserted that the meanings expressed by the participants can be blended with the horizon of the researcher, a practise which he referred to as a '*fusion of horizons*' (Clark, 2008), which continues in a cyclical process, which Gadamer described as the hermeneutic circle. Thus the interpretations of the researcher are fused with the interpretations of the participant in a cyclical, iterative process (ibid). It is this rejection of the possibility of bracketing pre-conceptions prior to interpretation (since they may not be known until the act of interpretation is taking place), but rather

acknowledging them and dealing with them throughout the *sense-making* process, which aligns Gadamer's premises with an IPA approach (Smith et al., 2009, p.26). To be clear, IPA does not reject the need to suspend presuppositions or critical judgements, but rather it moves away from Husserl's near total exclusion of all suppositions and instead advocates pragmatic methods for dealing with them – such as adopting a reflexive stance both prior to commencing the study and throughout the undertaking (Snelgrove, 2014).

Ricoeur (1976) also recognized the significance of being in-the-world or embodiment, and assimilated some of Gadamer's principles into his approach to hermeneutic phenomenology, such as the significance of language to uncover meaning and the fusion of horizon. However, although for Gadamer (1996/1975), conversation is considered a mechanism which is central to our understanding, Ricoeur (1976) placed a deeper emphasis on language and conversation, giving greater importance to the nature of discourse and arguing how discourse differed from language. Discourse was viewed by Ricoeur (1976) as speech which was spoken and constructed by humans, whereas language simply consisted of signs which contributed to discourse. For Ricoeur (1976) breaking down language through the interpretation of text did not fully reveal meaning, but rather meaning could be revealed through discourse. Ricoeur (1976) advocated that the researcher should analyse the text to uncover hidden meanings within language (Langdrige, 2007). Another central tenet posed by Ricoeur (1970), is the concept of two interpretative positions or strategies for understanding meaning: hermeneutics of suspicion which uses critical engagement or questioning to illuminate the phenomenon (Smith et al.,

2009; Shinebourne, 2011a), and a hermeneutics of empathy which attempts to reconstruct the original experience in its own terms (essentially recollection). According to Ricoeur (1976), meaning could only be understood through the analysis of metaphor and narrative and according to Langdrige (2007), his later works moved away from hermeneutics towards narrative and the use of stories to uncover meaning (Langdrige, 2007). Within IPA both modes of Ricoeur's hermeneutic engagement can contribute to a more complete understanding of a persons lived experience (Shinebourne, 2011a), however, as Smith (2004) noted, in an IPA study "*the empathic reading is likely to come first and may then be qualified by a more critical and speculative reflection*". (p.46).

4.7.3 Idiography

The third theoretical orientation which IPA relies upon is idiography. The idiographic and nomothetic standpoints were introduced by American psychologist Gordon Allport (1937) to represent two perspectives and methodologies for research. He defined the terms as follows:

The nomothetic approach . . . seeks only general laws and employ only those procedures admitted by the exact sciences ... the idiographic sciences . . . endeavour to understand some particular event in nature or in society. (p.22).

A more recent definition is offered by Conner et al., (2009) who said:

Idiographic methods are those that aim to identify patterns of behaviour within the person across a population of experiences or situations, and nomothetic methods are those that aim to identify

patterns of behaviour across a population of individuals, rather than for any given individual (p.292).

Prioritising a focus on the unique and particular rather than the nomothetic (general or universal accounts or probabilities), is key to an IPA study. IPA first attempts to understand the participants' world and to describe what it is like and secondly, it aims to interpret and by connecting the findings to existing literature, place the description within a wider social, cultural and theoretical context (Smith, 1996; Wagstaff & Williams, 2014). IPA involves highly intensive and detailed analysis of the accounts produced by a comparatively small number of homogenous participants (Larkin, et al., 2006), which then permits the identification of the unique experiences that are shared by a particular group of research participants in a particular situation or event (Smith, 1996). It is concerned with the accounts provided by the participants which reflect their attempt to make sense of the experience or phenomenon under study. Access to these are always dependent on what the participants say and how the researcher interprets that account in order to understand. It is acknowledged that we can never get directly to the experience so the aim is to get '*experience close*' (Smith, et al., p.33).

So far this section has examined the philosophical underpinning of the study commencing with phenomenology and concentrating on IPA. In the next section reflexivity, a particularly important aspect of IPA as a research method (Smith et al., 2009), will be described and I will explain how I addressed reflexivity in this study.

4.8 Reflexivity

According to Willig (2001) there are two dimensions to reflexivity; personal and epistemological. The former involves reflecting on how much the researcher, shapes the research in terms of for example, her/his own values, experiences, beliefs and social identities. IPA firmly positions the researcher as central to the research process, in that observations made during analysis of the accounts given by the participants, “...are necessarily the product of interpretation” (Willig, 2008, p.260). The way in which the researcher understands the participant’s experience of the phenomenon under study – in this instance psychiatric nursing, and the meanings participants made of this, is influenced by the researcher’s engagement with and interpretation of the participant’s account. Willig’s (2001) second dimension of reflexivity, epistemological reflexivity, requires the researcher to reflect on aspects of the study’s design and chosen method of analysis by asking questions such as: could we have conducted the study differently and if so, in what ways may this have produced a different understanding of the phenomenon under investigation.

The acknowledgement that the researcher always has an impact on research underpins most qualitative research (Mason, 2002). However, IPA embraces Heidegger’s view that pre-conceptions cannot be bracketed off or put aside at the beginning of a study and have to be addressed along the way, and used as a focus for more intense insight and therefore essentially reflexivity in the context of IPA is the acknowledgement that in order for a researcher to engage with other people’s experiences we need to be able to identify and

reflect upon our experiences, preconceptions and assumptions as we go along through the study.

Brocki and Weardon (2006) remarked that a focus on researcher characteristics may not necessarily benefit a reader's interpretation of an analysis and might perhaps even represent a misleading diversion. However these authors recognised that in research such as IPA studies, where researchers have had a significant impact on the final narrative account that is presented, it may be best practice to offer appropriate reflections on their role in the dynamic process of analysis and in the course of the research itself (p.92).

4.8.1 Addressing reflexivity in this study

Creswell (2007) maintained that pre-assumptions must be clearly acknowledged because they form the starting point for the research design. Reflexivity in my study began with an explanation of my positionality in Chapter 1, that is to say an account of my pre-assumptions, experience and knowledge of the phenomenon (psychiatric nursing). In this chapter I have explained my epistemological position and have reflected upon my assumptions about the world and how I believe knowledge can be drawn from it. Both of these can be linked to the way that I am conceptualising 'knowledge' in this research. During the course of the study I also addressed the matter of reflexivity by maintaining a reflexive journal throughout the research process, including post-interview notes, and by returning to my journal regularly to explore how my position was changing and influencing the analysis being conducted and the findings I presented. Furthermore in this thesis, personal reflexivity will be addressed through the inclusion of my

reflexive notes at the end of key chapters (rather than incorporate reflexive notes throughout the text, so as not to interrupt the flow of the text), and epistemological reflexivity will be revisited in the discussion in Chapter 8 in the discussion of the limitations of the study.

4.9 Limitations of IPA

American psychologist Amedeo Giorgi developed the *Descriptive Phenomenological Method in Psychology* (2009), which is a research method that is faithful to the philosophical stance of Husserl and aims to present a description of the universal essence of the subject under review (Giorgi et al., 2017) as opposed to IPA which relies on idiography, meaning that researchers focus on the particular rather than the universal (Smith, et al., 1995). Giorgi has been one of the harshest critics of IPA, standing fast in his belief that the lack of prescriptive structure on how to conduct an IPA study, a weak philosophical foundation in addition to a disregard for replicability, essentially render IPA an unscientific research method (Giorgi, 2010; 2011). Canadian phenomenologist Max van Manen (2017) also expresses doubts whether IPA can claim to be a phenomenological approach, essentially deriding it as a psychological inquiry masquerading as phenomenological inquiry.

IPA's founder, Jonathon Smith responded to such criticisms by claiming that these so-called limitations are in fact strengths, since IPA is an approach and method that can be adapted and moulded by individual researchers to their own unique context.

Other authors also support the IPA approach, such as Pringle et al., (2011) who in reference to the lack of prescriptive structure said:

It is the very complexity of such openness that can baffle those used to operating in the more rigid world of scientific experimentation and randomised controlled trials. (p.22)

Willig (2001) also suggested that IPA's status as a new and developing approach allows researchers "*more room for creativity and freedom*" (Willig, 2001, p.69) and indeed as Langdrige (2007) stated, the strength of IPA lies in illuminating "*a detailed description of the shared experiences of the particular cases studied,*" (2007, p.58). As IPA studies are primarily idiographic, and concerned with examining divergence and convergence in smaller samples (Smith et al., 2009), IPA cautions against attempts to generalise beyond the sample, and there is no assumption that the findings are representative, or reveal a universal feature of an experience for a broader population. Smith (2010b) claimed that in his opinion, replicability and generalisability are not essential criterion for many qualitative researchers.

Smith (2010a) acknowledged that carrying out meaningful IPA requires the researcher to develop complex skills in interviewing, analysis, interpretation and writing. Researchers who lack such skills may indeed produce poorly constructed, primarily descriptive studies, which according to Heffron and Gil-Rodriguez (2011) may be due to a lack of confidence in raising the level of interpretation in analyses. This issue was also addressed by Larkin et al., (2006), who observed that many IPA studies have been inclined to be over cautious, producing descriptive summaries of participants' accounts but

failing to develop further to an interpretative level. Concerns that the potential for '*rich and deep analysis*' (Smith et al., 2009, p.79) may draw the researcher away from the original intended meanings of the participants, is acknowledged by Pringle et al., (2011). However it is contended that going beyond the immediately apparent content is what sets IPA apart from primarily descriptive phenomenological approaches (Brocki and Weardon, 2006; Pringle et al., 2011). However, there has been criticism about the lack of clarity regarding the level of interpretation needed, and Willig (2001) addressed a similar concern related to lack of guidance on just how reflexivity should be incorporated into a study which seems to tie in with Giorgi's criticisms noted earlier, of a lack of prescriptive structure to accompany guidelines for IPA's use. Again, Smith (2010b) responded to such concerns by saying that the aspects people perceive as limitations are actually IPA's strengths, stressing that processes in qualitative research are not the equivalent of the carefully prescribed procedures in quantitative research. He observed that one cannot prescribe exactly how to conduct a good interview and then analyse it, and further, guidelines to good practice based on professional judgement and experience are no guarantee of doing good work. He illustrated this by stating that two researchers could interview one person, use the same questions, gain the same responses and yet '*one researcher may produce something inspired, another something pedestrian*' (p.188). The result, he says, depends on the professional and personal skills of the researcher, in addition to the inclination of the participant and the diverse interactions that occur in the meeting of researcher and participants. (Smith, 2010b).

4.10 Summary

IPA is a qualitative, experiential approach to research that has gained momentum and popularity since it was first developed in the mid-1990's (Pringle et al., 2011). It brings together two traditional means of accessing knowledge, the descriptive (phenomenology) and the interpretative (hermeneutics). It is phenomenological in that it maps out the opinions, cares and concerns of the participants and hermeneutical as it seeks to contextualise these claims within their cultural and physical environment, through a process of interpretation on the part of both the participant and the researcher (Smith, 2010a). This is described by Smith (2009) as the double hermeneutic. An IPA approach is employed by people who "*...are concerned with the human predicament*" (Smith, et al., 2009 p.5) and the analyses provides a "*warts and all*" account (Smith & Osborn, 2003, p.54). The IPA approach used in this thesis corresponded well with the exploratory aims of my study for several reasons. IPA's inductive and idiographic stance lends itself to my aim, to convey in detail the perceptions and understandings of a small, homogenous group of people as opposed to developing generalized claims or theories (Smith et al., 2009; Smith and Osborn, 2015). In line with my own ontological position, IPA contends that people construct individual meanings as a response to experiences and refutes that there is an objective reality to be uncovered (Smith et al., 2009). Finally, IPA acknowledges the influence of the researcher on the analysis process by maintaining that the knowledge produced will be dependent on the researcher's standpoint and that the researcher cannot break free of the influence of their own beliefs and preconceptions on the data. Reflexivity is therefore seen as essential in

order to provide transparency. Clearly there are other research strategies available that would potentially answer the research questions however for the reasons outlined in this chapter, I suggest that the potential strengths of the IPA approach outweigh acknowledged limitations.

This chapter has aimed to explain the decision making process which led to the situation of this study within a qualitative paradigm, a phenomenological approach and the use of Interpretative Phenomenological Analysis as a methodology. Having explained the theoretical basis for the design of this study, Chapter 5 will now describe and justify the study design.

The aim of my research is to examine ways in which nursing practice and service delivery is perceived and whether these have been influenced as a result of registered nurses undertaking a post qualification BSc in Psychiatric Nursing. In order to address this issue three main questions were posed:

- How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
- What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
- What do psychiatric nurses' perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

In light of the philosophical and theoretical discussion which precedes it in Chapter 4, this chapter provides a detailed description of the research methods adopted in this study in order to meet the research aim and answer the research questions. It presents an account of the methods that were used to collect the data within the two phases of my study (focus groups and interviews), I discuss the phases themselves, ethical issues pertaining to the study and the two methods of data collection are described, followed by an explanation of the data preparation and analysis process. At the end of the chapter I discuss my attempts to establish the trustworthiness of the study.

5.1 Eligibility of participants

My study is concerned with the experiences and stories of nurses employed within the study area (psychiatric hospital) who had undertaken a post

qualification conversion degree (Diploma to BSc) in Mental Health Nursing. I used a purposive sample strategy to identify all such nurses employed within the study location. Excluded from the study were those nurses who undertook the direct entry BSc in the same subject and nurses who undertook the Diploma to BSc course but are now employed in other areas such as community psychiatric services. The former group were excluded because the degree was their first nursing qualification and the latter because they had left the field of work and therefore no longer had any impact on the nursing care and treatment provided within the hospital. Additionally I chose not to include first qualification Diploma Psychiatric Nurses who had gone on to read for the BSc Mental Health as I felt that their experiences would be very different from those nurses who had started their career as general trained nurses thus detracting from the homogeneity of an IPA study.

5.2 Introducing the phases of the study

Phase one of the study consisted of four focus group interviews with psychiatric nurses who met the criteria for inclusion (as described above). These occurred between August and September 2015. Phase Two involved a series of individual semi structured interviews with six psychiatric nurses who had taken part in the first phase and these were carried out in November 2015.

5.2.1 Phase One – Focus groups

Semi-structured interviews have been the primary method of data collection in an IPA study, and Palmer et al., (2010) stated that focus groups may at

first appear to be less suitable for IPA researchers due to the fact that they create a considerably more complex interactional environment. These authors explained that first-hand claims, narratives, or reflections are likely to be encased within a somewhat complex set of social and contextual relationships, resulting in accounts which are likely to be influenced by not only the researcher's questions and reactions but also by the level of shared experiences among participants, pre-existing relationships, the sensitivity or privacy of the subject matter and the evolving dynamic of the interaction itself (Palmer et al., 2010).

Despite these issues, Tomkins and Eatough (2010) noted that focus groups are creating a '*burgeoning interest among IPA researchers*' (p.244).

According to Dunne and Quayle (2001), who themselves undertook a study which employed IPA to analyse focus groups:

Focus group technique is suited to researching a topic where the issues involved are of central concern to an accessible, circumscribed and homogenous population (p.680), and participants should: *[be representative of] the homogeneity of the population from which participants are drawn, and participants' [should have] intimate knowledge of and concern with the topic being investigated.* (p.681)

Flowers, et al., (2003) who conducted an IPA study using both focus groups and one to one interviews, noted that whilst both methods can elicit participants' perspectives regarding the subject under study, there are differences in the data they produce. They said that whereas in-depth interviews provide a detailed account originating from personal disclosure

within an interview setting, focus groups represent a *'much more public forum'* (2001, p.667) and result in data that tends to address debates concerning particular issues and, as such, often reflect the dialogue between participants and the clashing of opinions (2003, p.181). Nonetheless, Flowers et al., (2003) suggested that in their study, rather than diluting accounts of personal experience, the focus group data added something extra to their analysis which would otherwise have been missed

Jonathon Smith (2004), the developer of the IPA approach, whilst not rejecting the use of focus groups, had early on its development, also cautioned that within such a setting participants may not feel able to partake in such a detailed exploration of personal experience as with a semi-structured interview. More recently however Smith (2011) said that since IPA is now an established approach he welcomes researchers *'stretching the boundaries'* (p.56) of his original concept. Smith's view is that moving forward, while IPA focuses first and foremost, on the individual and experiential, other IPA studies will also include a more explicit social context and that the experience will be framed with a discussion of social and political forces which will be tackled in different ways (Smith, 2011). Smith reaffirmed this view later still when he asserted that IPA is *"open to working with other approaches in order to deepen experiential and subjective understanding"* (Eatough & Smith, 2017, p.204). This open minded view is reminiscent of an opinion expressed by Sandelowski and Barroso (2007), which also serves as a key justification for including focus groups in this IPA study. Sandelowski and Barroso said *"methodological prescriptions impede ... methodological innovation, imaginative analysis and interpretation ..."*. (2007, p.xv).

Despite taking on board the challenges that focus groups may have presented if they were to be used as the *sole* unit of analysis for an IPA study, I included this additional data collection method because in my study the groups were in *addition to*, or complementing, the one-to-one interviews that were to follow. As previously stated, having access to the total population of Diploma to BSc Mental Health nurses currently employed within the hospital, afforded me the unique opportunity to potentially gain an insight into the experiences and perceptions of the total sample, all of whom may be described as having intimate knowledge of the subjects under discussion. Conducting in-depth one-to-one interviews with all 35 potential participants would not have been possible within the time constraints of this study. Choosing to include focus groups therefore, allowed me to gather data to form a big picture and later during analysis and discussion, position the perceptions and experiences of psychiatric nurses that went on to participate in the interviews, in the surrounding organisational, cultural, sociological and political context elucidated by the focus group participants.

Using the data from focus groups as a starting point is supported by Larkin and Thompson (2012), who stated that IPA benefits from additional contextual data, getting to know participants and their contexts. Even though the participants in my study were already known to me on a professional basis, I did not know their individual back stories regarding their entry into psychiatric nursing or the particular reasons why they chose to undertake the conversion degree, or how they felt it had impacted their practice afterwards.

At the time of data collection, 35 nurses met the criteria for inclusion in the focus group part of the study (set out in section 5.1) and I contacted each nurse by email, briefly outlining the aims of the study and inviting them to

participate. Twenty one nurses accepted the invitation and took part in the focus groups.

5.2.3 Phase Two - Interviews

The principal aim of an IPA study is to elicit rich and detailed accounts of particular experiences and phenomena under study (Pietkiewicz & Smith, 2014) and in-depth interviews are one way of providing such a detailed account stemming from personal disclosure within the interview setting. Interviews are probably the most widely used method of data collection in qualitative research (Mason, 2002; Edwards & Holland, 2013). The term '*qualitative interview*' is described by Mason (2002) as referring to: "*in-depth, semi-structured or loosely structured forms of interviewing*" (p.62). Mason (2002) suggested that regardless of the research approach adopted, qualitative interviews have several core features, they: (i) involve the interactional exchange of dialogue, (ii) have a relatively informal style (i.e. conversation or discussion as opposed to a formal question and answer format), (iii) adopt a thematic, topic centred biographical or narrative approach as opposed to a sequenced script of questions, (iv) have a flexible and fluid approach to permit the development of unexpected themes and (v) are based on a belief that knowledge is situated and contextual and the scope of the interview is to bring the relevant contexts into focus to permit the production of situated knowledge. The informal and flexible style of qualitative interviews led DiCicco-Bloom & Crabtree (2006) to suggest that this method of data collection is one in which "*the person interviewed is more a participant in meaning making than a conduit from which information is retrieved*" (p.314), similarly Smith, et al., (2009) referred to these type of

interviews as “*conversation with a focus*” (p.57). Furthermore, according to Smith and Osborne (2003), semi-structured interviews facilitate rapport/empathy between the researcher and the participant which tends to produce richer data.

Despite acknowledging the potential enhancement that focus groups and other methods of data collection can bring to an IPA study, Eatough and Smith (2017) observed that IPA studies do not want to “*lose sight*” (p.205) of the particularities of individual lives, underscoring that convergence and divergence across these lives are “*more compelling when they emerge from a case-by-case approach*” (p.205) and therefore one-to-one interviews remain the central method of collecting data in an IPA study.

When considering who to include within an IPA study, Reid, et al., (2005) highlighted the fact that intrinsic to IPA is the belief that the participants are experts on their own experiences and it is because of their expertise in the phenomenon being explored that they are invited to participate. Furthermore in order to conduct an IPA study the researcher requires participants to be articulate and forthcoming, able to offer a meaningful perspective on the phenomenon of interest (Reid, et al., 2005).

Smith and Osborne (2003) stated that IPA interviews are generally conducted with small sample sizes, mainly for practical reasons such as the length of time a detailed case-by-case analysis of individual transcripts takes. They go on to say that there is no definitive answer to the question of the exact sample size, but given that the distinctive feature of the IPA interview is its commitment to a detailed interpretative account of the cases included, in many cases this can only realistically be done on a very small sample. Based

on these factors I invited six nurses to participate in the interview stage of my study. The six nurses who participated in the interviews were chosen from amongst those who had attended the focus groups. Selection was based solely on my subjective impression that they would be able to offer a rich and descriptive account of their experiences and perceptions before, during and after the Diploma to BSc conversion course. This is in line with the guidelines of Smith et al., (2009) who advised that participants are purposely sought out and selected because they have something to say about the phenomenon under study.

To summarise this section, Table below provides an illustration of the phases of the study as it developed:

Phase of study	Method	Criteria for participation	No. of potential participants	n =
1	Focus groups	Diploma to BSc Nurse Currently employed in study area	35	21 (divided between 4 groups)
2	Semi structured Interviews	Diploma to BSc Nurse (General Nursing Diploma) Currently employed in study area	21	6

Table 5: Phases of the current study

5.3 Ethical issues

Locally, research conducted by nurses is alluded to in the Maltese Nursing and Midwifery Board's *Code of Ethics for Nurses and Midwives* (1997), where it is stated that nurses are required to: "*participate in activities that contribute to the ongoing development of the professional body of knowledge, e.g., through research.*" (p.11).

In the absence of more detailed guidelines for nurses conducting research locally, one may refer to guidance issued by the UK's professional body for nursing – The Royal College of Nursing (RCN). The RCN (2011a), provide detailed ethical guidelines for nurses conducting research which are summarised here.

The RCN maintains that before research commences, certain areas must be addressed, namely: informed consent, confidentiality, data protection, right of participants to withdraw, potential benefits and potential harms. The RCN (2011a) notes that such issues will remain constant, no matter what type of research is undertaken.

Informed consent is crucial to ethical practice and should be obtained before entering into a research project. Potential participants should be fully appraised of the research aims and potential benefits and harms. Their consent should be given voluntarily without coercion or undue persuasion. Participants need to be aware of any risks that may occur as a result of their involvement in the research. Information given to participants, both verbal and written, is required to be transparent and in a language which the participant can understand and participants should be permitted to consider their involvement and ask questions. A signed consent form is required which includes the information for participants that they are aware from the start that they can withdraw from the process at any time without prejudice.

As a rule, the confidentiality and anonymity of the participants should be preserved when coding the data or assigning pseudonyms, and the identity of the participants' should not be recognisable in any reports or presentations which detail the study's findings. All confidential data should be stored safely,

preventing unauthorised access. Finally studies are generally subject to approval by research ethics committees (RCN, 2011a).

What follows is an account of how these principles were adhered to in this study. Prior to the data collection process approval to conduct the study was sought and received from The University of Sheffield Research Ethics Committee (U-REC) in January 2014. (Ethical approval letter may be found in Appendix 1). Permission to collect data from nurses within the psychiatric hospital was sought and received from the Chief Executive Officer and the Manager of Nursing Services (Appendices 2 and 3), and later from the nurse participants themselves (Example of consent form in Appendix 4).

5.4 Informed consent

The RCN, (2011b) stressed that informed consent is central to ethical practice, and that obtaining informed consent helps to ensure that people are not deceived or coerced into participating in research. To this end, potential participants in both stages of the study, were initially provided with an information sheet (Appendix 5) which outlined the aims of the research and their role in it. After being given opportunity to discuss any aspect of their participation, they were asked to sign a consent form (Appendix 4). At the end of the second phase (interviews) the subject of informed consent was raised again, and participants were asked to sign a post interview confidentiality form (Appendix 6).

5.5 Anonymity and confidentiality

Confidentiality and anonymity are two related concepts that are always given due consideration throughout all stages of a research study. Wiles et al.,

(2006) raised a thought provoking viewpoint on these concepts, stating that to assure confidentiality infers that what has been revealed will not be repeated, or at least, not without permission. However, these authors claimed that in the research context, confidentiality *per se* makes little sense; since researchers will necessarily report the findings of their research, they cannot do so if the data they collect cannot be revealed. Furthermore, reassurances regarding confidentiality and anonymity are invariably given at the start of the study, when it is not yet known what information will be revealed by the participants. Researchers can make sure that they do not disclose identifiable information about participants and try to protect the identity of research participants by taking steps to anonymise them. However, in respect of the study reported in this thesis, there was a significant risk of deductive disclosure, also known as internal confidentiality, which occurs when the traits of individuals or groups make them identifiable in the research report (Kaiser, 2009). Malta has one psychiatric hospital and therefore in disclosing the country location there is a risk that respondents may be identified through the information they give. Changing names or assigning codes may not be enough to safeguard the participants from identification. Risks of revealing third party information are also of consideration. Because Malta has only one psychiatric hospital and therefore many patients are well known to the staff as a whole and potentially to members of the general public, if identification of either respondents or third parties occurs, there is a risk of consequences such as prejudice and reprisal to the participant, or their wider social group and conceivably, to patients. These factors have been a significant challenge in the writing of this thesis. Changing details such as the country location, or type of hospital, to make

data completely unidentifiable would have distorted the original meaning of the data and rendered the data ineffective for addressing the research questions. One approach to the problem is to refrain from making public parts of the study, however this option may potentially restrict the possibility of using the findings to influence future practices. Kaiser (2009) provided an alternative approach to addressing issues related to deductive disclosure, advocating making respondents better informed about the use of data (i.e. who is the audience for the study results and how will the study results be disseminated), from the outset, and by taking practical steps to discuss with participants about how their data can be used. This may mean including different information in the informed consent process and other discussions and negotiations throughout the research process.

The information sheet and consent forms used in this study provided participants with general information about the aims of my study, what I planned to do with the data and stated who would have access to the findings; this allowed respondents to make clearly informed choices about the use of their information. However, as Kaiser (2009) pointed out, discussions about data use and confidentiality need not to be limited to the start of the study and should be ongoing. This, she said, can be achieved in a written consent form or verbally before, during or after data collection. A version of Kaiser's pro forma for a post interview confidentiality form was used after every interview conducted in my project (Appendix 6). All six of the participants in this study selected the second option on the consent form, name: *You may share the information just as I provided it; however, please do not use my real name. I realize that others might identify me based on the data, even though my name will not be used.* Through these strategies, I

extended my approach to informed consent thus making the study more ethically sound. Although at the beginning of the study, these steps seemed enough to protect my participants' anonymity and confidentiality, at the end of the study I became unsure whether these methods were indeed enough. Even though the participants gave the data freely, I feel that ethically my role after the completion of this study is that of gatekeeper. Based on the realities of their reported experiences and perceptions, and feeling a sense of responsibility for safeguarding the participants, I decided to limit access by embargoing the thesis for a period of three years. Although this will restrict access to the verbatim reports of the participants, this will not prevent the thesis being reported in other literary forms.

5.6 Data collection

As previously discussed, data from this study were collected from two sources: focus groups and interviews.

5.6.1 Focus groups

In the first phase of the study I invited each of the 35 nurses that were eligible to participate in the study, to attend a focus group to discuss their experiences and perceptions, both of psychiatric nursing locally and of the conversion degree course. Of the possible 35 nurses that could have attended, 21 people accepted the invitation. Ultimately I held four focus groups so as to keep numbers of participants in each group manageable and ensure all views were represented. This is in line with the recommendations of Phillips, et al., (2016) who suggested "*that keeping focus groups smaller when IPA is the intended analytic approach might be advantageous*" (p.299),

as smaller group sizes permit each individual to have time to discuss their experiences.

Brocki and Weardon (2006) found that IPA studies that had used focus groups as a means of data collection had all used a schedule to structure group discussions. Following this lead, I devised a schedule to add an element of structure to the group discussion. I drew on as many published research-based standards for psychiatric nursing as were available. (These were discussed in Chapter Three of this study. There are no formal standards for psychiatric nursing in Malta). It was clear that the standards, drawn from a number of different countries, were fairly constant in their key points (as can be seen in Chapter Three of this study) and I combined them into one list of key areas to be used as a discussion guide.

In each of the four focus groups, the participants briefly discussed their working experience, and their motivations to undertake the Diploma to BSc course. They then considered the list of combined international standards I had prepared and gave their views as to whether, in their experience, examples of any of the skills, behaviours and attitudes related to practice as defined by the standards, were being applied locally. With the participants consent, the focus groups were recorded (audio-visual) to facilitate transcription in preparation of analysis.

5.6.2 Semi-structured interviews

Pietkiewicz and Smith (2014), advocated preparing an interview plan or schedule in advance. Such a plan serves as a guide to facilitate a natural flow of conversation and can include key questions the researcher wants to

discuss. These authors also suggest that the use of prompts, or as Smith and Osborn (2003) described them, “*gentle nudges*” (p.61), may be beneficial particularly if participants find the questions to be too general or abstract or in order to go deeper to a more specific level. Pietkiewicz and Smith (2014) suggested that questions suitable for an IPA study may concentrate on exploring sensory perceptions, thoughts, memories, associations and crucially, individual interpretations. With regard to the number of questions that should be asked, Smith, et al., (2009) stated that between six and ten open questions, with prompts will lead to around an hour of conversation. I devised an interview schedule that incorporated 7 main guiding questions. (Appendix 7). The interview questions were developed based on the research questions, the extant literature and informed by the responses of the participants in the focus groups mentioned previously. All six interviews were audio recorded. Each interview lasted one to one and a half hours and immediately after each interview, I used a reflective diary to record my personal reflections about the interview the content and process. An introduction to the participants will be provided in Chapter Six of my study.

5.7 Data preparation

5.7.1 Focus groups

The first step in data preparation was the verbatim transcription of each focus group recording. Smith et al., (2009) in discussing the depth of transcription required, noted that since IPA aims to interpret the *meaning* of the content of each participants account, a particularly detailed transcription

of the '*prosodic aspects of the recording*' (p.74), is not necessary. They advised that although IPA calls for a semantic record of the interview, there is little point in transcribing information, such as length of pauses, or all non-verbal utterances, that will not be analysed. That said, Smith et al., (2009) also noted that transcription itself is also a form of interpretative activity and as such the researcher may decide to include notable non-verbal utterances, such as laughter or hesitations, usually recorded as a note within the text and I followed this lead during the transcription of my data (an example being when one of the participants in the interview stage started crying – this was noted within the text of the transcription). The audio recordings were transcribed by hand, and then typed into a Microsoft Word document, leaving wide left and right margins for analytic comments during analysis. Each group was assigned a letter (A through to D) and each speaker was identified by numbers 1 through 21, preceded by their group identifier. The text presented each speaker on a new line for ease of analysis. The transcripts were page and line numbered to enable easy reference back to relevant extracts and also to provide a tracking system for in-text quotes during the analysis stage of the study.

5.7.2 Interviews

The preparation of the data from six individual interviews followed the same transcription process as was followed for the focus groups with the exception of identifiers, as in this stage participants were anonymised by assigning fictitious names as opposed to numbers.

5.8 Data analysis

IPA has similarities with other data analysis methods. Grounded theory (GT) and IPA both look at real life situations and collect and analyse data that reflects their participants perspectives in order to explore an individual's experiences (Gelling, 2011). GT and IPA both start methodologically with data collection and generally share a descriptive approach in the first instance. Both methods deal with unstructured data that undergoes continuous refinement and interpretation and both develop central themes i.e. both are emergent strategies (Kompa, 2013). Although the analytic process adopted within IPA appears similar to the process in GT, there are distinct differences (Gelling, 2011). Willig (2001) explained that whereas in GT the goal is logically explaining the phenomena to enable the study of social processes and develop theories, IPA on the other hand, allows the researcher to gain insights into the way that participants make sense of their own world, capturing the essence of individual experience inclusive of what and how participants have experienced it. According to Kompa (2013) the essential difference lies in the aim of IPA being to interpret experiences whereas GT extracts themes from data.

In a similar way, IPA is also thought to share some features with discourse analysis in that both methods utilise conversations with participants as a data collection method and acknowledge the significance of language. However, discourse analysis is more concerned with examining how understanding is produced, through looking closely at the words the participants' use, defining verbal reports as functional behaviours in their own right (Starks & Brown Trinidad, 2007). In IPA on the other hand the actual words the participants

use are just one aspect that is analysed, and the process is concerned with exploring the underlying thought processes or cognitions, expressed in dialogue. It is the identification of such differences in research methods that provide the reasoning for the use of IPA as an appropriate approach to analysis of the data arising from my research questions. IPA researcher's use writing to compose a story that, based on their analysis, captures the important elements of the lived experience. By the end of the story the reader of the study should feel that she has "*vicariously experienced*" the phenomenon under study and should be able to envision herself coming to similar conclusions about what it means (Starks & Brown Trinidad, 2007 p.1376). IPA then, meets my aim which was to explore the stories and experiences of a group of general nurses who have undertaken a post registration degree in mental health nursing, with the intent of establishing how they perceive and experience their current role and the ways in which undertaking the degree may have contributed to changes in how they practice and deliver care.

The aim of data analysis and interpretation in an IPA study, irrespective of the data collection method, is "*to develop an organized, detailed, plausible and transparent account of the meaning of the data*" (Larkin and Thompson, 2012, p.104). Smith et al., (2009), in providing details of the analytic process used in IPA, advised that it is by no means intended to be a definitive prescriptive method but rather a set of common processes and principles which are applied flexibly according to the analytic task at hand.

Nonetheless, Smith has repeatedly provided an account of the stages involved within an IPA study (e.g. Smith & Osborn, 2003; Smith et al., 2009), and these are described as consisting of: (i) Multiple reading and making

notes (ii) Transforming notes into emergent themes and (iii) Seeking relationships and clustering themes (Pietkiewicz & Smith, 2014). The application of these steps in my study will be explained below.

In my study, the focus group data was analysed first, following the process from start to finish and this was then followed by analysis of the data from the individual interviews. The focus groups data were also considered in the light of the work of Palmer et al., (2010) which speaks specifically to focus group analysis. This will be explained later (section 5.8.4).

5.8.1 Step 1: Multiple reading and making notes

In keeping with IPA's idiographic commitment, each focus group and individual interview transcript was first analysed in-depth individually, before moving onto the next transcript (Smith et al. 2009). Each audio recording was listened to at least twice, and the transcript read and re-read several times. Initial notes were made in the right hand margin, these being exploratory comments, noting anything that stood out as interesting or significant and describing my initial thoughts about the content, certain use of language and more conceptual, interrogative comments (Smith et al. 2009). At this stage interpretation was on a very exploratory, tentative level (Smith et al., 2009).

5.8.2 Step 2: Transforming notes into emergent themes

The next step involved revisiting each transcript and using the left side margin to note emergent theme titles, drawing on both the transcript and the initial analyses. At this point in the analysis the main aim is to capture, reflect and understand the participants' original words, transforming the initial

exploratory notes in to something more particular (Smith et al., 2009; Eatough and Smith, 2017). It is at this stage that “*the themes reflect not only the participant’s original words and thoughts but also the analyst’s interpretation*” (Smith et al., 2009, p.92). The transcripts were re-read as the emergent themes were developed in order to ensure that these themes were embedded in the text and continued to represent the participant’s experience. Figures 4 and 5 provide worked examples of steps 2 and 3 of analysis of a focus group and an interview from my study.

Line	Emerging themes	Experiential Claims	Observations
126	primacy of experience	"we do risk assessments all the time" (A4)	experience
127		"there's no particular form to use, most times it's based on experience" (A1)	
128		"you sense someone that someone is going to be a risk" (A1)	
129		"there's no particular form to use, most times it's based on experience" (A1)	
130		"you sense someone that someone is going to be a risk" (A1)	
131	Lack of resources	"when the patient shows you that they are depressed or .. this comes with experience" (A5)	intuition over assessment
132		"if we have no resources with which to work how can we do everything, often with a shortage of nurses, and do these assessments too? We have till 2.00pm doing routine stuff, we don't even have time to eat" (A5)	?gp identity shared. nursing shortage
133		"but still we do them in our minds and we keep a close eye on them but we can't give them the attention they deserve" (A4)	importance of routines - above all else.
134		"it's in our best interest to take care of these things, to <u>save your skin</u> because if there's a suicide in the ward that's the worst thing that can happen" (A4)	hospital culture
135	organis-ation culture (blame)	"because when there are nurses and carers the nurses always take the blame because carers can't do anything unsupervised"	hierarchy of staff?
136			

Figure 4: Worked example of stages 2 & 3 analysis of a focus group

P1			
52	Compulsory Deployment	(laughs sarcastically)	
53		Not by choice then? So what made you do the degree? what made you think it would be a good idea for you?	
54			
55	Gaps in knowledge	Cos when I started working here I knew what I had to do and what I didn't	how did she know?
56		[interrupting] how long had you worked here before you did the degree?	
57	Increasing knowledge about mental illness	Two years I think or one year and a half nearly. But then I was about sort of limited about how to recognise if a patient is psychotic or not, or how to recognise if a patient is escalating or how to recognise for example that this is not the right treatment for the patient and maybe she needs a review or whatever or how the patient can show signs of suicidal ideations or whatever so I decided to do the course to be, to get much knowledge and be more prepared.	main reason; to increase M.I knowledge. Mentions hot areas - aggr. suicide psychosis medication ? to do battle?
59	Preparedness	So okay, that was your main reason for doing it then, you had experience, a year and a half experience and you thought you needed more knowledge. Ok. So what kinds of things encouraged you or stopped you or would have stopped you from doing the degree, personally or at work etc	
62	Driving factor for course (colleagues) peer pressure	At first I was a bit .. I was not that keen to do the course, but then .. I was encouraged by my colleagues, I was encouraged by my NO by then. I had back up from the management and everything but at times we had lack of staff I had to come in or whatever but it cannot be everything plain sailing. I was doing it as part time, still working and doing the course so there was a bit of obstacles even I was planning to get married, arranging the house by that time and everything so I had to manage time for studying and doing the other stuff as well	driving factor: colleagues. some interference with life events. making time. managing to fit everything in.
68	Life events	So let's just break that up a bit. You said that you were supported by the management, in what ways?	
72	Org support for course	We were exempted on the days of the lectures and even exams. We were allowed study leave so we could have managed well.	atisfied with support to attend.
74		In some countries they are not given study leave at all. If you had not been given the study leave would you have still done the degree? Would you have been able to still do the degree?	
76			
77			

Figure 5: Worked example of stages 2 & 3 of analysis of a one to one interview

5.8.3 Step 3: Seeking relationships and clustering themes

The next stage was to list all the emergent themes chronologically, in the order they came up and then move them around to form clusters of related themes which tied the most important and interesting aspects of the participant's account together. These clusters were given overarching descriptive labels and are referred to as sub-ordinate themes. Figure 6 shows a worked example of clustering of themes for participant 6 in the interview stage of this study.

This process was repeated for each subsequent transcript, i.e. all of the four focus groups and later the six interview transcripts. Once all of the transcripts had been analysed and sub-ordinate themes were established, the next step was to identify patterns across cases took place by spreading out the sub-ordinate themes from each individual analysis on a large table and comparing and contrasting the results, noting both the idiosyncrasies of cases and the shared qualities. Following this, the next step was to look for themes that were common across all the focus groups and all of the interviews, creating a final table of superordinate themes, which "*reflect the experiences of the group of participants as a whole*" and capture "*the quality of the participants' shared experience of the phenomenon under investigation*" (Willig, 2008, p.61-62). This process resulted in a final table of themes which represented the entire group and contained an illustration of super-ordinate themes with clusters of themes under each heading. These steps are illustrated in Figures 7 and 8.

before and nowadays before the mentality was different	the nurse is a key person in patient care	psych nurse is an appendage to general nursing	psych nursing cannot be learned from a book	standards are futile because we need to follow instinct	nurses do everything	rift between mngmnt & nurses
what has been done successfully before is repeated	24 hours a day	sometimes read research	in reality you cannot apply all the theory because u have to go by instinct	general nurses have gaps in knowledge about MI	union is first hurdle to bringing about change	
young trained staff have affected the mentality positively	high risk work	working as a psych nurse is limited because too many roles	keys are a symbol of control	primacy of general nursing skills	dominance of union	
	power of nurses to control	instinct guides practice	experience is needed to contextualise theory	lack of role clarity	paternalistic role of union	
preoccupied with psychotic / suicidal escalating patients	culturally some jobs are defined as professional, nursing is not	no clear connection between any changes & any of the research done by nurses	fitting studying around life events	BSc is something for management to boast about (bluff)	colleagues were driving force to do BSc	a mentality of control
affection for patients	local culture undermines nursing	short courses not mandatory training	BSc did not provide any value to organisation only to individual and patient	organisation supported BSc by study leave and no fees	Did BSc to increase preparedness	lack of standards / criteria for practice
patients are stigmatised by society	relevance of natural culture	cpd is important	Did BSc to gain knowledge about MI	Peer belittlement at first	academic knowledge alone is untenable	no internalisation of externally devised policies
new staff don't know how to handle patients in aggressive situations	less professional, autonomous & responsible than other countries	impossible to measure quality of care apart from subjective observations	Nurses with years experience know more than nurses who have done BSc	experience is more of an asset than knowledge gained from formal education	nurses have a low level of input & responsibility	individual interpretation of policies & procedures
patients are high risk	medical model	Them and Us	no say in ward rounds	God like Cons	Cons have the power	blame culture
		Them and Us	no say in ward rounds	God like Cons	MDT = them. Nurse = us	compulsory deployment
						lack of consultation in key areas like MHA

Figure 6: Worked example of clustering themes from one interview

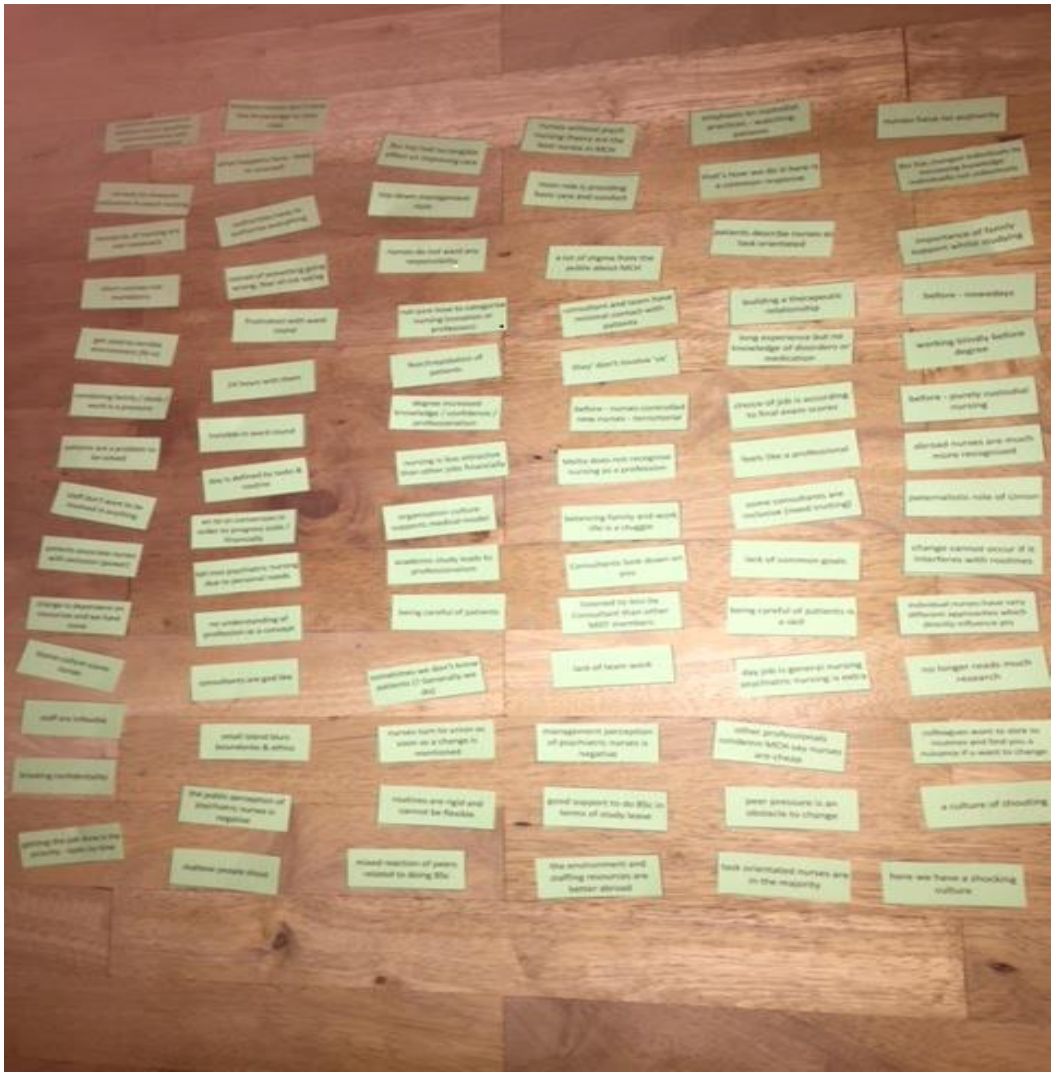


Figure 7: Sub-ordinate themes from across all participants

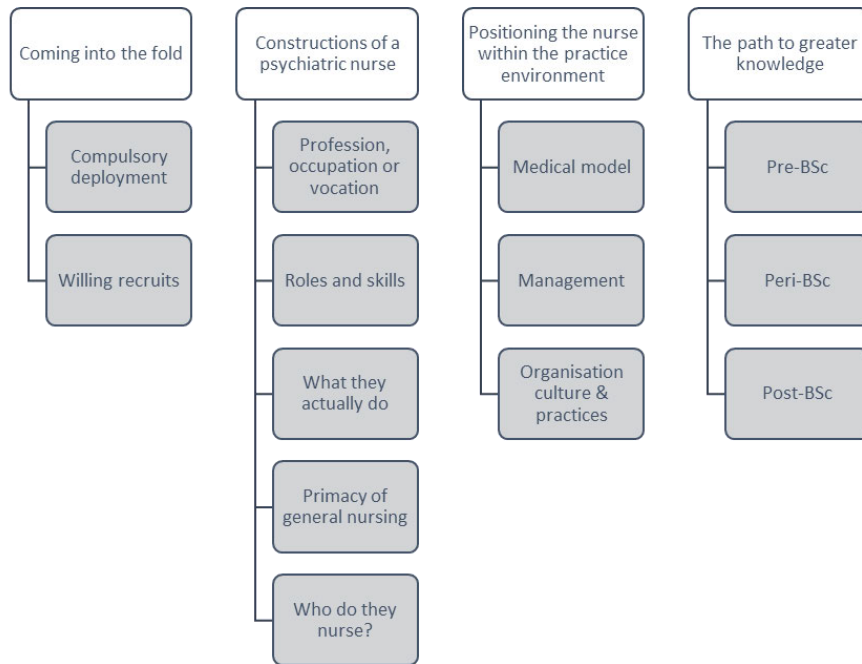


Figure 8: Final super-ordinate and sub-ordinate themes

5.8.4 Complimentary analysis of focus groups

Palmer et al., (2010) conducted an IPA study looking at understanding local mental health services [UK] from carers' perspectives, and they employed focus groups as the sole data collection method. Whilst subscribing to the mainstream IPA analytical approaches employed within the analysis of one-to-one interviews (as described in the previous section) in the course of their own work, they found that participants' discussions within their focus groups included narratives and reflections that offered "*extraordinarily powerful, rich, and illuminating insights*" (p.101) into social context and that these could not be ignored. As a result, they aimed to not only develop a meaningful analysis of the patterns in their participants' lived experience but also to acknowledge the wider socio-cultural factors involved. Palmer et al., (2010), working closely within the principles of IPA data analysis, developed a protocol, in the form of questions to be asked of the focus group data aimed at being able to offer an account of their participants' claims and concerns, keeping the commonalities of their experiences at the centre of the analysis but which also accounted more explicitly for the context in which those claims and concerns arose. Palmer et al., (2010) put together eight questions to be asked of their data and these were related to:

1. Objects of concern and experiential claims
2. Positionality (of facilitators and respondents)
3. Roles and relationships
4. Organisations and systems
5. Stories of participants
6. Language

7. Adaptation of emergent themes
8. Integration of multiple cases (multiple focus groups)

Staying true to the principles of IPA, in the sense that it does not prescribe a single method for working with data but rather provides a set of common principles which are applied flexibly according to the analytic task (Smith, 2009), Palmer et al., (2010), pointed out that these steps evolved from engagement with their own data and are not recommended to be “*simply taken as a recipe*” (p.105), applied to another data set.

This additional examination the focus group data was very appealing to me as it speaks to my world view that it is jointly constructed understandings of the world that form the basis for shared assumptions about reality and Palmer’s approach allows for the development of a real insight into the collective group perceptions of the social, environmental, organisational, cultural and political influences on their work as psychiatric nurses.

Therefore, I borrowed from the Palmer et al. (2010) protocol and applied parts of it as an additional tool for analysis, when analysing the focus group data. Specifically, I considered the data in light of the following questions recommended by Palmer et al., (2010):

Roles and relationships: Examine references to other people: what roles and relationships are described? What sorts of meanings and expectations are attributed to these relationships? What are understood to be the consequences of these? (p.104)

Organisations and systems: Examine references to organisations and systems: how are they described? What sorts of meanings and expectations

are attributed to these? What are understood to be the consequences of these? (p.104)

This involved re-visiting the transcripts and picking up on group co-constitution and the sense of shared experiential recognition amongst the participants. Although not followed prescriptively, making use of Palmer's questions brought an added dimension to the analysis of the focus group data that may have been lost had I just considered the individual responses rather than addressing them collectively in the study write up.

5.9 Appraising IPA

The question of how to judge whether a piece of qualitative research is good or worthy of paying attention to, has been one that has endured ever since qualitative studies began to gain popularity as a research approach in the early decades of the 20th Century (Tracy, 2010). Traditional criteria used to assess the scientific value of quantitative research (e.g. reliability, generalizability, objectivity) were increasingly considered as inappropriate for a qualitative research paradigm which has an opposing epistemological stance (Willig, 2008).

The concern about assessing quality has manifested itself in an abundance of guidelines for judging qualitative work (Mays & Pope, 2000; Walsh & Downe, 2006), however Smith, et al., (2009) maintain that in many instances these are easy to use checklists against which a paper is assessed and these authors are of the opinion that such appraisal tools are overly simplistic and prescriptive. Smith et al., (2009) point the IPA researcher towards the appraisal approach of Yardley (2000, 2008) stating that the suggested

criteria are “*broad ranging and offer a variety of ways of establishing quality*” (p.179).

Yardley (2000, 2008) presented four broad principles for assessing the quality of qualitative research. She stated that although these are not rigid rules or prescriptions, but are open to flexible interpretation and can take many different forms, these criteria should be present in all good qualitative research. These are:

- **Sensitivity to context:** Theoretical; relevant literature; empirical data; sociocultural setting; participants’ perspectives; ethical issues.
- **Commitment and rigour:** In-depth engagement with topic; methodological competence/skill; thorough data collection; depth/breadth of analysis.
- **Transparency and coherence:** Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity.
- **Impact and importance:** Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers).

(Yardley 2000, p.219)

What follows is an account of how this thesis can be seen to meet Yardley’s criteria.

Sensitivity to context

Yardley (2000) stated that awareness of the socio cultural setting of the study is considered important “*since language, social interaction and culture are understood by most qualitative researchers to be central to the meaning and function of all phenomena*” (p.220). This principle was met by presenting early on, an analysis of the context in which the study was carried out (found in Chapter Two). This principle was crucial for my study because the context in which the participants experienced the phenomenon was a significant part of what was being studied. Chapter Three of my study, the Literature Review, situated the present research within the historical and current research landscapes and provided a comprehensive background for understanding current knowledge. It outlined previous research and studies that can be located in the extant literature related to the role of psychiatric nurses, aspects which may influence the uptake of post qualification education, and influences that may impact practice. This information was then revisited in light of my own analysis in the discussion chapter (Chapter 7) of this thesis. In Chapter 4, the methodology of my study was explained, paying close attention to the philosophical underpinnings of IPA and in this present Chapter I have outlined how my methods were sensitive to the chosen approach. In certain qualitative approaches, researchers refer back to their participants once themes have been developed and interpretations drawn, in order to check that the meaning they have taken from the data matches that intended by the participants. In an IPA study, this approach is not indicated since as Meyrick (2006) argued, this can move the analysis away from the “*researchers’ interpretations of the data*” (p.806), thereby compromising the fundamental hermeneutical aspect of IPA. Therefore in

this study, sensitivity was demonstrated by paying close attention to how each participant's account unfolded and what could be learned from it. By using verbatim extracts from the participants own words I included the participants' voices in the analysis, providing the reader with the opportunity to scrutinise my interpretations. Smith et al., (2009) advocated the use of this method, as it allows the reader to check the researcher's interpretation and demonstrates that the conclusions drawn are grounded in the raw data.

Commitment and rigour.

Commitment to the process of data collection was demonstrated in this thesis by collecting two types of data (focus groups and one to one interviews) so as to gain an in-depth immersion with the topic by including as many voices as possible from the study area, from people who had experience of the phenomenon under study. This was enhanced by carefully selecting participants for the interview stage, who I felt could offer rich descriptions of their experiences and perceptions. In terms of assuring rigour, in this chapter I have described how Smith et al., (2009) direct the researcher to conduct an IPA study and I have aimed to explain how I followed their principles of sample size, data collection and data analysis. I have also presented an in-depth focus on individual accounts (Chapter Six - Findings) including ways in which the participants' experiences differed and were similar, and a final and complete account of the data is discussed in Chapter Seven (Discussion).

Transparency and coherence

Transparency refers to a clear description of all the steps taken throughout the research process when the study is written up. This was achieved in my

study by explaining the aims of the study and presenting the steps taken from the recruitment process through to the methods employed for analysis of the data in order to meet these aims. Transparency can also be demonstrated by explaining the details of researcher's reflexive processes and to this end I adopted a reflexive stance by presenting my positionality at the beginning of the study and also by providing the reader with an insight into my thoughts processes and pondering upon how my own pre-conceptions, values and experiences may have biased and/or shaped interpretations of the data. These were presented in reflexive boxes at key points throughout the write up. Coherence refers to the fit between the research question, the philosophical perspective adopted and the methods used, in addition to the clarity of the presentation of analysis and if the argument presented is logical. How I met these are clearly set out in this chapter and in subsequent chapters (Chapter 6 – Findings and Chapter 7 – Discussion). Limitations of the methodological approach have also been identified and considered in Chapter 8.

Impact and importance.

I have demonstrated in the discussion chapter that my research contributes to the knowledge of psychiatric nursing and the impact of post registration education. It also offers an original contribution by exploring the relationship between a particular set of psychiatric nurses and the socio-cultural context in which they work. Chapter 8 of this study presents practical recommendations for consideration at a local policy, organisational and individual clinician level. Moreover I am committed to the dissemination of my findings in the most appropriate professional settings such as professional journal publications and conference abstracts. Nevertheless, despite this

commitment to circulate my unique findings, as Smith et al., (2009) pointed out, the final evaluation of a study's importance and impact rests on whether the reader finds something interesting or useful in the final report of the study. Finlay (2011) stated that in order to achieve this, the presentation of the study findings:

... need to be plausible and persuasive in terms of the evidence presented to support the claims made and the writing needs to be bold and confident in presenting the interpretation of that unfolding evidence trail. (p.142)

Further, my consideration of the previous three criteria discussed above (*Sensitivity to context, Commitment and rigour, Transparency and coherence*) together contribute to the likelihood of the study to have *Impact and importance*. In terms of the theoretical, I have used my data and critical response to the literature to understand and enriching knowledge in the field. Further I have situated my study and its data in a socio-cultural context of mental health care in Malta. Finally, I have drawn on my interpretations of the data to develop and put forward practical suggestions for those working in the field, including community, policy makers, and health workers.

5.11 Summary

This chapter has discussed in detail different aspects pertaining to the selected research methods and procedures of my study. It has also addressed ethical considerations and processes, and demonstrated how established quality criteria were met. Below, to conclude this chapter, I provide a reflexive account related to issues of the methods chosen for my study. In the next chapter I will present the findings, (first from the focus

groups and after, from the interviews), that have emerged through the based on the 4 super-ordinate themes (Coming into the fold; Constructions of psychiatric nurse; Positioning the nurse within the practice environment; The path to greater knowledge) and the accompanying subordinate themes (Compulsory deployment; Willing recruits; Profession or vocation; Roles and skills; What they actually do; Primacy of general nursing; Medical model; Management; Organisation culture and practices; Pre-BSc; peri-BSc; post-BSc).

Reflexive box: 3

I was attracted to IPA through the commonality of this approach with my background as a psychiatric nurse which is grounded in the principle of the therapeutic relationship. This involves the nurse using his/her own verbal and nonverbal communication skills, emotional exchange, and other aspects of his/her personality to establish a relationship with the patient to encourage them explore their own experiences, interpretations and meanings in the context of their life. Furthermore, the fact that IPA acknowledges the difficulty of putting aside one's own experiences and attitudes and in fact eventually draws them into the study was also very appealing to me as I felt that it was impossible to ignore these factors. Moreover, I found it very appealing that within IPA the focus is on retaining the idiographic perspective, giving voice to the experiential accounts of the participants and at the same time exploring commonalities across cases to bring to light the big picture.

However, at the outset of the study I had very little experience or knowledge of IPA. I did have research experience from my first and second degrees, both of which were qualitative studies, which gave me some foundational knowledge regarding qualitative paradigms and permitted me to draw upon previous experience carrying out semi-structured interviews with nurses and this undoubtedly helped me prepare for the interviews I was going to be carrying out for this study. The fact that all the nurses in my study were known to me had both advantages and challenges.

continued

I had worked with some of the participants in a ward setting, been the ward manager to others and at the time of conducting the research I was in a position of seniority to all of them. Whilst acknowledging that these prior relationships were bound to have an impact on the study, I feel the fact that we had this previous connection ultimately led the participants to trust me enough to open up when describing their experiences and perceptions. This was very important, because as the findings reveal, nurses in the study area are extremely distrustful of what may be loosely termed 'the management'. On the other hand it was extremely testing to put aside, or bracket, my own previous knowledge or perceptions of their particular situations. A case in point was when one participant was describing in glowing terms the support she received whilst she was reading for the BSc. This was a complete contradiction to a conversation we had many months earlier when she had told me how she was struggling to complete the course due to a lack of support. In instances like these, where the participants' reports seemed contradictory to my own perceptions, I moved forward with their accounts and faithfully represented what they reported to me at the time of data collection. Another anticipated disadvantage was that since I have worked in the study area for a number of years and have myself undertaken the Diploma to Degree course, the nurses might have assumed due to my prior knowledge there was not the need to clearly or fully explain their own experiences. To deal with this issue, the nurses were clearly informed at the beginning of the focus group and interviews about my role as a researcher interested in understanding their own experiences from their points of view, and asked them to tell their own stories in as much detail as possible. I was keen to inspire confidence in my participants through the idea that they were simply having a conversation about something quite unique that had happened in their lives, and that they could feel confident sharing anything about their experiences. I was pleased with how open and eager most of the participants were to share their experiences but that is not to say everything went smoothly. There were a couple of interviews that required me to dig a bit deeper into my reserve of experience and resources than most others. One particular interview springs to mind, this being the last in the series of one to one interviews.

continued

The participant, who I had thought would have contributed a lot to the study since in the focus groups she was articulate and opinionated, actually said very little and was not very forthcoming despite my best efforts to draw her out with the use of prompts. Later I found out that she was passing through some personal issues at the time and perhaps that had affected her contribution on the day of the interview.

Smith and Osborn (2007) acknowledge that deciding which themes to focus on is challenging as it requires the researcher to prioritise and reduce them. I can appreciate this opinion as I felt a huge responsibility when deciding on what to give priority to and what to leave aside. Doing this called for a lot of self-reflection: Is this what they said? Is this really what they meant? Despite re-reading of transcripts and repeatedly listening to audio recordings, it was only at the end of Chapter 6 (Findings), when I had the written narrative account in hand that I was confident that I have represented the individual and collective experiences and stories faithfully and provided a coherent, plausible and interesting analysis.

6.1 Introduction

The aim of this study was to explore the stories and experiences of a group of general nurses who have successfully completed a post qualification degree in mental health nursing. The intention was to establish how participants perceived and experienced their current role and the ways in which they thought that undertaking the degree may have contributed to changes in how they practice and deliver care. In order to meet the study aim, three main questions were posed:

- How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
- What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
- What do psychiatric nurses' perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

This chapter will present an interpretative account of the findings of the focus groups and the one to one interviews which were the data collection methods for my study. I present my findings in two distinct sections because collectively 27 people participated in the study and I feel that by being jointly reported, this would mean that too many voices are represented at the same time, making it difficult to hear those voices clearly. Furthermore, the depth of

description by the participants of the focus groups and the interview participants is naturally different so to in order to ensure that due attention is given to all the participant's voices in both groups it seems prudent in this chapter, to present the findings separately as they were derived from the different data sets. They will then be brought together and discussed as a whole in the next chapter (Chapter 7 – Discussion).

6.2 The focus groups

In total 21 nurses accepted an invitation to take part in the focus groups. Of these 7 were originally general trained enrolled nurses (EN) who had later converted to diploma level general nursing. Enrolled nurses practice under the direction and delegation of a registered nurse having undertaken a two year initial training course. Malta, like many other EU countries, worked to phase out enrolled nurse training and offered all enrolled nurses the opportunity to undertake a conversion course (EN to Diploma), an 18-month course designed to advance their training level to EU diploma standards. The remaining participants originally held a diploma in general nursing (staff nurses or SN's). Finally all of the participants had completed the diploma to degree conversion course in mental health nursing within the last seven years.

Four focus groups were held. In Group A there were 5 participants; Group B – 7 participants; Group C -5 participants and Group D – 4 participants. As previously mentioned in an attempt to limit moderator bias, although I was present in each of the groups, I did not participate in the group discussion and these were facilitated by a representative of the Maltese Association for Psychiatric Nurses (himself a nurse). Although, as described in the methods

chapter, a summary of internationally agreed standards for psychiatric nurses were presented to the participants for discussion, the groups were relatively informal and conversational.

What follows is a narrative overall summary of the responses of the focus group participants. The findings are organised by the four identified super-ordinate themes: '*coming into the fold*'; '*constructions of a psychiatric nurse*'; '*positioning the nurse within the practice environment*' and '*the path to greater knowledge*'. (As explained in Chapter 5, the super-ordinate themes were established following clustering of the sub-ordinate themes arising from all of the focus groups and one to one interviews). In summarising the findings from the focus groups, I chose not to discuss the findings within the thirteen identified sub-themes since to do so would provide a disjointed narrative and detract from the cohesiveness of the responses of the focus group participants. Instead interpretative analysis is organised under the four super-ordinate themes. The quotations used to illustrate the interpretations of the findings are italicised, short quotations are included in the body of text, enclosed within quotation marks and longer quotations are indented in a separate paragraph. The participants own words have been modified only for the purposes of maintaining confidentiality by the changing of names of people and some places. Each direct quote is referenced in parentheses by the Focus Group identifier (A-D) followed by the participant number (e.g. A1, B2 and so on). Occasionally two separate but related pieces of dialogue have been quoted together, and the dialogue in-between removed if not considered relevant to the point. This is shown in the text by inserting "...". References to non-verbal communication are shown between square

brackets, and any words that I have added for clarity are also shown between square brackets.

6.2.1 Coming into the fold

In keeping with standard practice locally when allocating work placements within State hospitals, the majority of the participants (EN's and SN's) were initially 'sent' to the psychiatric hospital as opposed to requesting to be deployed there. This experience of enforced work placement was recounted by the participants with pragmatic acceptance with no articulation of anger or frustration but rather a resigned acceptance since that is the way things are done. A participant on the first group recounted that:

I had worked 11 years in a surgical ward, asked for a transfer to another ward and they sent me here instead. (A2)

Some of them started work at the hospital immediately upon completion of their initial nurse training course hence having had little or no experience of working within a general hospital or area beyond student placements, perhaps rendering the title 'general nurse' somewhat erroneous. Although the majority of these nurses immediately requested a transfer to the general hospital, by the time the transfer was approved, usually many months later, they had settled in and decided to stay where they were.

Those general nurses who had themselves sought deployment to the psychiatric hospital, had previously worked in diverse environments for varying lengths of time, in areas such as medical or surgical wards at the general hospital, state homes for the elderly and the staff nursery at the general hospital. Their motives for requesting a transfer to the psychiatric

hospital were interesting and indeed somewhat provocative as they seemed to be based on the premise that the workload at the psychiatric hospital was less physically and mentally taxing than that within the general hospital:

I was stressed at the general hospital and I had physical issues, which made me think to come here as there were benefits here. (C5)

This nurse explained that he had problems with his back and thought that there was more opportunity to sit down at the psychiatric hospital. From all the 21 focus group participant's only one nurse claimed that he chose to come to Mount Carmel Hospital because of a direct interest in psychiatric patients, more specifically he said: *"I chose to come here because I was interested in the social aspect of nursing people with mental illness"*. (A2).

6.2.2 Constructions of a psychiatric nurse

A key question common to all the focus groups was whether psychiatric nursing is perceived as a profession locally and it seems the prevailing perception is that not only do many other health care professionals and the management not consider it as such, even many of the nurses themselves seem to have an unclear self-perception of their status. Whilst all participants acknowledged that a tertiary level education is indicative of a profession rather than an occupation, there was no indication that any other criteria setting apart an occupation from a profession are in place. This was noted in the Literature Review (Chapter 3) as being: extensive theoretical knowledge base emanating from higher education; legitimate expertise based on a body of knowledge and theory in a specified field; an altruistic commitment to providing a service that benefits individuals and the wider community;

possessing autonomy, control and accountability; self-control through standards and a code of ethics and conduct overseen by a body of representatives within the field itself and a personal identity that stems from the professionals occupation.

Adopting professional standards is identified as being a means by which a group can be recognised as a profession (Halcomb et al., 2017). Collectively the nurses in my study indicated that they were generally dismissive of adopting professional standards, with one participant emphatically stating that they are not applicable in this country (A1), whilst others substantiated this claim by explaining that insufficient resources and too heavy a workload prevented the implementation of commonly held international standards of practice (A4 & A5). In discussing implementing standards related to various formalised assessments, the nurses expressed the view that individual experience trumps the need for adopting such methods since the individual nurse, through experience, knows best. One nurse, talking about assessing the risk of harm to self or others said:

It's a gut feeling, we do these in our heads, you just sense the risk, it's a calculated risk and then I deal with the consequences. (A5)

This view was confirmed by another participant who said “yes *it's a gut feeling, for example we know who might potentially be aggressive*” (A2). Experience is highly valued amongst the nurses, or as one of the nurse's explained “*Experience is everything*”. (A5). This was evident when a participant noted that a new nurse may *think* that a patient who appears depressed or withdrawn may hold a risk of self-harm, but a nurse with years of experience would actually *know* for sure which patients represented a real

risk (A3). Deference to experience in terms of length of employment within the hospital was apparent throughout the groups, and people with more experience are perceived as the torch bearers who pass on the skills necessary to do the day to day job of psychiatric nursing to new recruits. One nurse said that *“there is a responsibility on the psychiatrically trained nurses to teach general nurses who are sent here”* (D1) and this was confirmed by her colleague who said:

New nurses don't know what to expect and have serious concerns about things like for example what to do if a patient attempts suicide. We have to inform them and support them by using our own knowledge and experience. (D2)

Another nurse recounted that when she had first started at the hospital she learned by *“watching what others did and copying them”* (D3) as did her colleague, who said *“when I was sent here after qualifying as a general nurse I learned mostly from colleagues”* (C3). One participant stressed the importance of learning from colleagues more emphatically, stating that as a newly placed nurse at Mount Carmel one is motivated to learn from other nurses or else *“it is like working in hell”* (A5). This view may be reflective of the fact that upon being deployed to the hospital nurses hit the ground running:

New staff can't spend time observing, they are immediately part of the shift doing work they have no idea about or experience of. (C3)

This was corroborated by another nurse who explained that:

When new nurses start they are just straight into the job, they may even be immediately in charge of a ward for a shift, with absolutely no experience or information. (D1)

This can lead to problems, explicitly elucidated by one nurse who said: *“Experience is important. Most fuck ups are done by new young nurses. Experience is important!”* (C4). There are no mentorship or preceptorship systems in place for new staff and the day to day work, and routines are learned vicariously from ones colleagues, leaving a wide latitude for the propagation of tradition based practice be that good or bad practice.

Although one participant asserted that *“psychiatric nurses are unique, different from all other nurses and midwives”* (A5), when considering what the roles and skills of a psychiatric nurse might be, the participants were generally unable to describe these, beyond listing a few key aspects generally considered as the fundamental tenets of psychiatric nursing. Despite some participants listing that nurses *should* write care plans, facilitate counselling groups, undertake one to one work in the context of a therapeutic relationship and so on, invariably they were also quick to list innumerable reasons why they felt that locally these approaches and interventions could be implemented. One nurse, referring to the implementation of these basic interventions said:

It won't happen in our lifetime ... Here you cannot work as a psychiatric nurse, there are so few staff and we have to do everything for the patients ... meeting their physical needs, giving them medication... you can't just enter and do just the work of a

psychiatric nurse... not in any ward can you work like a psychiatric nurse. (A4)

There was a general recognition that psychiatric nurses are required to have enhanced communication skills, more honed than a general nurse, and also that within a psychiatric setting, nurses are required to develop more extensive problem solving skills that a nurse employed within a general nursing setting:

In general nursing there is a defined, planned solution for every health problem whereas in psychiatric nursing this is not the case. There is a greater individual responsibility, often you have to make on the spot decisions to solve problems. (D4)

There was an overriding sense that being a psychiatric nurse is not in and of itself a particular role, but rather is an adjunct to a central role of general nurse, something that is done 'as well as'. Moreover participants did not appear to perceive mentally ill patients as a patient group with specific needs. In fact there was the feeling in a majority of participants, that being a psychiatric nurse is something of an elusive position, with the expected duties associated with the role being largely unattainable within the current climate. This was illustrated by a nurse when she said:

Here the role of the psychiatric nurse in reality is to be all things to all patients. It's impossible to be just a psychiatric nurse because you have to do everything to them (sic), but being a psychiatric nurse helps with attitude and behaviour towards them. (A2)

The concept that psychiatric nursing does not have any manifest visible skills in the organisation was reinforced by a participant who, when discussing

differences between a general nurse and a psychiatric nurse, stated that the difference lies in the *knowledge* that psychiatric nurses have: *“The difference is the knowledge about psychiatry, patients and psychiatric emergencies”*. (D2).

A number of participants, even when speaking in English, refer to the patients collectively as *‘il-morda’* (singular – *il-marid*) directly translated into English as ‘the sick’. This colloquialism, although not an outright insult, is a label which indicates some level of condescension and stigma (similarly people with learning disabilities are referred to as ‘subnormal’s’ or ‘handicapped’) and although used in general parlance such terminology seems out of place when used by psychiatric nurses. Yet, *‘il-morda’* was a term frequently uttered throughout the focus groups when the participants were referring to their patients and the regularity of its use seems contrary to the positive regard for patients that one may expect from a group of psychiatric nurses. Moreover, interestingly absent from any of the responses was any sense of empathy or caring towards the patients they look after, but rather an emphasis on *doing things to* patients. When it comes to the day to day working life of the nurses, the priority seems to getting through to the end of the shift without problems. Collectively the participants gave a general impression that their working day is a challenge and the patients are the obstacles that need to be overcome: *“you pray nothing happens till 7.00pm”* (A4) and *“the patients are not always the priority, the workload is”* (A2). One nurse described the environment where they work as *“... high stress work environment, where violence and aggression are usual”* (B2), a theme also raised by another who said of her ward *“people with depression, dementia and schizophrenia are all stuck together in one ward, of course there is*

aggression" (D3). It seems that nurses can also develop subjective assessments regarding their patients that are largely unrelated to their presenting psychiatric condition and that these form the basis of interactions and interventions with them: *"Some patients are more difficult to get along with than others, and maybe everyone has their preferred patients"* (A5). Another nurse in the same group related that there are some patients with whom he is more comfortable to work with and for such patients, he is willing *"to go the extra mile"* (A1) although he did not elaborate what this might actually imply. Rewarding patients with time and attention was also noted to have a beneficial impact of the nurses' working day (as opposed to the benefit of the patients), not least because it equates to *better behaviour*. For example:

There are some patients, if you give them a bit of your time they behave better and the [nurses] day passes better with no problems... a patient didn't bath for three days and because I talked a bit with her, she bathed and even went to Mass and the patient thought I'd give her sweets and leave [permissions] from the ward. I give her the sweets at night so she stays good till night. (A4)

Whether or not all patients are 'deserving' of their attention or skills is also a question that the participants raised. The implication that patients are admitted to hospital for purely social reasons rather than psychiatric ones was indicated in the first group:

If you are admitted because you have trouble with loan sharks what kind of care plan do you do? They are not psychiatric patients. (A2)

In Malta, nurses not only constitute the majority of health care professionals within the hospital, but they also provide 24-hour care. The issue of hours spent with patients is offered by participants as a significant factor that in their view indicates the importance and uniqueness of nurses within the organisation. However the participants of the focus groups did not convey an impression of spending any time *with* patients beyond a custodial role, or give any indication of supporting patients activities of daily living in a supportive or therapeutic manner, and their sole focus seems to be getting through the basic key tasks of a working day such as assisting with personal hygiene or administering medication. Their responses showed most of nurses' time was spent on these and other activities which were not actually specified beyond an acknowledgement of the amount of paperwork they are required to complete (according to A4 – there is so much paperwork it is overwhelming and they couldn't be involved with the patients because of it, since they have no time), and the pressure to be responsible for administrative and maintenance functions, this might suggest that the ultimate goal for nursing staff is to carry out daily tasks and not get involved in their patients' therapeutic treatment.

6.2.3 Positioning the nurse within the practice environment

The psychiatric nurses in my study seem to perceive their professional practice environment in a less than favourable light. The participants unanimously identified the organisation as based and operated upon a traditional hierarchy model, a model which a participant described as being one that "*dominates nurses*" (C1). Rather like an inverted pyramid, the top of the hierarchy is considered by the nurses to be occupied by both the

psychiatrists and the hospital management and the nurses identify themselves to be at the lowest point. One participant reflected that some nurses that are “*actually scared*” of the Consultant Psychiatrists (B3), who generally portray themselves as “*God-like and expect nurses to follow their orders unquestioningly like servants*”; another nurse recalled that it is only in recent times that nurses have stopped standing up (as if to attention) when consultants enter the room (D3). Whilst identifying that the attitude and approach of younger consultants, who have trained abroad and then returned to practice in Malta, is less dictatorial and more inclusive of nurses than some of the older consultants, nonetheless the participants recognised the consultants as having absolute power regarding patient care (B2), or rather– “*patient control*” (B2), with one nurse going as far as to say “*every decision about the patients is made by the doctors*” (B3). This directly impacts the nurses working role as they feel they are unable to take even minor decisions and negates the possibility of any professional autonomy. This latter point was further explained: “*a basic role of psychiatric nurses is to do care plans, but we cannot because we are not supported by the MDT*” (C2) who was referring to the futility of writing plans and goals when in fact it is the Consultant who decides the plan and sets the goals. His colleague concurred, saying: “*the infrastructure of the organisation does not allow proper (nurse) care planning*” (C4). In addition, the nurses comments suggest that they feel that to add insult to injury, the allied professionals, following the lead of the Consultants, also undermine them, or:

The other professionals do not give us any importance, they exclude us in ward round and barely involve us when they are working with the patients. (A2)

There appeared to be a commonly held exasperation that although nurses, working in 12 hour shifts, collectively spend 24 hours a day with patients, and as such feel they are a central part of the multi-disciplinary team, they do not receive any recognition for this by the psychiatrists, the medical doctors or the allied professionals. Expressing some irritation, C1 stated:

In many things we are the experts but we have to do as we are told by other people who often have no knowledge of our wards or our patients. (C1)

In apparent agreement, another nurse noted that *“everyone has authority except nurses here, all other professionals are treated with respect”* (D4). Her statement was supported by a similar comment from (A2) who said that *“locally nurses have accountability but no authority”*.

Several explanations were offered to account for the position of nursing in the professional hierarchy. The recent lack of academic attainment at university level and an emphasis on practical skills training was according to (C2), a factor which might explain the status of nursing in relation to the other graduate level professions that form the multi-disciplinary team. However, without exception my study participants report that in their opinion unlike other health care professions in allied fields, such as psychiatry, medicine, psychology and social work who appear to be highly valued, both general trained and psychiatric nurses remain under-recognized and under-valued, irrespective of their level of education or role. This recurring issue which was strongly voiced in every group, was manifested as bitterness about having lower professional status and less credibility than other members of the multi-disciplinary team.

Nurses in this study have said that they feel that the allied professionals are able to focus solely on plying their trade and are clear about what is and what is not their job, whereas nurses have to do everything, even as one participant noted more than once “*reporting broken light bulbs*” (C4). In the same group, the perceptions of the nurses regarding the role of the allied professionals was made clearer:

They [the allied professionals] can do the work for which they are trained, nurses cannot, for example psychologists seek to protect their therapeutic relationship with the patient, for example they leave when a patient becomes disturbed or aggressive. We don't have that luxury. (C1)

This evident bitterness is most often felt at ward rounds, which are the regular multi-disciplinary meetings when a patient is reviewed by the multi-disciplinary team. The participants report a situation whereby all other professionals have a voice and are heard, with the Consultant Psychiatrist asking for the input and feedback of everyone except nurses (A1) and nurses feel they are perceived as little more than “*coffee makers for the team*” (B2), an attitude that the same participant explained “*hurts more now I've done the course*” indicating that the nurses have unmet expectations about how achieving the degree may have affected their status within the MDT. It was contended that this perception is then taken on board by patients, who afford importance and respect to the multi-disciplinary team members but who then also disregard nurses, not recognising them as being part of it (B5). Exacerbating the situation is the issue that whilst the MDT is peripatetic (moving from ward to ward, reviewing the allocated patients under their care), the members of the MDT do not change, and patients identify their

team professionals as being people to whom they *belong* whereas nurses are ward based and are not permanently assigned to the same MDT or to identified patients, adding to the perception of the nurse as an outsider to the main team (B4; C1), simply put *“nurses change, the firm doesn’t”* (B4).

Some participants suggest that nurses themselves add to the subservient image attributed to them, describing a reality where nurses don’t speak up or contribute to, or are poorly prepared when they attend ward rounds, with little knowledge of the patients and nothing to add to the discussion (A1; B1), with (B5) suggesting that some nurses are too scared to speak in a ward round. In response to these suppositions, it was suggested that nurses present as *laissez faire* because *“... of a long history as being perceived as less than other professionals”* (D3). It appears that nurses add further to the subjugation levied at them by the multi-disciplinary team by adhering to self-imposed restrictions, such as not writing in patients’ case histories, a document in which all medical and allied professional interventions with the patients are recorded. Nurses have their own record keeping system, but there are no organisational rules which, for example, do not permit them to write in a case history of a patient. What seems to exist is an unwritten rule imposed by the nurses themselves, which is now erroneously attributed to being a rule imposed by the organisation. Interestingly the issue of not writing in the case history was mentioned in three out of the four groups, suggesting that this is a widely held misnomer, with significant meaning to the nurses, summed up by a nurse who said: *“not writing in the files is a symbol of ‘us and them’ mentality where doctors are superior to nurses”* (D3).

The relationship between the hospital management and the nurses as described by the participants, is also fraught with tension and resentment. At the time of data collection every manager higher than the chief nursing manager had no previous experience in psychiatric health care (and in some cases even in health care in general). This situation is disconcerting to the nurses: *“the hospital management is hugely important, when they know nothing about mentally ill patients things do not go well”* (A3). This view was echoed by D2 who said *“when the management don’t have any experience or knowledge of mental illness how can they understand us and our needs?”* The nurses describe a significant disconnect from the people that manage the hospital: *“we don’t know the higher management, we don’t know who they are, they don’t come in the wards”* (D1) however her colleague recalled somewhat ironically that some members of management had visited her ward the previous week, she said:

Last week some of them went in the ward to distribute gifts. They didn’t ask us if the gifts were safe for our patients, they went in, took photos to post on the hospital’s Facebook page and left. They were second hand handbags. (D3)

The rift between higher management and the nursing workforce is evidently a major issue for the participants, however despite feeling disconnected from the management the nurses still seek their guidance and support, but the general feeling seems to be that this is not forthcoming. In reference to guidance from management, (B3) explains that *“constantly asking for policies has not helped”*. In the first group, (A2) said that organisational policies and guidelines are necessary but that few are available, he said *“if we have them we can measure whether we are going well or not”* which could imply that he

feels nurses need authority figures to set the parameters for measuring the outcomes of the nurses' work. Collectively the nurses' comments indicate that they lament the lack of official policies, procedures and guidelines whilst some individuals acknowledged that nurses are slow to participate in policy setting exercises when these do take place (B1). She recalled that the recent circulation of a key policy had been circulated to all nurses for feedback prior to implementation and only two nurses in her ward had taken the opportunity to comment. Lack of policies and guidance leave them without direction and the absence of an official job description for psychiatric nurses leaves them with no clear role definition, a position emphasised by a nurse who as stated previously, described nurses as "*jacks of all trades*" (B3).

There appears to be little communication between the management and the nurses regarding the short and long-term vision for the hospital, so much so that official information regarding currently topical matters such as relocating acute psychiatric services to the general hospital or the possible privatisation of national mental health services is not forthcoming and nurses look to the local media for information. This seemed to evoke a despondent attitude in the nurses as they expressed the feeling of being undervalued and misunderstood by the management and talked about a lack of a common goal or vision, which seems to result in the prevention of positive changes.

Another area of apparent deep concern to the nurses in this study is lack of managerial support and a number of examples were tendered to illustrate their perceptions and experiences. At the time of data collection, a major piece of legislation, The Mental Health Act (2012), was in the process of being implemented within mental health services. The Act replaced the country's previous legislation which had been in place since 1981. The

subject of the Act, in relation to the relationship between the nurses and the management generated much discussion in the focus groups. Even though the draft Act was circulated to all major stakeholders nationally, including nurses' representative organisations such as the nurses' union and the nursing management for dissemination and feedback, the nurses' perception was that they were not consulted prior to the introduction of the Act (B3). Once it was introduced, in the nurses' opinion *"the management have not helped at all, we were never given any training or information"* (B7). One of the participants recognised that unlike previous legislation, the Act held nurses legally accountable for their actions in certain areas, although as he stated: *"no-one seems to understand precisely what we have to do"* (C4). The fact that no formal organisational guidelines were issued to direct nurses on the Act's implementation, caused a participant to say *"we are lost before we start"* (B2). Another area in which nurses felt unsupported was in relation to the risk of physical aggression by patients of which they are often the target. One participant explained:

It is a high stress environment where violence and aggression are usual, but we don't have any protection such as a zero tolerance policy like they have at the general hospital where in fact violence is less likely. Management do not support us. (B2)

This nurse recounted that when he was assaulted by a patient (a patient whom the participant considered to be in full control of his actions as opposed to being aggressive in the context of his mental illness), he was told by management that if he wanted to make a police report he had to do it himself. The nurse said that this management response, *"makes you meaner"* towards patients. The perceived lack of managerial support or

protection was further exemplified by another participant who said that he believed that management do not acknowledge or respect the qualification or knowledge of psychiatric nurses and he illustrated his point by recounting an occasion when he was instructed by a Consultant Psychiatrist to administer a dose of a medication that contradicted safe prescribing guidelines. When he refused to administer the dose, rather than supporting him and recognising his knowledge and good practice, the management sent a nursing manager to administer the medication instead (C2). This caused the nurse to feel betrayed and served as a further indication that management hold little or no respect for nursing knowledge. His colleague stated that he too believed that the management hold no respect for nurses' knowledge or skills, but rather that they (the management) merely expect that the nurses control the patients, manage ward maintenance and keep things running smoothly and without incident (C5). This view was also echoed in the account of a nurse who recounted an occasion when a newly qualified nurse was discovered to be in an inappropriate relationship with a patient. When the participant reported the situation to higher management, he says that the management "*wanted to cover things up like the old way*" (C4), again reinforcing the nurse's opinion that management are merely concerned that things are running smoothly.

The complicated and strained relationships between nurses and other healthcare professionals and the hospital management cumulate to create an organisation based on a sharply defined hierarchical culture of structure and control. The strength of the organisational culture is acknowledged by the nurses. One nurse acknowledged that the BSc course may have increased individual nurse's knowledge but cautioned that "*culture always*

comes before knowledge in reality" (D1), and this theory-practice gap was also recognised elsewhere: *"when nurses are asked about anything, they all know the theory but then practice is completely different"* (B4).

The overall impression given by the participants is that despite bemoaning their subordination to what they perceive as the lowest echelon in the hierarchy, they do little to improve their status. They seem to look to others to define or lead them, for example the hospital management, who they feel detached from, and whom they blame for failing to provide policies and support. This lethargy is recognised and explained by some participants as resulting from the predominance of a blame culture within the organisation. According to the participants a blame culture is rife and nurses, being at the bottom of the ladder, are at best reluctant or at worst adamantly opposed to making decisions or taking responsibility even if mandated to do so. In the third group (C5) said *"management blame nurses for everything"* and in the fourth group (D4) ascribed a pervasive, all-encompassing lack of motivation amongst nurses as being due to the hospital *"running on a blame culture"* and therefore *"if we try something new and it doesn't work we are condemned"*. The concern of being blamed seems to even override basic compassion, whereby nurses first thoughts in a suicide attempt would be the fallout they would face from the management: *"Of course we think about risk. If someone commits suicide we would be blamed"* (A4).

Another noticeable characteristic of the nurses is that despite being the largest group of health care professionals within the hospital, the participants accept that they are by no means a unified group, in the way that other professionals seem to be: *"not all nurses are the same, not all wards are the same"* (B4), and the result is a situation that is more 'every man for himself'.

The hospital is divided into wards and units and these are often at odds with each other and have very different approaches, often causing animosity and disharmony. This was described by a participant as a territorial stance where nurses “*work against each other*” (D3) a point that was also brought up in the third group: “*we don’t stick together like other professionals, which is our weakness and their strength*” (C2). C4, when discussing an incident in which he reported another nurse to his managers for entering into an inappropriate relationship with a patient, he described being incredulous when even his colleagues turned on him for making a formal report, since as he asserted, it is the general view that one nurse should never report another.

An overall recognition that change occurs slowly and that effecting change in nurses’ practice and care delivery is very much dependent on individual characters and personalities was evident amongst the participants: “*the majority are held back by the minority*” (C5) and as (C1) observed “*all you need is one person to stop change occurring*”. Both A2 and C4 attributed the slow pace of change within the organisation as being due to a complete absence of motivation by nurses who are not only unamenable to change but seem to willingly block change in their areas, whereas (A1) feels that motivation is fluid and as such “*being an agent for change and trying to introduce change tires you out because people’s motivation comes and goes*”. Other views are that trepidation of the unknown, associated with introducing new practices makes nurses resistant, stressed or even fearful (A1; B6). Furthermore resistance to change appears to be propagated by poor management-poor staff relations, which in turn seem to lead to an prevailing pessimism that change is impossible and even when nurses wish to implement change, the current culture of the hospital does not encourage

or permit it, as (B1) explained: *“there is no interest from higher management to support nurses initiating change”*. This was summed up by a nurse when she said *“challenging the status quo is the most difficult thing”* (D4).

6.2.4 The path to greater knowledge

The participants were in full agreement that their original general nurse training did not prepare nurses for working within a psychiatric setting. One participant recalled that his original enrolled nurse training had only provided a one-hour lecture on the subject of mental illness throughout the entire two year course (A5) and those had trained more recently undertook one module and between 120 and 240 practice hours, being placed in just one psychiatric area for their placement.

Regardless of the number of years' experience working at the psychiatric hospital, (which across all participants ranged from approximately five years to thirty years), several of the participants referred to having gaps in their knowledge about specific psychiatric conditions in general and specific issues such as medication (A2, A3, B5). In fact knowledge of the use and side effects of psychiatric medication was the most cited reason for reading for the BSc. Despite the strongly expressed perception amongst the nurses during the focus groups that experience surpasses academic attainment, several participants referred to a growing recognition that experience alone was not enough for them to perform effectively within a psychiatric nursing environment and in most cases this fact prompted them to undertake the BSc course. This was illustrated by two participants (D3 and B6) who recalled that prior to completing the BSc they employed terminology or labels which they did not really understand, one said:

I used to use words that I didn't know what they meant, like 'personality disorder', even though I'd worked here for years. (D3)

For those that entered the first Diploma to BSc cohort available, the degree was considered something of a novelty and an opportunity too good to miss (B1, C2) but subsequent cohorts attracted several participants who were influenced to undertake the degree by their friends or colleagues and for some participants the initial reason that they decided to apply for the course was based primarily on the fact that if others had a degree then they too should have one: *"all my colleagues were doing it, that was the main reason I did it"* (B6); *"I did it for myself but I was influenced because my friends had done it"* (B5); *"I was influenced by the person I worked with on shift"* (D3). One nurse recounted that three of the younger nurses in his ward had undertaken the degree and he said this prompted him to apply for the course so that he could be *"on the same level as the young ones"* (B3).

For some of the participants the timing of the availability of the BSc course was very significant, as one nurse explained:

I realised that what you learn by experience is not always enough and that it was the right time in my life to do the degree. (B3)

The right time was also significant for another, who said *"I felt I needed to know more and my personal situation was not so bad, my children were growing up"* (C3). Whilst some of the participants experienced some anxiety about the academic requirements of following a degree course (A4, A5), others who had undertaken the enrolled nurse to diploma level nurse course felt that reading for the degree was something of a natural progression (D2, D4).

It seems that the nurses who have been employed for many years within the hospital harboured some cynicism with regards to their younger colleagues who followed the course. One nurse (A4), claimed that the fact that the course was free and fully funded by the government and that nurses were excused from work to attend lectures attracted nurses who may not otherwise have been motivated to undertake the BSc. She doubted that once these motivators are removed, whether the same level of uptake will be maintained. In the words of one participant:

Many people did the course for the wrong reasons. If they are young they get a rise in grade three years earlier than someone who didn't do it. Some nurses with longer years of experience didn't get any financial incentive. (A5)

As discussed earlier, the issue of ward rounds was clearly significant to the participants, and some suggested that a key reason for gaining knowledge and reading research was to *challenge* the Consultant Psychiatrists within this arena (A4, A5, B1), although it was noted that *"gaining knowledge has helped us to challenge doctors but still not everyone does"* (D2), and for one participant *"knowledge is power, especially in ward round"* (A5) and this seemed to be another driving factor for undertaking the degree course.

When discussing the overall impact of nurses achieving a BSc in Mental Health Nursing on patient care, not one single nurse in any of the focus groups suggested any specific identifiable positive effects. Although changes in patient care that have occurred over the years were mentioned (such as patients no longer being restrained in strait jackets – A5), the nurses were emphatic that none of these were directly attributable to the BSc but rather

were evolutionary changes that occur naturally over time. In group three this was illustrated by a participant who said that *“it is not the degree nurses which affected care, but more the change of mentality in the organisation itself”* (C4). Despite one participant emphasising that the nurses who had a bad attitude and approach toward patients before the BSc still had such an attitude after completing the degree, and another noting that:

... if people just do the degree for the sake of it and keep the same bad approach and attitude nothing changes. (C3)

For most of the participants the impact of having the degree was most significant on a personal level. For (B6) it increased her ability and confidence to contribute to the MDT, for B4: *“the course gave me the tools I need to work as well as confidence and the ability to prioritise”*. In the first group the participants credited the course with helping them develop a stronger character (A3) and delivering a sense of personal achievement (A4). Encouragingly, a nurse in the second group asserted that undertaking the course *“makes you question the things that we do that have always been done that way”* (B2).

After completing the degree, three of the participants went on to read for a Master’s degree, either in psychiatric nursing or a related subject. The remaining participants however have not continued to study, attend courses or read research. Reasons given for this included a lack of time and opportunity and perceived lack of support. (A5) claimed that nurses are unable to stay updated, unlike other health care professionals who he claimed *“spend one hour with patients and two hours on the computer”*. (D1) explained that although she occasionally looked at articles online or ‘Googles

things', she didn't see any scope in continuing to study because she felt that the hospital management did not care whether nurses were updated or not, this comment again reflected a sense of unmet expectations of a change in their recognition and status after completing the BSc. The most incriminatory comment regarding the BSc was made by a participant who said "*a BSc in psychiatric nursing means nothing per se*".

6.3 Summary

Despite being aware of the role of a psychiatric nurse in theory, collectively the participants of the focus groups presented a somewhat gloomy representation of what it actually means to be a psychiatric nurse locally. When describing their plight, the nurses were united in a general shifting of blame to external factors: they cited hurdles such as lack of resources, poor management, lack of autonomy and a general deference to a long standing, task orientated routine as preventing them from applying their theory and specialist skills in their practice. Perceptions and actual experiences of being oppressed and disempowered by higher management and an institutionalised organisational culture, seem to have resulted in deeply held feelings of frustration and bitterness towards the organisation, their colleagues, other health care professionals and even at times towards patients. This has resulted in low involvement in their specialised area, they lack initiative and motivation to challenge the status quo and be recognised as professionals and they are not proactive even when opportunities to do so are available. The reality they portray is that having achieved a BSc in Psychiatric Nursing seems to provide little more than entry into a sub culture

or social clique within the hospital but this does not translate to any global improvement in patient care.

The focus group data enabled me to progress the study on to the second phase of the study - individual interviews which were essential in creating data which included deep reflection on the central issues of the study. I needed to select participants who were experts on their own experiences (Reid, et al., 2005). In an IPA study the researcher seeks to recruit participants who are articulate and forthcoming and able to offer a meaningful perspective on the phenomenon of interest. Having the data from the focus groups permitted me to select six participants who I felt had met these requirements during the groups and would be able and willing, to provide rich and detailed accounts of their experiences and perceptions during the interview stage.

Reflexive box: 4

Being a silent observer in the focus groups was very challenging for me as was writing up this section of my study. At times the incongruity between the participants' responses and what I have experienced in my own work roles over the years was very frustrating. The recollections of the participants, especially when related to aspects of their work in which I have been actively involved, differed significantly at times. To give just one example, the nurses explained that they were not involved in the introduction of the new Mental Health Act, which I knew not to be the case since several informative sessions were organized but had a very poor response in terms of attendance by nurses within the hospital. After reflecting upon the differences between my recollections and theirs I realized that it really doesn't matter whether they were 'wrong', because their impression was that no training was given therefore it was a failure of the management (which included me in that instance) to reach the nurses on a level that was appropriate and accessible for them.

continued

Their 'truth' therefore is what I have reported in this study, in line with the theoretical underpinnings of IPA. Whilst reporting the data, I put aside my own perceptions of the situations being described and faithfully reported the participants views. However, I acknowledge that my own perceptions will have influenced how I interpreted their data in the discussion chapter of the thesis. Similarly, having worked as a ward-based nurse for a number of years I also felt that some of their responses in respect of why they cannot carry out the role of psychiatric nurse to be little more than often repeated excuses. Again, on reflection I recalled that when I was a ward-based nurse I too most likely used the same justifications for not engaging more therapeutically with patients.

What was notable was that across four groups with twenty one participants there were hardly any contradictions in recollection or opinions about any of the topics covered i.e. none of the participants said that they thought that the management were hugely supportive or that they felt at ease contributing at ward round and so on. Collectively their responses were fairly uniform, leading me to believe that the findings I have presented are an accurate reflection of the perceptions and experiences of the participants.

6.4 The interviews

In this section I will provide a short introduction to each participant. Following this, the findings from the interviews will be presented in a way similar to the previous section, whereby quotations which are used to illustrate the interpretations of the findings are italicised, and enclosed within quotation marks or indented as a separate paragraph. Again, the participants' responses have been modified only for the purposes of maintaining confidentiality by the changing of names of people and certain places. Each direct quote is referenced in parentheses by the participant's anonymised initial, followed by the page number of their transcript and line number(s)

(e.g. *D56/117-119*). Occasionally two separate but related pieces of dialogue have been quoted together, and the dialogue in-between removed if that was not significant. This is shown in the text by inserting "...". References to non-verbal communication are shown between square brackets, and any words that I have added for clarity are also shown between square brackets. My personal reflections regarding the interviews will be presented at the end of the chapter.

6.5 Introduction to the participants

This section introduces the participants who took part in the one-to-one interviews as part of my study. These summaries are not interpretative and did not form part of the analysis. **Some gender identifiers, dates and work placement details have been changed to protect the identity of the participants.**

6.5.1 Andi

Andi has worked at the hospital for ten years, the least time of all the participants. After following a two year access to nursing course at the local Junior College, she undertook the Diploma in General Nursing, qualifying as a staff nurse in 2006 where upon she was deployed to the psychiatric hospital as her first post. Her only previous experience of working within the psychiatric hospital was one short placement in her second year of nurse training. After spending a few weeks as a 'reliever' (no fixed ward, working wherever a vacancy existed on a day to day basis), Andi was placed in an acute ward, caring for female patients who present with all types of mental illness, often with concomitant behaviour problems or substance abuse

issues. Three years after taking up post as a staff nurse she started the Diploma to BSc in Mental Health Nursing, completing it in 2012.

6.5.2 Bobbi

Bobbi qualified as a general trained enrolled nurse in 1977. It was not until twenty eight years later in 2005, that she undertook the EN to Diploma in General Nursing and then two years after completing it she began the Diploma to BSc in Mental Health Nursing, finishing in 2011. She started working at Mount Carmel hospital in 1996, working on a part time basis, two nights a week. After completing the EN to Diploma conversion course she started working full time. Bobbi worked as a reliever, and over the years she has worked in every female ward and unit within the hospital. She currently is permanently placed on an acute admission ward.

6.5.3 Charli

Charli has thirty three years' experience as a nurse, twenty six of these as a general trained diploma level staff nurse, after which she undertook the Diploma to BSc in Mental Health Nursing course, completing it in 2009. Upon originally qualifying as a nurse, Charli spent six months working at the general hospital, and then she was transferred to Mount Carmel hospital. She has worked in every female ward in the hospital, for many years working nights only. She is currently working in a long stay ward for people with learning disabilities.

6.5.4 Danni

Danni has thirty three years of service, all of them at Mount Carmel hospital, despite originally qualifying as a general trained enrolled nurse. In 1998 he

completed the EN to SN conversion course and in 2009 he undertook the Diploma to BSc in Mental Health, finishing in 2011. Over the years he has worked in all male wards and units within the hospital and also in the two areas that are mixed gender wards. He is currently deployed in the nursing administration office.

6.5.5 Eddi

Eddi has been a nurse for just over eleven years. He originally qualified as a diploma general nurse in 2004 and later read for the Diploma to BSc in Mental Health Nursing, completing it in 2011. He has worked in the hospital's maximum secure wards, forensic wards and community services. Currently he works in the Young Persons Unit.

6.5.6 Freddi

Freddi has been a nurse for nineteen years. He qualified as a general trained enrolled nurse in 1996 and worked at Malta's general hospital for just over ten years. Upon transferring to Mount Carmel hospital he undertook the EN to Diploma in General Nursing and then a few months later began the Diploma to BSc in Mental Health Nursing, completing this in 2011.

6.6 Super-ordinate and sub-ordinate themes

As stated elsewhere throughout my study an interpretative phenomenological analysis of the four focus groups and the six interview transcripts led to the development of four super-ordinate themes and thirteen sub-ordinate themes. The themes presented are not offered as an exhaustive representation of all of the themes that emerged after the

participants' transcripts were analysed, rather they attempt to expose underlying and hidden meanings and are considered those that will best represent the participants' experiences.

As an aide memoire, the diagram below illustrates the super-ordinate and corresponding sub-ordinate themes:

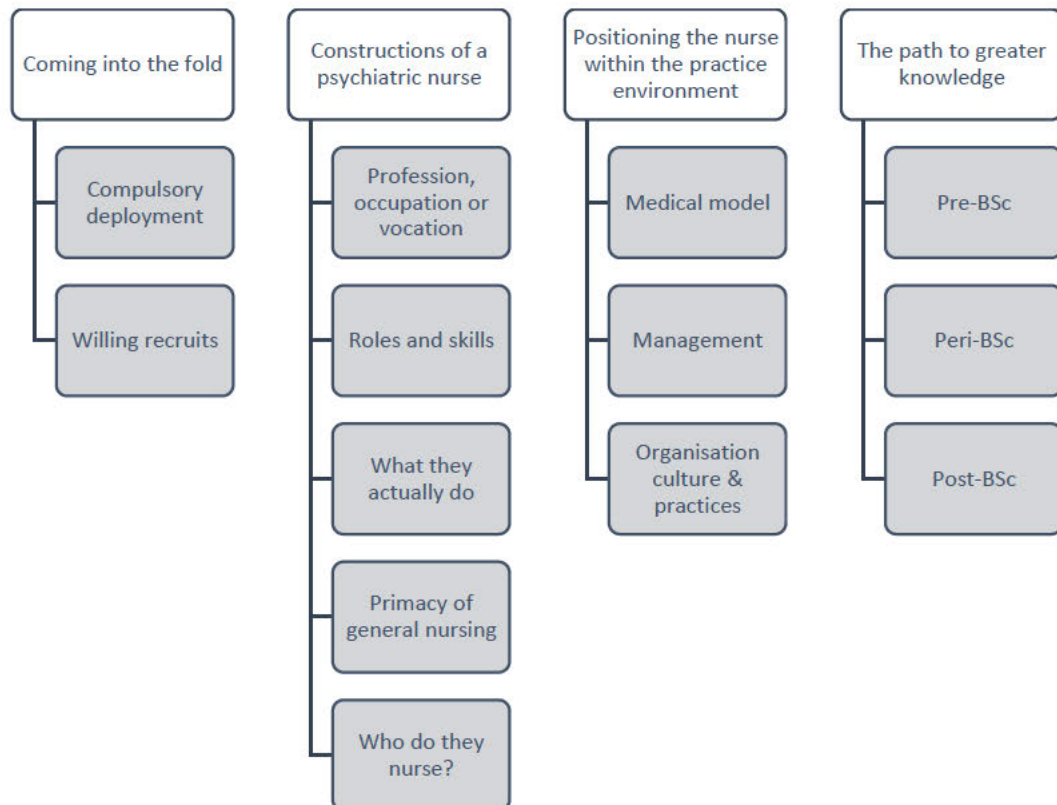


Figure 9: Super-ordinate and sub-ordinate themes

In the following sections a narrative overall summary of the responses of the interview participants is presented. The findings are organised in four sections, identified by the super-ordinate themes: '*coming into the fold*'; '*constructions of a psychiatric nurse*'; '*positioning the nurse within the practice environment*' and '*the path to greater knowledge*', and further delineated within the thirteen identified sub-themes.

6.7 Coming into the fold

Every story has a beginning and the story of these nurses starts from when they were first deployed to the psychiatric hospital. For some of the participants this was what might be considered a 'life time' ago. For others it was relatively recent. But in all cases the mode and reasons behind their deployment provides an interesting and significant foundation upon which their careers, and their stories to date, are built.

As might be expected some nurses chose to be deployed within the hospital, however others had no choice in the decision to place them there. The following sub themes illustrate the experiences of the participants as related to coming into the fold.

6.7.1 Compulsory deployment

Danni has worked at the hospital for 33 years. He recalled that when he first qualified as a general trained enrolled nurse, staff were informed of their respective work placements by telegram. He described the allocation of posts at that time as being influenced by national politics, he said:

They used to send you to Mount Carmel if you did something wrong or you support the other political party, you'd just be sent to Mount Carmel to get rid of you. (D56/112-113)

Once deployed to the hospital, a person's political leanings also influenced the ward where they would be placed. At that time allocation of patients to particular wards was unofficially by means of (patient) behavioural streaming, resulting in 'good' wards and 'bad' wards. In a conspiratorial tone, as if

sharing something that is usually not spoken out loud, Danni explained further. He said:

Now we are saying the truth, because otherwise if we can't say the truth then (shrugs), in some places you had to be Labour supporters because between '82 and '87 we was under a Labour government. Up to '87 I never worked at (certain wards). The staff were those people who support Labour. They were the easy going wards.
(D56/117-119)

When asked whether such questionable practises continue today, Danni replied in the affirmative but qualified this by stressing: *But it is very rare, very, very, very, rare occasions, very rare.* (D56/115)

Danni's responses appear to imply that 'saying the truth' is perhaps not typically a usual response and ordinarily what is said, is less than the truth. Furthermore, the repeated use of the word 'very' in his second comment could be perceived as implying that in fact the opposite is true and that politically motivated transfers still do occur with some regularity in the present day. Moreover even if it is a rare occurrence and only happens 'very, very, very rarely', the fact that it does happen at all, demonstrates that there are strong links between a historical culture of politically motivated work placements that span a period of almost thirty years (the time period that Danni has worked at the hospital).

Albeit in different circumstances Charli also came to the hospital as an unwilling recruit. After qualifying she spent six months working within a general nursing environment before being given a compulsory transfer to the psychiatric hospital, also related to her political affiliations. She immediately

applied for a transfer to return to the general hospital, but by the time her application had been approved six months had passed. The passage of time had altered her perspective and she chose to remain at Mount Carmel. She offered the following explanation for her change of heart: *At that moment I was fond of the patients, I had a good relationship with them so I stayed.* (C35/36-37)

Andi and Eddi were both deployed to the psychiatric hospital on completion of their diploma level general nurse training. Andi would have preferred to have remained at the general hospital but took the deployment in her stride. She recalled her friend, who started at Mount Carmel on the same day as her, spent the first day of work sat on a chair by the door of the ward crying. Andi was more resilient and although she considered asking for a transfer to the general hospital, like Charli, after some months had passed she was settled in her ward. Eddi was noncommittal about his placement to Mount Carmel.

6.7.2 Willing recruits

Not all the participants were reluctant recruits. Bobbi had previously enjoyed a long career in the unrelated speciality of urology nursing. After taking extended time out to raise her children, personal circumstances necessitated her exploring other work options. Bobbi had undertaken a two-month placement at Mount Carmel during her initial nurse training which she recalled as a positive experience. However, her primary reason for requesting deployment to Mount Carmel was because it would be permissible for her to work irregular hours (i.e. not a standardised working roster), an option not available to her in other hospitals. She explained:

In 1996 I wanted to come back because financially I was not well off and I tried to work in (another hospital) but they didn't need part timers ... the only time I had to come, it was on night duties.

(B19/132-134)

Freddi also worked as an enrolled nurse at the general hospital, but government plans to migrate from the old state hospital to a state of the art national general hospital facility led him to request a transfer to Mount Carmel which he thought might be a less stressful option in the long run. This position is similar to that of the respondent in one of the focus groups who had recalled that his reasons for asking to be transferred to Mount Carmel was because he thought there would be more opportunity for sitting down than there was at the general hospital. This reasoning is likely attributable to the low opinion of Mount Carmel held by healthcare professionals at the general hospital i.e. that it was an easier option than working at the general hospital.

Bobbi recounted that when she first qualified some 38 years ago, work place allocations were based on final exam scores, which is similar to the present day system for allocation of newly qualified nurses. For example in a group of thirty qualifying nurses, the ten highest scoring would be deployed to the general hospital, the second ten deployed to the elderly care hospital and the remaining ten sent to the psychiatric hospital. In this manner the status of the psychiatric hospital and the nurses who were deployed there, was firmly placed at a lower level than their general / elderly nursing counterparts. The effect of this manner of streaming on long term, commonly held perceptions of the hospital is clearly illustrated by Bobbi when she described the reaction

of her friends after she requested a job transfer to Mount Carmel much later in her career:

Uuu when I told them that I was coming to work here oh my god 'how is it you're going' like they don't say it but you're going to be that cheap, working there? (B21/205-206)

Interestingly the word 'cheap' was also utilised by Danni when he was discussing how he feels other people perceive psychiatric nurses:

From all the people outside Even from other professionals that are .. they don't have any idea of psychiatry. According to them, because really we are second to none ... but because we are at Mount Carmel we are cheap or we are ... whatever it is. (D56/104-105)

A notable observation is that none of the 'willing recruits' came to the hospital in the first place because they were interested in working with people with psychiatric problems, but rather they were motivated to some degree by personal need or gain.

6.8 Constructions of a psychiatric nurse

6.8.1 Profession, occupation or vocation?

It was quickly apparent that the participants were not able to clearly elucidate the differences between a profession and a vocation, with all participants unable to offer a succinct definition of either concept. When asked to describe what makes a person a professional, Andi stated that it is based on a commonly held perception of particular jobs, such as lawyers or doctors, whereby society in general perceives them to be professionals. She felt that

it is an aspect of both Maltese national and organisational culture whereby society does not perceive nursing to be a profession and this opinion was corroborated by Bobbi who also felt that society, patients and even other nurses did not view nursing as a profession.

Charli struggled to distinguish between the two concepts as she perceives both to be interwoven. She described a complex relationship between duty, spirituality, dedication, practice and vocation, which in her opinion are then married with research-based theories at which time a profession emerges.

The question of whether psychiatric nursing in particular is a profession or a vocation or an occupation elicited conflicting responses. Andi's use of past and present tense in her response seemed to indicate that the question of profession versus vocation is presently in a state of flux. She said:

Before it used to be a bit vocational nursing 'cos you tend to get a bit of pity, a bit of love, of these patients especially if we have young admissions or whatever but then we have to be careful and be aware of the boundaries. Nowadays we are more aware of the boundaries, more aware about the limits. You have to show a certain affection to the patients or whatever but to all the patients not giving special attention to one patient and but not the others no. So the role is a bit changing nowadays. (A2/34-39)

Here, Andi seems to infer that pity and love and a mothering role are indicative of a vocation, whereas being strict and working within certain parameters is suggestive of a profession. It appears that in her estimation being a psychiatric nurse is presently somewhere between the two.

Eddi was initially emphatic in his response that psychiatric nursing is definitely a profession or occupation and not a vocation. He personally had not experienced any particular calling to enter nursing and later was sent to the psychiatric hospital as a routine deployment. Therefore, by elimination he first felt that it was at best a profession, at worst an occupation. However after giving the matter further consideration he agreed that autonomy, responsibility, decision making and education may all be considered signs of a profession and upon accepting this, he felt that psychiatric nursing locally may better be classified merely as a 'job' since as he stated: "*There are only a few of the nurses that are professional*" (E76/105) and Eddi seemed to be including himself in this group.

Initially Danni was more convinced that nowadays nursing is a profession and that in the not too distant past (that is during the span of his career), nursing was little more than a secure occupation for life and it was this security that attracted people to nursing in the first place. However, he also echoed Charli's view that nowadays it is a vocation that attracts people to nursing and that the transition from job to profession occurs almost on a continuum as a result of education and recognition by the authorities. He said:

I can say nowadays it's more a profession because in those days the opportunities were very limited. Now if you go to the university there are much more, hundreds, of courses, so to choose to be a nurse today, with all those opportunities that you have at the same university ... and ... even we have a warrant, we are professionals now, with the degrees and going up, academically going up.

(D58/164-166)

Danni's account seems to be somewhat conflicting since, at first he identified nursing as a profession but yet described a situation whereby people choose nursing over and above numerous other available options, which leans more towards a vocational choice. Interestingly Danni brings to the fore, what might be described as 'badges' of the profession, in this instance, warrants to practice and paper qualifications. Notably Danni is clearly referring to nursing in general as opposed to narrowing his response to psychiatric nursing and this could denote that he still identifies himself more as a general nurse than as a psychiatric nurse. Moreover, he is directing his response towards new nurses, rather than considering nurses who like himself, undertook the degree post initial registration.

Danni's point of view is at odds with that of Bobbi, who is of the opinion that in fact it was in the past and not nowadays, that people entered nursing based on a drive or a calling, as she herself did, but that nowadays it is merely a secure occupation. She illustrated her opinion by telling of her own experience:

When I got married I started doing hairdressing because I always wanted that and then I had to choose, either take nursing or hairdressing. I used to make a lot of money, if I wanted that. But I think it's a vocation because I wouldn't have chosen to start nursing.

(B17/99-102)

Bobbi is equating personal sacrifice with vocation, in that she accepted to earn less money in order to pursue what she felt to be a calling. Bobbi did however concur with Danni in respect of the transition or graduation from vocation to profession being as a result of continuing academic education.

It is salient to note that collectively the participants did not offer a cohesive response as to whether they believed nursing to be a profession, vocation or an occupation and that furthermore all of them seemed to consider the issue as it related to general nursing, almost disregarding their present role and qualifications as psychiatric nurses. On the other hand, at the same time it was clear that the participants perceived the degree as an indication that nursing is developing into a profession. It may be contended that the advent of the degree in mental health nursing marked the opportunity for nurses to begin to make the transition from vocation to profession, an avenue that was not open to them before. It also marked the acknowledgement of psychiatric nursing as a distinct specialisation, recognition that was not previously afforded. This was important to older participants who were general nurses in a psychiatric setting, and who for the most part were placed there against their will. The degree gave them value and validation of their role.

6.8.2 Role and skills

It is apparent that participants perceive the role of a psychiatric nurse as being multi-faceted. Andi illustrated this view when she said:

you have to be a multidisciplinary person, not only doing the nurse only, psychiatric nurse, you have to go through social work issues, through health issues, through financial problems of the patients.

(A1/2-5)

She emphasised the centrality of being an advocate for patients, who many times may not be able to self-report or represent themselves and stressed that this is particularly critical when the doctor's prescription of essential

psychotropic medications may depend heavily on the nurse's assessment of the patient. For Bobbi the central role of the psychiatric nurse should be to engage with the patient in order to develop a therapeutic relationship since, as she stated "*that is the main focus of psychiatry*". She stressed that psychiatric nursing is about "*caring for*" and "*helping*" patients. Charli concurred when she stated that the most important aspect of psychiatric nursing is having a relationship with the patient.

Danni was less definite in pinning the role down so decisively but rather, like Andi, emphasised the holistic nature of psychiatric nursing, explaining that the nurse has to care for and meet the needs of the patients whatever these needs may be. Meeting the needs of patients, whatsoever these may be, may be construed as being paternalistic and the antithesis of a therapeutic relationship in which the focus should be on working with the patients to enable them to meet their own needs.

There was some agreement amongst the participants in respect of particular skills that are fundamental to psychiatric nursing. Charli alluded to the importance of communication skills in order to develop the therapeutic relationship, specifically listening and talking to patients. Danni and Eddi concurred but also suggested that being creative and skilled at problem solving are also essential requirements. Charli also described more practical skills that are required:

Uhuh teaching and coaching them. You direct them, you direct them to the right tasks for them because they will be in a state of depression most of them so you have to lift them up and encourage

them to do things by helping them too ... You will be the role model for them. (C34/19-21)

Charli seems to lack understanding of the therapeutic role when she refers to 'directing patients to the right tasks for them' which seems to imply a controlling approach rather than the collaborative one which would be desirable.

It was apparent that overall the participants were struggling to capture precisely either the role or in fact an inventory or list of skills specific to psychiatric nursing.

6.8.3 What they actually do

The overarching impression given by the participants was that psychiatric nursing is something of an elusive appendage to their daily work which in itself is characterised by tasks and routines. Recalling that Bobbi had asserted that the central role of the psychiatric nurse should be to engage with the patient, when describing what she actually does, she seemed to depict a rather more custodial role, devoid of any therapeutic interaction:

Basically we do the general nursing, sometimes we have to help the patients with her activities of daily living, there's the treatment where we give them the treatment and we have to accompany them during ward rounds. (B14/11-13)

Bobbi validated her belief that nurses are predominantly task orientated, by describing one of the results of her BSc thesis research which dealt with patients' perceptions of nurse:patient interaction. She said:

We are more task orientated, that was one of the main issues that came out, [in her thesis] the patients said it not I. (B25/301-302)

This is an opinion echoed by Danni who said:

In fact all the wards are much more focussed on task orientation than patient orientation. (D65/316-317)

Danni became quite defensive about the priority afforded to completing tasks and felt that this situation resulted from a lack of staff and resources. He said:

The things that, the manpower, the resources, we are mainly understaffed. How can you do these things if you have to do ... what are you not going to do? Not do the showers? You don't give them to eat? You don't attend to ward routines ... [shakes head] to find time with these number of staff. (D64/312-314)

Charli raised the lack of demarcation lines related to her daily work and stressed that by spending time undertaking non-nursing or administrative tasks, her relationship with the patients suffered:

We have a lot of documentation in our ward that I don't have enough time for the patients. Sometimes I am doing the writing of the report or anything and patients say can I talk to you. I have to say I am very busy right now. Can I talk to you and I never have time for them. Too much documentation. It's very important and everything I have to do in order. (C51/ 444-447)

There are qualified nurses that are doing the things that the maids do sometimes, or care workers or nursing aides, and they are BSc with degrees. (C42/218-219)

Freddi supported this view:

Many tasks that are not related to psychiatric nursing like preparing the breakfast, buttering the bread, opening the doors, everything is the nurse's job. (F90/174-175)

The notion that nurses are *jacks of all trades* was common amongst participants but well elucidated by Andi:

Being a psychiatric nurse it is limited because we have to overview everything apart from primarily assessing the patient's mental health, and mental assessment. (A1/9-11)

Social workers yes, they just do social work and then in case they just delegate to their colleagues to prospect in certain areas but we have to do everything. (A1/20-21)

Andi's comments draw attention to the supplementary role she ascribes to psychiatric nursing, it is something that she does 'as well as' in the same way that one might be a health and safety officer as well as a ward nurse.

The participants were unanimous in their belief that within the multi-disciplinary team, it is the nurse who is key, and furthermore there was consensus that this 'truth' is not one that is often acknowledged or appreciated by the other members of the team. They seemed to feel that the centrality of their role was expressed in actual time spent with patients:

Cos we are 24 hours a day there, not their social worker or whatever or OT's or the consultant. The consultant just comes once a week to visit the patient or whoever or maybe if we call them before. But we are there to keep assessing them and helping them and listen to them and everything. (A2/27-30)

I have to say this also because although we are the people who spend 24 hours a day with the patients, we are not ... we don't have the say the same as the social workers, as the psychologists, I think that they are or they think that are of something much more than we do. (D57/140-142)

The nurse is always with the patient, long hours, the consultant, doctors, physio, for some minutes or hours during ward rounds. (C37/83-84)

It is interesting that the nurses refer to the amount of time they spend with patients as an indication of their key role within the MDT, given that they report that their working hours are occupied with non-therapeutic duties. In fact Charli had stated that she doesn't even have time to speak to her patients in a full twelve hour shift.

Despite being able to suggest certain characteristics of the role of a psychiatric nurse there seems to be a great disparity between the theory and the reality described by the participants. But even more than this, is the sense that there is no individual or collective belief amongst the participants that it is possible to match practice to theory. The therapeutic relationship seems to be an abstract concept that they are aware of but yet don't believe is achievable, so they do not pursue it. Rather, like cogs in a machine, they

continue to perpetuate the minimum daily motions in order to just keep the machine running.

6.8.4 Equivalency / primacy of general nursing

Bearing in mind that all the participants began their career as general nurses it is perhaps hardly surprising that five of the six participants felt that it is essential for nurses to first complete general nurse training and then later, specialise as psychiatric nurses (as they themselves all did) and furthermore that having a general nursing qualification, even within a psychiatric hospital, is at least as beneficial as a psychiatric nursing qualification, especially when coupled with years of experience in a psychiatric hospital environment. Andi, who was deployed straight to the hospital upon qualifying as a general nurse said:

I believe that first you have to go through normal staff nursing direct entry, then you start working, then you realise and specialise.

(A9/216-217)

Charli and Danni seemed to concur with this opinion, Charli said:

I know psychiatric nurses [referring to direct entry diploma psychiatric nurses] that don't have the knowledge about physical ailments, how to recognise hypo diabetic coma, how to recognise a stroke is coming, these are skills that are practiced by the general nurse so in my opinion it is very much important that they have a general nursing background, then they would specialise in mental health problems. It's very important because the mental health patient they have a lot

of physical problems, overdose of medication, anything. (C46/333-338)

Similarly Danni also stressed the importance of having a general nursing background:

I agree that we have our own psychiatric nurses, but let's say you are in a ward and you don't know how to take a temperature, you don't notice that a patient has a rigor, that a patient has a heart attack or the patient ... because the ones who come with the direct entry they don't know the basic nursing skills, they don't know them. They learn about only psychiatry, not holistically but see if it was that first you do the basic nursing things and then you opt to study psychiatry that would be.... (D61 /224-227)

The majority of the participants would not entertain the notion that the general nursing skills that they held in high regard could be better incorporated into the direct entry psychiatric nursing programme, but rather were steadfast in their beliefs that it was imperative to first complete three years training as a general nurse. Danni and Andi seemed to take it to a deeper level, appearing to be calling into question whether psychiatric nursing really needs to be a speciality at all since in their view, years of experience trump academic qualifications Danni argued:

... let's say if you have a psychiatric nurse with only 2 years' experience and you've got a general nurse with 30 years' experience, the general nurse has much more knowledge about psychiatry than the other one. (D52/12-14)

Later he argued that '*Here there's no differences between the psychiatric nurses and the general nurses*'. (D61/229-230). Whilst Andi also suggested that time and nursing experience were important:

Uhuh if you've been a staff nurse here for 30 years you would know more than me although I'm a psychiatric nurse cos you have more experience than I have so it would make a bit of difference. (A8/202-203)

These individual and shared opinions demonstrate that the participants still feel as if they are general nurses first and foremost, therefore undertaking the diploma to BSc course in mental health nursing did not affect their positionality as general nurses. Nor did it seem to instil the perception that psychiatric nursing is worthy to stand alone as a nursing specialisation and reinforced the notion that psychiatric nursing is something that is an accessory to 'real' nursing and cannot exist independently of it.

The participant who did not feel that general nursing was an essential pre-requisite to psychiatric nursing was engaged to be married to a 'direct entry' psychiatric nurse and therefore it may be that this factor affected their opinion.

6.8.5 Who do they nurse?

Andi, who works on an acute admission ward, described patients who, on admission, are aggressive in the context of their mental illness and can remain in this state for prolonged periods of time. Her patients present with hallucinations and paranoia and suicidal ideations (thinking about or planning suicide). She said that there is a need to "*be careful even how to approach*

patients” as there is a risk that they may become verbally or physically aggressive towards nurses. Dealing with aggression is a regular occurrence for Charli, currently employed in a long stay ward which caters for patients with a learning disability and mental illness, she stated that:

Every now and then we are sometimes threatened verbally and physically threatened and abused. (C43/239-240)

When considering the patients that she has nursed in other wards, Charli described them as being *in a state of depression* and as such need everything doing for them. She also talked about working with substance abusers:

Yes I was very sorry for them. ...They've been through a lot of things during all their years, from very young they've been through ... (C49/401-404)

Trepidation and a certain amount of caution clearly colour Bobbi's approach towards her patients:

If you see an isolated, withdrawn patient you have to be careful how to speak to her, if she wants you to speak to her, you have to ask her. We have to use different approaches. (B14/19-21)

Freddi, who presently works in an admission ward, seems to perceive his patients as dependent on him to meet their basic daily living needs:

You can't just leave a patient, telling him okay you can go and shower, somebody has to assess the patient. (F85/72-73)

In addition to being of the opinion that his patients are largely dependent on staff to meet their basic needs, Freddi also acknowledged that patients are also individuals, but then categorises them into two groups with some being prone to aggression and others being difficult to work with:

Not all patients are the same. Some patients need more time to engage with them ... its well known that psychiatric patients are more prone to get aggressive (F91/211-213) and some patients with borderline personality disorder, you do everything for them and they still complain how you treat them. (F91/206-207)

The emergent picture of how the nurses perceive the patient population is that of generally depressed or aggressive people, who are largely ungrateful for the care the nurses give and who the nurses either feel sorry for or are afraid of. This is in stark contrast to the principles of therapeutic nurse:patient relationship since once nurses want the patients to like them, or do as they suggest, or to be grateful and appreciate them, then the needs of the patient cannot be adequately met and the interaction could become damaging to the patient.

6.9 Positioning the nurse within the practice environment

6.9.1 Multi-disciplinary team

Interestingly, in describing their experiences and perceptions of their relationship and place within the organisation, all of the participants indicated a very strong sense of 'us and them'; nurses against everyone else whether managers or other health care professionals or even patients. Within Mount Carmel, the care and treatment of patients is organised under the guidance

of what is referred to as a multi-disciplinary team (MDT), led by a consultant psychiatrist and comprised of a senior doctor, psychologist, social worker and occupational therapist. On admission patients are allocated to a particular consultant and their team (colloquially referred to as 'the firm'). Nurses do not form a constant part of the team since each team is peripatetic whereas the nurses are permanently deployed within wards and units. There is at present no 'named nurse' system operational within any of the wards within the hospital. (A named nurse has responsibility for an identified group of patients and works closely with them to develop and plan their care and also liaises with the MDT regarding their patients' care). The 'firm' conducts weekly ward rounds, whereby they review each of their inpatients in the ward where they are placed. Although a nurse is present for ward round, to record the proceedings, the nurse would be randomly selected from whoever is on shift. The subject of their input into, and recognition from, the MDT is one that elicited strong responses from the participants.

Andi, in a rudimentary way, seems to describe a positive and professional approach when she explains her role in the ward round:

Some patients if they are very psychotic they cannot tell the doctor what they are feeling or what they are doing or about everything. You have to be there to assess them, to give your assessment to ward round. (A1/12-14)

Charli too stressed the importance of the nurse's input at ward round, going as far to claim that such feedback supersedes any proffered by the other team members: She said:

They say what they have to say but the feedback has to be given by the nurses and doing what's best for the patients, we know the patients inside out. And what they do, the treatment they are given, is according to the feedback we give. (C37/84-86)

Charli's opinion is clearly that it is the nurses' feedback that underpins the care and treatment plans of the other members of the team. However, her strong choice of words: *we know the patients inside out* sounds territorial and may be a somewhat blinkered view since as she said earlier, very little of her time is actually spent with patients in any therapeutic way.

The MDT is led by a consultant psychiatrist and it is s/he who not only prescribes medication but also makes every decision related to the patient including whether they can go on leave, attend therapy, have visitors and so on. This approach has been in place for as long as any of the participants can remember and is supported through legislation such as the Mental Health Act (2012). Danni described the power and control of psychiatrists when he first started working at Mount Carmel:

At that time, as I told you before, there was only what the Consultants say its factotum [sic], even when the doctor enters the room, enters the ward, you stand up just because the doctor is in the ward. (D57/132-133)

According to Andi, very little has changed over the years as is evident in her opinion of psychiatrists:

In Malta the consultant is something that you can't reach, you cannot touch and everything and the nursing staff is right underneath the hierarchy tower. (A7/172-173)

Freddi gives an evocative example of how he feels undermined by certain consultants:

Even when he introduces the team to a patient or a relative. 'Hi, my name is Dr Bla Bla Bla, this is Jennifer the occupational therapist, this is Paul the psychologist' and I'm invisible. The nurse is invisible.
(F84/43-44)

Bobbi also alluded to the superiority of consultants but is optimistic that the situation may be changing as new consultant psychiatrists take up posts:

Because sometimes the consultants want to be there (indicates upwards) and always stay there. Other consultants, they come and they speak to you, they call you, I mean it's different, they involve you automatically. There's no – a lot of – you know – you speak to them you give feedback and it seems like it's one whole team. You feel it you know. But there are some consultants who want to be there [indicating higher up] and they stay there, and they are always looking down on you rather. (B16/66-71)

Similarly, Freddi also recognised that there are two types of consultant psychiatrists:

I think most of them, no not most of them, 50%, the traditional consultant over here they still apply the medical model – he's the Consultant, you're the nurse, you open up the doors, he tells you what to do, he tells you who comes next, who goes in for the ward round, but the modern psychiatrists they are different, yes, they consult with you, they listen to you. (F84/38-40)

But he went further and attributed this situation arising as a reaction on the part of the consultants to the approach of the nurses:

I'm not saying that the doctors are totally to blame because some nurses, from experience I can say that they go in for a ward round without any errr ... they don't speak to the patients, they don't know exactly what happens so ... [shrugs]. Doctors told us these things, that some nurses don't, are not prepared for the ward round.

(F84/44-47)

Eddi contemplated why some consultants are reluctant to involve nurses more fully in decision making and concluded: "*I think its fear that they lose power somehow*" (E73/88). In fact it seems that calling the consultant a member of the team is a misnomer since the impression given by the participants is that in reality the consultant is actually over and above a team of allied health professionals, all of whom are answerable to him/her, and it is the consultant alone who holds ultimate dominance over not only the patients psychiatric treatment, but indeed many other aspects of their lives whilst the patients are under their care.

However, the participants clearly feel that even amongst the other team members they are afforded less recognition. Bobbi felt that her input at ward rounds was not given any acknowledgement by the rest of the team:

I mean I take part in the ward round that's what I can say and we seem to be [indicates pushing aside with arms] put aside. We give our feedback about the patient and that's all [wipes hand to indicate finished]. Then the psychiatrist talks with the social worker or the psychologist but we're not that involved. I don't feel that we are very

much involved in the MDT although we are a MDT, but they don't try to involve us as I see it. (B15/40-44)

Conversely Danni feels that his input at ward rounds is much more relevant than in the past and is as important or on par with other professionals within the MDT. He said:

Nowadays the nurses are much ... they are part of the team, they are part of the decisions, ward rounds at least every week.

(D57/133/134)

However, when considering whether the other MDT members regard his input with equal importance as theirs, he did almost reticently acknowledge that:

Still, they think that, they think that ... I have to say this also because although we are the people who spend 24 hours a day with the patients, we are not ... we don't have the say the same as the social workers, as the psychologists, I think that they are, or they think that they are of something much more than we do. (D57/140-142)

The perception that other members of the MDT feel superior to nurses was also noted by Eddi:

Although other members of the multi-disciplinary team think that they are superior I don't believe them. I think the nurse is in a better position to, to ... (E73/71-72)

However, Eddi does not feel that this situation is entirely the fault of the MDT members. Like Freddi he suggests that nurses themselves are the root of the issue:

Unfortunately no, unfortunately but it's not only the fault of the other professionals. It's also the fault of nurses that do not get the, the ... they do not take charge, but I mean the problem is here, nurses don't want responsibility, but to take decisions you need responsibility. With some consultants they tell me listen - do a leave plan and it's completely up ... and it's written in the file, completely up to let's say me or someone else. But nurses' don't want that responsibility.

(E73/79-82)

Clearly the participants do not feel valued by doctors and other health care professionals. The role of the nurse within the MDT seems to be in a state of flux, with some nurses' content to cast themselves in a subservient role, albeit frustrated at the attitude of the other members, whilst others are more proactive and keen to have their voice heard within a professional team context. There seems to be two barriers to greater participation on the multi-disciplinary team. Firstly, some of the MDT members have yet to acknowledge the unique contribution that the psychiatric nurse can bring to the team and secondly, some nurses seem reluctant to challenge the status quo.

6.9.2 Management

Overwhelmingly, the participants description of their relationship with the hospital management was negativistic and implied a large rift between the higher management especially and the nurses working in the wards. Andi described a disconnect which she feels is due to lack of appreciation by the management about the day to day job of nurses:

They don't realise things because they don't work 24/7 with the patients. You have to experience day by day and the daily work routines we do and the things that happen in the ward to know what we're about. (A6/144-146)

The fact that the management are not always health care professionals was apparently a decisive factor in causing the perceived divide and adding to the notion that the management don't 'know' the nurses. Charli put it simply when she said *they don't have a clue, they don't have a clue (C43/237)*.

Danni was a little more expansive, in reference to the hospital management he said:

But at least there has to be some nursing input sort of, because how can you implement things without nursing input. How can anyone from another profession or even from not a medical profession, someone from the legal profession or someone from the industrial profession, how can they implement these things in our hospital. (D66/340-342)

Danni's use of the term '*our hospital*' reinforces the observation that nurses are in a 'them and us' relationship with the hospital management and moreover that nurses euphemistically lay claim to the ownership of the hospital, perhaps perceiving the management as outsiders.

Danni's views on the background of the management are clearly supported by Freddi:

At least they need some experience. That's the main thing, to know what the nurse is saying and what he needs. The needs of the nurse dealing with psychiatric patients (F89/158-159) and ... As I said they

would know the needs of the patient and of the nurse dealing with the patients. Even when we complain. They wouldn't just say no no no totally not [makes hand washing gesture]. They would listen to us and they would see, they would understand much better. (F89/169-171)

Charli raised an aspect that develops from the perceived lack of understanding of the nurses' role by the management and this was the issue of blame. She said:

... because if something happens to the patients we show that we did all the things that is right for the patient, but we are always blamed. (C43/247-249)

Danni said that nurses are 'scapegoats' (D66/349) and Eddi said that the fear of being blamed stops nurses from making decisions that they are otherwise qualified to take. He used phrases like '*my defence*' and '*I cannot defend myself*' (E76/159-161) implying that he perceives himself on trial by the management. According to Charli this commonly held perception can have dangerous repercussions:

... that's why some staff do medication errors and incidents happened and they don't talk. Me I always told them, you have to talk cos a mistake is not going to change with another mistake. You have to talk to prevent other mistakes but some of them are afraid of the punitive [sic] they may encounter afterwards. (C43/251-254)

Eddi recollected an occasion that he initially felt supported by the management. He had developed a new keyworker system for the unit where he works and he received an email from the hospital management team

congratulating him on his good work. However, the situation soon became tainted when one of the staff refused to follow the new system. Eddi recalled:

you receive emails like good work but then people who don't want to work as a key worker they just ignore completely my suggestions and they are not helping their assigned patient completely. What do you do, do you leave the patient suffer until it's settled that the keyworker is doing nothing? One day I told somebody off. Really politely I did it and I was phoned by top management not to tell this person what to do and the implication was that they can do what they like. (E80/242-245)

Without knowing the full merits of this particular situation, it is still safe to assume that Eddi's enthusiasm towards implementing positive changes in the future may have been negatively impacted by this instance.

6.9.3 Organisational culture and practices

Andi acknowledged the effect of Maltese national culture on the culture of the organisation. She described a maternalistic, philanthropic approach to patient care which as she pointed out, may be at odds with more progressive approaches to caring for people with mental illness:

Here in Malta it's a cultural issue because we tend to get friendly to everyone, love everyone and that's our country, that's our culture, that is how we grew up, so that can be a bit contrary to our work. (A2/43-45)

Furthermore, Andi also suggested that it is part of Maltese culture to hold consultant doctors in excessively high regard and that this translates into the

supreme position that the consultant psychiatrists hold within the hospital (A7/172-174).

Maltese people are well known for shouting when they talk, and this is fondly ascribed by many as being part of the culture. Although in everyday parlance it is mentioned almost fondly, its place within a nurse:patient relationship is highly questionable and it is something that both Bobbi and Charli drew attention to. Bobbi had conducted a research study into discharged patients' perceptions of the nurse:patient relationship. She recounted that the main finding of her study:

The main issue that came out was that Maltese nurses shout. But it could be our culture. We Maltese shout it's our culture. (B25/294-296)

Charli too, talked about her experiences of nurses shouting at patients. She recounted:

First of all when I first went to my ward I heard the nurses shouting a lot with the patients. I hated that so the first thing I told them was if you shout I will go out. The patients' are shouting but you too – no. Sometimes you have to higher your voice for the patients to do things because they will stay in the bed all day, they don't eat, you have to be strict and assertive but not that shouting that I've heard. So first of all I talked to the nurses and staff, please no more shouting. If you have any problems we'll deal with it but there is to be no more shouting at the patients. (C44/279-284)

Charli did not seem to recognise that raising one's voice towards a patient at any level and for any reason, could be considered as bad practice. Rather she seemed to be taking exception to the volume of raised voices.

Modes and methods of working are slow to change within the hospital. Bobbi recalled that from working there as a student up until she returned some 12 years later, little had changed in terms of practice. Generally, the participants were of the opinion that within the organisation nursing is conducted in a tradition-based manner. Day to day work is organised according to long standing, time-bound routines. Freddi reminisced about times gone by, when patients were told to queue up and were washed with a hose pipe. The thought of this made him '*laugh*' (F86/75). However, he finds the current day practice of generally only allowing patients to shower in the morning, with some exceptions, more acceptable. He vociferously dismissed the possibility of patients being to shower at any time of the day and he said:

In our ward if a patient is dirty, or when he comes back from work, of course we let him, but not if a patient says I don't want to shower in a morning, no you cannot do that. (F86/81-82)

The implication made by Freddi here is that showers outside the allotted time / routine are out of the question, a rigid approach which one might contend in years to come will make nurses 'laugh' too.

The participants seemed to hold a generally low opinion of the way that their colleagues treat and care for patients. Bobbi reiterated the opinions of the patients who participated in her study, she said:

And during that interview they used to tell that one nurse is very different, the approach, the approach of the nurses influences the patients care. (B26/309-310)

Furthermore, her frustration at her colleagues' preoccupation with tasks in preference to interacting with patients was evident when she said:

There's a lot of work yes, work because cleaning or giving them something to eat - you know that they're not going to starve or else if there are 4 nurses or 3 nurses and you can stay with a patient talking with to her which might improve a patient's condition, that's not important for them. You have to go and help them because it's time for the meal or you have to go and help them with the tea or coffee. (B24/263-267)

Charli "worked in nearly all the wards in Mount Carmel" (C35/30) and her response to the attitude and approach of her colleagues' was heartfelt and indicated a lack of comprehension of her colleagues' behaviours:

... even if a patient wants to drink and you don't care, why? [imploring] If I want a drink I would have gone to have some, so the patient has to have what she wishes if it's the right thing for her, for them.... [imitating] ah I have to go for the break now, I will see later on and that later will never come, I'm sure that I've met some people like that. It's not right ay? Even the parameters [recording of blood pressure, temperature etc.]. It may be lifesaving [imitating] oh I am very busy now I'll do them later on. Why? [imploring] (C35/52-57) and ... they are still harsh with the patients, talk foul language with the patients and they don't respect them. (C49/413-414)

Eddi recognised the direct effect of staff attitudes on the patients:

And I say it again, is that the problem is that people don't do their job. Let's say at work, you find people who not only don't do their job, but even with their attitudes okay, negatively affect the wellbeing of patients. (E78/203-204)

Formalised standards of practice are one way of counteracting tradition-based nursing and several countries have such standards in place to guide practice and assist in measuring outcomes. Collectively the participants in this study responded somewhat dismissively to both the notion of the need for standards of practice for psychiatric nurses within the hospital and the necessity of measuring outcomes. Andi reported that within her area of work there are no written standards or criteria to guide their work. This did not present a problem for Andi, as she said:

You cannot go step by step as it is written. You have to go through instinct and through experience and everything. (A12/294-295)

An approach that relies on instinct and previous experience may stifle innovative practice and positive change and propagate tradition-based nursing methods as opposed to research-based practice. Bobbi and Charli also do not recognise a need for standards or criteria related to practice. Bobbi feels that subjective assumptions based on observation are sufficient to measure whether treatment and care has been effective, whereas Charli measures effectiveness by the patient's length of stay in hospital:

I don't think that they are necessary cos there's no need to measure cos when we see the patients' improvement it's enough I think. I mean from his condition. (B31/443-444)

You measure outcomes by how much the patients are improving. If they are always there, not sending them on leave because they are still not fit to send on leave or be with other people it's not healthy like that. (C48/371-373)

Autonomy of nurses is perceived to be restricted by organisational practices. This was demonstrated by Andi when describing what would happen if the organisation introduced any new policy or procedure related to nursing. She stated that first the nurses' union would have to approve it and secondly, she noted that even if nurses are experientially and academically able to make decisions, or implement practice, the organisation still requires them to acquire permission for most things from a 'higher' authority such as nursing management or doctors.

A 'what if' scenario was suggested in the interview, asking the participants what the reaction of nurses would be if the management were to issue a policy stating that nurses themselves could prescribe or stop constant supervision of high risk patients. Currently when a patient is considered to be at high risk of harming themselves or someone else, a doctor is called to the ward or unit and it is s/he who 'orders' constant supervision. This is a practice of one nurse being assigned to remain within arm's length of the patient at all times. It is also doctors who decide when to stop the constant supervision. The reaction of the participants to the suggestion that nurses might order / stop constant supervision was mixed. Bobbi was incredulous and momentarily bewildered. Responding in the third person, and visibly flustered, she said:

First of all, they have to know if we have the right to do it, the legal right, if the union approves of it, they start calling the union first and foremost and even I think the authorities. We have to get the approval from the authorities first. If it is legal you mean? (B28/368-370)

She went on to say:

Maybe if something goes wrong, we are not able ... I think, us Maltese, I think we don't have the knowledge how to cope with that, ourselves, individually. I think we have to get the ... from the union and the errmmm ... (B29/382-384)

Clearly Bobbi was uncomfortable at the suggestion of taking on such a responsibility and in her discomfort, she begins to doubt nurses' ability and knowledge to do so. Freddi was also sure that nurses would not accept such a responsibility. He was emphatic when he said:

What for? For obvious reasons. Even the doctors don't want to carry any responsibility. Every patient admitted they make them Level 1. [local term for constant supervision]. Why? Just to be on the safe side basically. And then I'm going to be responsible me to start a Level 1 or stop it! I could suggest. Some new doctors tell me what do you think? Do you think this patient is for Level1? I might say no, we know the patient, he's just a little bit down, a bit depressed. He doesn't have any suicidal plans though he's got some death wishes, we know the patient. But not to start it! Or stop it! (F88/139-142)

Freddi is happy to contribute to the decision to place a patient under level one, so unlike Bobbi he clearly feels that he has the knowledge and

experience to do so. However, Freddi seems to reject the notion based on the premise that it is too much responsibility and this could be in part, due to the existence of the blame culture that the participants described. A 'wrong' decision to either start or stop the elevated supervision status of the patient could result in the patient harming themselves or others and the implication is that there would be repercussions if this were to occur.

Although Eddi would be ready to order constant supervision he said that in the current climate only "*crazy people*" (E77/167) would do so, again alluding to the blame culture within the hospital. Eddi felt that such a bold move amongst all nurses would not be possible at this time, his reason being:

I think first people have to be empowered, they have to accept responsibility. Again I mention responsibility because if you don't accept responsibility then you will tend to do the easiest thing, not the most effective. (E76/148-149)

If the approach of the nurses is perceived as maternalistic, it seems that the approach of the organisation could best be described as paternalistic. Andi described what occurs when new ways of working are implemented. New policies or procedures are imposed onto nurses and Andi feels that a lack of prior consultation and involvement is a certain predictor of failure. As an example she recalled the recent implementation of the country's mental health act. According to her, nurses were not involved in the development and the writing of the 2012 Act and the consequences in her opinion, are that the Act is detached from the reality of what can reasonably be implemented by the nursing staff. Danni also commented on the implementation of the Act. He recalled that the nursing staff received *one or two lectures* (D67/365)

after the Act was already ratified into law hence even if the nurses had wanted to raise any pertinent points, it was too late and consequently, as it has been implemented, problems are arising (D67/365-371).

One way of establishing the culture and practices of an organisation is to raise the question of how participants would describe it to a newcomer, if that newcomer was someone known to them. The participant's responses to this question provide perhaps the most illuminating description of how they perceive their work and where and how it is delivered:

Bobbi: *what happens here you have to keep to yourself. (B31/458)*

Charli: *You have to do what the staff tell you because you are new here but if they shout don't worry. Because they shout not because they want to shout with you, because they shout. That's why I will tell them. Even the students when they came to [ward] when I was at the psycho-geriatric ward. I told them some of the staff, they shout. Don't take any notice because they usually shout but they don't do no harm. The main thing is the patients are done well and respected and all the things that should be done are done. (C50/430-435)*

Danni: *Take good care of the patients. Don't lie to the patients and you are here for the patients not the patient is here for you ... I would tell them, listen I'm not going to tell you against this person or this person, you are going to observe and then you have to judge yourself, but take care when you work with this staff, give much more attention than when it's with the other shift. Or if its someone that I know or someone that I trust I*

would tell him, listen to that shift ... because everyone has his bad things and everyone has good things, you explain the good things of everyone and then observe the bad things of the others ay. But don't take the example of the bad things. Try to get example of the good things so you can improve. Improve for us and improve for the patients. (D68/398-404)

Eddi: *Basically they have to decide whether to go with the flow or otherwise they are not treated very well if they don't. Believe me I have learned my lessons about going with the flow. (E82/289-290)*

Freddi: *Maybe I would tell them about the system in our ward, how it works. I think everyone would do that. To stick to the system in our ward. (F91/215)*

These comments provide a powerful imagery of a closed institution, soaked in task-orientated, tradition-based practices that one should adhere to, or else face negative consequences such as an inherent risk of being ostracised.

6.10 The path to greater knowledge

6.10.1 Pre-BSc

Andi followed the four-year Diploma in General Nursing course and qualified as a staff nurse in 2006. Immediately upon qualifying she was deployed to the psychiatric hospital against her wishes. Some two years later Andi felt that she had certain limitations and gaps in her knowledge and abilities to

recognise and deal with mental illness so she enrolled in the diploma to degree conversion course:

But then I was about sort of limited about how to recognise if a patient is psychotic or not, or how to recognise if a patient is escalating or how to recognise for example that this is not the right treatment for the patient and maybe she needs a review or whatever or how the patient can show signs of suicidal ideations or whatever so I decided to do the course to be, to get much knowledge and be more prepared. (A3/57-61)

She recollected that initially she did not really want to read for the BSc in Mental Health Nursing (MHN) but was encouraged to do so by the nurse in charge of the area where she worked and some of her colleagues. Like Andi, Charli originally qualified as a diploma level staff nurse. Transferred to the psychiatric hospital less than a year after qualifying, some twenty years passed before she undertook the Diploma to BSc Conversion. She said that the reason for this lengthy gap in her studies was: *“because I had a family, I had four children. I continued my nursing but I couldn’t study too”* (C39/153). In the interim she had taken several short courses and was keen to increase her understanding of psychiatric conditions and treatment. Eddi qualified as a diploma level staff nurse in 2004 and like Andi was immediately deployed to Mount Carmel. After working in several different areas within the hospital he felt that although he had a lot of experience he lacked knowledge and therefore after four years he decided to read for the BSc MHN.

Bobbi also described how a feeling that she lacked knowledge led her to undertake the degree. Bobbi qualified as an enrolled nurse in 1977 but it was

not until 28 years later that she undertook the EN to SN conversion course, by which time she had been working at the psychiatric hospital for ten years on a part-time basis. Three years after becoming a staff nurse, and by then working on a full-time basis, Bobbi embarked upon the SN to BSc conversion course. Her reasons for undertaking the course seem quite disconcerting in view of the number of years of experience she had accrued. Bobbi said:

Yes, but to be honest I didn't know anything, I mean I used to understand, to read about the mental illness disorders but I was not actually ... even when I was giving out medications I didn't know what are they for, what side effects they can have, I was working blindly actually I felt. (B20/170-172)

Similarly, a number of years passed before Danni undertook the EN to SN conversion, however unlike Bobbi he had been sent to the psychiatric hospital as soon as he qualified in 1982. Danni explained that in order to progress his career wise it was necessary to undertake the EN to SN conversion:

I'd been an EN for 23 years. The course, when I did the course there was two options, or be a pupil nurse to become an enrolled nurse or a student nurse to be a staff nurse, or SRN as we used to call them at that time, and once you were an EN that's it, you have to spend all your life as an enrolled nurse but in the 90's someone invented this conversion course which was about two years I think, 18 months and those who wanted to, did the conversion which most enrolled nurses did (D60/197-200) and ... You had to be a staff nurse to keep going up otherwise no. In fact there was much more enrolled nurses at that

time than staff nurses with a huge ... hundreds of people difference. Nowadays there are more staff nurses because of the conversion apart from the ... the enrolled nurses was stopped, the course was stopped about 15 years ago I think. (D60/204-206)

Three years after achieving staff nurse status, the opportunity arose for Danni to read for the degree. Although his primary motivation was to gain more knowledge, Danni also raised the premise of competing with his peers. He said:

First of all, to be a bit selfish, whatever. I don't know how to say it. But to keep on, competing with others, you have to do these things. Because otherwise you do the EN conversion and you stay just a staff nurse. If you want to compete with others you have to show certificates or something to show that you are doing something not just ... (D62/251-253)

Danni was further motivated to gain knowledge to put himself on an equal footing with other members of the MDT. He explained:

... compare let's say we are in a ward round with all the multi-disciplinary team, I, in my opinion, I don't want to be less knowledgeable than the others are, so you have to keep yourself updated, so to be just the same as the other professionals do. (D63/272-273)

In 2006 Freddi had requested a transfer to Mount Carmel from the general hospital where he had been working for ten years as an enrolled nurse. Immediately upon his transfer he undertook the EN to SN conversion course.

Unlike the other participants, he immediately started reading for the BSc upon completing the EN to SN course. His reasons for this were twofold:

I was very interested in the degree in mental health. It's not because of the degree. Particularly for the wage, to increase my income, but secondly, I was ... now I got used to Mount Carmel, I started to like the psychiatry, the psychiatric nursing of my job. I wanted to know more about the treatment, how to liaise with other members of the team, how to work particularly with psychiatric patients, so I said yes, this is a course I should take. (F83/11-14)

It appears that some of the participants received something of a cool response from their colleagues when they first considered undertaking the BSc. Andi recalled:

... even at first they were saying you are going to do this for nothing, you'll still have the same wage and the same everything, so they try .. [laughing]. (A4/85-87)

Bobbi appeared less amused with the similar reaction which she received:

Behind my back uuu [imitating] with the degree now, what are you going to do with the degree, we're not seeing an improvement with the degree. (B23/232-233)

Bobbi formed part of the fourth cohort of diploma to degree students and clearly her colleagues had reservations, manifested as mockery, about the overall impact of the previous course participants on patient care. The reaction encountered by Charli was more of a personal nature, calling into

question her ability to cope with her personal responsibilities as well as the degree:

Shall I tell you exactly? [what they said] When I said I'm going to do the degree [imitating] oh you cannot do the degree you've got 4 children, working fulltime at that moment I had my mother too to take care of. (C40/166-168) and most of them told me you're not going to manage, how you are going to apply, you cannot, you're full time, you have four small kids. (C40/182-183)

6.10.2 Peri-BSc

The experience of returning to studying was different for each participant. For Freddi, there was almost no gap between undertaking the EN to SN conversion and he didn't note any struggles with embarking upon a degree course. However, for Danni, despite only having completed the conversion course three years earlier, the return to studying was something of a challenge:

Maybe let's say I went again on the school bench after 23 years now. It was a bit ... until it settled down and even computer things. Nowadays you have to be much more familiar with computers because in our era there was nothing of these things. But then things settle down. When you settle down with the bench again then it won't be that ... and you learn how to use much more the computer, you won't be that ... (D63/278-280)

Andi, Danni, Charli and Bobbi all touched upon the effects of studying on family life and the support they received from their families:

I was doing it as part time, still working and doing the course so there was a bit of obstacles even I was planning to get married, arranging the house by that time and everything so I had to manage time for studying and doing the other stuff as well. (A3/69-71)

It's another commitment. First of all you have to get permission from the family to do these things because, I don't know, if I stay 8 hours studying or I have to do these things, this is time that I am going to take from my family aye, or from my place of work sort of. You have to tell everyone what you are doing so they can understand you much more and you'll get much more help (D63/284-286).

Nowadays I don't know, I have 2 kids. I try to ... and if something arises I ... [whistles imitates calling son to computer] ... listen what's the problem, what am I doing wrong, but he'll tell me listen do this or do this, things by time you learn. (D63/280-282)

Yes my husband encouraged me. Every Sunday he used to, because he works during the week but every Sunday he just told me go upstairs don't do anything, I'll do everything for you today, it's your day and I had a day for my own on Sunday. Then during the week he helped me in the evening but as a whole I had a lot of support even from the children. (C40/161-164)

To be honest my husband did support me in a way because he didn't use to grumble even though the house was [waves hands] especially when I had to finish my thesis and then when I finished my exams he

told me now you have to give some time to us because you've been ... I used to stay on the desk upstairs and he'd bring me a sandwich, even at 10'clock in the morning or 2 o'clock ... (B22/224-227)

All of the participants benefited from organisational support in terms of being released from work to undertake the course, which ran on a part time basis, one full day each week. The participants were released from work duties if the study day fell on one of their shifts and if they were rostered for duty the night before the study day, they were also exempted from the night duty. The course was also provided for free in that there were no tutorial fees or other costs incurred by the nurses. Furthermore, they were released from duty on exam days and also entitled to twelve additional study days each year to avail of as they wished. Andi and Bobbi would not have undertaken the course had this support not been available since they had other personal priorities and would not have wished to use their normal annual leave to attend for lectures. Charli however was emphatic that she would have still chosen to follow the course in the absence of study leave or if she had been required to pay for it.

6.10.3 Post BSc

In Malta, a diploma level nurse begins work at salary scale 12. Each salary scale contains 5 annual incremental steps. After receiving the five annual increments, the diploma level nurse jumps to Scale 10, which is the maximum scale that a diploma trained nurse can progress to. Upon completion of the BSc, nurses receive a monthly 'degree allowance' of thirty-five euros. In addition to this their pay scale is also fast tracked to Scale 9 after two years of completing the degree. Scale 9 is only available to degree

level nurses. The extent of this is dependent on their current pay scale and years of service. (I.e. someone who was Scale 12 at the time they undertook the degree would advance straight to Scale 9 two years after graduating – representing a potential jump of five annual pay steps in scale plus the additional five steps that would become available to them in Scale 9; someone already at the maximum number of steps in Scale 10 when graduating could move up to Scale 9 after two years and then enjoy five more annual increments in the scale). Since Danni already had a number of years of service and had been promoted into a ward management post, he did not benefit from the fast tracking. The remaining participants were all fast tracked up to Scale 9 according to the organisations framework. Freddi had been candid in his response that for him the main motivation for undertaking the course had been to improve his earning potential and he benefitted from the fast track system:

You are scale 9 and they give you a degree allowance too ... [without the BSc] ... you stay at Scale 12 or 10 for 10 years I think. I don't know exactly but with the degree you get into Scale 9. (F83/16-18)

Andi pointed out another benefit of achieving the BSc, which was related to promotion. When a nursing post is advertised, the selection process is based on a points-based scoring system, and having a BSc would permit a job applicant to gain valuable extra points. Given that there are often hundreds of applicants for lower level management posts (deputy nursing officer / nursing officer) the ability to secure extra points is most desirable.

Eddi, like Danni earlier, also felt that the acquisition of knowledge gave him some kind of authority in ward rounds. The following paragraph demonstrated how he perceives knowledge to be equated with power:

If you learn about let's say the conditions, the medications, the side effects. I think knowledge is power. Even like if you have a ... even if you are in ward round, okay, today some doctors, even senior doctors ask me about treatment or what treatment would I suggest. That's something that is possible because I did the degree. And because you do a lot of further reading. For example, like we have a patient now, ... with a particular condition and with this condition three quarters of the psychiatric medication can't be used on him because they can do permanent damage. (E72/52-56)

There were mixed responses to the crucial question as to whether achieving the BSc had changed their individual practice. Danni was able to list several areas where he felt his knowledge had increased i.e. ... *about doing group meetings, about doing some counselling, medication, about everything*" (D52/20), but when asked if he applied this knowledge in his work, he acceded to his earlier comments in that there are insufficient staff and resources to undertake group work or counselling with patients. Similarly, Bobbi was of the opinion that her practice had changed but then qualified her response by stating that her colleagues prevented her from applying what she had learned:

But sometimes you can't even, you're not allowed to do it even by your colleagues cos they like the routines and they find you a nuisance. (B24/260-261)

Charli did not feel that her practice had changed following the course, however she was of the opinion that her practice was already the best it could be prior to undertaking the course, however she acknowledged that the course had increased her knowledge which she found helpful in her daily work. Both Andi and Freddi seemed to imply that completing the course had afforded them the ability to foresee amongst other things, that a patient will become aggressive, with Freddi saying that:

Yes my practice in general changed. The way how I see the patient. I can now say what the patient feels, I can forecast, foresee a patient getting aggressive, I can see it from before... and ... Yes anticipate, so de-escalation can be used better. Yes I can anticipate when a patient is going to escalate ... I didn't used to know. (F86/91-96)

And for Andi:

As soon as I see the patient I know that he is psychotic, or he's listening or that he has auditory hallucinations or visual or whatever. (A8/195-197)

Similarly Bobbi commented:

But then reading for the degree, it made me more ... I found myself that I am more efficient. I can speak to the patient, I know what I'm talking about, I know about that patient, that education, which interacts with what, that's how I felt that it helped me (B20/172-175).

The most striking element of the participants' collective responses is that no one identified that they had implemented any of the degree course's extensive theory related to the working phase of the therapeutic relationship,

whereby nurses work with patients to develop recovery or rehabilitation focussed individualised care plans. Rather, they seem to acknowledge the acquisition of knowledge such as related to medication, or else the attainment of a set of skills that sound similar to armour one might wear when going into battle.

A substantial part of the BSc in Mental Health Nursing is related to group therapy and provides students with the theory and instructions on how to implement and lead groups. Participants were asked if they had applied this aspect of their learning within their practice. Bobbi's response is clear confirmation of the tendency to put tasks and staffing issues before the nurse:patient relationship:

It would be very difficult to start a group. The only time that we can take opportunities are on Sundays, when there are full staff otherwise we won't do it. (B27/343-344) [If it was a Sunday and full staff?] ... There will be problems because of the visiting hours on a Sunday and the nurses' breaks that would be difficult of course. (B27/347-348)

Bobbi gives the impression that no matter how favourable the circumstances are, there is little chance of her coordinating patient group therapy in her ward. Freddi claimed that there had been instances in the past when groups were conducted in his area, but like Danni, said that the volume of patients meant that these were no longer possible. However, when faced with the suggestion that there are occasions when groups could be initiated he offered a more candid response:

When you have at least a day when you're not busy, I will admit it, you say 'at least once let's stay a little bit relaxed' ... I wouldn't just do nothing though. I do it informally to be honest because when I have got some time I open up the garden I gather up like 3 or 4 patients and start talking with them. (F90/189-191)

As to what benefits the organisation had achieved through their commitment to supporting nurses to read for and achieve the BSc, the general consensus was that there were none. A cynical response was provided by Andi who said that the only benefit was that the organisation could '*bluff*' that they had specialist nurses. Bobbi could see no benefits to the organisation and felt that overall the standard of care had not changed at all. The latter she ascribed as being partly due to the lack of authority available to nurses to implement change.

Charli felt that the organisation as a whole had not benefited from a large number of nurses having studied at degree level, but rather any change was limited to an increase in individual knowledge. She attributed the lack of collective change as being the fault of the management who failed to utilise the skills and knowledge that the nurses gained from the course, and like Danni, she thought that a lack of resources and also a lack of authority and the dominance of the psychiatrists, prevented nurses from implementing changes into their practice. She also expressed her opinion that the mass undertaking of the BSc *per se* could not be credited with any positive changes that have occurred in the hospital.

No – not any credit because some of these nurses that have done the BSc, I notice them. With the BSc or without, they are still harsh with the patients, talk foul language with the patients and they don't respect them. I recognise these things. Still they're not nice people. So it's not the BSc, it's the character of the person. And there are staff nurses who did not do the BSc and they are very dedicated to their job and to the patients, yes. I don't know if I'm saying the truth but it's my opinion. (C49/412-416)

Eddi takes a similar position, being of the opinion that the management have failed to utilise the knowledge and skills that the nurses acquired on the course:

I don't believe the management enforces the majority of the nurses to do a good job. I think that's one of the reasons ... if you're working here as a general nurse or a psychiatric nurse you have to do the job correctly (E76/138-139) and I think first people have to be empowered, they have to accept responsibility. (E76/148)

Every nurse who read for the BSc was required to undertake a research study or literature review, the former presented in a thesis, the latter in a long report. Therefore, this means that a substantial number of individual studies were conducted in the hospital, each one of these presented with recommendations for informing or changing future practice. When considering whether this wealth of local data was being utilised and applied within the nursing practice of the hospital, the majority of the participants responded with an overwhelming 'no'. Although the participants described areas in which they had seen positive changes, they were unable to

convincingly directly link these in any way to the research conducted by the BSc nurses. Andi said:

... there are a few things that they were done as a research and now things have changed. Maybe it's due even to the research done and everything. (A5/106-107)

Danni was unique in that he alone felt that his thesis had been recognised and utilised by the organisation and other nurses. He explained, proudly:

... at the same time as I finished there was something going on and I went to the principal nursing officer at the time and I presented my thesis, it was used ... even in the others, I was quoted, I know nurses that quoted my thesis in their thesis. (D64/299-302)

Despite this recognition of his work, there was no suggestion that his findings and recommendations were implemented or heeded. After completing the course, the participants remained convinced that theory alone is ineffective unless it is married with actual working experience. Andi said:

Uhuh you need the experience and you need the academic also but you cannot have lack of experience and the academic alone. You need to do by time, although you have everything on the books you need to experience the thing to visualise yourself how they are psychotic, how they have hallucinations, how they have paranoid ideations. How they be suicidal. It doesn't matter that I read patients will have suicidal ideations because ... see that and that ... you have to experience it, so through experience and academic. (A8/206-211)

Speaking to the question of keeping oneself updated by reading and referring to research to inform their practice, the participants all claimed to do so, however their responses ranged from 'rarely' to 'sometimes'. Since the participants do not demonstrate an active pursuance of keeping abreast with research, it is fair to assume that no universal or meaningful change took place in this regard. This is relevant because evidence-based research is not static and by no longer updating themselves, the participants' knowledge base remains fixed at the point they completed their course.

All of the participants said they would recommend undertaking to SN to BSc course to their colleagues. None of them however felt that it should be mandatory. Nevertheless, Andi felt that short courses of an update nature regarding specialist subjects should be mandatory. Bobbi advocated a more informal approach to CPD:

If you can do it [the BSc] why not, but if you cannot there are leaflets, other seminars, 2 day seminars or 1 day seminars or conferences.

(B44/266-268)

6.11 Summary

Regardless of their pathway into psychiatric nursing, only one of the participants reported having arrived in their current role as a result of a desire to work with mentally ill patients. The responses of the participants demonstrate a common inability to articulate their role or to identify unique differences between a specialist psychiatric nurse and a general nurse and collectively participants appear to describe a dichotomy between knowing

how best to 'do' psychiatric nursing and the realities of how it is done on a daily basis.

Participants reported that they viewed their role as challenging in relation to several factors which affected their capacity to meet the expectations of their role as a psychiatric nurse. They seem to be lodged between the twin imperatives of care and control, bound by deep-rooted informal and tradition-based practices, rules and norms that are based on risk minimisation, devotion to routines, staff comfort and patient containment. They identify several obstacles that prevent them being psychiatric nurses, not least the sharply defined hierarchical culture of structure, control and blame which is prevalent within the organisation. They describe working within a system under pressure, due to lack of resources, an ever-present risk of aggression and chronic understaffing. They feel undervalued and misunderstood by their peers, by the patients, by society and by the members of the multi-disciplinary team. Rather than rising to meet the challenge posed by such obstacles, and actively pursuing professional recognition and status, nurses have instead, it seems, generally taken the path of least resistance and continued to perpetuate the asylum model of psychiatric nursing, in which the nurse is merely custodian and giver of basic care. The undertaking of the Diploma to Degree course was at first novel and has later been identified by the participants as a means of personal self-improvement, in some instances for financial gain. Overall participants indicated that they were generally happy that they had put in the effort to undertake further study. However, despite acknowledging that by undertaking the course their own knowledge in certain areas had increased, none of the participants were able to identify

any tangible effects on patient care giving practices that could be ascribed to them having followed the course.

The next chapter will discuss the major findings of this study with reference to the existing literature. The implications for policy and practice will be discussed together with recommendations for further research into this field of study.

7.1 Introduction

The study reported in this thesis has examined how a group of general nurses who have undertaken a post registration degree in mental health nursing, perceive and experience their current role, sought to determine what factors influenced them to undertake the degree and explored the ways in which undertaking the degree has contributed to changes in the way they practice and deliver care.

Three main research questions were posed.

1. How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?
2. What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?
3. What do psychiatric nurses' perceive to be the factors that impact their working practices after having completed a BSc in mental health nursing?

In this chapter the findings presented in Chapter 6 will be discussed in relation to each of the research questions. With reference to the extant literature, this chapter provides a meaningful and coherent interpretation of the findings to create a rich understanding of the experiences of the participants. This leads to a consideration of theoretical and clinical implications, limitations of this study, and reflections on possible future directions in research and practice.

7.2 How do general trained nurses who have undertaken a post qualification degree in mental health nursing interpret their role?

7.2.1 Inauspicious beginnings

Shedding light on the past and acknowledging how the participants in my study arrived in their current role permits consideration of how the early steps in each of their journeys to becoming a psychiatric nurse influenced their present day role and perspectives. The participants came to work at the psychiatric hospital in a variety of ways. For the majority this was an imposed drafting or deployment, for a small number it was a personal choice, however of the latter group only one said that working there was because an expressed desire to work with psychiatric patients.

The subject of general nurses being drafted to work in a psychiatric hospital has not been found to have attracted discussion within the extant literature either locally or internationally. However in Malta, since the School of Nursing opened in the 1960's (Savona-Ventura, 2005) and training specific to psychiatric nursing was not offered as an option until 1992 (Gafa, 2016), it follows that for the greatest number of years the majority of qualified nurses hailed from a general nursing background. This suggests that the experiences of the participants in this study may well be representative of most of the nurses who are currently employed within psychiatric services in the country.

Further, there is no indication that the practice of deploying general trained nurses to work at the psychiatric hospital is set to change at any time in the

near or distant future. The World Health Organisation (2007) undertook an extensive global survey of nurses (including both general trained and specialist trained) working in mental health settings and considered their role, availability, training and education. The findings show that health systems in many countries encounter nursing shortages as they strive to recruit and retain nurses in areas of mental health. WHO (2007) maintained that such shortages are related to a number of reasons: lack of interest and a lack of incentives for mental health nursing; lack of safety and security within the work environment and the stigma associated with mental disorders (WHO, 2007 p.9). Like many other countries, Malta is experiencing extreme challenges in the recruitment of nurses of all genres (Sammut, 2012). For over a decade stakeholders in the healthcare sector have expressed concern that there is a growing shortage of nurses nationally (ibid). In response, the Department of Nursing at the University of Malta adopted measures such as restructuring four-year nursing programmes into more intensive programmes with a three year duration, and lifting the *numerus clausus* (fixed maximum number of entrants) for nursing courses meaning that all eligible applicants were accepted by the University (Sammut, 2012). The government has also attempted to address the problem in several ways, including: i. issuing a call for applications for retired nurses to return to work for period of three-and-a-half years or up to the age of 65, whichever is earlier (Caruana, 2018a), and ii. since 2010 actively recruiting nurses from other countries to solve the 'crisis' (Galea Debono, 2010). According to the Maltese Union of Nurses and Midwives (MUMN), there are presently around 3,500 nurses in total employed by the State, which is insufficient for health service requirements, with at least 500 more nurses required to fill the existing gaps in all Maltese

hospitals (Cassar, 2017). In a recent recruitment drive spearheaded by the nurses' union and supported by the current Minister for Health, the Minister drew attention to the present national nursing shortage and said that around 60 to 80 nurses, preferably psychiatric nurses, are needed for the psychiatric hospital (Leone Ganado, 2018).

The number of direct entry psychiatric nurses is small in comparison to those who follow the general nursing programmes. The Diploma in Mental Health Nursing course ran between 1992 and 2003, with just 22 nurses completing the course in that time period. The full time BSc in Mental Health Nursing course commenced in 2009 and to date around twenty nurses have completed the course. It therefore becomes apparent that the practice of drafting nurses (who initially entered the profession in order to work within general health care settings), to the psychiatric hospital is set to continue. Moreover, the present day selection of which nurses will be drafted to work within the psychiatric hospital continues to be closely based on the system explained by some of the participants in my study whereby the final course scores of each nurse qualifying from the general nursing programmes determined their first work placement. Top scorers were placed within the general hospital, the remainder being divided between the State geriatric hospital and the psychiatric hospital. Although slightly different, the current selection process is described by the current Director of Nursing, Nursing Directorate as being:

When they sit for their interview for the call of staff nurse, the students are asked what are their first, second and third preference to work in an entity. When their final result is issued they are then deployed to the area of choice according to their course ranking. The

Degree students are chosen first according to their ranking, then the diploma students in the same order. (V. Saliba, 6th March 2018).

Since each hospital has a share or quota from the total number of graduating nurses, despite the suggestion that there is some choice about their placement, it remains the case that anyone falling below the identified number of staff nurses for placement at the general hospital really has no choice but to work either in the State geriatric hospital or psychiatric hospital.

This mode of 'recruitment' paints a very clear picture to newly qualified nurses- essentially implying they are less than - or not as good as, their better scoring peers, or as one participant in this study described, they are seen as "*rejects from general nursing*". The fact that general nurses then seem to hold a low opinion of nurses working within psychiatric services is understandable and was evident when two of the participants in this study, describing how their general trained peers perceive nurses working at the psychiatric hospital, used the word '*cheap*', a word with derogatory connotations in any language. The opinion of general nurses with regards to psychiatric nurses has been discussed in the literature. Halter (2008) conducted a survey amongst 122 nurses in order to elicit their perceptions of psychiatric nursing. Those surveyed suggested that psychiatric nursing was one of the least desirable nursing careers, both from their personal and societal perspectives. Psychiatric nurses were predominantly seen as "*unskilled, illogical, idle, and disrespected*" (p. 24). Furthermore they were considered more likely to be identified as introverted, dependent, disinterested, and judgmental than their counterparts in other types of nursing. Other authors have focused on the perceptions of student nurses regarding psychiatric nursing as a career option, and as a result have

identified the perceptions of psychiatric nurses held by this group. In a longitudinal study conducted in Australia, Happell (2002) first surveyed 793 first year student nurses, and then re-administered her survey tool to 521 of the same student nurses when they were due to finish their training some three years later. Happell sought to establish their career preferences upon qualifying as a nurse. Psychiatry rated just above nursing the elderly as the least preferable area to work. She found that the students held an image of psychiatric nursing as being depressing, sad and stressful. In a similar study conducted in South Africa, Jansen and Venter (2015) also surveyed nursing students who had worked in two or more psychiatric placements, therefore having had experience of psychiatric nursing, and who had indicated that they were not interested in pursuing psychiatric nursing as a career. These authors reported that the reasons student nurses did not aspire to be psychiatric nurses were manifold, but significant here is that the participants cited the unprofessional, undisciplined and unethical behaviour of psychiatric nurses as being central to their decision not to opt for psychiatric nursing.

There is little literature on the degree to which negative attitudes held by students toward psychiatric nursing carry over into the professional health care setting, however the findings reported in this thesis, around nurses' choice of work setting, indicate that student nurses perceptions do not undergo a drastic transformation as they cross the bridge from student to practicing nurse.

In a novel finding, my study highlighted the unique phenomenon of politically motivated allocation to, or transfer of staff within the psychiatric hospital. No studies or discussions of party political influences in sending nurses to certain areas either as a punishment or even merely because they supported

the opposition political party have been found in the literature. The fact that no literature could be located is in itself significant as it suggests that it is a phenomenon that is not acknowledged, at least publically, in academic studies in other countries. Despite there being no academic reporting of such occurrences, a cursory glance through the Maltese daily newspapers reveals example after example of instances where party politics either positively or negatively directly affects the employment circumstances of individuals. Tanti (2016) explained that the Constitution of Malta disallows distinction, exclusion or preference in favour of or against any person in respect to his/her recruitment to a public office by reason of his/her political opinion. Yet, Tanti (2016) also attested that it has been a longstanding practice by both of the main political parties to recruit political appointees directly on the basis of trust, making it possible for people who do not possess the required competencies to gain a public service post at the expense of appropriately qualified, experienced and skilled individuals. Moreover a person who may have helped in some way, a political party or a candidate within a party could not just be rewarded by a job for him/herself but also family members. Cassar White (2012) suggested that this state of affairs is something that Malta has in common with other small southern European states. He said: ... *Southern European states are plagued by endemic corruption nepotism, cronyism, favouritism and political patronage* (Times of Malta, August 30th 2012).

Whilst Cassar White's opinion emanates from the popular media rather than academic peer reviewed research, it seems to reiterate the ethnographical observations of Boissevan (1977/2013) which were highlighted in Chapter Two of this study. Boissevan drew attention to the influence of politics in day

to day lives of Maltese people, referring to a 'friends of friends' network which operates on a *favour – payback* system. According to the participants in the study reported in this thesis, political interference seems to be an enduring practice locally right up to the present day, albeit to a lesser degree than in times gone by. Forced transfers to the hospital seem to be considered the norm amongst the participants and accepted almost with a certain pragmatism as a *fait accompli*, painting a picture of an uneven playing field where individual merit is given less importance than political affiliations.

Whilst it may have initially seemed encouraging that at least some of the nurses in this study actually chose to work at the psychiatric hospital, by delving into their stories it transpires that all but one of them gave reasons suggesting their requests were motivated by some kind of personal gain as opposed to any interest in psychiatric nursing *per se*. Studies have shown that people choose an occupation when it is compatible with factors they perceive as significant for an ideal career, be these intrinsic factors such as altruism, self-fulfilment, challenge, creativity, responsibility and professional status or extrinsic factors such as job security, flexible hours and comfortable working conditions (Ben Natan and Becker, 2010). Heyman (2012), in an article which considered misconceptions related to psychiatric nursing, acknowledges that among other nurses, psychiatric nursing is not perceived as a speciality and that it has a less complex knowledge and skill base than general nursing and as such, requires less knowledge and expertise. There may be a tendency to presume that these factors may deter general trained nurses from opting to work in a psychiatric hospital, however interestingly, some of the participants in this study reported being drawn to work there because of them or in spite of them. In fact it was these extrinsic factors,

associated with the working conditions and perceived working practices at the psychiatric hospital, which attracted those participants who were transferred there by their own volition. This speaks to the reputation the hospital holds within the local healthcare sector locally. It also demonstrates the mind-set of one of the nurses that requested to be placed at Mount Carmel, captured quite vividly by a participant from the focus groups, who thought that he might be able to sit down more at Mount Carmel than he could at the general hospital. Moreover, the picture that emerges here is that by a variety of avenues, the participants came to work in a place that was (and one may contend, still is), considered '*cheap*' by society, other professionals and their peers and '*cheap*' by any interpretation holds no positive associations.

Whereas retention of nurses may not present the same problems as in other countries where staff can move on if they are unhappy in their work place, (simply because there is not another alternative locally), it does point towards a workforce whose members are disenchanted and disheartened at the very beginning of their career. In a study which considered factors that influence staff morale in psychiatric wards, and speaking to the effect of low morale within psychiatric nurses, Totman et al., (2011) stated that psychiatric inpatient wards are potentially extremely stressful places to work. Whilst noting a lack of research into the issue of staff morale in hospitals in the UK, Totman et al., (2011) asserted that substantial associations have however been found in healthcare settings between staff well-being and patient outcomes. These authors stated that:

Good morale among staff on inpatient psychiatric wards is an important requirement for the maintenance of strong therapeutic

alliances and positive patient experiences, and for the successful implementation of initiatives to improve care. (p.1)

Not all nurses who participated in this study planned to take on the role they now find themselves in and understanding the biographies of the study participants is crucial to answering the research questions. Taken together they show a distinct picture of a professional group whose members have come, unintentionally and at times unwillingly, to their current roles as psychiatric nurses. Their starting points may conceivably have ramifications upon their role that still exist to the present day and may also illuminate the experiences of the countless number of other general nurses who have been drafted to psychiatric services locally. Whilst little evidence of these issues can be located in the literature, the study reported in this thesis points to the importance of understanding professional biographies when examining nurses' motivations to effect positive and innovative psychiatric practices.

7.2.2 Identity crisis

The great majority of participants in this study clearly identify themselves first and foremost as general nurses, having all undergone training for either a certificate or diploma in general nursing as their first nursing qualification. This is somewhat paradoxical given that the majority of the participants have little to no experience of ever working within a general hospital setting. Nonetheless all of the participants seem to emanate a sense of pride and affiliation towards general nursing, something that is not apparent when they discuss being psychiatric nurses. In fact the overwhelming impression given both by the interview participants and the nurses who attended the focus groups, is not only that they are resolutely general nurses but also that their

psychiatric nursing qualification is a supplementary one, in much the same way as any other continuing professional development course would be. This seems to be an outlook that they maintain even to the point of denouncing the validity of direct entry psychiatric nurses (i.e. those that enter nursing directly into the mental health nursing programme), to be considered as real nurses at all.

This raises an interesting question. Since all of the participants in my study have worked between ten and thirty years at the hospital and all have attained registration status as psychiatric nurses, why do they still reject their current status as psychiatric nurses in favour of identifying with general nursing? Perhaps the answer lies outside of nursing and is rooted in society's perception of nurses. During the interviews both Andi and Bobbi had referred to local society not acknowledging psychiatric nurses as professionals. Ten Hoeve, et al., (2013), stated that nurses derive their self-concept and professional identity from, amongst other things, their public image. Commonly, stereotypical public images of nurses being angels or even physicians' handmaidens have endured despite significant progress toward professionalisation over the past decades (Takase, et al., 2002). In a local context, Sharples (2017) recorded that in Malta nursing was perceived as being very much a vocation implying an inherent spiritual calling and a sense of dedication. It could be contended that this kind, servile image of general nurses locally, albeit still not that of a professional group, is nonetheless preferable to the public image of psychiatric nurses and as such the study participants are less inclined to align themselves with psychiatric nursing which has yet to establish a positive image amongst Maltese society.

Regardless of their underlying motives for clutching to their general nursing status, in almost total consensus, the participants are steadfast in their belief that all nurses should first undergo general nurse training, and then specialise in psychiatric nursing courses later on. They justify this strongly held view based primarily on the increased incidence of physical illness amongst the patient population. Research shows that people with mental illness do indeed have a higher prevalence of physical ill-health, related directly to their mental illness, its treatment and lifestyle risk factors and barriers to receiving adequate physical care (Osborn, 2001; Happell et al., 2015). On average people with severe mental illnesses can expect to live 10 to 25 years less when compared to the general population (WHO, 2010). Apart from suicide, most deaths are related to chronic medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension (WHO, 2010). When the participants in this study elaborated on the particular general nursing skills that are required, or in fact as they suggested are crucial for a nurse working within a psychiatric hospital, they only actually referred to proficiencies that any person could learn over a few hours in a basic first aid course, such as taking a temperature, recognising low blood sugar or the signs of a heart attack. Even so, their views are upheld in a recent report published by the Foundation of Nursing Studies [UK], (FoNS), who found that despite the title 'nurse' suggesting that psychiatric nurses can take care of the physical wellbeing of patients in their care, the reality is that training in the necessary skills is minimal or even absent from psychiatric nurse training programmes (Butterworth and Shaw, 2017). Furthermore the FoNS, reported that this reality may be contributing to possible significant changes in UK mental health policy, namely that the

specialisation of psychiatric nursing be stopped in favour of a single generic nurse registration (McKeown and White, 2015). Such measures have already been initiated in many parts of Australia, where psychiatric nurse training changed from being a separate program to psychiatric nursing became incorporated into a comprehensive, generalist nursing course (Happell, 2009). Since trends in health care policy locally tend to reflect the directions taken in the UK, albeit many years later, it certainly seems to suggest that educators locally need to address the issue of lack of knowledge and skills related to physical health, if they are in favour of continuing with a specialist psychiatric nursing qualification.

Since there is no evident internalisation of their role it is hardly surprising that the participants are not sure whether psychiatric nursing is a profession or vocation or is merely an occupation. The perplexity displayed by the participant's as to the status of psychiatric nursing, is not limited to the local perspective and continues to be an enduring focus of discussion and debate within nursing literature, as was illustrated in Chapter Three of this study. Certainly there was little evidence found within my study to suggest that psychiatric nursing or even general nursing has evolved to a professional level locally. The concept of delayed nursing professionalisation in general in Malta was discussed in an unpublished doctoral thesis by a Maltese researcher (Sharples, 2017), who observed:

The popular image of nursing in Malta is still that of an occupation that is largely subservient to the medical profession and not really one to aspire to. Maltese society in general is hardly aware of the contribution of nursing and therefore possibly cannot regard it as a valuable profession. (p.36)

According to Crawford, et al., (2008) many people outside of nursing, (for example the general public and other professionals) consider nursing as an inferior and inadequate undertaking, negating the possibility of regarding it as a profession. The low opinion of psychiatric nursing in particular, is well documented within the literature and has been discussed earlier in this section. Sharples noted that this widely held image is prevalent amongst the general population of Malta and probably extends itself amongst Maltese nurses and as such, contributes towards a lack of self-knowledge and identity, which would account for the finding in this thesis, that not only are the participants unclear about their status but they seem almost apathetic, even accepting of the felt inferiority. This apparent low self-esteem is the antithesis of a professional self-esteem that would ordinarily be associated with a developing profession, and seems at the opposite end of the spectrum from Boling's (2003) description of a nursing as a "*profession on a trajectory toward ever-greater professionalism*" (p.28). None of the participants gave any real indication of pursuing a more elevated professional status and there were no parallels between the extant literature and the transcripts of the participants, the former generally describing psychiatric nurses in vociferous pursuit of recognition of their skills and input. Much more apparent in my findings was the notion that nursing, or in fact any public service post in Malta, is considered to be a job for life. This latter point is perhaps understandable when placed in context: despite diverging trends in employment in Malta resulting in greater generation of jobs in the private sector (Government of Malta, Employment Policy, 2014, pg.22) up until the present day, the public sector in Malta continues to be one of the islands largest employers, in an economy that is otherwise largely dependent on

foreign trade, manufacturing and tourism none of which offer an assured job for life. The average age of the participants in the study reported in this thesis was 44 years, each with an average of 22 years' experience, and this may support the general perception in the not too distant past, which was that working for the government was a safe choice. Interestingly two of the male participants recalled that it was their mothers that had suggested nursing as a career choice, and perhaps this is indicative of a commonly held belief that because nursing is a safe occupation locally, as such it is one that parents would want their children to pursue.

In my study, the apparent absence of a professional identity associated with being a psychiatric nurse is disconcerting. Tsakissiris (2015) described professional identity as being:

... one's self as perceived in relation to a profession and to one's membership of it. Professional identity is created through one's beliefs and attitudes, values, motives and experiences through which individuals define themselves, in their current or anticipated professional life. It is associated with the accrual of symbolic resources including status and esteem, mastery, sense of belonging and attachment. (p.ii).

Casa and Creary (2016) outlined the significance of developing a professional identity. In the first instance these authors claim that it is a key way in which people assign meaning to themselves, shaping work attitudes, affect and behaviour. Moreover, the way in which a person defines their self in their professional role becomes an important means to understand and define their self and their life's purpose more generally. Through the

construction of a professional identity, people are able to claim purpose and meaning for themselves, and illustrate how they contribute to society. Casa and Creary (2016) stated that in addition to being a meaning-making device, one's professional identity can also affect psychological well-being. Since the term 'professional' is positively associated with a person who has advanced training and unique knowledge and skills which allow them to provide an important service to society, it is therefore seen as a desirable self-description. Based on these factors, according to Casa and Creary, it is likely that when a person identifies with a professional role, there will be psychological benefits such as well-being, esteem and pride. Professional identity also affects individual behaviour within the workplace, impacting attitudes, determining moral decision making and shaping behaviour through professional norms and values (Casa and Creary, 2016).

The importance of nurses developing a professional identity that has received examination within the literature, with various authors approaching the subject from different perspectives. Johnson et al., (2012) considered the impact of nurses' professional identity on other stakeholders:

A positive and flexible professional identity is critical for nurses to function at a high level and benefits not only nurses themselves, but also patients and other healthcare workers. (Johnson et al., 2012, p.564)

Johnson et al. (2012) also pointed to a significant link between professional identity and the perceptions of society regarding nurses. Benceković et al. (2016), considered the nurses role as a type of ambassador for their organisation, recognising that nurses represent the largest number of

employees in health care institutions and within hospitals, most of their time is spent in direct contact with patients and their families, the latter point being one that was strongly emphasised by the participants in my study. Nurses influence the impression held by patients and other stakeholders of the institutions where they are employed, having a significant impact on the position and respect of a health care institution within the community and the perception of the services provided, hence a positive professional identity can improve the image of both nursing and the organisation in which it occurs. Similarly, Hercelinskyj et al., (2014) claimed that understanding how psychiatric nurses comprehend and portray their professional identity is crucial to promoting a clear representation of the profession which affects recruitment and retention. In a similar vein, Guo et al., (2017) recognised professional identity as a critical factor for nurses in providing a high level of care to optimise patient outcomes, and further, that a positive professional identity reduces negative effects in a stressful workplace and minimises attrition rates. These authors contend that the lack of a professional identity may be contributory factors to nursing students leaving educational programmes and to some nurses resigning from their jobs.

In line with the findings of Sharples (2017) referred to previously, my participants also indicate that Maltese society in general, including patients they care for, does not acknowledge nursing as a profession but rather, nursing is perceived locally as a maternal role and furthermore it is considered by the nurses in my study that without the recognition of society, it cannot claim to be a profession. The way in which psychiatric nursing is socially constructed is significant because nurses are themselves also

representative of society and as such, could contribute to or identify with those same constructions.

In my study, the participants have not only struggled to identify themselves individually as professionals with a developed professional image but also, as a group, they do not appear to be even seeking to do so at this stage in their careers. An example of this apparent passive stance is the almost unanimous rejection of the need for professional standards for psychiatric nursing, with the participants favouring individual work experience over research driven theory. Öhlén and Segesten (1998) in an analysis of the concept and development of a professional identity amongst nurses found that the professional identity of the nurse is integrated with the personal identity of the nurse. They stated that:

It [professional identity] consists of the person's feeling and experience of her/himself as a nurse, the subjective part, and other people's image of the person as a nurse, the objective part. It appears on a maturity continuum with the opposite poles of strong and weak professional identity. It is developed in socio-historical context through intersubjective processes of growth, maturity and socialization where interpersonal relations are important, and attained maturity of the nurse influences further growth". (p.725)

Crigger & Godfrey (2011) seemed to concur with the concept that professional identity is developed over time when they observed that:

Professional identity formation, like any life experience, is a process, not an event, and is nested within everyday experience. Nurses are either in the process of developing a growing sense of professional

identity, and flourishing or failing to expand their notion of professional identity by not living up to their own moral ideal of who and what a nurse is. (p.59)

Accepting these viewpoints leads to the conclusion that at the present time, psychiatric nurses who participated in this study are only at the beginning of developing a mature professional identity and are yet to progress along to the continuum towards growth and maturity as a profession. Indeed the findings of this study indicate that the participants do not conceive of themselves as professionals, hence creating something of a self-fulfilling prophecy resulting from an invalid or incorrect social belief leading to its own fulfilment. Self-fulfilling prophecies can contribute to the maintenance of stereotypes, because the people who hold the negative impression (society) look at the objects of their negative opinions (nurses) and feel that their opinions are validated, since the behaviours or attitudes of the person or group (nurses) support their beliefs (Jussim & Fleming, 1996). Hence, if they themselves do not feel that psychiatric nursing is a profession, then neither will anyone else.

Patients' experiences and perceptions are considered one way of evaluating the quality of healthcare provision, and this was the subject of one of the participant's BSc thesis. When looking at the perceptions of discharged patients regarding the nurse:patient relationship she reported that ex-patients held two significant views, firstly that nurses shout and secondly that they are predominantly task orientated. Such practices reinforce negative, stereotypical public perceptions of psychiatric care and consequently, psychiatric nurses themselves, which then impacts how they are perceived amongst other professionals and society. When exploring common

perceptions held of psychiatric nurses, Heyman (2012), contended that whilst psychiatrists are linked to science, professionalism and prestige, the same cannot be said of psychiatric nurses. Rather psychiatric nurses are often viewed by the public as corrupt, evil and mentally abnormal. The pervasive *laissez faire* attitude of the nurses locally in respect of challenging commonly held societal beliefs, does little to dispel false impressions such as these.

7.2.3 Cuckoo's nest

The extant literature portrays an image of contemporary psychiatric nursing as having a unique and important role, one that is acknowledged by the nurses themselves but recognises that they struggle to articulate their vital role and skills, resulting in their work being overlooked or misinterpreted (Lakeman, 1995; Delaney and Johnson, 2014; Butterworth and Shaw, 2017). Just like the nurses in the informal study by Phil Barker (Barker and Buchanan-Barker, 2011), in which he asked psychiatric nurses to provide a brief and concise definition of what psychiatric nurses do, the participants in my study similarly struggled to articulate their role. Initially offering a brief list of a few well used terms such as 'engage in a therapeutic relationship', 'be a role model', 'communication skills', upon delving deeper they were unable to substantiate these with any in-depth description, explanation or examples of when they have made use of these abilities or skills, and their apparent struggle to list the terms gave the impression that these are not internalised as being part of their everyday working with patients. Their interpretation of their role as psychiatric nurses is marked by ambiguity and a strong connection to tradition-based nursing practices and a seemingly slavish observance of tasks separate from patient-centred care. The participants in

this study do not attempt to portray the notion that psychiatric nursing is in any way unique nor even does it seem that they perceive the key psychiatric nursing skills they listed as being a vital part of their daily work. Rather, their interpretation of their role seems to deny the plausibility of nurses being able to undertake the role or work behaviours that are often described in the literature, offering a number of reasons for this, most commonly related to lack of resources, poor management, institutionalised staff and an entrenched medical model dominant within the organisation. The widespread commitment to a rigid, task orientated approach to their work, reinforces the dependency and incapacity of patients, which is the polar opposite of the intended outcome of a psychiatric nurse's role, in which engagement leads to patient empowerment and recovery (Delaney and Johnson, 2014). Whilst the literature is replete with similar concerns of nurses with regards to barriers that prevent them fulfilling their role (recordkeeping, lack of resources and so on) (Cowman et al., 1997; Sabella & Fay-Hillier, 2014), no recent literature could be located which reported psychiatric nurses as being actually supportive of a task orientated custodial approach in the present day, which seems to be the case in my study. In order to locate international literature which describes roles that are comparable with my participants' reported experiences, one has to go back almost three decades. In 1990, Reynolds and Cormack observed that psychiatric nursing had its (then) recent history in a custodial model of care, which they described as being one which isolated mentally ill people, often in environments from which they could not freely leave, secluded from the general population. Within these institutions, the emphasis was on meeting the basic daily living requirements of patients,

and treatment was limited to providing physically based treatments.

Reynolds and Cormack (1990) stated that:

For the most part, psychiatric nurses functioned in support of this 'isolate and tranquillize' philosophy... and ... The main purpose of psychiatric nursing was to contain patients, keep them in reasonable physical health, and prevent patients from harming themselves, other patients, and staff. The custodial role of the nurse in these areas was of paramount importance, with the psychiatrist being the sole source of decision making, determining the type and focus of nursing care, and generally being responsible for all aspects of patient treatment.
(p.3).

Although struggling to describe the role of a psychiatric nurse, when the question of what they actually do was explored in greater detail, the nurses were much more outspoken and their descriptions were found to be comparable to those outlined by Reynolds and Cormack reported above. They described working in an environment that is controlled by routines and institutionalised practice, where everything has a time slot and this must be adhered to at all costs. They spoke in terms of doing things 'for' or 'to' patients as opposed to doing things 'with' them, indicative of a controlled institutional approach as opposed to a therapeutic and caring one. Acknowledging that the common nursing approach in the hospital is not patient centred but rather firmly task orientated, there was a general resolve amongst the participants that things needed to be done the way they were for the smooth running of the ward and furthermore, the participants expressed their views in terms which portrayed them as being largely defensive of this approach as necessary and unavoidable. Taking the

example of the participant who couldn't conceive of patients being able to take a shower outside of the fixed times without a very good reason and approval from the nurses, it is clear that, whilst not hospital policy, there is strong evidence that historical and custodial practice remains dominant within the hospital. However it is also apparent that this is not necessarily recognised or identified as being the case by the participants themselves, who become defensive of their practices. One participant gave many reasons why therapeutic groups could not be implemented by nurses and her ultimate reason was that staff breaks take precedence when prioritising the working day. Another spoke of the absolute need to work through the daily tasks even at the expense of not talking to patients for an entire twelve hour shift. It is interesting then that the participants' were unanimous in stressing the point that it is they, amongst the health care team, who spend the greatest amount of time with the patients (*'24 hours a day'*), and the prevailing view was that this aspect alone makes nurses the most knowledgeable amongst all health care professionals about the patients. This is a curious stance when taken in conjunction with their own accounts of their working day, which gives the impression of comprising of very little interaction of any type with the patients.

In my study a strong underlying theme is the custodial and controlling nature of the nurses' role and daily work and these findings correlate with similar studies conducted elsewhere and reported in the literature. In a small exploratory study which looked at how much time nurses in an acute psychiatric ward spend with patients in what could be considered psychotherapeutic interactions, Whittington and McLaughlin (2000) found that the nurses spent less than half the working day having any kind of

contact with patients and out of that time, only a fraction was spent in what could be considered therapeutic interactions (6.75%). Loukidou et al., (2010) also reported that the majority of nurses' time is spent on documentation or on interaction with their colleagues. However, Loukidou et al., go on to say that although the administrative demands placed upon nurses may provide a valid explanation for limited interaction with patients, it can also be considered as a justification for nurses to avoid potentially unpleasant contacts with patients. Cameron et al., (2005) observed that even when nurses do interact with patients, these are generally non-therapeutic exchanges. Not all surveillance and control is gratuitous, since in many situations it is essential to ensure the safety of patients and others. However in a situation where nurses guard, dominate and control patients, patients who are in a position in which they have to rely on nurses to meet even their most basic needs, the possibility of developing a therapeutic nurse:patient relationship is improbable. Cleary (2004) suggested that the pursuit of the ideal (the therapeutic relationship) is confounded by such issues as organisational pressures, diversity in the nurse's role and ever increasing competing workplace demands. Delaney and Fergusson (2011), concurred and defended the elusiveness of the interpersonal connectivity inherent in the therapeutic relationship, in environments that are characterised by time and role pressures and a turbulent work life. Another possible dimension is considered by Rungapadiachy et al., (2004) who reported on the perceptions of student nurses with regards to the role of psychiatric nurses. The participants of Rungapadiachy's study postulated that nurses may avoid therapeutic interventions because they do not feel skilled enough to undertake them. Locally, the BSc course emphasises the importance of

group therapy and two semesters are dedicated to teaching nurses how to initiate and deliver such groups. From the participants' accounts it is apparent that this learning does not translate to practice. In the study by Rungapadiachy et al., (2006), it was also suggested that some nurses are far more concerned with their own comfort and prefer to remain apart from patients in the office:

... and the office was out of bounds for the patients as well ... They were spending a long period of time in there talking, drinking coffee and drinking tea, gossiping about other nurses. (p.719)

Rungapadiachy's participants suggested that nurses often not only withdraw from the immediate vicinity of patients, but also that they adopt a negative approach that can lead to malpractice. In my study there were certainly accounts that supports such views. One participant described instances where patients' are denied drinks, whilst staff drink freely, and that basic nursing care is withheld in deference to taking their own breaks. Another description referred to nurses not reporting medication errors. It seems lamentable that the therapeutic relationship is not actively pursued, irrespective of the reasons why this is the case. In their metasynthesis of research related to the role of the psychiatric nurse, Delaney and Johnson (2014), drew attention to the significance of the therapeutic relationship not only to patients, but also to nurses themselves. The development of such a relationship brings meaning and purpose to their role, beyond the connection that develops when attending to patients' basic everyday needs. They maintain that this aspect of the therapeutic relationship is in and of itself professionally stimulating and certainly the participants' of this study supported this view when they recalled instances where they felt a sense of

usefulness and personal satisfaction on the occasions that they interacted with patients in a therapeutically meaningful way. However, these occasions are the exception not the rule in their everyday working lives.

7.2.4 Summary

The emergent accounts of the participants in this study provide an insight into how they interpret their roles as psychiatric nurses and this in turn furthers the understanding of psychiatric nursing within the local context. Their stories and experiences – of how they came to work at the hospital, their conceptions of their role and the reality of their working lives, point to a divergence from the contemporary descriptions of the role and practices of psychiatric nursing found within the literature. Hurley et al., (2009) stated that establishing a distinctive professional identity has traditionally required a group to demonstrate distinctive characteristics and these in turn generate a label that is associated with that distinctiveness. The nurses in my study seemed unable to pinpoint with clarity any such distinctiveness, instead their descriptions were marked by uncertainty and ambiguity and were more indicative of ingrained role behaviours. Their accounts indicate nursing practice which operates in deference to experience and a high regard for traditional psychiatric care culture, characterised by a task orientation approach at the expense of patient interaction. Furthermore, the participants seem to embrace this culture, and are defensive of it. Rather than rejecting the status quo they instead propagate it, handing down time worn traditions to new staff and apparently disregarding the need to adhere to evidence based competencies such as professional standards.

Locally psychiatric nursing seems to be at a very preliminary stage on a continuum from being a steady occupation to emerging as a new profession. Although this may be a description that is applicable to psychiatric nursing in many other countries, given the circumstances at play locally, it is difficult to draw comparisons with other groups of psychiatric nurses in other countries. This factor must be considered in light of the local context which sheds some light on the apparent slowness of the evolution of the role of a psychiatric nurse. Only a handful of nurses opt to specialise in mental health, and as a rule psychiatric nursing is not a desirable position. Enforced placement of unwilling nursing recruits and political manoeuvring do nothing to elevate the professional image of this speciality area. The stigma attached to the role, both by society at large and even amongst their peers, may account for the participants' apparent lack of interest in moving the profession forward.

7.3 What factors influenced general trained nurses to undertake a post qualification degree in psychiatric nursing?

7.3.1 Served on a plate

The importance of continuing education for nurses as reasoned within the literature, was discussed in Chapter 3 of this study, together with factors purported to affect nurses' participation in continuing professional education (CPE) programmes. The main reasons why the participants of this study chose to undertake the diploma to degree course will be discussed in the following section, however in the first instance it is of interest to look at the issue of obstacles to accessing the Diploma to BSc course locally. Richards

and Potgieter (2010), set out three categories of barriers to CPE reported by nurses, these are summarised here:

- ***Physical, or situational barriers***, which includes lack of time to study because of work responsibilities; family and child care responsibilities; difficulties in paying course fees and struggling with numeracy and academic reading and writing skill;
- ***Attitudinal, or dispositional barriers*** encompassing negativity due to previous experiences in academia; lack of both emotional and physical energy and anxiety about not being able to keep up academically; low self-esteem; lack of confidence in general and specifically related to learning;
- ***Structural or institutional barriers***, identified as including unavailability of nearby education institutions; staff unavailability; lack of knowledge about learning opportunities, unattainable entry requirements; lack of appropriate courses and difficulty in obtaining study leave.

The experiences of the participants in this study certainly mirrored many of the obstacles noted within in the literature. The older nurses had concerns about their abilities to keep up with the academic requirements, those with children mentioned family responsibilities and many generally lacked confidence in their ability to achieve the degree prior to the commencement of their studies. However, my findings show a significant divergence from commonly reported barriers reported in the literature in two key areas.

Generally studies that look at barriers to accessing CPE consistently report factors such as the financial cost of CPE and also the lack of managerial support through for example paid study leave, as being crucial deciding factors in uptake (Richards & Potgeiter, 2010; Richardson & Gage, 2010). A 2015 descriptive explorative qualitative study by Eslamian, Moeini and Soleimani which explored the challenges of nursing continuing education, found that participants cited their working shift being parallel to the educational classes and having night shift before the classes as being key barriers to uptake. For the participants in my study however, factors related to study leave and course costs were not barriers at all since at the time they undertook the course they were excused from work (i.e. could attend during work hours if a study day fell upon their rostered shift) and they were also excused from night duty if this fell before their study day. Pursuing any undergraduate degree course in Malta does not incur tuition costs for Maltese and EU citizens. According to findings from other studies, full financial support to attend courses is rare but not unheard of (Dowswell, et al., 1998; Clodagh Cooley, 2008; Richardson and Gage, 2010), but no studies could be located in which both full release from work to attend *and* course costs were borne by the employing organisation.

There is no doubt that having knowledgeable, well-educated nurses is desirable for any health organisation. The World Health Report (2010) asserted that human resources are the most important part of any health system's inputs since the performance of health care systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering services. Logically then, education and training are key investment tools for health systems (World Health Organisation, 2000).

According to Murdock Krischke (2013), employers have a vested interest in promoting and making CPE available to their nurses. Having nurses who are up-to-date on the most recent evidence-based practices may lead to better patient outcomes and organisations who support and invest in the professional development of their nurses by offering the time, resources and funds for CPE courses often see increased job satisfaction among their employees with lower staff turnover rates. Such support may also elicit a sense of loyalty from the nurses towards the organisation (Murdock Krischke, 2013).

The findings of my study suggest that had the Diploma to Degree course not been free and had study leave not been given in full, the majority of participants may well not have chosen to undertake it, not least because for many of them there was no identified need to do so, after all the participants were very clear that, in their opinions, it is general nursing coupled with work experience within a psychiatric environment that makes for the most effective nurses. Therefore, it seems that the organisation by offering access to the course on such attractive terms, reduced the reasons for non-participation and thus increased the take up of its nurses. Once the nurses overcame other more personal and circumstantial obstacles (such as addressing their concerns about the academic requirements and so on) other financial and work constraints did not create barriers. However, it may be contended that although the generous support of the organisation attracted nurses to the course in the first place, given the fact the majority of nurses applying did not either recognise the need for a psychiatric nursing degree in order to perform adequately or have to invest their own time or money, it calls into question

the value that they ascribed to it after completion. This point will be explored in greater detail in subsequent sections.

7.3.2 The reasons why

The question of what motivates nurses to undertake formal education at tertiary level after qualifying has been addressed in a number of published studies (Spencer, 2006; Clodagh Cooley, 2008; Richardson & Gage, 2010; Watkins, 2011; Zahran, 2013; Olsson et al., 2013). The main findings of these studies are briefly summarised in Table 6.

Authors & Paper Title:	Country:	Brief Summary of Main Motivations:
Olsson, Persson, Kaila, Wikmar & Boström (2013). Students' expectations when entering an interprofessional Master's degree programme for health professionals	Sweden	Increase professional competence for clinical practice; Enhance inter-professional collaboration; Personal Development; Increase quality of patient care
Zahrán (2013). Master's level education in Jordan: a qualitative study of key motivational factors and perceived impact on practice.	Jordan	Self-development; Broaden career opportunities; Developing practice.
Watkins (2011). Motivations and expectations of German and British nurses embarking on a Master's programme	UK & Germany	Personal challenge: previous under achievement and personal development; accessibility and availability. Professional challenge: credibility and 'catch-up'; professional/career enhancement; improving knowledge and skills.
Richardson and Gage (2010). What influences practice nurses to participate in post-registration education?	New Zealand	Self-improvement, increase use of evidence based practice; personal satisfaction; knowledge is power; improve nursing skills; increase intellectual stimulation; changes in role and patient groups; improve professional image
Cooley (2008). Nurses' motivations for studying third level post-registration nursing programmes and the effects of studying on their personal and work lives.	Ireland	Aid professional development by updating knowledge and learning; to gain access to a nursing speciality; increase promotion and employment opportunities; for professional survival; to be academically credible (previous registration training inadequate/to gain credibility and respect with MDT); it was the right time in their lives.
Spencer (2006). Nurses', midwives' and health visitors' perceptions of the impact of higher education on professional practice.	UK	Professional reasons: Work related pressure to undertake study; for career progression; to keep up academically; to keep up with better qualified staff. Personal reasons: for academic stimulation; personal satisfaction; to continue after previous study.

Table 6: Findings from studies discussing nurses' motivation to undertake CPE

My study found that the motivations of Maltese nurses to undertake a tertiary level course, such as the Diploma to BSc in Mental Health Nursing,

demonstrate close parallels with the identified motivators that are reported within the literature. These are shown in Table 7.

<i>Author/title</i>	<i>Brief Summary of Main Motivations</i>	<i>Similarities in motivations in this thesis</i>
<i>Olsson, et al., (2013)</i>	Increase professional competence for clinical practice; Enhance inter-professional collaboration; Personal Development; Increase quality of patient care.	Increase professional knowledge; Level of educational parity with other professionals; Personal development.
<i>Zahran (2013)</i>	Self-development; Broaden career opportunities; Developing practice.	Personal development; Broaden career opportunities.
<i>Watkins (2011)</i>	Personal challenge: previous under achievement and personal development; accessibility and availability. Professional challenge: credibility and 'catch-up'; professional/career enhancement; improving knowledge and skills.	Personal development; Credibility and 'catch-up'; Career/salary enhancement; improving knowledge; Accessibility & availability.
<i>Richardson and Gage (2010)</i>	Self-improvement, increase use of evidence based practice; personal satisfaction; knowledge is power; improve nursing skills; increase intellectual stimulation; changes in role and patient groups; improve professional image.	Self-improvement; Increased knowledge; Knowledge is power; Improve professional image.
<i>Cooley (2008)</i>	Aid professional development by updating knowledge and learning; to gain access to a nursing speciality; increase promotion and employment opportunities; for professional survival; to be academically credible (previous registration training inadequate/to gain credibility and respect with MDT); it was the right time in their lives.	Increased knowledge; Increase promotion and employment opportunities; For professional survival; to be academically credible (previous registration training inadequate/to gain credibility and respect with MDT); It was the right time in their lives.
<i>Spencer (2006).</i>	Professional reasons: Work related pressure to undertake study; for career progression; to keep up academically; to keep up with better qualified staff. Personal reasons: for academic stimulation; personal satisfaction; to continue after previous study.	Increased knowledge; For career progression; To keep up academically; To keep up with better qualified staff; To continue after previous study.

Table 7: Summary of findings from studies discussing nurses' motivation to undertake CPE and their links with the study reported in this thesis.

The main significant motivators reported in these published studies which seem not to be identified by my participants were related to increasing quality of patient care, increased use of evidence-based practice or developing practice.

The similarities between the motivational forces that drove my participants to undertake the course and those that were cited by comparable studies conducted in six other countries, (none of which were specific to psychiatric nursing - Table 6), was an unexpected finding. Earlier in this chapter, and in Chapter 6, it was established that both internationally and locally psychiatric nurses are often portrayed as 'poor relations' within a wider health care system, perceived by some as little more than custodians by other professionals and even in some cases by the patients and society they serve and looked down upon by their general trained peers some of whom who hold a low opinion of them. Inherent within these disparaging perceptions is the idea that there is an antipathy by nurses working in psychiatry towards academic advancement. But my findings refute such perceptions since the motivations of my participants clearly parallel international health care professionals when it comes to CPE. The parallels indicate that irrespective of any local challenges or variables which may conceivably influence motivational factors, such as a prevailing country specific culture, or socio-political influences, organisational culture and so on, the Maltese nurses in this study reported that they were driven to participate by precisely the same complex array of factors as other health care workers internationally.

7.3.3 Summary

The findings of my study are by and large consistent with the published body of literature which addresses motivational factors to undertake formal, post registration education. Whilst these findings answer the question of which factors influenced them to undertake a post qualification degree in psychiatric nursing, they raise another provocative one. The majority of participants in this study did not choose to pursue a career in psychiatric nursing, yet nonetheless found themselves working within a psychiatric hospital. Despite this unsolicited career path, all of them, after differing periods of time, showed a strong positive interest in pursuing the Diploma to BSc course in this speciality area once it became available. Later in this chapter it will be seen that despite achieving personal gains, none of the participants believed that successful completion of the course has led to a concomitant improvement in the nursing care of patients within the hospital where they work, though this would irrefutably have been the primary aim of the education providers and the health care organisation funding and supporting attendance for the course. So the question now is: since these Maltese nurses started from the same point as many other health care professionals in terms of *why* they wanted to follow the course – why did this not bring about change in practice? In a workforce that is increasingly graduate level dominated, I must ask what the participants of my study perceived to be the reasons for the lack of improvements in patient care? This issue will be addressed by answering the third and final research question.

7.4 What do BPN's perceive to be the factors that impact their working practices after having completed a BSc in Psychiatric Nursing?

The ultimate aim of continuing professional education is to enable nurses to enhance the care that they provide to patients (McCarthy & Evans, 2003). In this study, participants individually identified differing levels of personal growth in knowledge, skills and attitude after undertaking the BSc. Increased self-confidence and communication skills and greater knowledge in areas such as symptoms of mental illness and medications used in psychiatry, are aspects which they perceive to have translated positively, albeit minimally, into their working practices. This suggests that patient care at least indirectly and possibly intangibly, benefitted in some ways from the nurses undertaking the conversion course. In a study with very similar objectives as my own, McCarthy and Evans (2003) assessed the impact of further education as perceived by nurses and midwives in Ireland, who had all followed higher diploma and degree programmes. Their findings concur with those of my study in that their degree participants also reported similar personal benefits as those mentioned here, such as increased knowledge and confidence and improved communication skills in general.

However the participants' in my study unanimously assert that no positive changes in the *collective* working practices of nurses, and consequently no widespread, tangible improvement in patient care, occurred as a result of the significant number of nurses undertaking the (general) diploma to (mental health) degree course.

The participants ascribe a number of factors within their professional practice environment as negatively affecting their working practice, factors which they

perceive as being present *before* and *after* they completed the course.

Collectively these factors are reported by the participants as being the barriers which prevent their practice developing as a result of undertaking the degree course.

7.4.1 Professional practice environment

The term 'nursing professional practice environment' is explained by Hinno (2012) as describing a complex and multidimensional construct, encompassing several components and the relationships between them. El Haddad et al., (2013), explained that it is a concept that arose in the 1980's stemming from a growing international concern about the lack of people entering nursing as a career. Researchers were eager to establish which organisational characteristics were likely to attract and retain nurses (El Haddad, 2013). As one might imagine the list of characteristics can be extensive and in the absence of a definitive list of characteristics, different researchers have tackled the concept from numerous stances.

Lake (2002), described the term *professional practice environment* as referring to "*the organizational characteristics of a work setting that facilitate or constrain professional nursing practice*" (p.178) Similarly Lambrou et al., (2014) defined it as being "*... a complex social environment where nurses carry out their practice*" (p.299). Lambrou et al., (2014), stated that the term *working environment* is used interchangeably with *professional practice environment* and say that:

... the working environment generally could be described as the place, conditions and surrounding influences in which people carry

out an activity. In the case of health care it refers to a set of concrete or abstract features of an organization, related to both the structures and processes in that organization that are perceived by nurses as either facilitating or constraining their professional practice. (p.299)

In this present study the participants perceived several concrete and abstract organisational features as negatively impacting their working practices. For the purpose of discussion these can be grouped into three key themes: professional relationships; relationship with management; organisational culture which will be discussed in the next sections.

7.4.2 Professional relationships

The 'consultant led medical model' is a familiar and longstanding organisation of work within health care in general and as described in earlier sections of this thesis, is an approach to patient care and treatment whereby patients are admitted to hospital under the care of a particular clinician. The clinician, in this case the Consultant Psychiatrist, heads up a multi-disciplinary team consisting of professionals such as a social worker, a psychologist and an occupational therapist. The nurses are not part of the core team since the team is peripatetic, visiting patients in whichever ward they are based, whereas nurses are deployed to a particular ward.

In an early relevant research paper regarding medical dominance within UK psychiatry, Samson (1995) asserted that psychiatrists have been the most powerful group in defining mental illness, determining which patients ought to be admitted to hospital and under which administrative and legal powers they are held. After conducting an ethnographic study amongst psychiatrists and

hospital managers, Samson (1995) found that psychiatrists perceive themselves as both intellectually and clinically superior to other professionals in the field of psychiatry, based largely on the self-belief that not only are they uniquely able to diagnose and treat mental illness, they are also best placed to handle psychological, social and interpersonal issues with which the patient may present. These perceptions seem to be very much in play in the local context of my study. Participants describe the Consultants as '*God like*' and with '*every decision about the patients*' being made by doctors, who are seen to yield complete power over the entire life of the patients they treat. Moreover, Samson observes that since historically psychiatrists have been the "*organisers, supervisors and regulators*" (p.247) of other allied professionals, their dominance extends beyond the power that they yield over patients to encompass other professional groups. Again, this stance is reflected by the participants of my study, who give examples of being completely disregarded by the consultants, who '*expect nurses to follow their orders unquestioningly like servants*', even to the point whereby one participant said that nurses are '*invisible*' to the psychiatrists. Yet Samson (1995) and Brimblecombe (2005), were of the opinion that certainly within the UK, policy changes such as (psychiatric) care in the community, a managerial reorganisation of health services and legislative empowerment of groups of professionals who were previously subordinate to doctors, contributed to what Samson refers to as '*a fracturing*' (p.245) of medical dominance.

Castledine (2005) agreed with this analysis, saying that:

The state of the doctor/nurse relationship today remains very variable. There is no doubt that things are changing and a new culture of collaborative practice is emerging. (p.3)

These opinions are also echoed in my study, as the participants acknowledge that more recently trained psychiatrists are found to have a more inclusive, respectful approach towards nurses and at times, albeit rarely and somewhat superficially up until now, encourage participation from the nurses when planning and delivering care.

So according to the published literature, at least in the UK, a change in the relationship between psychiatrists and nurses became apparent at least twenty years ago, due largely to changes in organisational management and changing trends in care delivery. Locally however, the relationship between nurse and psychiatrist remains by and large one of dominance in favour of the psychiatrist. This relationship features in the stories and experiences of my participants as a significant bone of contention they hold in relation to their workplace conditions in the context of this study. For many of the participants, a major motivating factor for undertaking the diploma to BSc course was, in their own words - "*to challenge*" the psychiatrists, in the hallowed arena of ward round, although quite how this challenge was to be executed was not made clear. As explained elsewhere in this study, ward round is the weekly ward visit of the consultant psychiatrist and his multi-disciplinary team to each of the patients under his/her care. The majority of the participants appear to attach a great deal of meaning to these ward rounds, specifically related to the attention given by the psychiatrists to other professionals present in terms of inviting their input as opposed to the perceived exclusion of nurses. Castledine (2005) observed that:

The ward round is a ritual and symbolic of medical power within a hospital, sending a clear message to patients (and I would suggest – everyone else present), that the consultant is the top of the hierarchy.
(p.3)

This symbolism is definitely reinforced when the psychiatrist sends the nurse to make the coffee or introduces everyone present, barring the nurse, to the patients and their relatives, both of these examples being experiences reported by the participants in this study.

The question of why the medical model with its attached meanings and apparent disregard towards nurses continues to be the predominant approach to organising patient care within Maltese psychiatric services is interesting and is answered in part by the participants themselves. Whilst the current situation is a source of frustration for some, if not most of the nurses, the participants in my study seem to be of the belief that the majority of nurses do little to take their place at the table so to speak, they are said to enter ward round ill-prepared and have nothing of relevance to contribute to the discussion of the patients' care and treatment and hence are easily overlooked by the psychiatrist and the team. Furthermore, the fact that the psychiatrists are not criticised by the nurses when being asked to make coffee or act as ushers by opening doors, gives them impunity to continue as they always have done. But as Castledine (2005) remarked: "*nurses have not been (professionally) socialised for such (collaborative) roles in their (nursing) preparation*" (p.3). As my findings show, it was not too long ago that nurses locally stood to attention in deference when doctors entered the room, so the thought of confrontation regarding their attitude towards nurses is perhaps a little too much to expect in the present day although there was

some indication that a small number of the respondents were starting to make themselves heard within the ward round arena. Moreover, apart from this obvious self-subjugation by the nurses, as noted by Samson (1995), medical dominance is dependent upon alignments of political and cultural power. Undoubtedly within Maltese society doctors, especially consultants, are revered and held in high regard, both within the health care system but also by the general public. Their elevated status within psychiatry is also enshrined in legislation, since in both the previous Mental Health Act (Malta, 1981) and the current Mental Health Act (Malta, 2012) it is the psychiatrist, as 'Responsible Specialist' who is held legally accountable for all aspects of care and treatment given to people during their time as either in-patients or whilst on-leave from hospital in the community. This state of affairs also explains in some way why psychiatrists are perhaps reluctant to relinquish any aspect of the care and treatment of their patients, since ultimately they may be held responsible for the actions of other professionals involved in the case.

Dissatisfaction with the medical model is not restricted to the nurses' relationship with the consultant psychiatrist but extends to the other professionals who make up the multi-disciplinary team. In fact, whereas there is a certain amount of respect for psychiatrists, this is not the case for the rest of the team. My participants barely attempt to conceal their disdain for the psychologists, social workers and occupational therapists. Perceiving that these professionals do not respect either nurses' qualifications, experience or ability to participate in the care planning of patients, nurses seem to regard them as opponents whose views are given credibility, when in fact it is nurses who clearly know the patients best, not least because it is

nursing staff that are with the patients 24 hours a day, dealing with the most acute situations, whereas the team members are rarely directly involved in patient care and exit the area as soon as problems, such as aggressive behaviour, arise. These views of feeling undervalued and under respected by the MDT are not limited to the local context and are comparable with previous nursing research. For example, in a similar study to my own, conducted in Ireland, Clodagh Clooney (2008) also found that one of the reasons that nurses there were motivated to undertake a third level academic course was to be on par with, and gain the respect of, the MDT members, based on a feeling that these members viewed nurses as apprentices rather than equals. Likewise the nurse participants in Megginson's (2008) phenomenological inquiry into incentives and barriers to undertaking a conversion BSc, described credible professional identity (defined in her study as the inherent respect, based on educational level) as a distinct view of degree level nurses held by others and this was a key motivator which underpinned her participants decision to embark upon the degree programme.

The findings of my study suggest that achieving the degree was not in itself a means to an end, for example there was no clear impression that getting the degree was the first step in a process of developing themselves as a profession and raising their professional image. Rather the degree was an end in itself. It is clear that the participants in my study felt that by merely undertaking the degree course, and matching their academic level with at least that of the members of the multi-disciplinary team i.e. having a first degree, their status would be automatically enhanced and their opinions heard. But in fact there were very few examples given of occasions where

the nurses have visibly applied their new found knowledge or skills which, had these been more evident, may influence the perhaps negative preconceptions of the psychiatrists and MDT members about the value of nurses beyond having a custodial role. Only a few of the participants appear to recognise that by being passive and compliant, being *invited* to participate is not likely to happen and that ambivalence does little to raise their professional image amongst the other professional groups.

7.4.3 Relationship with management

Aronson, et al., (2003) conducted an extensive study involving over 3000 staff in a number of USA psychiatric hospitals (including over 500 nurses). Their study aimed to investigate the job satisfaction of psychiatric hospital employees. They concluded that, amongst a number of factors which affected job satisfaction:

Without question, the most important dimension influencing employee satisfaction in psychiatric hospitals is this: beliefs about the respect and integrity conveyed in management's actions and attitudes ... [namely] respect for employee input, openness in communication, operating ethically, responsiveness to complaints, and fairness ... (p.448)

The relationship between managers and their employees impacts the overall practice environment and influences whether employees remain within an organisation or not (Nichols, 2003). Whereas retention of nurses in the local context may not be as much of an issue as in other countries (as noted earlier there are very few options for moving on to work elsewhere), this

relationship is none the less significant since the job satisfaction of nurses can have immense bearing on the workplace. Nichols (2003) stated: “*An unhappy workplace is typically characterised by low motivation, high absenteeism and rapid staff turnover*” (p.34). Nichols (2003) described three qualities that attract and retain staff within a health care organisation. These are:

- A good reputation and a good working environment
- Strong management and quality leadership
- Well defined employee roles and expectations

Nichols (2003) said that nurses seek to work with managers who are supportive and foster communication, and who display a commitment to the welfare of their nurses. Additionally, nurses require a clear definition of their roles and the management’s expectation of them. Nurses expect their managers to be present and knowledgeable about their work and they look to be afforded responsibility concomitant with their expertise.

Whilst acknowledging that my participant’s views only represent one side or perspective of the relationship that exists between the nurses and the management of the study area, my findings clearly show that, in the apparent absence of any of the attributes mentioned in the studies discussed above, the nursing/management relationship can be at best described as at times dysfunctional if not totally fractured. Comparing the participants’ experiences of the hospital management with the writings of Aronson (2003) and Nichols (2003) above, the opinions of the nurses in my study, suggest that the

management do not demonstrate any of the attributes expected by nursing management.

For a number of years the respective CEO's of the hospital have had no relevant health care management background. (There have been five CEO's in the past seven years up to 2018). Looking at the local press reports at the time of some of the more recent appointments, provides an insight into their backgrounds prior to being placed in charge of the psychiatric hospital:

The Labour election candidate and former mayor of Msida (a 29 year old lawyer)... now entrusted with running the country's mental health hospital, has told MaltaToday that his role is to be purely administrative. (Balzan, Malta Today, 2013);

Surgeon ... has been appointed acting CEO of Mt Carmel Hospital, after the post was vacated by (Labour Party) MP (The CEO is) ... a resident specialist in cardiothoracic surgery at Mater Dei Hospital". (Camilleri, Malta Independent, 2016);

Mr X has been appointed CEO of Mt Carmel Hospital, the Health Ministry said. (He) is a member of the Chartered Institute of Bankers and for many years worked in the senior management of a local bank. He is currently a board member of (two organisations) and ... He was formerly chairman of (another company) where he handled the liquidation of the company. He is also the Labour mayor of Sta Venera. (Caruana, Times of Malta, 2018b).

This lack of experience in psychiatry and no apparent knowledge of nursing practices is seen by the nurse participants as the hurdle in developing a working relationship between the two factions, as the nurses feel that

someone without an appreciation of clinical/psychiatric matters cannot hope to understand their perceived stresses and struggles of their daily work. Irrespective of whether or not one is of the opinion that hospital managers should hail from a clinically specific background, the reality is that healthcare organisations have been faced with the need to reshape their traditional management models in an attempt to control costs and improve efficiency and outcomes (Nassar et al. 2011), and it is for their abilities in these areas, that hospital managers tend to be employed, which perhaps speaks to the reasons behind at least two of the local hospitals CEO appointments (experience in finance and law). I suggest that the dissatisfaction with the managers' lack of direct clinical experience may have been mitigated somewhat had the other factors Nichols described, (good reputation; good working environment; strong management; quality leadership; well defined employee roles and expectations) been in place. But the experiences of the participants present a clear picture of a management system that does not communicate with its nursing staff. Unaware of the organisations aims and vision, a lack of policies, procedures and even a job description have all resulted in the nurses feeling that they are marginalised, in effect invisible to the management, without voice or guidance.

One of the few occasions that the participants feel that they are acknowledged by the management is when something goes wrong. A commonly recurring theme throughout both the focus groups and the interviews, was the ever-present notion of a blame culture within the hospital. Khatri et al. (2009) claimed that a blame culture is more likely to exist within health care organisations that operate hierarchical, compliance-based functional management systems. Wand (2017) seemed to concur when he

stated that a blame culture evolves from a control-based style of management, in which adverse events are dealt with by increased monitoring of employees and are regulated by means of various control mechanisms. Wand (2017) went on to say: “*The culture of blame imposes a poisonous and paralyzing power on mental health care and service delivery*” (p.4), and this a view which is upheld in my participants account. They describe a strongly felt blame culture, so much so that they are reluctant to take even minor decisions that are well within their abilities and scope of practice. According to Khatri et al., (2009), health care organisations need to develop a culture that harnesses ideas and resourcefulness, by employing an empowering management philosophy rather than crushing employees by overregulating their behaviours using a control-based philosophy. The managerial approach described by my participants prevents the nurses from trying anything new or deviating from the norm since as one participant observed, should it fail they would be ‘*condemned*’. Based on these commonly held perceptions, it is not difficult to understand why nurses feel that they cannot implement evidenced based practice, or translate into practice, knowledge that they have acquired in their conversion course.

7.4.4 The rules of the game

So far in this section, the relationships between the participants and other professional groups and the hospital management have been discussed, painting a picture of the prevailing culture of the organisation in which this study takes place. This has thrown some light on how local organisational culture may impact nursing practice and potentially support or hinder nurses from developing their professionalism and applying theory and skills they

have acquired during their conversion course. The nurses' described the organisational values and practices of the hospital in this study as being defined by a rigid hierarchy, marked by an absence of organisational communication, strict control and sanctioning of staff and little expressed appreciation of nurses within the organisation. But organisational culture is not something that is wholly imposed upon nurses, indeed the nurses themselves are not passive onlookers in the perpetuation of the hospitals culture not least because they represent the largest group of health care workers within the organisation.

Perhaps one of the most commonly employed definitions of organisational culture is that it is "*the way we do things around here*" (Lundy & Cowling, 1996; Davies et al., 2000). Yet another loose, also simplistic definition was provided by Sullivan and Decker (2009), who described organisation culture as "*the unstated rules of the game*" (p.27). These two albeit minimal characterisations seem to resonate with the accounts of my participants when interpreting their contribution to the prevailing culture which influences their attitudes, guides the nurses' behaviours and underpins their daily practices.

The collective accounts of nurses in both the focus groups and the individual interviews give a strong impression of a poorly motivated occupational group, who harbour strong feelings of being devalued and disempowered by those occupying the higher echelons within the organisation. However there was very little indication that they offer any resistance to the current state of affairs, but rather perpetuate the status quo. This issue has already been discussed in relation to their interactions with other professional groups, but it is also apparent in the way that they organise their own working patterns.

Manojilvich and Ketefian (2002) discussed the effects of organisational culture on nursing professionalism. They stated that organisational aspects often conflict with the practice of professional nursing. However in my study whilst the impression conveyed by my participants is that a small number of them are emerging as competent professionals, who are ready, willing and able to challenge the status quo were it not for the restrictive operational systems in place, for the majority of nurses pushing the boundaries of their current role is out of the question, indicating that they are not actively pursuing a professional role. Paradoxically, whilst verbally decrying the predominance of a task orientated, routinised care delivery approach, their self-reported work behaviours indicate that in fact this approach is seen as a necessity by nurses, both in terms of working with limited resources but primarily as a means of avoiding problems or having to deal with unexpected occurrences which may necessitate on the spot, autonomous decisions. The latter are to be avoided at all costs since the fear of recrimination by management if things go wrong is a strongly felt concern that impacts most of what they do on a daily basis. But I venture that apart from this persistent concern, there is an element of personal comfort tied in with the adherence to tasks and routines. A commonly inferred goal of nurses was to pass through the day without problems occurring, furthermore some participants acknowledged that staff breaks took precedence over interaction with patients as did meeting their own basic needs before addressing those of patients. Therefore there is a certain advantage in not implementing patient centred activities such as facilitating group discussions or one to one interventions as these could impinge upon the well-established daily running of the ward which might favour the nurse's needs above the patients. This

staff centred approach appears to form the backbone of the nursing culture. Glisson and James (2002) stated that organisational culture sets out the way work is approached and these beliefs and expectations are then the basis for socialising employees in the way things are done within the organisation. Manojlovich and Ketefian (2002) stated that professionalism is instilled in new nurses through a process of socialisation that begins in formal nursing education and the values and beliefs regarding what it means to be a nurse are then either developed further or alternatively abandoned after the student nurse commences employment. This particular viewpoint lends itself well to the accounts of my participants as they describe how new nurses are integrated into the workforce (as they themselves once were). New general trained nurses are perceived as naïve, new psychiatric nurses are deemed *useless*, and with both groups their inexperience is considered as likely to cause them to make mistakes. This is problematic for nurses as they fear that the consequences of mistakes will result in management apportioning blame onto them. Therefore in the absence of any formal organisational measures to facilitate induction of new staff, the nurses take it upon themselves to pass on the baton as it were, as new staff are acculturated from day one as to the informal rules and ways of organising their work. The nurses perceive this as a *responsibility*, and significantly this is perhaps only one of a couple of times throughout their entire accounts that the participants acknowledged any kind of individual responsibility as part of their nursing role, signifying the level of seriousness that the nurses give to this perceived obligation. The local application of *the way things are done around here* attitude is exemplified in one nurses account of what advice she would give to a new nurse – *you have to do what the staff tell you because you are new*

here, and by another, who would advise – *stick to the system in our ward*. A point that was not acknowledged by my participants was that these new nurses, in addition to being instructed in behavioural expectations are exposed, also from day one, to the attitudes of the existing nursing body. Scammell (2018) explains that organisational culture is made apparent in:

“... shared routines and rituals; it reflects staffs’ values and beliefs revealed through... the way staff act, talk and think (the latter often apparent in choice of language)”. (p.263)

An illustration of Scammell’s view is found in this study in the way that the participants talk about their patients. In relaying their stories, my participants gave the impression that patients are something of a hindrance in the sense that they are either people to be pitied, or alternatively undeserving of their time and attention, people who are aggressive and hence feared, or standing in the way of their routines. These types of stigmatising attitudes towards patients are poles apart from the modern day perspectives of people with mental illness and contemporary approaches to their nursing care in which nurses are tasked with ensuring that *“the treatment and care of people with mental health problems is informed by evidence of the diverse range of causation, care, and best practice”* (Kellehear, 2014, p.141). The possibility of working against the established routines and pervasive attitudes towards patients, even if one is an established member of the nursing team and not a new nurse, was deemed improbable by some participants, who emphasised that they *have to* maintain the time bound routines, even at the expense of losing valuable therapeutic opportunities with patients, or else they will face the ire of their colleagues. Moreover the expectations of the management are that they provide a custodial role and therefore there is no personal or

collective mileage in breaking ranks and pushing for changes within the established order or work. The consequences of existing nurses not observing the unwritten rules and working contrary to their peers, was not explicitly stated by the participants, but can be assumed from comments such as: *what happens here you have to keep to yourself and one nurse should never report another*. In the case of new staff breaking ranks, the reaction was unambiguous: new nurses have to decide from the very start of their working life within the hospital whether or not to follow the working patterns or else *they are not treated very well*. One can only try to imagine the first impressions of new nurses on their first few days of work. Taking into account that most new nurses have been, and are likely to continue being, general trained nurses who have had limited exposure to both theory and practice in psychiatric nursing, and very possibly are at the very start of their nursing career, and yet to develop their own attitudes and behaviours towards mentally ill people, it is easy to see how traditional approaches to both the patients and their nursing care are perpetuated as the novice nurses abandon their theory based values and beliefs in favour of going with the flow in order to survive in an environment that is both alien and potentially threatening to them.

Spencer-Oatey (2012) stated that culture not only influences the behaviour of each member of the organisation but it also influences how they interpret the meaning of other people's behaviour. The issue of other people's behaviour, specifically that of their peers, led to an interesting observation arising from the responses of my participants when they were suggesting reasons why they cannot initiate change and implement practices aimed at improving patient care. They tend to apportion a certain amount of responsibility or

blame for this on their fellow nurses, who they perceive as having negatively impacted their ability to translate their newfound theory into practice. The participants interpreted their peers' behaviour as ritualistic and non-pliable and that they shirked responsibility, opting for the easiest approach to care rather than the most effective. Rather interestingly, none of the participants identified themselves as part of this resistance group who are seen to be holding back the tides of change. Instead most of them seem to perceive themselves as on the side lines, neither impeding change nor championing it. My interpretation of this stance is that it is comfortable for nurses to hold this self-perception – as it shrugs off any individual responsibility towards implementing change. I also consider that it is a misnomer that any nurse can truly be positioned on the side lines as a spectator to the cultural milieu since the predominant culture incorporates each of them, and therefore if they are not themselves change agents or at least supporters of change agents, their ambivalence renders them as part of the resistance group which they have condemned in their accounts.

For decades researchers have looked at the notion of organisational culture as a way to explain the more perplexing and irrational aspects of what goes on in organisations (Schein, 2004). Another perplexing aspect that is woven throughout the participant's stories is the preoccupation of nurses with the notion of a dominating and oppressive blame culture within their organisation. Their obvious fear of being blamed, and punished, seems to permeate every aspect of their work, and significantly for this study, stands as a substantial stumbling block to the possibility of developing their professional role, implementing change, increasing their autonomy and so on. However, it is noteworthy that throughout their accounts they did not, as

one may well have expected, validate the existence of an aggressive blame culture by providing examples of any actual consequences or punishments being meted out by higher management. In fact, in giving an account of a serious untoward incident, one participant described how management had shut down the participant's attempts to formally report the incident and *wanted to cover things up like the old way*, implying that serious actions were not taken against the offending staff member. I am therefore led to conclude that perhaps the threat of being blamed and suffering untold consequences is something of an urban legend or myth amongst the nurses. Urban legend is defined as an often shocking story or anecdote of ambiguous origin, which is based on hearsay and widely circulated as true (Merriam Webster, 2018). What is not established in this study, is why this may be the case. Certainly the idea that nurses are too intimidated to break ranks or try to act outside the very set boundaries of their current role may well to be one that would appeal to a strict and domineering management who wish to exert total control on their staff. But in this instance it is the nurses themselves who continue to maintain the myth, and the possible reasons are less than clear. Perhaps for some nurses the risk of incurring adverse consequences is used as justification for not extending their role, or making more work for themselves. Others might recall much earlier times when nurses were actually sanctioned for unfair reasons (such as the politically motivated transfers some of the participants described) and are fearful of the return of such consequences. Some nurses may not feel qualified or able to initiate change, perhaps still internalising the *doctor knows best* model that prevails locally and therefore they cling to the myth as a safeguard from being

pressed to make changes beyond their abilities. However without further research this remains a puzzle yet to be solved.

7.5 Summary

In addressing the question of what factors impact their nursing practices after they have completed the conversion course, the participants have described a complicated interplay between nurses, other professional groups and organisational management style and systems. In deconstructing the complex perceptions and accounts of the nurses, this study has highlighted a number of stumbling blocks which together result in a practice environment that is perceived as being unamenable to nurses initiating change in their care practices.

Nightingale (2018) in a discussion paper about the development of organisational culture in health care appears contemptuous of the simplistic definition of organisational culture as being *the way things are done around here*. She is of the opinion that this definition:

... infers that organisational culture is not accepting of change and that the culture is static rather than evolving. It implies that new people entering in to an organisation will continue to work in the existing way, rather than bringing new ideas and ways of working.

(p.54)

Ironically, what Nightingale sees as the limitations of the definition, seems to be a more than adequate expansion of the definition which is most aligned with the prevailing culture of the organisation in my study.

Nurses are so entrenched within the culture of their organisation that they do not acknowledge their own contribution to perpetuating the disempowering culture. At this point in time a fractured relationship with management and other professionals appears to share only one commonality, which is that neither nurses, doctors, allied professionals or the management seem to have any expectation from nurses beyond maintaining a custodial role and ensuring the smooth day to day running of the ward.

Unlike other countries the impact of a poor practice environment may affect nursing retention, locally the limited possibilities for moving on to a new work place results in a largely disenfranchised, poorly motivated workforce.

Although pockets of discontent about their working environment and practices, and their image as a professional group are evident amongst the nursing body, this is at a very premature juncture and is not yet significant or empowering enough to have driven any real change in approaches to patient care by nurses. There seemed to be two predominant schools of thought as to why significant change has not occurred as a result of a large number of nurses undertaking the degree course. Firstly there is the opinion that research and theory is all well and good but that it does not apply locally since there are insufficient resources and an overwhelming lack of organisational support and too many organisational barriers to implement it; secondly there are those nurses who believe that research and theory is novel and interesting but that it cannot compete with hands on experience, a stance described by Clarke (2003) as the "*evidence in their eyes*" (p.14) referring to situations whereby something has been seen to work consistently, and so it then acquires occupational currency amongst psychiatric nurses.

The impressions given by the descriptions of the practice environment and the participant's personal experiences within it are worryingly reminiscent of descriptions of early day asylums such as those found in the work of Goffman (1961), in which unquestioning attention to tasks and routines are the primary means of organising the nurses' work, where staff comfort takes precedence over that of the patients and the patient is perceived less as the ultimate focus of their practice and more as a burden to be carried.

8.1 Introduction

This thesis has explored the stories and experiences of a group of registered general nurses who have successfully completed a post qualification degree in mental health nursing, with the intent of establishing how they perceive and experience their current role as psychiatric nurses, what factors motivated them to undertake the course and the ways in which achieving the degree may have contributed to changes in how they practice and deliver care.

Chapter Two provided an exposition of the background and development of the social, cultural, political and environmental milieu in which this research was conducted, thus establishing the context and lived experiences of the locus of the research. Chapter 3 explored core issues directly related to the central topics of psychiatric nursing and CPE. Chapter 4 outlined the decision-making processes used to inform the selection of a research strategy and Chapter 5 provided a detailed description of the steps taken to conduct the study presented in this thesis. Chapter Six provided a comprehensive reporting of the accounts of the participants from the focus groups and individual interviews, followed by an analysis of the participants' accounts in Chapter Seven which also presented and discussed those accounts in relation to the research questions, utilising extant literature to locate the findings in the established field of study. In drawing this thesis to a close, this current chapter provides a reflection of the main findings, drawing together the major features of Chapter 7 and, importantly, highlighting the implications of these for nursing practice, nurse educators, patients,

organisational stakeholders. Based on the implications, practical and research recommendations will be made. Consideration of the originality and contribution of the study and findings will lead to an exploration of its strengths and limitations. Finally, the chapter concludes with some deeply personal closing reflections.

8.2 Main findings

Multiple elements of the historical, political, social and organisational milieu of psychiatric nursing locally have been identified as directly influencing the attitudes and daily working practices of nurses both prior to, and after completing a post qualification degree in mental health nursing. These inter-related elements are intricately woven together, and although they have been separated here for the purpose of discussion, they present something of a causality dilemma as it seems that each component acts *on* and reacts *to* the others in a manner that makes it challenging to distinguish cause from effect and vice versa.

In common with their international counterparts, the nurses' accounts in this study reflect a pervasive ambiguity in relation to their role as psychiatric nurses. This is consistent with what is already known about the tensions related to the role and the absence of a tangible and unique contribution of psychiatric nursing within the sphere of mental health care. The only unique aspect claimed by the nurses in this study was that it is they who spend the most time (in hours) with the patients in their care. The majority of participants seem incognizant of the fact that in the absence of therapeutic interventions with their patients, in all likelihood this renders them as little

more than custodians, reminiscent of those described in the early accounts of psychiatric institutions of old.

Hand in hand with role ambiguity, the nurses appear to possess very little professional image. Whilst it was shown that the low professional image which prevails amongst the participants in this study is reported elsewhere within the literature as a common characteristic of psychiatric nurses, no related nor comparative literature could be located which described nurses, like most of those represented in this study, who have been motivated to further their studies but appear to hold no aspirations to develop their professional image and role upon completion of their academic course. An additional commonality shared with nurses internationally was the motivational aspects which led the participants to follow the conversion course in the first place, which suggests that the individual motives of nurses to pursue continuing education prevail regardless of location, culture or background. However, unlike their international counterparts, for the majority of psychiatric nurses in this study the attainment of the degree itself appears to hold more personal and professional value than the skills and theory they learned, these being perceived as largely irrelevant in their present day role. This outlook may stem in part from the *'what's in it for me'* attitude that Boissevain (2013) suggested was characteristic of many Maltese people. Upon completing the degree, nurses are eligible to automatically shift to a higher nursing grade with an associated raise in salary. They also receive a small monthly allowance and are able to claim points which are awarded to candidates applying for a more senior post such as ward manager. Therefore completing the degree guarantees all the associated financial bonuses and it seems that at that point, when there is no further personal gain, their interest

abates and they revert to the care practices with which they are most familiar and comfortable. Moreover, the majority of the nurses reported that they did not choose to maintain nor continue to build on their new knowledge and skills base is puzzling, because knowledge is dynamic and in healthcare in particular, some things become outdated relatively quickly (such as new medications used in the treatment of mental illness) and failing to update themselves will surely result in skill deterioration which in itself can threaten the sought after promotions and associated rewards.

Since the opening of a formal nurse training school was first opened in Malta in the 1960's, it is general trained nurses who have been the mainstay of the nursing body at the psychiatric hospital. The literature reviewed in Chapter 2 shows that for many decades it appears that very little attention was given in the curriculum in relation to the care of the mentally ill patients. Some of the participants in this study undertook their general nurse training more recently, when the number of combined taught and practice hours had increased, however, the lack of preparedness that general nurses said they continued to feel when sent to take up posts within the psychiatric hospital seems to imply that the academic body which holds responsibility for nurse education did not adequately prepare them for their new roles. Some participants in this study reported that they were unaware of even the basics such as the types of mental illnesses and stated that they had no knowledge about the medications they were administering. This lack of preparation of nurses by the academic body is also apparent in relation to the BSc conversion course which the participants in this study undertook. There is no indication that the academic institution, in developing or delivering the BSc conversion course, recognised the immense impact of the organisational

culture on the ability of nurses to influence changes in practice within their workplace. The ensuing chasm between theory and practice resulted in the majority of nurses concluding that the course content was not applicable to their work and suggesting that the BSc, as one participant said, “*meant nothing per se*”.

Whereas evidence based theory is considered extraneous by many of the participants in this study, years of working experience and individual intuition, are held in high regard by the nurses who reported that they considered these to be indicators of competence and ability. Vicarious learning seems to form the main mode of knowledge transfer in the workplace of the nurse participants, thus creating an environment where tradition based practices which are ineffective in the rehabilitation of people with mental illness, are propagated. Further, here is a risk that such practices - which do not keep pace with modern psychiatric care and therapies - could be considered abusive, as they stand in polar opposition to more effective research-based, patient-centred practice. Nurses in this study seemed unaware of the inherent risks of relying solely on experience and intuition rather than taking advantage of evidence-based theories and assessments, as was illustrated when the participants said they discounted validated assessment tools used for assessing risk of suicide or self-harm.

The working day of nurses in this study appeared to be dominated by firmly set routines, with suggestions about of changing these rejected. The nurse’s comments indicated that they were entrenched in task oriented routines which left little time for therapeutic work and caring aspects of their role. Patients, it seemed, were at times perceived by participants as either objects of pity or as interruptions to the nurse’s routines. The participant’s reports,

indicated that patients were often informally categorised by imprecise gauges such as their potential to disrupt the day (in differing ways) or their potential to become violent or suicidal. On occasions some nurses reported that some patients were considered not truly requiring hospital care.

The image of nurses as custodians providing a highly routinized, task orientated approach to patient care is not one that is exclusive to the nurses in this study. This representation is reinforced within their professional relationships with medical staff and allied professionals. The impression given by the participants as a whole is one where they feel that their nursing knowledge, skills and abilities are devalued and underutilised of by other medical and medical-related professionals. This suggests that medical hegemony endures within the local context and that nurses are not only subject to subordination by doctors but also marginalised by other related professionals. Despite a growing frustration of this lack of recognition, only a few of the participants in this study reported that they made any concerted effort to challenge the attitudes and approaches to which they are subjected. Some nurses said that they believed that achieving a graduate level of education would automatically elevate their status, even in the absence of any tangible change in their behaviour and practice. According to the nurses reports of their practices and beliefs, the apparent lack of effort to showcase their nursing knowledge and skills resulting from their specific graduate-level mental health CPD, seems to reinforce the attitudes and approaches of the doctors and allied professionals. Thus, there appears to be something of a missed opportunity since some of the participants acknowledged that more recently appointed consultants are more likely to include nurses in care

planning and decision making – replacing the previous regime where nurses were sometimes ignored by consultant psychiatrists.

The bureaucratic management styles adopted by a rapid succession of managers over the years was identified by the participants as one of the most significant factors that inhibited nurses improving their practice upon completion of the conversion course. Nurses stated that what they identified as imposition of authority and control of procedures and practices by the management, led to dissatisfaction and distrust amongst the nursing workforce. Nurses conveyed that their perceived lack of autonomy or support to utilise their knowledge and skills added to their sense of frustration and disempowerment. This appears to have created a general acceptance amongst the nurse participants, of their diminished status within the organisation, which in turn, had led to an absence of impetus to challenge themselves or push at the boundaries created by the management style. This seems to have resulted in a collective resistance to either implement or accept change.

It seems that, by failing to recognise or utilise the potential skills and knowledge that these nurses possess, hospital managers, have not capitalised on the substantial organisational investment in continuing professional education that should have positively influenced practice.

The issue of 'power' and power relationships across all aspects of psychiatric care and treatment has persevered since the inception of asylums at the end of the 18th century. Within the literature, the traditional and enduring, power imbalances between doctors and patients (Rahimi, 2012) and nurses and patients (Henderson, 2003, Cutcliffe & Happell, 2009) are frequently

acknowledged and discussed. The focus on power issues attends generally in terms of moving away from a biomedical approach to care - and reducing custody and control of people with mental illness - towards facilitating more balanced relationships based on empowerment and collaboration. Power imbalances are evident in the accounts of the participants in this study where a cycle of power and powerlessness can be seen to underlie themes that are woven throughout the participants' narratives.

Although as Barker (2009) noted, nursing is not commonly considered as being a powerful profession, power dynamics frequently come to the fore when considering relationships within nursing, particularly within mental health since the *therapeutic relationship* is considered as the core of psychiatric nursing (Barker, 2009). When one participant recounted that patients are not permitted to shower outside of the allotted time frames, and another spoke of withholding drinks, they exemplified the wielding of (one may contend – abusive) power by nurses towards patients. At the same time as describing situations where they appear to be wielding power, the participants described a picture in which they felt powerless within the organisation, unable to influence change or to fulfil their own potential. A pervasive sense of powerlessness appears to characterise each and every relationship in which nurses engage, be that with patients (when caring for people they do not perceive as *real patients*), medical professionals, allied professionals or the management of the organisation. The apparent unacknowledged relevance of this to the accounts given by psychiatric nurses is regrettable and shall need attention in future research, since As Pieranunzi (1997) noted: “*Powerless people and groups tend to acquiesce because it is difficult to effect change*” (p.156).

Issues of power are not the main focus of the study reported in this thesis, however, it is important to acknowledge that they are all pervasive and the findings need to be viewed in the context of power imbalances. Whilst those who provide care may perceive themselves as being powerless to effect change, in the context of their relationships with vulnerable patients they are often the dominant person in an imbalanced power relationship.

This study has provided a deep and contextual understanding of the nature and reality of the influences that may be impacting on the role of psychiatric nurses and affecting their capacity to improve their care delivery practices. The findings of the study give rise to practical and research implications that can help address the challenges highlighted. These will be addressed in the following section.

8.3 Implications and recommendations

The current image and practice of psychiatric nursing locally is not likely to positively raise the profile of psychiatric nursing amongst their general trained peers, patients, relatives and the wider society in which they live. This is likely to continue to negatively impact on recruitment of undergraduate psychiatric nurses and voluntary deployment of general nurses to the hospital. Therefore the current practice of enforced deployment, to address staff shortages, is set to continue for the foreseeable future. When nurses are placed in a hospital where they have not chosen to work, with patients whose conditions they have not been trained to nurse, there can be negative impacts on care practices. To counter this, increased exposure of nurses during their basic general nurse training, to evidence-based psychiatric nursing theory and practice is necessary.

Established nurses on a ward are a powerful influence on newly appointed nurses. It is clear from the participant's responses that from their first day of work, they are guided and instructed by other nurses and that this has, in this case, promoted the continuation of task orientated practices and custodial roles. There is evidence of a 'we do it this way because we do it this way' mentality to nursing practices and care routines. To counteract the deleterious effects of this vicarious learning, nurses could be required to undertake an orientation programme designed to bridge the gap between either their student status or their last work placement. Supportive practice environments that promote a culture of nurturing new nurses, can help reduce anxiety and stress associated with role transitions, ensure that new staff are clear about the organisations expectations of them and provide initial job training and information which will prepare them for the diverse challenges they can expect to encounter.

As stated earlier in this thesis, once a nurse becomes registered with the state council for nurses and midwives they remain registered for life. Many other countries such as the UK, have advocated a system of revalidation of registration for nurses every three years. Aimed at supporting a culture of professionalism, nurses in the UK are required to demonstrate that they deliver care safely, effectively and professionally, by meeting criteria such as undertaking a minimum number of hours of CPE, reflecting on their work and obtaining recorded feedback from colleagues, patients and other healthcare professionals (NMC, 2017). In Malta, nurses are not presently obliged to update their knowledge and skills – perhaps due to recruitment difficulties – and as has been shown, the participants in this study identified very few incentives for them to do so. Implementing a system of revalidation, which

includes investment in their professional development would serve to incentivise nurses in Malta to update their practices. Apart from attaching value to the work that the nurses do, revalidation will also raise public confidence by demonstrating enhanced professionalism and a commitment to striving for development in their work.

Related to this, is the absence of any obligation to disseminate the skills and knowledge received during the course. The majority of participants recounted that even the major research study they were required to complete had not been given any attention by hospital managers. This was the case when the research subject was related to policy and procedure developments taking place at the time, and participants explained that they felt demoralised by this lack of acknowledgement of their work, which could have made a contribution to change. However, not all participants were enthusiastic about participating in organisational policy development, and to change this might require further incentive. Nurses could be encouraged to share their knowledge, skills and achievements if the current system of awarding a higher pay scale for completing the course, were modified to include a component which requires nurses to take on a practical ward-based teaching role possibly linked to the earlier recommendation of providing orientation programme for new nurses.

A central theme in this study is the participants' stated belief that they perceived themselves to be unable to initiate or influence change, largely, they said, due to the complex organisational culture of their workplace. If this is the case, I suggest that nurses need to be better equipped to translate the course contents into the realities of their everyday nursing practice. The educational body responsible for curriculum development therefore might

consider including some content in the conversion course which addresses issues such as implementing and managing change in a hospital environment and the effects of organisational culture on individual and group practices and behaviours, offering practical and evidence based suggestions as to how nurses can apply their knowledge and skills to bring about practical and organisational change in their wards and hospitals.

Some of the participants in this study expressed frustration that it was often the case that other nurses in their own wards had prevented them from applying the skills and knowledge acquired from undertaking the conversion course. Furthermore it was also acknowledged by the participants that it might only take one person to inhibit the introduction of positive changes. Currently nurses who have completed the conversion course are located with not apparent strategy throughout the wards and units of the hospital, and they often remain in those wards and units where they were employed prior to undertaking the course. This can have the effect of diluting skills and knowledge which could weaken the impact of those nurses who are keen to implement new care practices. This could be addressed by deploying all graduate nurses to one area at a time, building capacity ward by ward. By declaring a particular ward a nursing development unit, whose main aim is to innovate and improve care practices, and by inviting applications to transfer to work there from graduate nurses only, this purposeful selection of staff would support those who wish to improve practice. Further, by encouraging nurses with the CPE experience to work together would be a strategic approach to raising nursing standards one ward or unit at a time. This approach could also inject an element of elitism amongst the nursing staff which may well serve to further elevate the professional image of the more

qualified nurses amongst their peers and other professionals within the hospital.

This study found no evidence of homogeneity with regard to how long ago the participants' had completed the conversion course, since all of the cohorts were represented in the sample population. Moving forward it may be beneficial for managers seeking an understanding of why the conversion course has appeared ineffective in improving practice, to examine perceptions and experiences related to implementing the course teachings at different intervals or stages. For example surveying staff immediately upon completion of the course and then at timed stages afterwards could illuminate key factors such as at what point they are motivated to implement change, or at which point nurses revert to tradition based practices. This would assist the organisation in identifying and strategically targeting key areas to be addressed and identifying positive elements which could then be extended to other parts of the hospital.

In Malta, like elsewhere internationally, the apparent absence of an understanding of the unique contribution of psychiatric nurses to mental health services has multiple ramifications: as a career option it is proving to be an unattractive option to potential nursing students and to experienced general nurses seeking to transfer. Both groups appear unable to see any purpose in the role of a psychiatric nurse; for other professionals and hospital managers the lack of tangible contributions by nurses makes seems to lead to view of them as people who simply 'look after' and keep order on a ward. For patients, relatives and society in general, there remains a perception of nurses as custodians and handmaids to the consultants. Unless nurses demonstrate and articulate their unique contribution, they will continue to be

overlooked and undervalued. This issue raises a certain urgency for the need of further research into the actual work of psychiatric nurses in Malta.

The findings of this study represent the perceptions and experiences of just one sub set within the group of stakeholders who are involved in mental health care. As such it is important to acknowledge that the views expressed in this study cannot to be considered to be generalisable and could be laden with perceptions that may or may not accurately reflect the opinions which underpin the approaches of other stakeholders towards the participants. A representative and more comprehensive study which involves all stakeholders as participants is much needed.

Furthermore, the conclusions of this study could be confirmed and expanded upon by adopting different research approaches such as an ethnographic case study. Ethnography is “*the description and interpretation of a culture or social group*” (Holloway et al., 2010, p.76), generally achieved by collecting data from both interviews and participant observation over an extended period of time, in which great importance is assigned to the observation of events and rituals, which reveal elements or aspects of the culture of the group (Fusch et al., 2017).

8.4 Originality and contribution

The first claim to originality made by this thesis rests on the innovative methodological approach in relation to the participant sample. This interpretative phenomenological study is the first of its kind to have explored, described and enhanced understanding of the role of Maltese psychiatric

nurses and the impacts on their practice, of undertaking a post qualification degree. As such, it also enables an original and in depth understanding of a group of people (psychiatric nurses) who are not commonly represented in the literature internationally and even less so in local studies. Few published studies have highlighted in such detail the often complex stories of psychiatric nurses who choose to follow post qualification tertiary level education courses. Those which could be located gave scant consideration to external challenges they face in applying learned theory and skills. The findings of this study provided rich and descriptive accounts of challenges that arise as a result of their professional relationships and the prevailing culture in the practice environment, which impact the nurses' abilities to implement positive changes to their practice after achieving the BSc in mental health nursing. In this study the detailed accounts and subsequent idiographic analysis which illustrate the significant impact of organisational culture on the act or craft of psychiatric nursing, may not only be of interest to local stakeholders but may also resonate with a wider international audience, especially in smaller countries similar to Malta, who have limited psychiatric facilities and resources and who are in the early stages of developing mental health services.

A further original contribution made by this research is that it serves as an important record of psychiatric nursing in Malta. In researching the history of psychiatric nursing locally only two texts dedicated to the subject could be located, none of which covered the more recent history of the development of the role locally. This is not a deficit that is particular to Malta, as Happell (2007) noted:

History is consistently acknowledged as crucial to the identity of a profession. In the case of mental health nursing this is perhaps more so, as published accounts of the history of nursing rarely pays attention to the specialty of mental health. (p.1439)

Some twenty-five years ago, Nolan (1993) also observed that psychiatric nurses have only been allocated a negligible role in the pages of history, resulting in what he termed as “*a professional amnesia*” (p.1) since having a history authenticates the legitimacy of the service one gives, as opposed to tagging on to the history of another group which implies subordination. The findings of this study, which point to a pervasive lack of professional identity amongst the participants, most of whom reject the notion of it being a profession at all, make Nolan’s view all the more relevant here. Smith (2016) said about the importance of acknowledging nursing history:

History is also a story. It is a jigsaw puzzle, the piecing together of disparate elements to paint an interpretation. It is not the facts “as they actually happened”, because who knows how they actually happened, and maybe it’s not the happening that was important, but the way the happening was experienced. (p.4)

Since the history of the role, and its associated struggles locally, continue to impact nurses in a myriad of ways, recording the development of the profession in the country is an essential component of enabling critical and reflective practitioners in the future and can only aid in the development of a professional image.

This study also adds to the body of knowledge regarding continuing professional (nursing) education, emphasising to academic institutions

involved in the delivery of continuing professional education, the vital need to consider the influence of professional relationships and workplace culture in applying learned skills and theory.

8.5 Strengths and limitations

A key feature of IPA studies is the flexibility it offers to stretch the boundaries of its original form. In this study I chose to take advantage of this feature and step outside of a traditional IPA study design which generally recommends a small sample of participants from whom data is collected by means of interviews. Instead I opted to conduct focus groups as an additional data collection method. The focus groups (with a total of 21 participants) enabled me to highlight key areas to further explore within in-depth interviews with six participants, and when combined, both data sets were found to complement each other in terms of commonalities of perceptions and experience.

However they also produced an extensive volume of data. The rationale given for a small number of participants in a mainstream IPA study is the idiographic analysis that is required in order to achieve in-depth interpretative analysis. This is suggested as being easier to achieve when working with a small sample. In fact this was brought home to me during the preparation and analysis of the two data sets, which was extremely intensive and time consuming and it may be suggested that had I followed the usual IPA approach, I may have been able to concentrate on a more extensive analysis of the interview data. That said, I feel that the decision to use both methods adds to the robustness of the study's findings, since the findings from one method are corroborated by the other and when combined, have served to deepen the level of understanding of the topics which arose. The harmony between the accounts of the participants' in the focus groups and the

detailed stories of the interview participants provides some indication that their stories may well reflect the experiences of other nurses within the study area.

My own influence on the study, as an insider researcher, was acknowledged in Chapter 1. Being an 'insider' was challenging at times, especially in the interview phase of the study, since the participants naturally responded to questions with the belief that I know as much as they do about being a nurse, working in the study area and having undertaken the conversion course, which may have meant that they did not necessarily go into as much detail with their accounts as they may have done with someone who did not have this pre-existing knowledge and experience. However now, as the study comes to an end I believe that the fact that I am a psychiatric nurse, have worked in the study area in various capacities and know all the participants to differing degrees, has proven to be much more of a strength than a limitation. I believe that had I not been known to the participants, the richness of their stories would not have emerged in their narratives and I contend that had an 'outsider' conducted the same study their lack of fore-knowledge of the setting, and in the absence of pre-existing interpersonal relationships, they would have been unable to elicit the same depth and richness of descriptions from the participants. With this comes inevitable risk. The participant's expressed views that what happens there (within the study area) stays there, and this familiarity and confidence with the nurses created an interview environment which allowed the participants to speak freely and in the face of this, some of their accounts contain recollections of experiences that may best be described as incriminatory. This latter point leads to another issue, which is that of confidentiality. As discussed in Chapter 5, although

measures were taken to ensure that the participants were not recognisable in the thesis, the fact that there is only one psychiatric hospital, where everyone is acquainted with everyone else, could still cause participants' to be recognised by their responses, particularly those nurses who participated in the individual interviews. If they are not identified as individuals, the whole nursing staff will be identified. Having acknowledged this early on in the study I had revisited the issue of confidentiality at the end of the interviews, by asking the participants' how they wanted their data to be handled. All of the interview participants reaffirmed their permission for their responses to be used verbatim with only their names being changed. However, I feel that since according to their own accounts, the research studies which they conducted whilst following the conversion course were generally not acknowledged or referred to by anyone in authority within the organisation where they work, they may have assumed that this study would also go unnoticed by their managers or external authorities. This may be a short-sighted assumption and I feel a sense of responsibility to safeguard their stories even in light of their consent. For this reason the findings of the study will be disseminated selectively so as to both protect participants from any organisational recriminations and also potentially protect patients and their families by avoiding undue and unhelpful media attention which could cause distress to all parties. Further this thesis is under embargo by the University for three years.

IPA relies on the verbalisation of the participants stories. The focus groups and the interviews in this study were conducted in English, and although the Maltese participants all possessed strong English language skills, it maybe that they would have been more comfortable and more able to offer richer or

more revealing descriptions had they been speaking in their first language. Although I am confident that this did not detract from the final conclusions, this should definitely be a consideration for future researchers embarking upon a similar method of research, (interviews) who unlike me, may be in a position to confidently conduct the data collection in Maltese and then translate accurately their findings.

This study delved into the perceptions and experiences of a particular sub group of nurses within local mental health services: those employed within inpatient hospital care. It did not invite the participation of those nurses who had undertaken the same conversion degree who are employed within community services, nor those who are direct entry psychiatric nurses (for whom the BSc Mental Health Nursing is their first nursing registration).

Although the exclusion of these two groups from the study was purposeful in order to maintain the IPA requirement of homogeneity, their inclusion would have added several other informative dimensions to the findings. Likewise, as noted earlier, this study presents the experiences and perceptions of a sample of just one occupational group of people involved with the delivery of mental health services within the organisation where the study was conducted. Other key stakeholders voices are not heard within the study (educators, hospital management, allied professionals, patients) resulting in a biased representation of the current situation. This a limitation can be addressed by further research.

8.7 Closing reflections

This comprehensive analysis of the participants perceptions of their role and experiences related to undertaking the diploma to degree conversion course

have revealed hitherto unacknowledged complexities in their practice environment, demonstrating that the influences exerted by a strong bureaucratic organisational culture should not be underestimated for their potential to obstruct change. At first sight the findings of this study may lead to the assumption that the fundamental worth and value of undertaking a post qualification BSc in mental health nursing is questionable in the current local socio-political and organisational climate of the study area. My initial interest in conducting this study stemmed from a personal frustration at the apparent lack of tangible outcomes in nursing practice that one may expect to have seen, given that a significant number of nurses completed a BSc in mental health nursing. However the in-depth and detailed analysis permitted by an IPA approach has revealed that a complex array of interrelated factors, mainly linked to the prevailing organisational culture, have in combination inhibited the potential for a post qualification degree to positively impact on the care provided by psychiatric nurses. Nonetheless, woven into the stories of the participants is a glimmer of optimism that the aspirations of some participants could become the spark that lights the fire of change. It is apparent that a small number of nurses are at the precipice of stepping out of their organisational and role-bound state and are ready to embark upon the transition from 'custodian' to professional psychiatric nurse. But they need organisational recognition and support to do this. In order to address the negative impact of organisational culture, organisational leaders must first acknowledge their influence on working practices and on the achievement of desired outcomes; they must aspire to change the organisation, and fully engage to make change happen.

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Appendices

Appendix 1: Ethical approval, University of Sheffield



**The
School
Of
Education.**

Sally Zammit
PhD/Education (Malta)

Head of School
Professor Cathy Nutbrown

School of Education
388 Glossop Road
Sheffield
S10 2JA

30 January 2014

Telephone: +44 (0)114 222 8096
Email: mphil-phd@sheffield.ac.uk

Dear Sally,

ETHICAL APPROVAL LETTER

Factors which influence nurses' uptake of a post qualification degree and the impact of such a degree on practice.

Thank you for submitting your ethics application. I am writing to confirm that your application has now been approved.

We recommend you refer to the reviewers' additional comments (please see attached). You should discuss how you are going to respond to these comments with your supervisor BEFORE you proceed with your research.

This letter is evidence that your application has been approved and should be included as an Appendix in your final submission.

Good luck with your research.

Yours sincerely

Professor Dan Goodley
Chair of the School of Education Ethics Review Panel

cc Peter Clough, Cathy Nutbrown

Enc Ethical Review Feedback Sheet(s)

Appendix 2: Permission from CEO of Organisation

9, 'BitBit' Flat 2
Buontempo Estate
Balzan Valley
Balzan
BZN 1173
15 June 2013

Ms. Dolores Gauci
Chief Executive Officer
Mental Health Services

15 June 2013

Dear Ms. Gauci

As you are aware I am currently reading for a PhD in Education with the University Of Sheffield (UK). In fulfilment of my studies I am required to undertake a research study. My research questions are "**Which factors influence nurses' uptake of a post qualification degree and what is the impact of such a degree on practice**". The purpose and aims of the study will be to establish personal and occupational factors which encourage or constrain participation in a post qualification BSc; ascertain nurses' perceptions of the impact of obtaining a BSc with regards to changes in their professional behaviour and practice and to ascertain nurses' perceptions of the benefits of following this course of study, as they pertain to patients and to the organisation.

The study will adopt an interpretative approach. Initially a purposive sample of around 10 participants will be asked to complete a reflective journal for a period of time. Based on the content of the reflective journals, a questionnaire will be developed by the researcher and distributed to all Diploma to Degree BSc Psychiatric Nurses working at the psychiatric hospital where the study will be conducted. The questionnaire will investigate the aims of the study, making use of the journal material to identify and delineate themes in an organised manner. Finally a case study strategy will be employed. An as yet undetermined number of in-depth interviews will be conducted to delve into the factors developed from the previous two modes of enquiry. After all data has been gathered a process of thematic analysis will be undertaken to highlight the main findings of the research and these will then be presented in a final report.

I am seeking your approval to conduct this study amongst nursing staff satisfying the criteria of being nurses currently employed within Mental Health Services, who have undertaken the Diploma to Bsc in Mental Health Nursing course. I am aware that I have to adhere strictly to ethical issues related to informed consent and confidentiality. Prior to commencing the study, ethical approval will be sought from the University of Sheffield's Ethics Committee.

Should you require any further information about this study, please do not hesitate to contact me.

Thanking you in advance for your attention.

Yours Sincerely

Sally Zammit
RNMH, RMN, BSc(Hons) Mental Health Nursing, MSc HSM (Melita)

I hereby grant my approval subject to ethical approval by the university of Sheffield Ethics Committee.


Ms. Dolores Gauci
Chief Executive Officer.

Date

Appendix 3: Permission from Manager Nursing Services of Organisation

9, 'BitBit' Flat 2
Buontempo Estate
Balzan Valley
Balzan
BZN 1173
15 June 2013

Mr. Mario Hili
Manager Nursing Services
Mental Health Services

15 June 2013

Dear Mr Hili

As you are aware I am currently reading for a PhD in Education with the University of Sheffield (UK). In fulfilment of my studies I am required to undertake a research study. My research questions are "Which factors influence nurses' uptake of a post qualification degree and what is the impact of such a degree on practice". The purpose and aims of the study will be to establish personal and occupational factors which encourage or constrain participation in a post qualification BSc; ascertain nurses' perceptions of the impact of obtaining a BSc with regards to changes in their professional behaviour and practice and to ascertain nurses' perceptions of the benefits of following this course of study, as they pertain to patients and to the organisation.

The study will adopt an interpretative approach. Initially a purposive sample of around 10 participants will be asked to complete a reflective journal for a period of time. Based on the content of the reflective journals, a questionnaire will be developed by the researcher and distributed to all Diploma to Degree BSc Psychiatric Nurses working at the psychiatric hospital where the study will be conducted. The questionnaire will investigate the aims of the study, making use of the journal material to identify and delineate themes in an organised manner. Finally a case study strategy will be employed. An as yet undetermined number of in-depth interviews will be conducted to delve into the factors developed from the previous two modes of enquiry. After all data has been gathered a process of thematic analysis will be undertaken to highlight the main findings of the research and these will then be presented in a final report.

I am seeking your approval to conduct this study amongst nursing staff satisfying the criteria of being nurses currently employed within Mental Health Services, who have undertaken the Diploma to Bsc in Mental Health Nursing course. I am aware that I have to adhere strictly to ethical issues related to informed consent and confidentiality. Prior to commencing the study, ethical approval will be sought from the University of Sheffield's Ethics Committee.

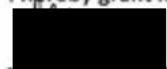
Should you require any further information about this study, please do not hesitate to contact me.

Thanking you in advance for your attention.

Yours Sincerely

Sally Zammit
RNMH, RMN, BSc(Hons) Mental Health Nursing, MSc HSM (Melita)

I hereby grant my approval subject to ethical approval by the university of Sheffield Ethics Committee.


Mr. Mario Hili
Manager Nursing Services

18.6.13
Date

Appendix 4: Consent form

Consent Form

Title of Research Project:

Factors which influence nurses' uptake of a post qualification degree in mental health nursing and the impact of such a degree on practice

Name of Researcher: Sally Zammit

**Participant Identification Number for this project: _____ Please
initial box**

1. I confirm that I have read and understand the information letter, dated _____ explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.
3. I understand that my responses will be kept strictly confidential.
4. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
5. I agree to take part in the above research project.

Name of Participant

Date

Signature

Appendix 5: Information sheet

Information Sheet

Title of Research Project: Factors which influence nurses' uptake of a post qualification degree and the impact of such a degree on practice.

Name of Researcher: Sally Zammit

I am currently reading for a PhD in Education with the University of Sheffield. I would like to invite you to take part in my research project. Before you decide whether to participate or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information please do not hesitate to contact me. Thanking you in anticipation of your assistance.

The Project

This study aims to explore which factors influence nurses' uptake of a post qualification degree and what is the impact of such a degree on practice. In order to answer these questions I hope to establish personal and occupational factors which encourage or constrain nurses' participation in a post qualification BSc; ascertain nurses' perceptions of the impact of obtaining a BSc with regards to changes in their professional behaviour and practice and ascertain nurses' perceptions of the benefits of following this course of study, as they pertain to patients and to the organisation.

Why have you been chosen?

You are being invited to complete a journal/questionnaire/in-depth* interview because you are a psychiatric nurse who undertook the Diploma to Degree in Mental Health Nursing and are currently employed at Mount Carmel Hospital. The study will focus on nurses who under the BSc in Mental Health Nursing.

What I am required to write about in the journal?

You will be asked to make brief notes about your interaction with your patients and to describe which of these are directly related to skills or knowledge that you acquired whilst undertaking the BSc in Mental Health Nursing. As the study develops I may ask you to record additional information or reflections.

What is the questionnaire/interview about?

The questionnaire asks about your experiences, perceptions and knowledge regarding those factors which either encouraged you to follow the Diploma to Degree course and those factors which may constrain people from following such a course. It also asks if you feel that your professional behaviour and practice has changed as a result of undertaking the course and what you feel are the benefits to your organisation and the people you care for.

Do I have to take part?

It is entirely up to you whether to take part or not. If you decide not to, you don't have to give a reason. You can opt out of the study at any time, also without having to give a reason.

Will my taking part in this project be kept confidential?

Yes. All the information that I collect about you during the course of the research will be kept strictly confidential. Once analysis of the results has finished, all data will be deleted. You will not be able to be identified in any reports or publications unless you have given consent for this. Your consent will be sought before the project publishes any comment that may be directly or indirectly traceable to you personally (for example, comments referring to particular work areas which may identify you indirectly).

All data collected will be stored on my personal computer as digital files in password protected folders.

What are the possible benefits of taking part?

This study aims to add to the body of knowledge about post nurse registration education and to offer to people concerned with designing curriculums of nurse education, a view of a group of nurses selected for this study. The study is important for organisers and facilitators of educational packages locally to have a better understanding of how nurses translate theory into practice and the issues that they face in doing so. Furthermore, this study will be of value to health care managers who support nurses in undertaking such courses by releasing them from work and offering paid study leave. By telling your story it may help others to research or define other groups of learners with whom they participate or serve. Finally, there is no similar research that has been conducted locally and therefore country and culture specific factors may not be known. By contributing your experiences and your particular examples to the study, you are helping to potentially facilitate change that could improve the learning experience and nursing practice of future students.

What will happen to the results of the research project?

The project will be written up and presented in a number of forms, both within the University (e.g. research presentations as part of my PhD) and within Mental Health Services here in Malta (hard bound copies at the hospital library). All writing-up of the study and presentations related to it will be done by myself. You will not be able to be identified in any reports or publications unless you choose to be. If you would like to be kept informed about the research presentations/publications arising from this research please just let me know.

Who is supporting and authorising this research?

This study is being undertaken as part of a PhD programme. It is funded solely by the researcher. The project has been approved by the Ethics Review Panel, which is monitored by the University's Research Ethics Committee. Furthermore, approval to conduct the study has been given by the Manager of Nursing Services and the Chief Executive Officer of Mental Health Services (Malta).

More information or complaints?

If you would like more information about this research please feel free to contact me either by email: sally.zammit@gov.mt or by telephone: 9972 2212.

Appendix 6: Post interview confidentiality form

Post-interview confidentiality form

Factors which influence nurses' uptake of a post qualification degree in mental health nursing and the impact of such a degree on practice

It is my goal and responsibility to use the information that you have shared responsibly. Now that you have completed the interview, I would like to give you the opportunity to provide me with additional feedback on how you prefer to have your data handled. Please check one of the following statements:

- You may share the information just as I provided it. No details need to be changed and you may use my real name when using my data in publications or presentations.
- You may share the information just as I provided it; however, please do not use my real name. I realize that others might identify me based on the data, even though my name will not be used.
- You may share the information I provided; however, please do not use my real name and please change details that might make me identifiable to others. In particular, it is my wish that the following specific pieces of my data not be shared without first altering the data so as to make me unidentifiable (describe this data in the space below):

- You may contact me if you have any questions about sharing my data with others. The best way to reach me is (provide phone number or email): _____

Participant's signature _____ Date _____

Researcher's signature _____ Date _____

Appendix 7: Interview schedule

Interview Schedule

1. Can you tell me a little about how you came to be working here?
 2. In your opinion is nursing a job, a profession or a vocation?
 3. Can you describe what the role of a psychiatric nurse is here?
 4. Thinking about experience and qualifications, do you feel one is more important than the other to help you do your job?
 5. What is it like working for this organization? What made you decide to undertake the conversion course?
 6. Can you think of any ways in which nursing care delivery has changed since people started doing the degree?
 7. If someone you know personally started working here next week, what 3 things would you tell them that you think they should know about working here?
-