

CHAPTER 2

Literature review

2.1 INTRODUCTION

Chapter 1 introduced the study, outlining the background and motivation, problem statement, purpose of the study and conceptual framework. This chapter discusses the literature review undertaken by the researcher on the perception of general hospital nurses nursing mentally ill people. Mavundla (2000:1570) states that in South Africa the prevailing socioeconomic status leads to mentally ill people being admitted in general hospitals. Brinn (2000:32) found that mentally ill patients are frequently found in general wards. Therefore general hospital nurses without basic psychiatric training nurse mentally ill people. The literature review covered the stigma associated with mentally ill people by society, the media and health care professionals, as well as knowledge of and attitudes towards nursing mentally ill people.

2.2 STIGMA ASSOCIATED WITH MENTALLY ILL PEOPLE

Stuart and Laraia (1998:216) describe a stigma as a mark of disgrace used to identify and separate people whom society sees as deviant, sinful, or dangerous. Furthermore, stigma is often linked with the concept of mental health problems.

2.2.1 Societal perception of the mentally ill

Stigmatisation of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. This has a serious impact on mentally ill people. Although society has become more open, showing greater tolerance towards mentally ill people, negative attitudes still remain. These attitudes make it hard for nurses to become involved with clients and lessen their ability to assess and manages the clients' mental health problems. According to Brinn (2000:32-

33), a change of attitude may lead to behavioural change in this regard.

There is a common belief that clients with mental health problems are potentially dangerous. Similarly, patients often behave violently in their homes as well as in public. Some have been known to kick doors, throw stones at people and passing cars as well as break chairs, windows, crockery, furniture and household appliances. Destructive behaviour also takes place in other people's homes resulting in the family of the mentally ill patient having to pay for damage to other people's belongings and property (Kritzinger & Magaqa 2000:299).

Kritzinger and Magaqa (2000:298) found that several caregivers emphasised the destructive nature of some mentally ill patients. One caregiver mother related the following story about her son:

“My son was reported by the School Master for breaking a school window and I had to fetch him immediately.” On another occasion “he visited his friends with a guitar, as he was very fond of it. That evening I received a telephone call from his friends telling me that he was violent, breaking their glasses and fighting with them.”

At the present time, however, families take on the responsibilities of care giving without receiving the necessary training and support to undertake such a task. This inevitably places a burden on families, communities and health services in rural areas, compounded by the relative shortage of mental health workers in these areas. Meanwhile provincial governments in South Africa purport to create “mentally healthy” communities in their respective provinces. At the same time, however, the lack of infrastructure and mental health programmes usually results in the families of mentally ill patients having to take the responsibility for caring for them.

2.2.2 Media and general public perceptions of mentally ill people

The language used by the public and media generally constructs negative images of mentally ill people and describes them in a derogatory manner. Perpetrators of acts of violence are often described by the media as “schizos”, “nutters”, “psychos”, “fiends” “monsters” and “maniacs”, making a clear link between

violence and mental illness particularly in the tabloid press making a clear link between violence and mental distress, for example “schizophrenic” is often used in describing violent events. The term is used as if the diagnosis explains why the violence occurred. Meanwhile the person who happens to have a diagnosis of schizophrenia may have been taking illegal drugs or may be inherently violent.

The press has an interest in stories that are extraordinary and frightening (<http://www.mind.org.uk> ...). This was addressed in *The Guardian* (<http://www.mind.org.uk> ...): “Start with the scary statistic that someone is killed by a mental patient every fortnight. It sounds like confirmation of the psycho-killer myth but it hardly survives scrutiny.” Tabloid tales of “crazed killers” are statistical flim, designed to tap into a deep and ancient fear of the lunatic mad, bad, and dangerous.”

Steve Hyler, an American psychiatrist, largely blames the role of the media for public perceptions of mentally ill people Brunton (1997:893). He is of the opinion that countless films in which someone with a psychiatric illness is shown as a killer. Some notable examples are *Psycho*, *Halloween*, *Friday the 13th*, *Nightmare on Elm Street*, *The Hand that Rocks the Cradle* and *Silence of the Lambs*. This causes a link between violence and mental illness in the minds of the public (Brunton 1997:893).

Philo, Henderson and McLaughlin (1993) (cited in Brunton 1997:894) complement these perceptions, studies on violent behaviour have shown that over a number of years lurid stories and headlines in the tabloid press cause a link between violence and mental illness in the minds of the reading public. These authors cover highly readable and interesting reports on mental illness in national and local newspapers, magazines, children’s comics and soap operas (Brunton 1997:894). Selective media reporting has been found to reinforce the public’s stereotypes linking violence and mental illness and encouraged people to distance themselves from those with mental disorders (Heginbotham 1998:125; Swartz 1998:273). Brunton (1997:893) categorises violent behaviour as follows:

- Violence towards the self/suicide stories where self-harm is attributed to mental illness. Mentally ill people are at risk of endangering either themselves or other people, or being endangered by other people, all of which impact on the family’s daily life.

- Violence to property. Most violent attacks are directed at the destruction of property. In some instances, mentally ill people break other people's belongings and owners demand to be compensated by the respective families.
- Violence towards others, such as nurses other patients and doctors. Mentally ill people are portrayed as being violent or when reporting on violence terms associated with mental illness are used.

Given the media's preoccupation with a link between mental illness and violence, it is important to ask whether this link actually exists other than in the minds of newspaper editors. Penn, Guynanki, Dally and Spaulding (1994:568) demonstrate that negative perceptions about severe mental illness can be lowered by furnishing empirical information on the association between violence and severe mental illness.

Much reporting on mental health issues continues to link violence and mental illness although there is evidence that the press coverage of mental health issues is beginning to change. For example, in 2003, *The Sun's* (2003) headline "Bonkers Bruno locked up", covering the story of ex-boxer Frank Bruno's sectioning under the Mental Health Act, caused a public outcry, not only from mental health organisations, but also from members of the public and was rapidly withdrawn and changed to "Sad Bruno in mental home" ([http://www.mind ... 2004/05/08](http://www.mind...2004/05/08)).

2.2.3 Consequences of stigma to mentally ill people

The literature indicates that society's attitude towards psychiatric conditions has been mostly unfavourable. Stigma leads mentally ill people to avoid living, socialising or working with, renting to, or employing especially those who suffer from a severe mental disorder such as schizophrenia (Glozier 1998:793-796). It reduces patients' access to resources and opportunities (eg housing, jobs) and leads to low self-esteem, isolation, and hopelessness. In its overt form stigma results in outright discrimination and abuse. Glozier (1998:793-799) states that "stigmatisation may be extended to workplace in the form of discrimination, with possible consequence of reduced chances of employment. More tragically, it deprives people of their dignity and interferes with their full participation in society." The stigma might have been greater today had not public education resulted in a more scientific understanding of mental illness (Chan & Cheng 2001:436).

2.2.4 Health care professionals' perception of mentally ill people

Healthcare professionals are not immune to feeling negatively disposed towards mentally ill people. Mavundla and Uys (1997:3-4) found that even nurses have negative attitudes towards the very people they are supposed to care for. The stigmatisation by health care professionals is evidenced in their attitudes. People's attitudes are influenced by a variety of factors, such as behaviour, experience, knowledge of a problem and their general belief.

Apart from the stigma attached to mentally ill people, there is a belief that clients with mental health problems are potentially dangerous, prone to violence and general hospital nurses are often afraid when nursing mentally ill people. This is evidenced by statements such as "we will not be held responsible if this patient jumps out of that window and dies" (McDonald 1998:23). Nurses are therefore nervous about mentally ill patients' unpredictability and reluctant to care for them. Mavundla and Uys (1997:3-8) found few nurses who had positive attitudes towards mentally ill people. Most nurses did not find the idea of caring for the mentally ill in these settings appealing.

Mavundla (2000:1575) found that general hospital nurses had negative feelings about nursing mentally ill people in general hospital.

2.2.4.1 Violent behaviour

According to Kaplan, Sadock and Grebb (1994:560) describe violence as "an unlawful exercise of physical force caused by patients with thought disorder characterized by hallucinations commanding them to kill someone and require psychiatric hospitalization and antipsychotic medication".

Patients in the grip of a violent episode pay no attention to the rational intercessions of others and probably do not even hear them. When armed, they are particularly dangerous and capable of murder. Such patients should be disarmed by trained law enforcement personnel without harming others in their surroundings if at all possible. If unarmed, such patients should be approached with sufficient help and overwhelming strength, so that there is effectiveness and no contest.

In a study of workplace violence to mental health nurses and psychiatrists in the United Kingdom (UK), Lewis and Dehn (1999:29-33) and Nolan, Dallender, Sqares, Thomsen and Arnetz (1999:934-941) found that inpatient psychiatric nurses were more likely to have been exposed to violence than outpatient nurses.

Lewis and Dehn (1999:29-33) found that nurses faced increased violence from patients and 85 % of 310 general hospital nurses had been victims of patient aggression. Lawrie (1996:201-203) found that doctors responding to patients with schizophrenia were significantly more likely to perceive the client as violent, regardless of their previous psychiatric experience. This attitude might have some grounding as in one study, 50 % of assaults on general practitioners came from mentally ill clients Brinn (2000:32). Furthermore Lewis and Dehn (1999:29-30) found that 12 nurses reported a total of 20 attacks, 40 % of which resulted in minor injuries. Laskowski (2001:16) found that most nurses experienced verbal threats, including indirect threats, such as “I know where you live”, and verbal threats can be as disturbing as actual physical assaults to staff. Furthermore, some mentally ill patients were verbally abusive and threaten nurses and other patients in the wards.

Whittington and Wykes (1992:481-482) found that attacks by patients are an important source of stress for psychiatric staff, with serious ramifications for patients and nurses’ employers. General hospital nurses feel helpless and uncertain because they did not know what to do. Task orientation was a barrier to building a person-to-person relationship between general nurses and mentally ill people.

2.2.4.2 *Dual diagnosis*

The term “dual diagnosis” is increasingly used in psychiatric practice to describe the combination of severe mental illness (mainly psychotic disorders) and substance misuse (Weaver, Renton, Stimson & Tyrer 1999:137).

The treatment of patients diagnosed with a coexisting psychiatric and psychoactive substance misuse disorder remains an important clinical challenge in mental health nursing. This is not only because of the complexity of the disorder, but also because an increasing number of patients are presenting with both

disorders (ie, coexisting psychiatric and psychoactive substance disorder).

According to Ryrie and McGowan (1998:137), the term “dual diagnosis” describes those individuals who represent a heterogeneous group usually comprising persons who have different types of mental disorder, with differing degrees of severity, and who may be using one or more psychoactive substances, with varying frequency and in varying amounts.

According to Steel (1997:7-8), the term “dual diagnosis” is misleading as it implies that only two components (psychotic disorder and a substance misuse disorder) exist within a particular presentation. Steel (1997:7-8) maintains there is no such thing as a separate “mental health problem”, “an alcohol problem”, or a “drug problem” since because of the complexity of the clinical presentation of dual diagnosed patients, it is very difficult and potentially misleading to assume that in any dual diagnosed patient, one could easily identify and indeed treat two separate components (a psychotic disorder and a substance misuse disorder). Furthermore, mental health problems can present in various forms, from psychosis to mild depression. Koku (2001:243-244) reveals that dual diagnosis, therefore, encompasses a collection of various behaviours and consequent problems, instead of two defined components in a particular presentation.

According to Koku (2001:243), a comparison of the above definitions of dual diagnosis, or “comorbidity” as some authors prefer to call it, reveals the imprecision, ambiguity and inadequacy surrounding the current classification systems in describing these complex presentations. Koku (2001:242-243) states that patterns of substance misuse vary considerably among the general population, but the use of as well as dependency on illicit substances and alcohol among the mentally ill is especially problematic because of the complexity associated with the clinical presentation and management of this patient group in general hospital settings. Weaver et al (1999:137-138) found that some types of substance misuse, particularly alcohol, cannabis, hallucinogens and some stimulants like amphetamines, can produce psychotic symptoms directly, even without previous diagnosis of mental illness.

Mavundla (2000:1575) is of the opinion that dual diagnosis of mentally ill patients makes nurses perceive such patients as being in the wrong place due to the fact that some of the mentally ill people have both

medical and mental illnesses. This situation leaves general hospital nurses confused when nursing mentally ill patients. In addition, there is the critical factor of collegial relationship between psychiatric staff on the one hand and non-psychiatric consultants and nurses on the other (Mavundla 2001:1576). Dolinar (1993:14-20) examined the obstacles to the care of patients with ambiguous dual diagnosis (ie, with medical-psychiatric illness) in general hospital psychiatric units. Dolinar (1993:14) found that such patients were refused admission at psychiatric units despite stable vital signs and further that had such patients been in the psychiatric unit they would have received intensive psychiatric care, which was impossible or unavailable in medical-surgical units.

Contrary to the above, research has shown that illicit substance use and/or withdrawal can precede and contribute to the development of psychiatric disorders (Koku 2001:243). Meanwhile it is generally believed that the greatest risk of violence is from those who have dual diagnosis, that is individuals who have a mental disorder as well as substance abuse. Furthermore, Heginbotham (1998:125) states that general hospital nurses are often under stress when attending to patients with dual a diagnosis of physical and mental illness as they feel that such patients should be admitted to the psychiatric unit.

2.2.4.3 *Bizarre behaviour*

According to Perko and Kreigh (1990:480), behaviour is “a set of actions characteristic to an individual which can be observed and recorded”. Kaplan, Sadock and Grebb (1994:112) describe behaviour as “a symbol of intra-psychic process and a symptom of unconscious conflict. Behaviour is motivated by the organisms’ attempt to reduce tension produced by unsatisfied or unconscious drives, whereby repressed fear is learned and is transformed into anxiety.”

Bizarre behaviour is difficult to predict although general nurses regard mentally ill people as potentially dangerous due to their lack of knowledge and skill in nursing mentally ill people. This leads to irrational fears that impair their clinical judgment which, in turn, may lead to premature and excessive use of sedation or physical restraint.

Mavundla (2000:1575) found that mentally ill patients displayed inappropriate behaviour with which nurses

were unfamiliar, such as urinating in the ward or walking naked in front of other patients and nurses. This surprised other patients and the nurses in their respective units.

2.2.4.4 Perceived feelings

Mavundla (2000:1576) states that general hospital nurses expressed feelings that made it difficult for them even to be near the patient. They were concerned with questions like: “Is it safe to come close to him/her?” “If she/he assaults me, will I be covered by the employer?” Professional nurses expressed fear, frustration, despair and helplessness (Mavundla 2000:1576).

◆ Fear

Sideleau (1992:6-8) describes fear as “an unpleasant, excited, activating effect with psychologic and physiologic components elicited by a specific threatening person, object, or event”.

Wilkinson (cited in Basheer 1998:33) maintains that the principal elements underlying general nurses’ negative attitudes towards mental illness and mentally ill people are fear and distrust. Wilkinson found that general nurses nursing the mentally ill often regarded mentally ill people as more frightening, less likely to need strict control in hospital. The subsequent finding that these components of fear and distrust prevailed even after a psychiatric training course.

Nurses were of the opinion that mentally ill people were capable of doing anything to nurses and other patients. General hospital nurses feared the unlikelihood of compensation in the event of injury and what they thought the patients might do to them. Mavundla (2000:1576) found an element of marked apprehension and nervousness in nurses’ attitudes towards the “unpredictability” of mentally ill patients.

George-Tamara (2000:106) found that mental illness carried a public stigma in the dominant culture that is characterized by public fears, ignorance, and isolation of the mentally ill from the local and larger world. This further supports the notion that people believe that individuals labelled mentally ill are dangerous and especially prone to violence, and they fear them.

◆ Frustration

According to Sideleau (1992:8-10), “frustration is an unpleasant effect characterized by a build-up of emotional energy when needs, wishes and/or desires are obstructed by others, one’s own abilities, or given situations”.

Nurses in the wards were not willing to take care of patients with a history of confusion. This prevailing situation was further displayed by medical officers who claimed that they do not understand psychiatric patients and are not trained in the field (Maphorisa et al 2002:22).

Mavundla (2000:1577) found that nurses are frustrated by certain features in a general hospital setting such as the following:

... ill patient but violent ... time spent by the patient at outpatient department whilst waiting for the psychiatrist ... this duration of time causes stress for both nurses and patients and is worse during holidays and weekends ... can’t get help from the security personnel at times ... lack skills with which to help the patient ...

Maphorisa et al (2002:25-26) state that community mental health nurses working in mental health units attached to general health facilities experience unhappiness, frustration, discouragement, disappointments, loss of interest in mental health work, disbelief and confusion due to the negative attitude of their supervisors, management of the facilities they work under, top authorities, in the ministries, doctors and general nurses towards mental health services and personnel. They cited the following:

- *Unhappiness* related to being overwhelmed by work and lack of co-operation from general health workers, especially medical practitioners who made unnecessary referrals and admissions to mental health units of people with a history of mental illness coming with physical complaint.
- *Disappointment* related to general health workers’ disinterest in mental health, especially health facility

management such as exclusion in budget and other health activities.

- *Confusion* related to being ignored by general health workers, especially their supervisors and management who did not appreciate their work or their contribution towards mentally ill people. Community mental health nurses regret having chosen mental health specialisation which frustrates them.
- *Despair*. Despair means loss or absence of hope. General hospital nurses expressed feeling despair because of fear of violence or loss of patients. According to Mavundla (2000:1576), nurses approached the security guards or the nursing managers for help without success.
- *Feeling helpless*. Granskar, Edburg and Fridlund (2001:249-252) found that student nurses felt helpless. Nursing students were not familiar with psychiatric nursing, and stated that their feelings were influenced by their own prejudices, especially when patients did not accept their help. Expectations and attitudes prior to their psychiatric practice were based on information from others, which did not always convey a positive view of mentally ill people. One student feared that handling a situation in the wrong way might arouse angry feelings in the patient, which made her feel helpless:

I could not get through to her, I did not know how to treat her, or how much I dared to do when she was only sitting there ... She might be furious or something ... that was frightening ... so I tried ... But she only sat there and I thought: What shall I do now?

Another student felt helpless because she lacked knowledge of how to handle rejection by mentally ill people. The nursing students were eager to help and felt helpless when they met a patient who was negative towards them or not interested. Therefore a student rejected by a patient did not feel prepared to face verbal aggressiveness, but criticised herself:

I was not prepared for the negative and critical approach and took it almost as personal criticism in the beginning, asking myself, what am I doing wrong?

The question is whether or not the feeling of helplessness caused the students to increase their efforts to

convince others of their own capacity instead of making them focus on the patients' needs.

Health care professionals share the attitudes of the general public regarding mentally ill people. Negative attitudes cause feelings of helplessness and ineffectiveness and can lead to resistance against providing adequate care to mentally ill people (Murray & Steffen 1999:505).

2.2.4.5 Perception of environment

Mavundla (2000:1576) found that general hospital nurses perceived environment as a serious problem to the recovery of the mentally ill people in a general hospital wards. They were of the opinion that staff shortage and overcrowding are additional problems that make it very difficult for them to render adequate nursing care to mentally ill people (Mavundla 2000:1576).

◆ Staff shortage

Research literature shows that South African mental health service is characterized by substantial inter-provincial inequalities of mental health services and staff. These are manifested by most health service indicators, for example, the bed/population ratio, which is defined as the number of psychiatric beds per 100 000 population. It provides an estimate of the extent of service provision for psychiatric in-patients. In South Africa there are about 48 public sector beds per 100 000 population for the country as a whole which is considerably lower than developed countries. This is exemplified by the fact that the UK, which has relatively well-developed community health services, has a ratio of 104 per 100 000 .

Another useful mental health service indicator is the staff/population ratio, defined as the number of staff per 100 000 population. A situational analysis of mental health care in the Mount Frere district of the Eastern Cape found that the focus was on pharmacological management and that poor infrastructure reduced access to the limited services that were available. However, the medical practitioners were the only health professional authorised to prescribe psychotropic agents. One medical practitioner admitted that he did not have any protocols for managing mental health problems. It frequently occurred that when the psychiatric nurse was not available, people with mental disorders were locked in a side ward. In some cases they were

then forgotten about (<http://www.hst.org.za/sahrs/99/chap25.htm> ...).

Thipanyana and Mavundla (1998:28) report severe shortage of nurses in the rural clinics of the Eastern Cape. This makes it difficult to conduct home visits. The impact that mental illness has on general hospital nurses nursing mentally ill people is largely disruptive and tends to cause interpersonal difficulties. The effects are particularly devastating for the general hospital nurses.

◆ **Overcrowding**

General hospital nurses complain of inadequate care rendered to mentally ill people due to patient overcrowding. Maphorisa et al (2002:23-25) found that nurses and medical teams at Emergency units send or admit anything bordering on psychiatric illnesses consequently general nurses are overwhelmed with a lot of unnecessary work in the general hospital unit. Literature revealed that staff/patient ratios were 36:2 and 8:1, respectively. This was examined in a cost-quality analysis in both public and privately contracted hospitals in Gauteng, KwaZulu-Natal and the Northern Province. This problem is perceived as a serious threat to the recovery of mentally ill people when viewed in the context of the necessity for tranquillity (<http://www.hst.org.za/sahr/99/chap25.htm> ...).

2.3 KNOWLEDGE AND ATTITUDES ASSOCIATED WITH NURSING OF MENTALLY ILL PEOPLE

The literature indicates that experience in contacting clients with mental health problem with regard to possession of knowledge and skill is believed to promote a more positive attitude.

2.3.1 Knowledge

According to Cutcliffe (1997:325), all nurses need to be equipped with a multidimensional pool of cognition which can be readily recalled and situational activated. This is in line with Mavundla (2000:1573-1574) who found that general nurses considered themselves inadequately equipped to nurse mentally ill people effectively. Owing to their lack of knowledge about nursing mentally ill people, they tend to speculate about

the origins or causes of mental illness in patients they encounter, and at times even go so far as to conclude that the condition of a patient is due to “dagga” or “pretence”. As a result they fail to comprehend the patient’s condition. Mavundla (2001:8-9) proposes education as a strategy to increase people’s awareness.

2.3.2 Skill

According to Cutcliffe (1997:325), “skills refers to application of doing for or with the patient, this is the action-interaction component of expert psychiatric nursing practice such as positive therapeutic relationship, effective communication, flexibility, balance and inquisitiveness”. General nurses had to get the relationship right, if they do not have trust, care, and mutual respect present, then the effectiveness of any interventions will be generally reduced. Cutcliffe’s (1997:326) view was to make an expert dissimilar from other nurses, which was their ability to balance their commitment to the patient’s best interests with their commitment to their colleagues and to the organisation as a whole.

2.3.3 Effects of education and contact on attitude change

In South Africa psychiatric nursing has been phased into the basic educational programme. Although nursing students’ attitudes are similar to those of the general public, the introduction of psychiatric content in the curriculum has been found to change negative perceptions (Mavundla et al 1999:35).

There has been some speculation that negative attitudes are related to inadequate specialized education related to working with people with serious mental illnesses. Chan and Cheng (2001:434-443) found that variables such as level of education and contact with mentally ill people impact on nurses’ attitudes towards the mentally ill. Chan and Cheng add that students had a more positive attitude towards clients with mental health problems after taking the “mental health nursing” course. They support the premise that knowledge and contact promote a more positive attitude. The results of the above study are consistent with some previous studies. Penn et al (1994:567-568) found that nurses with psychiatric exposure demonstrate less authoritarian and restrictive attitudes, with a more positive and tolerant view of people with mental health problems.

Granskar et al (2001:255) found that a therapeutic relationship developed when students uncovered similarities between themselves and their mentally ill patients. Furthermore, the nursing students could understand the patients as individuals like themselves.

Chan and Cheng (2001:436) found that knowledge and contact promote a positive attitude among student nurses towards people with mental health problems. McLaughlin (1997:1221-1228) found that classroom theory had a positive effect on students' attitude towards people with mental health problems. However, Callaghan, Cheung, Lau, Lo and Tsui (1995:12-16) found that contact with mental health problems had no significant effect on nursing students' attitudes.

Mavundla (2000:1575) found that only 3 % of nurses had positive attitudes towards mentally ill people. The positive nature of general nurses' responses was based on their perception of their external environment as well as self-adequacy with regard to possessing appropriate knowledge and skills to nurse mentally ill people.

2.4 CONCLUSION

This chapter discussed the literature review undertaken on nurses' attitudes towards nursing mentally ill people, including stigma, knowledge and skill. The researcher is of the opinion that negative attitudes towards nursing mentally ill people are related to a lack of knowledge and skill and positive attitudes to the possession of knowledge and skill.

Chapter 3 the researcher describes the research methodology.