TITLE

The experience of being a psychiatric nurse in South Africa: a qualitative systematic review

Authors:

Francisco Alburquerque-Sendín, [a] Angelica Viana Ferrari,[b] Daiana Priscila Rodrigues-de-Souza,[c*] Paula Paras-Bravo,[d] Juan Francisco Velarde-García,[e] Domingo Palacios-Ceña[f]

Affiliations:

a. PhD. Full Professor. Department of Social and Health Sciences, Radiology and Physical Medicine. Universidad de Cordoba, Spain.

b. Physical Therapy Degree Student. Federal University of Sao Carlos, Sao Paulo state, Brazil. E

c. PhD. Assistant Professor. Department of Social and Health Sciences, Radiology and Physical Medicine. Universidad de Cordoba, Spain.

d. PhD, RN. Associate Professor. Nursing Department. Universidad de Cantabria, Spain.

e. PhD, RN. Full-Professor. Department of Nursing. Spanish Red Cross, Universidad Autonoma de Madrid, Instituto de Investigación Sanitaria Gregorio Marañón (IiSGM), Spain.

f. PhD, RN. Full-Professor. Department of Physiotherapy, Occupational Therapy, Rehabilitation, and Physical Medicine, Universidad Rey Juan Carlos, Spain.

Abstract

Background: The African continent can be a challenging working environment for nurses. Understanding the experiences of African psychiatric nurses can assist in improving the quality of care and the overall support of South African nurses.

Purpose: The purpose was to summarize the experiences of African psychiatric nurses in their workplace by examining the findings of existing qualitative studies.

Methods: A systematic review incorporating meta-synthesis. Seven databases were searched between 1998–2016. All qualitative studies in English, Portuguese, and Spanish were included that explored psychiatric nurses' experiences in Africa. Meta-aggregation was performed to synthesize the findings of the included studies.

Results: After removing duplicates, 18 full-text articles were reviewed. Eleven qualitative studies met the inclusion and quality criteria. All studies were conducted in South Africa. Five key findings were identified: a) organization and management; characterized by the lack of resources and institutional support, the presence of work dissatisfaction and the difficulties of applying quality care, b) the perception of insecurity; characterized by an unsafe environment for the nurse and the patient, the presence of violence and aggressiveness and the blaming of the assaulted nurses, c) the relationship with the psychiatric patient; characterized by both a lack of training and lack of knowledge concerning the management of the psychiatric patient, d) emotional experiences; highlighting feelings of fear, anger, anxiety, mental and physical exhaustion, and e) proposals for improvement; needs for greater training opportunities, institutional support and inter-professional collaboration.

Conclusions: Measures to increase the job satisfaction of psychiatric nurses are needed in order to improve the service they provide.

Introduction

According to the WHO (2008; 2013; 2015), mental health is integral to the general well-being of both a society as well as individuals. However, to date, health systems have been unable to sufficiently meet the needs and demands of those suffering from mental disorders. The latest figures reveal that among low and middle-income countries, between 76% and 85% of people with severe mental disorders receive no treatment whatsoever (WHO, 2013).

In Africa, the concept of mental illness is influenced by the historical context, the culture, the scientific knowledge accepted by the society and the educational level of the population (Njenga, 2007). These considerations, which are applicable to many countries in the world, can affect the care for mental disease in some African countries, as there is a predominant vision of mental health and those who suffer from it based on magic/religious beliefs, rather than scientific knowledge (Jenkins et al., 2013; Njenga, 2007; Okasha, 2002). Furthermore, the presence of any stigma could influence the provision of healthcare, the distribution of resources and the development of policies and strategies directed towards mental health (Cohen et al., 2016; Makanjuola et al., 2016; Reta et al., 2016; WHO, 2013).

Caring for people with mental illness requires extensive training, dedication and motivation (Abera et al., 2014; Jenkins et al., 2013; Reuter et al., 2016). However, in Africa, a number of barriers towards such care exist, (Maritz, 2010) such as: the lack of training, prolonged shifts, low salaries, low social and professional recognition, burn-out, and patient aggressiveness (Maritz, 2010; Mayundla, 2000; Tema et al., 2011).

In most African countries, mental health is poorly developed when compared to other areas of health (Jenkins et al., 2013; Okasha, 2002). Indeed, most African countries have no mental health policies, programmes or action plans against the stigma of mental illness, or for improving human resources and providing specialised training, whatsoever (Okasha, 2002). Previous studies (Cohen et al., 2016; Okasha, 2002; Reuter et al., 2016) have highlighted specific barriers to mental health development programmes in Africa, such as both a lack of awareness of the extent of the problem as well as a reliable information system, insufficient resources, both economic and human, the lack of national mental health policies, a shortage of specialized staff, the presence of civil unrest and violence and, occasionally, supernatural attributions for mental disorders. Additionally, the shortage of mental health programmes and the necessity to make the pertinent fiscal, staffing, and structural changes to these services can result in inferior levels of care (WHO, 2008; 2013). As a result, mentally ill people in Africa can become easily marginalized by both the social and care services, resulting in an unequal access to care (Jenkins et al., 2013; Okasha, 2002). This lack of an appropriate infrastructure means that these patients are admitted into general hospital wards which can lead to feelings of vulnerability. (Poggenpoel et al., 2011).

Throughout Africa, the presence of traditional healers constitutes a further challenge. Many of these are strongly against taking any medication, which can negatively affect the provision of mental health care (Cohen et al., 2016; Okasha, 2002). Indeed, it is reported that across Africa, no models of multi-sectoral collaboration with traditional or religious healers are in place (Hanlon et al., 2014).

The WHO states that the number of both specialized and general health workers who are working with mental health in low-and-middle-income countries is insufficient (WHO,

2015). In fact, in the early 21st century, the African continent had a woefully low number of just 1200 psychiatrists and 12,000 psychiatric nurses for a population of some 620 million (an average number of psychiatrists of 0.05/100,000 population in the African region). This, compared to Europe, which had over 86,000 psychiatrists and 280,000 psychiatric nurses for a population of 840 million (Okasha, 2002). In several African countries, mental health services are provided by psychiatric nurses (Okasha, 2002). In South Africa and Kenya (Maritz, 2010), much of the workload is carried out by nurses in clinics that only receive weekly or monthly visits by a psychiatrist (Jenkins et al., 2013). Nurses are often overworked and demoralized, and this negatively impacts the provision of any continuity in providing appropriate care (Jenkins et al., 2013). Currently, in Uganda, South Africa and Ethiopia, several initiatives are in place for implementing integrated mental health care in primary care (*PRIME*) and community settings (Hanlon et al., 2014). As an example, the *PRIME* programme (Mendenhall et al., 2014) uses non-specialist health workers to deliver mental health care.

In addition, throughout Africa, the access to specific medication for treating psychiatric disorders is extremely limited. Financial problems and a fear of stigmatization also act as barriers to accessing quality mental treatment (Reuter et al., 2016; WHO, 2013). Moreover, there is a shortage of basic medication for mental disorders (in comparison to those available for infectious diseases), and their use is restricted because of the lack of qualified health professionals who are authorised to prescribe such medications (WHO, 2013). As an example, in Ethiopia, all psychiatric clinics are operated by nurses who prescribe medications and treat acute illnesses (Okasha, 2002). In South Africa, Maritz (2010) states that in the Western Cape Province, it is solely the nurses who are responsible for identifying any mental health disorders in their patients, as well as the management

of the same, including the administration of psychotropic medication or recommendations for changes in medication, and timely interventions in situations of crisis.

The roles and functions of psychiatric nurses can vary based on the country of origin (Delaney and Johnson, 2014; Grant et al., 2016), although they share common actions (Fung et al., 2016) such as: respect for a patient's intimacy and autonomy (Delaney et al., 2017; Fung et al., 2016) the accompaniment of the patient and the family (Fung et al., 2016), intervention in the community and the social context (Delaney et al., 2017), controlling the patient's safety (Delaney and Johnson, 2014; Higgins et al., 2016; Slemon et al., 2017), and the need for discovering the person behind the illness (Moonen et al., 2016; Salzmann-Erikson et al., 2016). On the other hand, according to previous studies, nurses highlight the organization of the health services and psychiatric services (Phoenix et al., 2016; Rocha et al., 2016), the lack of resources (Delaney, 2017), the lack of organizational support (Delaney and Johnson, 2014) and the difficulty for retaining nurses in the field of mental health (Mahoney et al., 2016; Prosser et al., 2017), influencing the care applied and the time dedicated to patients (Tenkanen et al., 2016). Furthermore, on occasion, nurses suffer from episodes of aggression on behalf of patients which may condition their wellbeing and their perception of the mental health work (Berring et al., 2015; Pekurinen et al., 2017; Stevenson et al., 2015). Despite these episodes, nurses perceive these situations as part of their job, and they implement programs to intervene and decrease the episodes of aggression by working with the patients, the professionals (Berring et al., 2016a), and the community (Berring et al., 2016b).

Aims

Understanding African psychiatric nurses' experiences of nursing care and the nursing profession can help care managers design appropriate programmes and better prepare

nurses to cope with mental healthcare in Africa. We performed a comprehensive search in the Cochrane Library and the Joanna Briggs Institute (JBI) Systematic Review Databases, which revealed that, as far as we are aware, no systematic review has addressed this issue to date. The aim of this study was to synthesize the existing qualitative evidence in order to acquire a deeper understanding of the experiences that psychiatric nurses may have when working in Africa.

Methods

Design

A qualitative meta-synthesis study was conducted. The preparation of this manuscript followed the recommendations for qualitative studies developed by the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) (Tong et al., 2012) (http://www.equator-network.org/reporting-guidelines/entreq/). The choice of the method for the review and synthesis of knowledge is determined by its ability to respond to the research question and study aims (Kastner et al., 2012; 2016). The researchers chose a qualitative meta-synthesis approach, as this responded to the aim of providing an in-depth description of the experiences of psychiatric nurses, based on qualitative studies, compared to other designs such as integrative reviews, which gather other non-qualitative documents (quantitative studies and/or mixed) (Kastner et al., 2016). Meta-synthesis approaches are used to combine and present qualitative findings (Thomas and Harden, 2008; Walsh and Downe, 2005). This enables the preservation of meaning with regards the individual studies while producing a new and integrated interpretation of findings. It also helps enhance the development of clinical practice, and theory development (Finfgeld-Connett, 2010). The expectations, preferences, knowledge, and values of health professionals are all factors that may influence the effectiveness of a

health intervention. These factors provide rich contextual details that can be used to establish theories as to why certain interventions work (or fail) in particular settings and contexts (Delaney et al., 2017; Tricco et al., 2016). As such, the perceptions, and values, of social contexts are important factors to consider when planning, implementing, and evaluating health care interventions, and which may modify previous frameworks or theories (Tricco et al., 2016). This review focused on the following questions: (1) What are nurses' experiences of psychiatric nursing jobs in the African context? (2) What are African psychiatric nurses' roles and duties?, and (3) What is the work environment like for African psychiatric nurses?

Search methods

Sampling

Electronic searches were undertaken in order to source journal articles published in English, Portuguese, and Spanish in Medline/Pubmed, Scopus, Web of Science, Nursing and Allied Health Database, ProQuest, Psycinfo, and CINAHL. We selected these databases as they are known to be the most appropriate regarding the inclusion of relevant articles. This search was restricted to papers that were published from January 1998 to December 2016. Search terms and subject headings were developed and used where feasible and adjusted for different databases. Six groups of terms were combined: (1) Nurses, nursing, nurs*; (2) Psychiatric Nursing, psychiatr*; (3) mental health; (4) experiences, experienc*, perception*; (5) qualitative, qualitative research, qualitat*; (6) Africa, Afric*.

Also, we performed other online searches to identify grey literature that did not appear in previous searches, by consulting the following databases (Aromataris and Riitano, 2014):

Open Gray, NLM, Catalogue, OpenDOAR, Lenus, RIAN, e-publications@RCSI, Social Science Research Network, EthOs, DART-Europe, Bielefeld Base, and Google Scholar. These online searches used key words to standardize the search in all databases. The keywords used were: "nurse", "experience", "psychiatric", "qualitative", "Africa".

Throughout this review, the following key terms are used as follows: **African nurse** was defined as a registered nurse who has graduated from an accredited and/or approved nursing programme, successfully passing the nurses registration examination and who has been working in any African country (Wilson et al., 2015). In this manner, we avoided including works where the care of people with mental health needs was applied by other participants such as the family, local leaders or other professionals. **Psychiatric nursing** was defined as the application of psychiatric principles in caring for the mentally ill. It also includes the nursing care provided to the mentally ill patient (https://www.ncbi.nlm.nih.gov/mesh/68011568). Two authors (AVF, DPRS) read all the papers retrieved from the databases, and a team of researchers (FAS, PPB, DPC) read and discussed those papers considered to meet the eligibility criteria for inclusion.

Inclusion and exclusion criteria

The study inclusion criteria were: original research, qualitative studies, focused on bed-side nurses, and on psychiatric nurses working in African countries, and written in English, Portuguese, or Spanish. The primary qualitative research studies considered by this study included, but were not limited to, methodologies such as phenomenology, narrative stories, grounded theory, action research, ethnography and qualitative case studies (Carpenter and Suto, 2008; Creswell and Poth, 2017). Participants were limited to an African context or setting, but included studies conducted in any care setting.

Papers were excluded if they were: not primary research or quantitative studies, regarding nurses who did not work in Africa, about African nurses who were not working in psychiatric units, and not in English, Portuguese or Spanish.

"Africa", the term used in the inclusion criteria, included (https://www.ncbi.nlm.nih.gov/mesh/68000349): a) Africa, Northern, and b) Africa South of the Sahara with Africa, Central, Africa, Eastern, Africa, Southern, and Africa, Western.

Search outcome

The initial search using the above strategy resulted in a total of 6771 articles. After reviewing the same, duplicates were removed. The articles were subsequently assessed for relevance using the inclusion criteria and based on their respective title and abstract. This led to the exclusion of 6753 citations. The full texts of the remaining 18 citations were retrieved for potentially relevant citations. Two independent reviewers then assessed these based on the inclusion and exclusion criteria. After an in-depth study of the full-texts, seven articles were excluded. The remaining eleven studies were subsequently appraised by two independent reviewers. This search process is shown in Figure 1.
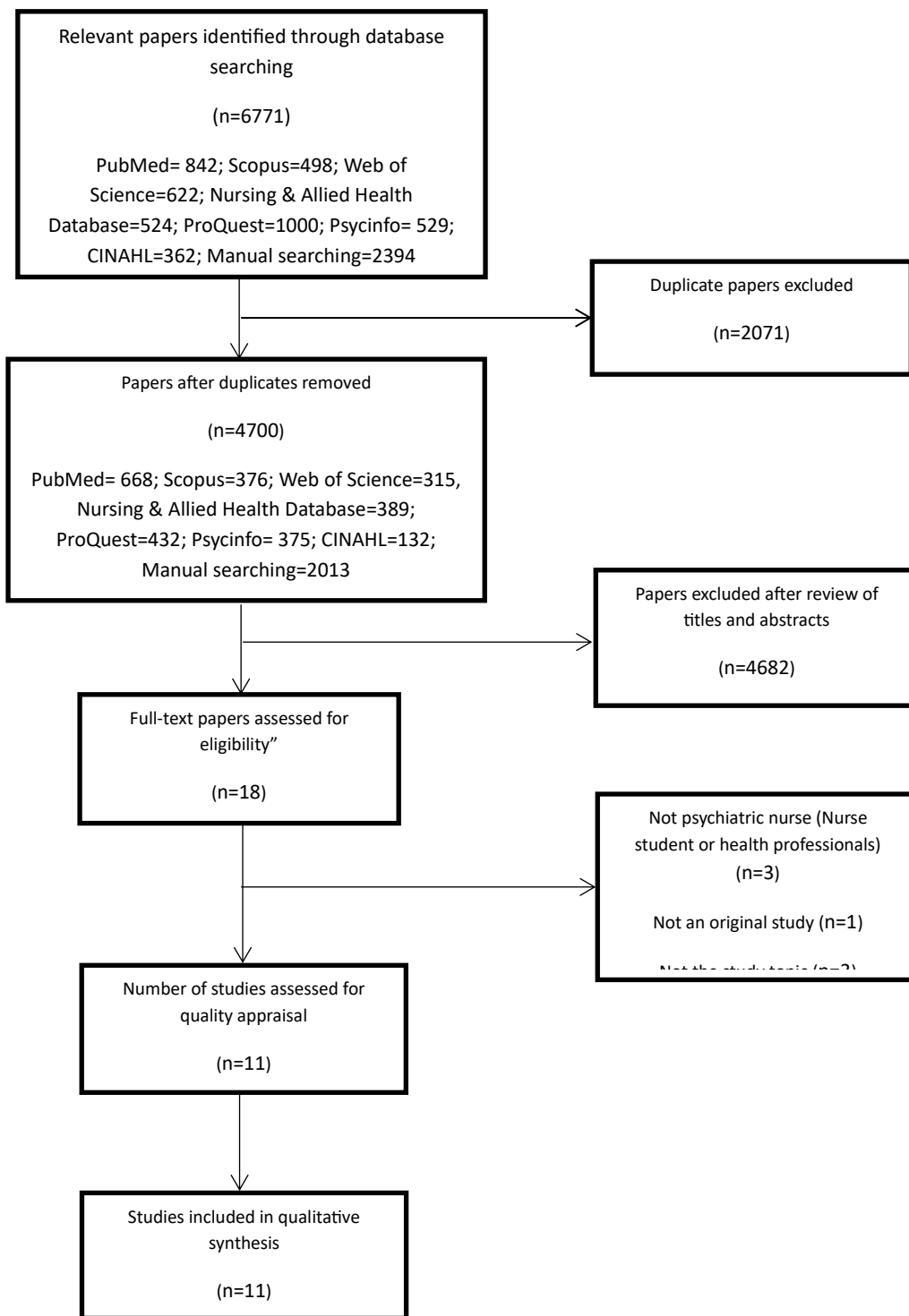
Relevant papers identified through database searching

(n=6771)

PubMed= 842; Scopus=498; Web of Science=622; Nursing & Allied Health Database=524; ProQuest=1000; Psycinfo= 529; CINAHL=362; Manual searching=2394

Duplicate papers excluded

(n=2071)

Papers after duplicates removed

(n=4700)

PubMed= 668; Scopus=376; Web of Science=315, Nursing & Allied Health Database=389; ProQuest=432; Psycinfo= 375; CINAHL=132; Manual searching=2013

Papers excluded after review of titles and abstracts

(n=4682)

Full-text papers assessed for eligibility"

(n=18)

Not psychiatric nurse (Nurse student or health professionals) (n=3)

Not an original study (n=1)

Not the study topic (n=3)

Number of studies assessed for quality appraisal

(n=11)

Studies included in qualitative synthesis

(n=11)

Figure 1. Flow chart of search results.

Quality appraisal

The quality of the 11 included studies was determined using the Critical Appraisal Skills Programme checklist (CASP, 2016). This tool has been proven to be effective in many previous metasyntheses (Morrow et al., 2016) and is useful in order to depict the range of quality among the studies (Finfgeld-Connett, 2010; Thomas and Harden, 2008; Tong et al., 2012). The tool comprises 10 questions which are aimed at quickly and efficiently appraising the research studies by requiring a mere 'yes', 'no' or 'can't tell' answer for each question. The initial two screening questions focus on the research aims and the appropriateness of qualitative methodology for addressing the study goal. Only in the case of a study scoring 'yes' for both questions does the researcher continue with the appraisal. The remaining eight questions are related to appraising the research design, recruitment strategy, data collection, relationship between researcher and participants, data analysis, ethical issues, research findings statement and research implications.

In this review, two researchers from the study team independently assessed the quality of each paper (AVF, FAS), and, after conferral of findings and scores, a final decision was made regarding the inclusion of each study.

Data abstraction and synthesis

Data extraction

Kastner et al., (2102; 2016) defend the need for synthesis studies to include the essential content (sections) of the documents obtained in order to display their characteristics and thus be able to assess the quality of its contents and methodological development. Data extraction included key descriptive details of the included papers, such as bibliographic

details, participants, setting, purpose of the study, data collection, analysis, and the main results.

Data synthesis

We used meta-aggregation to synthesize the findings of the qualitative studies. This is a method of systematic review that involves both the categorizing and re-categorizing of the findings of two or more studies in order to develop synthesized findings (Joanna Briggs Institute, 2014). First, the papers were carefully read and re-read at least a second time by the researchers to give them a preliminary understanding. Subsequently, each finding was then extracted together with the textual data that either illustrated or supported the finding. The level of congruency between the findings and supporting data was then assessed independently by two of the research team members in order to communicate to which point the interpretation of the researcher was credible. Each finding was provided a level of credibility: unequivocal, credible or unsupported (Joanna Briggs Institute, 2014). The text of the findings was then coded line by line according to its content and meaning. The researchers looked for similarities and contradictions between the findings and the illustrative data, after which they created categories designed to determine the meaning of groups of initial data. These categories were then repeatedly read and re-read in order to identify similarities and thus form synthesized results.

Results

Study characteristics

All studies were conducted in South Africa and all were written in English. Ten of the studies used in-depth interviews while one used focus group methods (Ngako et al., 2012). All studies recruited participants using purposive sampling, and two also included

snow-ball sampling techniques (Manyedi and Dikobe, 2016; Maritz, 2010). Of the eleven studies included in this review, seven were original articles, three were master's theses (de Beer, 2013; Machailo, 2013; Sobewa, 2012) and there was one conference communication (Manyedi and Dikobe, 2016). Ten studies recruited participants within hospital or psychiatric institution settings and one recruited participants in the primary care setting (Maritz, 2010). The total number of nurses who participated was 161, of which there were 128 women, 21 men and 12 whose sex was unspecified (Mavundla et al., 1999) (Table 1).

Furthermore, all the studies reviewed included nurses who had graduated from an accredited / approved nursing program and who had been working at a hospital-based psychiatric ward or community mental health services, although the training program they followed to become a nurse was not described, nor whether the nursing degree had been obtained in an African country or outside Africa. However, the studies did include: whether the nurses had psychiatric nursing training or were specialised in psychiatric nursing (Bimenyimana et al, 2009; de Beer, 2013; Machailo, 2013; Manyedi and Dikobe, 2016; Ngako et al, 2012; Poggenpoel et al, 2011; Tema et al, 2011), the minimum work experience with people with mental illness (de Beer, 2013; Machailo, 2013; Mavundla, 2000; Mavundla et al, 1999; Manyedi and Dikobe, 2016; Sobewa, 2012; Tema et al, 2011), which varied between 6 months experience (Machailo, 2013; Sobewa, 2012) and 5 years (de Beer, 2013), and whether they were registered at the South Africa Nursing Council (Bimenyimana et al, 2009; Mavundla, 2000; Mavundla et al, 1999).

Reference	Setting	Participants	Aims of study	Data collection	Sample	Findings
Manyedi and Dikobe, 2016	A psychiatric hospital in North West Province, South Africa	Nurses caring for psychiatric patients with dual diagnosis with more than three years of experience	To explore and describe the experiences of nurses in caring for psychiatric patients with dual diagnosis and to make recommendations that could assist nurses to improve the care for psychiatric patients	Unstructured individual interviews	Purposive sampling and snowball technique (n=12; female)	Negative and positive experiences about caring for psychiatric patients with dual diagnosis; Suggestions to consider in caring for psychiatric patients with dual diagnosis
de Beer, 2013	A psychiatric institution in Pretoria, South Africa	Psychiatric nurses working in a psychiatric institution with at least five years' experience working in a psychiatric institution	To explore and describe the experiences of psychiatric nurses who have been exposed to aggression by mental health care users while working at a psychiatric institution	In-depth individual phenomenological interviews and field notes	Purposive sampling (n=8; 6 female, 2 male)	Emotional distress by psychiatric nurses; Experiencing aggressive behaviour manifesting as both verbal and physical aggression; Exposure to aggressive outburst; Participants experience conflict between their job mandate (that is to treat mental health care users with due care) and a need for personal safety; Experiencing that supportive organizational factors serve to restore and or maintain a psychological security and confidence among nurses
Machailo, 2013	A psychiatric institution in Guateng, South Africa	Registered psychiatric nurses working at a psychiatric institution with between one and fifteen years' experience, and at least 6 months	To explore and describe the lived experiences of psychiatric nurses, working with children diagnosed with mental illness and to formulate guidelines in order to facilitate these	In-depth phenomenological interviews and field notes	Purposive sampling (n=10; female)	The psychiatric nurses' experience of challenges associated with tensions inherent to the contextual demands; The experience of psychiatric nurses of the contextual demands that require a process of continuous adjustment

		experience working with children diagnosed with mental illness	psychiatric nurses' mental health			
Ngako et al, 2012	A public mental health care unit in Gauteng, South Africa	Registered psychiatric nurse practitioners who had more than one year experience working in a public mental health care institution	To explore and describe psychiatric nurses' experiences of working with mental health care users presenting with acute symptoms	Focus group	Purposive sampling (n=21; 8 male, 13 female)	The experience of entering an unsafe world; Negative emotional reactions and attitudes towards mental health care institutions that compromise quality nursing care; A plea for a nurturing environment that would enhance quality nursing care
Sobewa, 2012	A psychiatric hospital in Western Cape, South Africa	Nurses caring for mental health care users, with more than six months of experience in the unit	To explore and describe the lived experiences of nurses caring for mental health care users' at an acute admission unit at a psychiatric hospital	In-depth, semi-structured one-on-one interviews	Purposive sampling (n=8; 5 female, 3 male)	Challenging working environment; unsafe working environment; positive job aspect; Compromised clinical care; Negative work experiences
Poggenpoel et al, 2011	Medical wards of three public hospitals in Johannesburg, South Africa	Registered nurses working for more than 12 months in three medical wards	To explore and describe registered nurses' experiences of interacting with patients with mental health challenges in the medical wards of a public hospital	Individual in-depth phenomenological interviews	Purposive sampling (n=8; 7 female)	Frustration because of perceptions of patients' behaviour as being unpredictable; unhappiness and fear because of lack of resources; Perceptions of danger and confusion because of lack of knowledge and skills that lead to feelings of fear and anger.
Tema et al, 2011	Forensic ward in a psychiatric institution, Limpopo, South Africa	Psychiatric nurses working in a forensic ward with more than one year experience in forensic wards	To explore and describe the psychiatric nurses' lived experience of hostile behaviour by patients in a forensic ward, and make	In-depth, phenomenological interviews, participant	Purposive sampling (n=9; 2 male, 7 female)	Psychiatric nurses' experiences of fear related to threats of aggression from patients; Experience of disempowerment related to a lack of recognition; Psychiatric nurses

			recommendations for nurse managers to empower psychiatric nurses in the forensic ward.	observation and field notes		experience emotional and physical distress related to interactions with patients; Psychiatric nurses utilized defence mechanisms to maintain their mental health
Maritz, 2010	Thirty primary care clinics in South Africa	Mental health care users in the primary care setting	To explore and describe nurses' experience of the follow-up and follow-through of mental health care users in the primary care setting, and to describe guidelines for those providing follow-up and follow-through care	Nine semi-structured interviews and 46 naïve sketches	Purposively sampling and snowball technique (n=55; female)	Inadequate service provision related to availability of resources (human, time, infrastructure); Practice system support; The attitudes of mental health care users and the family
Bimenyimana et al, 2009	A psychiatric institution in Gauteng, South Africa	Psychiatric nurses with two years of experience in the psychiatric institution	To explore and describe the lived experiences by psychiatric nurses of aggression and violence from patients in a psychiatric institution	One-on-one interviews	Purposively sample (n=10; 5 male, 5 female)	Contributing factor to violence and aggression from patients; The experiences of aggression and violence from patients include certain feelings and emotions; The experience of aggression and violence from patients leads to ineffective coping mechanisms
Mavundla, 2000	A tertiary hospital in Durban, South Africa	Nurses working in an urban general hospital who were involved in nursing mentally ill, with at least 2 years of experience in a general hospital	To explore and describe the general hospital nurses' perception of nursing mentally ill people.	Phenomenological semi-structured interviews and observations with field notes	Purposively sampling (n=8; female)	Perception of self, perception of the patient, perception of the environment and perceived feelings that hinder the nursing care of the mentally ill patient

| Mavundla et al, 1999 | An urban-based general hospital, South Africa | Nurses working in an urban general hospital who were involved in nursing mentally ill, with at least 2 years of experience in a general hospital | To explore and describe the general hospital nurses' experience of violence when nursing mentally ill people | In-depth, individual phenomenological semi-structured interviews | Purposively sampling (n=12) | Physical violence as experienced by nurses; Feelings experienced by nurses (fear and despair); Need for support from security staff, superiors and doctors; Strategies used by nurses for coping with violent patients; Lack of protocols or policies for dealing with emergency situations; Victim blaming of nurses by their superiors; Incidentation or writing of statements in the Ward; Consequences of violence for nurses |

Table 1. Characteristics of qualitative studies included.

Regarding the quality of the included studies, all studies covered all items of the CASP (2016), with the exception of two items; item 6 (Relationship considered between research and participants) which appears in eight studies and item 9 (clear statement of the results), which appears in 10 studies (Table 2).

	Manyedi and Dikobe, 2016	de Beer, 2013	Machailo, 2013	Ngako et al, 2012	Sobewa, 2012	Poggenpoel et al, 2011	Tema et al, 2011	Maritz, 2010	Bimenyimana et al, 2009	Mavundla, 2000	Mavundla et al, 1999
1. Clear statement of the aims of research	√	√	√	√	√	√	√	√	√	√	√
2. Appropriateness of qualitative design	√	√	√	√	√	√	√	√	√	√	√
3. Research design consistent with the aims of research	√	√	√	√	√	√	√	√	√	√	√
4. Sampling strategies method appropriate	√	√	√	√	√	√	√	√	√	√	√
5. Data collection strategy appropriate	√	√	√	√	√	√	√	√	√	√	√
6. Relationship considered between research and participants	√	√	√	x	-	√	x	x	√	√	√
7. Ethical issues considered	√	√	√	√	√	√	√	√	-	√	√
8. Data analysis rigorous	√	√	√	√	√	√	√	√	√	√	√
9. Clear statement of the results	x	√	√	√	√	√	√	√	√	√	√
10. Value of the research	√	√	√	√	√	√	√	√	√	√	√

Symbols indicate: √ Yes; – Cannot tell; x No.

Table 2. Methodological quality of qualitative studies (CASP 2016).

Results of the synthesis

The findings were aggregated into 27 categories on the basis of similarity in meanings. From the 27 categories, five synthesized findings (Table 3) were developed: organization and management, perception of insecurity on behalf of professionals, the relationship with the psychiatric patient, emotional experiences and proposals for improvement.

		Manyedi and Dikobe, 2016	de Beer, 2013	Machailo, 2013	Ngako et al, 2012	Sobekwa, 2012	Poggenpoel et al, 2011	Tema et al, 2011	Maritz, 2010	Bimenyimana et al, 2009	Mavundla, 2000	Mavundla et al, 1999
Organization and management	Lack of institutional support/management of professionals	√	√			√	√	√		√		√
	Insufficient resources	√	√	√	√	√	√	√	√	√	√	√
	Lack of support and/or discoordination with the family and the professionals			√	√				√		√	√
	Difficulty providing quality care and follow-up	√				√	√		√		√	
	Work dissatisfaction		√			√	√		√	√	√	
Perception of insecurity on behalf of professionals	Unsafe working environment	√	√	√	√	√	√	√	√	√	√	√
	Difficulty for ensuring the security of the patient/professionals						√					
	Aggression and/or violence towards professionals		√		√	√		√		√		√
	Blame and/or lack of support towards assaulted professionals		√			√						√
Relationship with the psychiatric patient	Difficulty and/or lack of knowledge regarding managing patients	√	√	√		√	√	√		√	√	

	Patients with unpredictable behaviour and/or difficult management	√	√			√	√	√			√		
	Ineffective communication with the patient		√					√					
	Lack of respect and/or intimidation on behalf of patients		√		√			√					
	Lack of skills and knowledge	√	√	√			√	√	√	√	√		
Emotional experiences	Negative feelings towards patients	√	√				√	√		√	√		
	Frustration		√			√	√	√		√	√		
	Feelings of unhappiness and anger		√				√						
	Fear	√	√			√		√		√	√		√
	Anxiety							√					
	Mental and physical exhaustion		√			√		√					
	Ineffective management of emotions				√								
Proposals for improvement	Displaying a positive attitude												
	Developing skills and competencies				√		√	√				√	

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Institutional support		√	√	
Need for emotional support		√	√	
Improvement of installations and resources	√	√	√	√
Collaboration multidisciplinary team	√			

Symbols indicate: √ Yes.

Table 3. Findings of meta-synthesis.

Organization and management

This finding was based on 5 categories; Lack of institutional support, insufficient resources, discoordination with the family and the professionals, difficulty to provide quality care, and nurses' work dissatisfaction.

First of all, the nurses described a lack of support on behalf of the psychiatric centre institutions (Bimenyimana, 2009; de Beer, 2013; Manyedi and Dikobe, 2016; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012; Tema et al., 2011): *"When we talk about management, these people do not help with anything."* (de Beer, 2013); *"To add on what you said about the support from management, the support is not there."* (Sobekwa, 2012). This lack of support derives in the dissatisfaction of nurses who felt that their efforts were unappreciated (Sobekwa, 2012): *"All that we want is the management to care, if something happens to a person, they must care and they should take initiatives not the people."* (Sobekwa, 2012)

Secondly, a common issue in all studies, was that of insufficient resources, considered a set-back for the provision of care, this includes: the lack of staff (Bimenyimana, 2009; Maritz, 2010; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012; Tema et al., 2011), crowded conditions for patients due to the lack of available beds (Mavundla, 2000; Sobekwa, 2012), a lack of communication between professionals (Maritz, 2010), the premature discharge of patients due to the lack of available beds (Manyedi and Dikobe, 2016) and deficient infrastructures (de Beer, 2013; Poggenpoel et al., 2011; Tema et al., 2011): *"….I'll make you an example, like now…here in the ward we have 34 patients and that thing has been happening since the beginning of this year. The capacity of this ward its 30…but it has been happening"* (Sobekwa, 2012); "*Psychiatric patients with dual diagnosis are discharged prematurely; maybe if there was enough space and the half way houses, the centres that I was talking about maybe it could help, those who are better can be taken to half way houses*." (Manyedi and Dikobe, 2016)

The third category described how the nurses acknowledged that many of the resources were not being correctly used due to a lack of support or coordination among different professionals, which can make the nurse feel isolated (Bimenyimana et al., 2009; Maritz, 2010; Mavundla, 2000; Mavundla et al., 1999; Ngako et al., 2012): *"The nurses are expected to do everything, like when the psychologists come here first of all they will depend on you for assistance but at the end of the day, they will not respect you. A doctor will expect you to do everything: patients 'files and different forms, yet when you are alone, nobody helps"* (Bimenyimana et al, 2009); *"The most difficult and challenging point is lack of support from colleagues, supervisors, families and the communities at large."* (Ngako et al., 2012). Ngako et al., (2012) and Mavundla (2000) go so far as to highlight a lack of support on behalf of the security staff: *"...can't get help from the security personnel at times..."* (Mavundla, 2000).

Category number four described how all the above leads to a poor quality of care (Manyedi and Dikobe, 2016; Maritz, 2010; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012;), excessive work loads (Maritz, 2010; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012), and considerable delays that can affect patient care (Maritz, 2010; Mavundla, 2000; Ngako et al., 2012): *"Nurses need to be allowed to have quality time with their client to be able to give quality services"* (Maritz, 2010)

Finally, the last category showed that work dissatisfaction is apparent among nurses (de Beer, 2013; Bimenyamina, 2009; Sobekwa, 2012), together with burn-out (Sobekwa, 2012) and work absenteeism (de Beer, 2013; Bimenyamina, 2009). Due to the work overloads, conditions of insecurity and lack of support were reported (Maritz, 2010; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012): *"Instead of getting moral support from their managers and other members of the team, nursing staff get blamed for each incident that happens. These things end up causing*

emotional stress to nursing staff and this leads to alcohol abuses and a high rate of absenteeism" (Bimenyimana, 2009).

On the other hand, Sobekwa (2012), describes how, despite the difficulties, the nurses felt reassured by the recovery of their patients and thanks to the passion they feel for their job: *"...really sometimes fulfilling when you see there's a change in the patient and you really... there is a difference in the life of that patient and the family...really that's rewarding of working in psychiatry with our patients...even if it takes some time but it's rewarding."* (Sobekwa, 2012).

Perceptions of insecurity on behalf of the professionals

The perception of insecurity is described in all studies. Insecurity affects nurses and the difficulty of maintaining a safe environment for patients, especially those with suicide attempts or those who may assault other patients (Manyedi and Dikobe, 2016; Poggenpoel et al., 2011): *"So imagine being me alone and the patient in the room, it is not safe, the person is physically aggressive he can hit you with anything and they become so strong, they can hit you with a table, they can hit you with anything."* (Manyedi and Dikobe, 2016).

Although acts of aggression are infrequent, they cause considerable emotional stress, especially to those who have suffered previous assaults (de Beer, 2013). The nurses modify the way they relate with patients, reducing contact periods and care times (de Beer, 2013). Furthermore, feelings of helplessness, anger and rage appear towards patients: *"The way you talk to them then it ended up making them angry because you didn't approach them nicely as a human being."* (de Beer, 2013).

In certain studies, differences are described between the aggression experienced according to the gender and the age of nurses (de Beer, 2013; Ngako et al., 2012; Sobekwa, 2012; Tema et al., 2011). Sobekwa (2012), describes how nurses were fearful of the male patients and that, on occasion, being a young woman and a nurse increases the risk of being physically abused and suffering sexual abuse (de Beer, 2013), to the point of suffering harassment and sexual abuse (Ngako et al., 2012; Tema et

al., 2011): *"That huge man proposed love to me, saying he likes young women. He kept on throwing glances at me. I was scared"* (Tema et al., 2011)

Such aggression can cause physical and mental problems (Mavundla et al., 1999; Sobekwa, 2012) which can lead to such potentially harmful behaviour as excessive alcohol consumption (Bimenyamina, 2009; Tema et al., 2011): *"Maybe that's why in the nurses' home there are so many bottles empty everywhere; they drink on an almost daily basis because I know people who drink every day. No matter in or out, off or on duty, every day they must drink."* (Bimenyamina, 2009).

In general, nurses are blamed for suffering these assaults and do not feel supported by the system (de Beer, 2013; Mavundla et al., 1999; Sobekwa, 2012): *"Now if you are injured by the patient, they say it's your own carelessness because you are not supposed to hold the patients"* (Mavundla et al., 1999); *"No…I was still saying…the managers when something happens to the patient they are very quick to come and ask where were the nurses? What where they doing?... but when the nursing staff gets assaulted not even a single person comes to enquire how is that employee doing today, and perhaps make a follow up the next week on the injured employee or even just doing what is called "debriefing" for all the staff members"* (Sobekwa, 2012).

On occasion, these situations occur due to the lack of sufficient staff, not due to an inappropriate provision of care (de Beer, 2013; Bimenyimana, 2009): *"There was a time when a patient was kicking windows and then we had to put her in a side room and we were only two in the ward. So we couldn't take her in a side room and she was fighting us, yeah and our clothes were torn."* (Bimenyimana, 2009).

Relationship with the psychiatric patient

Psychiatric patients are a challenge for nurses. Indeed, a lack of knowledge regarding the management of psychiatric patients hinders the ability to provide appropriate care. The studies reveal that nurses complain of possessing insufficient skills for providing quality care

(Bimenyimana, 2009; de Beer, 2013; Machailo, 2013; Manyedi and Dikobe, 2016; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012; Tema et al., 2011): *"It was difficult to understand their behaviour. And to match behaviour with the condition, as also their management as well, because we did not know what the right thing to do is"* (Machailo, 2013).

On occasion, asymmetric relationships develop with patients (de Beer, 2013; Tema et al., 2011), especially in the case of male patients who may consider themselves to be superior to the female nurse (de Beer, 2013; Ngako et al., 2012; Tema et al., 2011): *"I think male patients if you are female nurse, they tend to disrespect you maybe knowing that as a female you are powerless than like you know that males are powerful than females"* (de Beer, 2013).

Emotional experiences

The studies highlight negative feelings such as: frustration, unhappiness, anger, fear and anxiety (Bimenyimana, 2009; de Beer, 2013; Manyedi and Dikobe, 2016; Mavundla et al., 1999; Mavundla, 2000; Poggenpoel et al., 2011; Sobekwa, 2012; Tema et al., 2011). Furthermore, the combination of situations that are beyond the nurse's control and the effects of mental and physical exhaustion increase the risk of substance abuse and apathy (Bimenyamina, 2009; Machailo, 2013; Tema et al., 2011): *"And at times when the patient starts swearing at, at you, you become so, I become so personally eh… frustrated"* (Poggenpoel et al., 2011); *"Most of us smoke and take alcohol to deal with the stress, sometimes I just smoke continuously, I don't like that, but it relieves me".* (Tema et al., 2011); *"Tired! You get tired because you got have to do everything, you got to do your administration work, you got to do your supervision work, you have to give the patient quality care and with the….nurse patient ratio here is very bad. So you get yourselves to do things that…you…that are impossible, giving attention to 35 patients at once. And acutely psychotic patients!"* (Sobekwa, 2012)

The studies highlight the difficulties described by nurses in managing their emotions (Ngako et al., 2012; Tema et al., 2011): *"Caring for some of these patients is frustrating. One young patient challenged my authority, I felt like bursting, but I couldn't do that in front of other patients, I absorbed my angry feelings. I pretended as if I was fine. Now that I have shared that with you, I feel better"* (Tema et al., 2011)

Proposals for improvement

The articles also include proposals for improvement directed at the nurses and related with their education, the improvement of the quality of care and the work conditions. The need for increasing the training and skills of nurses is also described to improve the management of psychiatric patients (Mavundla, 2000; Ngako et al., 2012; Poggenpoel et al., 2011; Tema et al., 2011), as well as improve the multidisciplinary coordination in order to facilitate the relationships between the nurses and the family and the use of protocols of nursing care (Manyedi and Dikobe, 2016): *"The doctor refers the patient to the social worker or the psychologist and also refers them for rehabilitation to occupational therapy"* and *"to intensify the working relationship between the multidisciplinary team."* (Manyedi and Dikobe, 2016); *"The protocol is there to help you to see what to give the patient when he is aggressive."* (Manyedi and Dikobe, 2016).

This institutional support is relevant for nurses to feel valued and also for providing the necessary resources (staff, installations and security) to facilitate correct patient care and conditions of safety (Maritz, 2010; Manyedi and Dikobe, 2016; Ngako et al., 2012; Tema et al., 2011): *"Management must give us 100% support; they shouldn't come when there is something that is why I said they should motivate us." "Management should not just come when there is a problem, they should show their support."* (Manyedi and Dikobe, 2016).

Lastly, nurses require emotional support (Ngako et al., 2012; Tema et al., 2011) to avoid the inappropriate management of stress (alcohol consumption) and to protect their mental health: *"Once*

you work with these people you should go for therapy regularly, in any way you know just to debrief what you are feeling" (Ngako et al., 2012).

Discussion

A qualitative systematic review on the experience of African psychiatric nurses was performed in different databases and after a manual search. After the review, 11 manuscripts were selected, all of which were from South Africa. The prior questions that guided this review (What are nurses' experiences of psychiatric nursing jobs in the African context? What are African psychiatric nurses' roles and duties? What is the work environment like for African psychiatric nurses?) helped clarify what the themes suggested in terms of answers to the questions. The meta-synthesis identified the following themes: organization and management, the perception of insecurity on behalf of professionals, the relationship with the psychiatric patient, emotional experiences and proposals for improvement.

A prior review was conducted in the United States by Delaney and Johnson (2014). Their metasynthesis of research focused on the perceptions of psychiatric nurses regarding their role and practice in psychiatric units, reporting the nurses' efforts to forge engagement with patients, the importance of aspects such as a cohesive nursing team and their sense of self-direction in their role. Furthermore, according to the authors, nurses encountered difficulties in enacting their role which included multiple responsibilities for patient care and management of the milieu. The authors included studies from Europe, America and Australia, including 10 years of searches (2000-2010), and a review of three databases (CINHAL, PubMed and PsychINFO). The process of metasynthesis was described as being based on the 5-step proposal by Cooper, however they did not include the

algorithm of the search process, nor the criteria applied to determine the quality of the studies included. Despite the methodological differences, they display similar results compared to the studies included in our results, such as the responsibility of nurses for maintaining safety and caring for patients, at times feeling disrespect and misperceptions regarding their work.

It is important to note that all the documents found belong to the same country, South Africa. On the African continent there is a great diversity of cultures and ethnicities, this entails different perspectives and experiences, which may influence the results. In our opinion, this lack of publications in the African continent may be due to the following reasons (Okasha, 2002; WHO, 2008; 2013; 2015): a) the geopolitical and economical conditions of many countries, b) the situation and development of psychiatry and care in mental health, c) a lack of support towards research in mental health nursing and psychiatric care, and d) the health needs mean that the resources for research and dissemination of knowledge are prioritized towards other areas (vaccination, infectious illnesses and pandemics, malnutrition and health care in war conflicts) (Creo et al., 2017; Gottlieb et al., 2016; Jamison et al., 2006).

Our results coincide with previous studies in other contexts, such as Europe and the United States (Delaney, 2017; Delaney and Johnson, 2014; Phoenix, et al., 2017; Prosser et al., 2017; Rocha et al., 2014), where the psychiatric nurse encounters difficulties for caring, due to the organization of healthcare which is unable to satisfy all the needs of nurses and families, due to the lack of material resources and specialized nurses and due to the abandonment of mental health as a work area. We believe that these difficulties are due to the global conditions faced by many African countries, which conditions the actions that are taken towards improving mental health. In the case of Africa, Okasha (2002) reported that patients are often marginalized by the social and health care services. The shortage of money, staff and facilities means that unequal access to care is far more likely, and that any available resources are inadequate. Another important factor to consider is stigmatization.

In Ghana and Ethiopia, people with mental illness are likely to experience some stigmatization, and, on many occasions health institutions have not helped to improve such stigma (Barke et al., 2011; Girma et al., 2013; Reta et al., 2016). Negative and stigmatising public attitudes towards people who are mentally ill can impact the prevention and treatment interventions, together with the overall quality of life (Barke et al., 2011). Moreover, previous studies in Nigeria, Ghana, and Kenya (Iheanacho et al., 2014; Makanjuola et al., 2016; Stefanovics et al., 2016) have shown that individuals who hold a religiomagical explanatory model of causation show more stigmatization towards people with mental illness. In Nigeria, Cohen et al. (2016) reported that people who are influenced by traditional beliefs in supernatural causes and remedies, may lead to an unhelpful or health-damaging response to mental disease, and a delay in seeking appropriate care.

As expected by the researchers, in South Africa, nurses play an essential role in the empowerment of individuals with mental disorders. Indeed, nurses should involve mentally-ill patients in mental health planning, service provision, monitoring, research and evaluation (Ngako et al., 2012; Poggenpoel et al., 2011). Prior studies in the United States, Europe and China (Delaney and Johnson, 2014; Fung et al., 2016; Moonen et al., 2016; Salzmann-Erikson et al., 2016), show how the nurse has a great responsibility in the care and follow-up of patients and their relationship with the family and social environment in the community where they live. The great responsibility that psychiatric nursing has in South Africa regarding mental health can be explained due to the fact that, in some African countries (Ethiopia, South Africa, Uganda), a comprehensive response for addressing mental health warrants collaboration between multiple sectors (such as health, education, and social sectors), professionals (health and social workers) and the involvement of local leaders (Hanlon et al., 2014; Maritz, 2010; WHO, 2013;). Together with the need for multidisciplinary teams, there is a great demand for qualified professionals, especially nurses and doctors (Okasha, 2002). In South Africa, Maritz (2010) explained that this demand means nurses must assume a polyvalent role, which includes the education of the patient and the family, the diagnosis, and administration of

psychotropic medication, as identified in our results. However, in Ethiopia, South Africa, and Uganda, despite the fact that nurses cover many care needs, it is necessary to increase the number of professionals who care for people with mental illnesses (Hanlon et al., 2014), even if they are not health professionals (Mendenhall et al., 2014). It is difficult to make general recommendations for the entire African continent due to the variability from country to country regarding the number of psychiatrists and psychiatric nurses available, the policies destined towards mental health and the total population requiring care (Okasha, 2002).

The novelty of our results, and what makes these differ from other studies conducted in Europe and the United States, is concerning the relationship of the nurses and their patients, and the feelings of insecurity perceived by the nurses. Our results reveal great difficulties on behalf of psychiatric nurses in South Africa for being able to establish a relationship and close contact with a psychiatric patient, which ultimately affects the care provided and the communication with these patients. In the United States, Delaney et al., (2017), and Delaney and Johnson (2014), reported how nurses' engagement with patients is a critical element of inpatient psychiatric care, essential to safety, the hospitalization experience and the development of a culture of care. As a result, psychiatric nurses support patients in the development of their mental health and well-being. Furthermore, our results show how South African nurses experience an unsafe work environment without support from their superiors. European and American studies have highlighted the resilience of psychiatric nurses in adverse work conditions, which enable them to work as a cohesive nursing team with a sense of self-direction in their role (Prosser et al., 2017; Rocha et al., 2016). Likewise, the works by Pekurinen et al. (2017) and Stevenson et al. (2015), describe how the nurses perceive the episodes of aggressiveness or hostility on behalf of patients as part of their job, applying strategies for de-escalation of aggressive behaviours (Berring et al., 2016a; 2016b).

An aspect that surprised the researchers was the lack of support perceived by the South African psychiatric nurses, on behalf of their superiors and directors. This may be explained due to the fact that policies, plans and services for mental health need to take into account the health and social needs experienced throughout a person's lifespan (WHO, 2013; 2015), however, questions regarding the most prevalent problems in many communities are unanswerable in most African countries (Okasha, 2002). This lack of mental health planning can negatively affect the perception that the nurses have of their administrators.

From the point of view of clinical practice and education, these results help clarify how South African nurses apply care to mentally ill patients. In addition, they identify areas for improvement, such as communication, training, knowledge regarding mental illness and the management of the psychiatric patient. These results help to reveal organization and management issues with the aim of improving the organization of multidisciplinary team work, the distribution of resources and by raising awareness of the importance of institutional support as well as support from other professionals.

Limitations

This study has several limitations. First, the studies included in this review come from the same country, South Africa, therefore the ability to apply these findings to other African countries is limited, especially due to the great socio-cultural and economic diversity between countries. Finally, only the experiences of caregiver nurses are described. In future research, it would be necessary to include more nurse profiles, such as case management nurses.

Conclusions

This systematic review shows how the work of psychiatric nurses in South Africa takes place under adverse work conditions, which can generate negative attitudes towards professional duties, the patients themselves and mental illness. Nurses may feel let down or worn out, increasing the risk of consuming harmful substances, such as alcohol. The efforts towards improving the psychiatric care available in the different African countries should not only be directed towards increasing infrastructures and health resources, but also towards improving the training, support and protection of these professionals during the performance of their work duties.

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