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# An Ethnographic Study Examining Nurse-Client Relationships in a Jordanian Mental Health Care Setting

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*The University of Western Ontario*

Graduate Program in Nursing

A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

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An Ethnographic Study Examining Nurse-Client Relationships  
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By

Wafa'a Falah Ta'an

Graduate Program in Nursing

A thesis submitted in partial fulfillment  
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Doctor of Philosophy

The School of Graduate and Postdoctoral Studies

The University of Western Ontario

London, Ontario, Canada

## **ABSTRACT**

The nurse-client relationship is viewed as the primary human contact that is crucial to providing nursing care. Interaction processes need to be investigated within their cultural context in order for the nurses to establish a therapeutic nurse-client communication that is congruent with the culture in which it takes place. The nursing discipline in the Middle Eastern country of Jordan presents an interesting paradox; that is, nursing students study Western texts and are taught Western nursing models. However, the assumptions behind these concepts might be different from the cultural values and beliefs of Middle Eastern countries (Hawamdeh, 2002). Thorough understanding of how cultural values and beliefs shape the nursing care is an essential step toward achieving a culturally competent therapeutic care. However, there is very limited published research to investigate the mental health nursing care in Jordanian mental health settings and the role of cultural values and belief systems in shaping it.

The purpose of this study was to explore and describe the Jordanian mental health care system, and investigate the cultural meanings of nurse-client relationships and how the cultural values and beliefs of Jordanians shape mental health nursing care in general and the nurse-client relationship in particular. The study utilized an ethnonursing approach.

The data were collected through observation and interviewing. Nine nurse-client dyads were purposefully recruited from a Jordanian mental health care setting. A total of 34 open-ended semi-structured interviews with the communicators were held to explore their perceptions on nurse-client interactions. Three months of intensive observation-participation were held on site. Peplau's (1952) theory of interpersonal relations, and Leininger's (1995) theory of cultural care provided the theoretical lens that frames the research inquiry.

Thematic/pattern analysis of the interviews and field notes was conducted. The main themes of study findings regarding the Jordanian mental health care system were; the journey from community to hospital and back to the community, the lack of resources: an obstacle to providing standard care, the establishment of the new model unit: a look into the future, the stigma of mental illness: societal responses and responsibilities.

Focusing on nurse-client relationships, findings from this study revealed diverse views on the progress of nurse-client relationships. Both nurses and clients who participated in this study expressed mixed responses to how they described their nurse-client relationships. Several qualities, facilitators, and barriers to their relationships were identified. In addition, different views on ‘the same relationship’ were sometimes depicted. Variations were also portrayed with collected data in regular units in the center versus the newly established unit ‘the model unit’. Congruent with Leininger’s theory, culture and society were found to intensely influence nursing practices. Both nurses and clients in this study expressed that there is a conflict between creating/being in a positive supportive environment at the hospital setting versus the pervasive mental health stigma presented in the society.

The quality of mental health care in Jordan is significantly improving. However, limited resources were the main limitations to the nurse-client relationships. Several implications were derived from this study toward improving mental health nursing in Jordan. Recommendations for practice, education, policy, and future research are provided.

Keywords: Mental health, psychiatric nursing, relationships, nurse-client relationship, therapeutic relationship, Jordan, nursing, ethnography, ethnonursing, culture, Leininger theory, Peplau theory.

### **CO-AUTHORSHIP**

Wafa'a Ta'an performed the work for this thesis under the supervision of Dr. Cheryl Forchuk, Dr. Helene Berman, Dr. Carole Orchard, and Dr. Fatima Alzoubi who will be co-authors on the publications resulting from the chapters of this dissertation.

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## **Chapter 1 - Introduction**

The nurse-client relationship is viewed as the primary human contact that is crucial to providing nursing care (Peplau, 1952, 1997). It is considered to be a fundamental requirement to all nursing interventions and a primary intervention in psychiatric mental health nursing (Registered Nurses Association of Ontario [RNAO], 2002). The nurse-client relationship facilitates collaboration between the nurse and the client to both recover from illness and promote health (Peplau, 1997; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). However, there is limited knowledge about the cultural meanings of nurse-client relationships in non-Western countries, including Jordan.

There is growing concern at an international level about the importance of increasing nurses' knowledge of the range of different communication styles of people of diverse cultures, awareness of the person's own style, and sensitivity to contextual issues (RNAO, 2007), all of which influence the enactment of the nurse-client relationship. Effective nurse-client relationships require understanding cultural values and beliefs and each of the parties' roles in the context of nurse-client relationships. Peplau (1997) stressed that within contemporary nursing practices, nurses need facts, theories, and methods to obtain information about their clients' different cultures, which can increase the quality of care they provide to people from multi-ethnicities. However, there is limited research in nursing that has investigated the nurse-client relationship within a cultural context such as that in Jordan.

Thorough understanding of how cultural values and beliefs shape the nurse-client relationship is an essential step toward achieving a culturally competent nurse-client relationship. However, there has been no previous research investigating the nurse-client relationship in

Jordanian mental health settings and the role of cultural values and belief systems in shaping this unique relationship. Leininger emphasizes that in order to provide culturally competent care, nurses need to explore the meanings associated with cultural care, its practices, and factors influencing that care including educational, social, political, economic, religious, and technological factors (Leininger, & McFarland, 2006).

The overall goal of this ethnographic study was to explore and describe nurse-client relationships within the context of Jordanian mental health care utilizing an ethnonursing approach. It is expected that this study will enhance nurses' knowledge in critically questioning and challenging their current practices in establishing and maintaining culturally appropriate relationships with their clients.

### **Background and Significance**

The Hashemite Kingdom of Jordan is a small developing Arab Middle Eastern country. Jordan shares borders with Palestine/Israel, Syria, Iraq, and Saudi Arabia. The population of Jordan is estimated to be 6.9 million people, of whom approximately 90% are Muslims and 10% are Christians. The fluidity of the political environment in the Middle East has major influences on the history of Jordan at the social, cultural, financial, and political levels, and on the various government services in the country such as education and health services. The central location of Jordan in the Middle East has led to the migration of increasing number of refugees. People from Arab Spring-affected countries such as Syria, and Libya, and neighbouring civil war-torn countries, such as Iraq and Palestine are moving to Jordan seeking a peaceful place to live. The net result is greater diversity of the Jordanian population in terms of backgrounds and cultures influenced by their country of origin. Within the healthcare sector, the Jordanian system has been affected by increased demands on health care services by the migrants.

Nursing as a profession started in Jordan approximately 60 years ago. The number of nurses in Jordan is estimated to be 29.5 per 10,000 people. This number is considered to be relatively high in the region, but low compared to Western countries. Hence Jordan is suffering from a nursing shortage which has been exacerbated by the increasing migration of refugees from bordering countries (Jrasat, Samawi & Wilson, 2005). In Canada, for example, the estimated number of registered nurses between the years 2006 and 2010 was 78 per 10,000 people (CIHI, 2011).

The Jordanian mental health system is composed of services provided by public (Ministry of Health), university and private sectors, and the military services (Royal Medical Services). Mental health services in Jordan include hospitals, addiction centres, and outpatient mental health facilities. A major limitation of the Jordanian mental health care system is the absence of community-based psychiatric inpatient units or community residential facilities in the country. According to the WHO (2011) report, there are 8.27 beds per 100,000 people in Jordan's mental health hospitals, which serve 45 clients per 100,000 people with an occupancy rate of 97%. Exact numbers of human resources within Jordanian mental health are unknown for both the public and private sectors. However, estimates based on existing data reveal relatively low numbers of mental health professionals per capita; there are an estimated 1.09 psychiatrists, 0.54 other medical doctors (not specialized in psychiatry), 3.95 nurses (both associated and registered nurses, without specialized training in mental health), 0.27 psychologists, 0.3 social workers, and 0.09 occupational therapists per 100,000 population (WHO, 2011). Furthermore, these mental health human resources are disproportionately distributed, as a large percentage of these professionals work in mental health hospitals near Amman, the capital city, where only 36% of the population live.



Cultural values and beliefs in any culture can have a significant effect in shaping the health care practices of nurses as well as the health-seeking behaviours of clients with mental health issues. In general, within the Jordanian culture there is a negative attitude toward mental illness and people with mental illness. This negative view is even more worrisome as it also exists among the sub-culture of mental health care professionals (Hawamdeh, 2002; Hamdan-Mansour & Wardam, 2009). It is deeply concerning that mental health care providers themselves may stigmatize people with mental illnesses. Such stigmatization underscores the need to investigate the value system that underpins such attitudes and how values may shape the nurse-client relationship.

Research is needed to explore concepts and processes in the nurse-client relationship (Peplau, 1997; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Understanding the values and belief systems within the Jordanian culture can enhance nurses' understanding of health care-related behaviours/practices, which in turn can improve the nurse-client relationship, and eventually promote the quality of mental health client care. The nurse-client relationship cannot be holistically understood without understanding the cultural context that shapes the relationship between nurses and clients. Studying the values and belief systems that shape the nurse-client relationship may facilitate providing culturally competent quality care for people with mental illnesses in Jordan and in Middle Eastern communities at a broader level. Moreover, investigating the nurse-client relationship within the context of its culture may provide nursing educators and researchers with information that will facilitate evaluating appropriateness of available teaching resources and models of care in the Jordanian culture.

## Statement of Purpose

The purpose of this study was to explore and describe the nurse-client relationship within mental health care provided within the Jordanian culture utilizing an ethnonursing approach. The study describes the Jordanian mental health care structure and system, and how cultural values and beliefs of Jordanians shape nursing practices and influence nurse-client relationships. Furthermore, the study investigated the dyadic relationships between nurses and clients to provide a deeper understanding of these interaction from each of their perspectives.

## Research Questions

This study seeks answers to the following main research questions: 1) What is the current structure of the Jordanian mental health care system? 2) What contextual and environmental factors impact nursing care in Jordanian mental health care settings? 3) How do Jordanian cultural values and beliefs shape mental health care practices? 4) How do cultural values and beliefs influence people with mental illness from the perspectives of mental health nurses and clients? 5) How do mental health *nurses* employed in a Jordanian mental health center describe nurse-client relationships? 6) How do mental health *clients* admitted to a Jordanian mental health center describe nurse-client relationships? 7) How do Jordanian cultural values and beliefs shape mental health care practices including nurse-client relationships? 8) What are the facilitators, and/or barriers to developing therapeutic nurse-client relationships within the Jordanian mental health care system?

## Integrated Article Format

As required by the School of Nursing, this dissertation has been prepared in an integrated article format. This format expedites dissemination of the dissertation research through the development of 3-5 articles in a publication format. This dissertation contains six chapters. The

first is the introductory chapter presented here. The second, third, fourth, and fifth chapters represent four manuscripts that were constructed so that it could stand alone as a journal article. As such, some repetition is evident between chapters. The sixth chapter provides a general discussion and concluding remarks related to the study findings as well as their implication for practice, policy, education, and future research. Supplementary information such as ethics approval for the study, the study letter of information, semi-structured interview guide, and the protocol for data collection can be found in the appendices.

### **Overview of Chapters**

This study contributes to a deeper understanding of nurse-client relationships within mental health care in the Jordanian culture. This dissertation has been organised into six chapters. The first chapter sets the context for the entire dissertation.

*The second chapter, “Existing Knowledge on Nurse-Client Relationships: A Jordanian Perspective”,* provides a comprehensive review on the existing literature to identify current knowledge and gaps within nurse-client relationships in Western and Middle Eastern cultures. The review presents discussions on the historical and theoretical issues of the nurse-client relationship, definitions and therapeutic dimensions of nurse-client relationships, and the Jordanian cultural impact on nurse-client relationships.

*The third chapter, “Ethnonursing: An Innovative Way of Researching Transcultural Nursing”,* discusses the conceptualization of culture in nursing literature, and the philosophical assumptions on culture from a nursing perspective. This chapter also discusses the role of ethnonursing, as a research method, in inquiring transcultural nursing care, and the use of Leininger’s “Sunrise Enabler: Culture Care Theory” as a means of studying nursing care practices within its cultural context.

Because there was rich information among the collected data on the context of Jordanian mental health care system and the delivery of care within, I divided the findings into two chapters. *The fourth chapter, “Jordanian Mental Health Nursing Care: The State of the Art”,* describes the Jordanian mental health care system, and investigates how the cultural values and beliefs of Jordanians shape mental health nursing care. This chapter provides a description of the clients, the nurses, the system, and how clients gain admission to the National Center of Mental Health (NCMH); along with a fairly comprehensive understanding of the structure and context in which mental health nursing care practices take place. A comprehensive discussion of cultural care, situated within Leininger’s Theory of Cultural Care, from the perspectives of Jordanian clients and nurses at the NCMH will be presented.

*The fifth chapter, “Nurse-Client Relationships in Jordanian Mental Health Settings: An Ethnographic Study”,* focuses on the cultural meanings of nurse-client relationships within the Jordanian mental health care system utilizing an ethnonursing approach (Leininger, 1995, 1997, 2002). Data collection, analysis and presentation were guided by Peplau’s theory of interpersonal relations (Peplau, 1952) (Appendix A) and Leininger’s culture care theory (Leininger, 1988, Leininger, & McFarland, 2006) (Appendix B). The chapter provides an understanding of the process of nurse-client relationship across Peplau’s stages. A discussion of cultural care from the perspectives of Jordanian clients and nurses is provided in this section in addition to the cultural and contextual facilitators and barriers to developing therapeutic nurse-client relationships.

*The sixth chapter, “Conclusion”,* provides a summary to the thesis. This chapter briefly discusses the research findings presented in chapters four and five, and then consider the possible implications of these findings. Based on the results of the study, directions for future research are

provided regarding the Jordanian mental health nursing and nurse-client relationships within that culture.

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## **Chapter 2 - Nurse-Client Relationships: A Jordanian Perspective**

### **Introduction**

The nurse-client relationship is viewed as the primary human contact that is crucial to providing nursing care (Peplau, 1952, 1997). It is considered to be a fundamental requirement for all nursing interactions and a primary intervention in psychiatric mental health nursing (Registered Nurses Association of Ontario [RNAO], 2002). The nurse-client relationship facilitates collaboration between the nurse and the client to facilitate both recovery from illness and promotion of health (Peplau, 1997; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). However, there is limited knowledge about the cultural meanings of nurse-client relationships in non-Western countries, including Jordan.

Thorough understanding of how cultural values and beliefs shape nursing care is an essential step toward achieving culturally competent therapeutic care. However, there is a paucity of published research investigating the mental health nursing care in Jordanian mental health settings and the shaping role of cultural values and belief systems. The overall goal of this chapter is to critically analyze the existing knowledge on the topic of nurse-client relationships. The focus will be on the Jordanian mental health care context to explore nurse-client relationships from a cultural and societal point of view.

### **Search Methods**

A literature search was conducted using the CINAHL, PsychINFO, and ProQuest Nursing Journal database. The keywords included in the search were: nurse-client relationship, nurse-client interaction, nurse-client communication, cultural nursing, psychiatric nursing, mental health nursing, Jordan, and Jordanian health care. Two previously published literature reviews authored by Suzanne Lego (1946-1974), and Linda Beeber's (1974-1994), were



included to comprehensively cover the topic of nurse-client relationship between the years 1946 and 1994. Therefore, a primary search was done to retrieve articles published between the years 1990 and the present. Although health care relationships have been extensively studied from as early as the beginning of the 19<sup>th</sup> century (O'Brien, 2001), more attention was drawn to relationships within the mental health care context only occurred in the 1990s. That may be explained by the increase of professionalism in mental health care practices and replacement of attendants for nurses (Oudshoorn, 2011).

A manual search was then done to include seminal relevant work in the field. Collectively, the literature review covered the time period between 1946 and the present. This literature review also included reports and publications from highly reputable associations and organizations, including the World Health Organization (WHO) and the Registered Nurses Association of Ontario (RNAO). The vast majority of research studies have been conducted in Western countries. This literature search was also extended to include research articles published in Arabic without locating any studies. To date, no studies were found that holistically investigated the nurse-client relationship within the Middle Eastern or Jordanian mental health care. The main findings from the literature review are summarized herein.

### **The Nurse-Client Relationship**

Most of the early research studies on the topic of nurse-client relationships tended to apply quantitative research methods using mainly surveys and interviews. More recent literature, however, reflects the use of qualitative methods to gain more in-depth understanding of the different aspects of this relationship. The shift toward using qualitative methods in studying the nurse-client relationship occurred from the desire to investigate in-depth the nature and reality of the relationship without detaching it from the complex context in which it takes place. Main

issues addressed in the literature included the historical and notable events affecting the nurse-client relationship, its definition, and characteristics of nurse-client relationships, factors influencing the relationship, communication patterns and barriers to its enactment, perceptions about theories and theoretical issues related to interactions.

**Historical and theoretical issues of the nurse-client relationship.** Early in the 1940s nurses started to write in general terms about how nurses were to participate with their clients in nurse-client relationships. Naranick (1947) pointed out that the nurse should have a personality that allows her to adjust to challenging situations. Other nursing work implied the importance of seeing the client as a person and using kind assertiveness with difficult situations such as suicides (Lego, 1975). The Group for the Advancement of Psychiatry (1952) outlined the role of psychiatric nurse in mental hospitals as being one of assessing how therapeutic team members modified clients' behavior in a more healthy direction. However, the enactment of the nurse-client relationship to achieve this aim was not elaborated.

In 1952, Peplau systematically assembled anecdotal data, identifying scientific terms that could be further studied, applied, and integrated in the practice of psychiatric nursing. Peplau (1952) published her book "Interpersonal Relations in Nursing" in which she identified the therapeutic relationship as the key component of nursing interactions. Peplau's work was the first systematic theoretical framework for psychiatric nursing. In addition, she clearly identified the 'counseling role' of the psychiatric nurse. Specifically, Peplau wrote: "[counseling] has to do with helping the patient to remember and to understand fully what is happening to him in the present situation, so that the experience can be integrated with rather than dissociated from other experiences in life" (p.12).

In the same year, Tudor (1952) published a study in which she described the strong positive relationships she developed with clients, by providing unconditional care which involved placing almost no demands on the client, anticipating their needs, and setting limits only as needed. The author demonstrated that this kind of nurse-client relationship helps the client to improve. It was noted that when this study was first reported, there was no existing nursing journal that could accommodate the length or content of the paper. This gap was an incentive for the start of the journal “Perspectives in Psychiatric Care” in 1963 (Lego, 1975).

Orlando’s theory of the dynamic nurse-client relationship appeared in 1961. Briefly, Orlando’s theory involves the nurse assessing clients’ needs or distresses, the nurse validating assumptions related to this assessment with clients and then helping clients to express the specific meaning of their behavior to ascertain their distress, and then helping the clients to explore the distress to ascertain the help they require in order to relieve their distress (Orlando, 1961). A number of psychiatric nurses have built their work on this theory; however, Orlando’s theory was critiqued as being less developed and systematic than Peplau’s theory (Forchuk, 1991a; Lego, 1975). In addition, Orlando’s theory was not developed specifically for psychiatric nursing that may explain why it was far less used in psychiatric nursing as compared to Peplau’s theory.

**Studies on Peplau’s theory.** According to Fleischer, et al.’s (2009) systematic literature review on the nurse-client interaction and communication, Peplau’s theory is still the most frequently used interpersonal relational theory in nursing literature. Forchuk took the lead in further studying Peplau’s theory and empirically testing the theory and its clinical applications (Forchuk & Brown, 1989; Forchuk, Beaton, Crawford, Ide, Voorberg, & Bethune, 1989; Forchuk, 1991a & b; Forchuk & Voorberg, 1991; Forchuk, 1992;1993; 1994; Forchuk, Jewell,

Schofield, Sircelj & Valledor, 1998; Forchuk, Westwell, Martin, Azzopardi, Kosterewa-Tolman, & Hux, 1998; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Peplau's theory was originally criticized for not having a conceptual model to clearly exemplify the concepts and relations. Therefore, Forchuk's (1993) further analysis of Peplau's works resulted in the identification of theoretical concepts, including relationship phases, pattern integrations, competencies, and anxiety, and the relationship among these concepts. In addition, she clearly identified nine assumptions of Peplau's theory. Another major contribution of Forchuk's analysis to Peplau's theory is the change of the nurse's role from being "a spectator and observer" of the client to "a participant observer" as an outcome of her systematic study of interactions (Forchuk, 1991b, p.55).

Further, the work of Forchuk developed and tested instruments to measure the phases of the therapeutic relationship. Forchuk (1994) used a prospective design to examine the orientation phase of the nurse-client relationship for 124 newly formed nurse-client dyads. The results showed that preconceptions of both clients and nurses were related to the duration of the orientation phase and development of therapeutic alliances. Anxiety was not found to be significantly related to development of therapeutic alliances. However, the author ascertained the need for further research specifically testing nursing theory.

**Definitions and therapeutic dimensions of nurse-client relationships.** There is no single universally accepted definition for the nurse-client relationship (Hewitt & Coffey, 2005; Howgego et al., 2003; Martin, Garske, & Davis, 2000, Spiers & Wood, 2010). A number of terms are used interchangeably in the literature to refer to this relationship. The most commonly used terms are: nurse-client/patient relationship, nurse-client/patient interaction, therapeutic relationship, therapeutic alliance, working alliance, and the one-to-one interaction/relationship.

The previously mentioned terms appear synonymously in the literature. However, terms specifically built around communication such as therapeutic communication, or nurse-client communications are actually not the same as a “relationship”. Nurse-client communication is a part of the nurse-client relationship that is concerned with the verbal and non-verbal forms of communication taking place within the interaction. However, the focus of this chapter is the enactment of nurse-client relationships in Jordan.

The literature shows that the central emphasis of nurse-client relationships approaches is on establishing a helping working relationship with clients. Saunders (2001) defined “therapeutic alliance” as the mutual experience and expression of feelings, attitudes, thoughts, and behaviors between the client and the therapist during the therapeutic encounter. In the same vein, Beeber (1995) had conducted an integrated literature review on the “one-to-one relationship” in the psychiatric mental health nursing practice context. She defined the relationship as “the systematic interaction of a psychiatric nurse and an individual client for the purpose of providing PMH [psychiatric mental health] nursing care” (p.9). Both definitions stress the importance of focusing on the dyad as a unit of interaction. Although other systems such as family and community contribute to the nurse-client interaction phenomena, they are not the focus of the intervention. However, some concepts such as “therapeutic self”, “use of self”, and “clinical supervision” concentrate on the nurse as the focus of analysis (Beeber, 1995). The Registered Nurses Association of Ontario best practice guidelines stress the importance of conceptualizing the therapeutic relationship as an interpersonal process that occurs between the nurse and the client(s), guidelines further declare that a “therapeutic relationship is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client” (RNAO, 2002; 2006, p.13).

The therapeutic qualities of the nurse client relationship are among the most important aspects of the relationship discussed in the literature. The Registered Nurses Association of Ontario (RNAO, 2002; 2006) best practice guidelines summarize the qualities of the therapeutic relationship as: active listening, trust, respect, genuineness, empathy, and responding to client concerns. Most research, however, has focused on the quality of empathy in such relationships (Olsen, 1991; Morse, et al., 1992; Olsen, 1995; Reynolds & Scott, 1999; Reynolds & Scott, 2000; Kunyk & Olson, 2001, Hewitt & Coffey, 2005; Brunero, Lamont, & Coates, 2010).

Hewitt and Coffey (2005) published a literature review on the therapeutic working relationship with people with schizophrenia (1986-2003). The results showed that the nurse-client relationship could be facilitated using the therapeutic presence of the helper, and his/her ability to facilitate catharsis in the interaction that perceived warmth between the parties. The authors also concluded that creation of the bond between the nurse and the client requires trust, empathy, liking, support, and respect. Goals within the therapeutic relationship are set through mutual agreement and valuing of the outcomes of interventions through provision of sufficient explanations and addressing reciprocal actions. Among all the therapeutic qualities, empathy seems to be the cornerstone of nurse-client relationships. There is a current debate in the literature as to whether empathy is a personality dimension, an experienced emotion or an observable skill. Nevertheless, there is agreement that empathy is highly valued by both nurses and clients (Reynolds & Scott, 1999; Hewitt & Coffey, 2005).

In a recent study, Ketola and Stein (2013) used mixed methods to survey 67 baccalaureate students about their experiences in their practice placement portion of a psychiatric nursing course. The study aimed to explore the impact of a psychiatric clinical course in helping students learn to relate to distressed clients. The results revealed facets of how empathetic

interactions with their clients affected these nursing students' perspectives. The students stated that their time with clients had changed them. Ninety-nine per cent were no longer frightened of the clients. Students realized their clients were distressed and were glad to help them. This practice experience sensitized them to the individual rather than the generic client. It commenced a process in self-awareness, leading to their sensitivity to the feelings of another person through their interactions. These are steps in the development of an empathetic presence. The students recognized the importance of these skills in all their nursing practice.

**Influences affecting nurse-client relationships.** Cleary, Edwards, and Meehan (1999) conducted a qualitative exploratory study using semi-structured interviews with ten nurses in an acute psychiatric setting in Australia. The researchers aimed to identify and describe the factors perceived to influence nurse-client interactions. The authors identified: the ward environment, something unpredictable that always comes up, nurses' attributes, client factors, instrumental support and the focus of nursing as influencing the nurse-client interaction. The ward environment included the physical setting that provides opportunity for privacy and space, and maintains "the safe environment" in which the nurse can sit and talk with the client. The unpredictable nature of the setting was one factor that can impede interactions such as unplanned admissions, discharges, transfers in, transfers out, and critical incidents. The clients' factors mainly were concerning the acuity and complexity of their needs, which were proportionally related to the care needed. Instrumental support associated with a unit's culture and the nurses' competence and confidence in interacting with clients was identified as a factor that influenced interactions. Avoidance of clients was one of the undesired nurses' attributes, whereas being non-judgmental was defined as an important aspect of care. The authors suggested that issues which emerged from the study could provide managers and clinical nurses with an opportunity

for generating new possibilities for nurse–client interaction. These issues, however, must be addressed in a sensitive way that takes into consideration the complex and dynamic nature of acute care settings. Whether these findings are applicable to the nurse-client relationship in Jordan is not known at present.

### **Jordanian Cultural Impact on Nurse-Client Relationships**

Literature revealed some cultural connotations among Jordanians that may have an impact on the delivery of health care and the interaction between healthcare providers and their clients. There is a significant value related to the status of insiders (family members) and outsiders (everyone else) among Arabs. This is manifested by resistance to the disclosure of personal information outside the family (AbuGharbieh, 1998). Health-related concerns can be considered a private topic that is only discussed within the family, and frank questions and discussions of diagnosis and prognosis can elicit negative reactions (Meleis & Jonsen, 1983). However, there is no literature that has examined the role of these values in shaping the relationship between the client and health care providers.

Jordanians' communication patterns are influenced by a hierarchy of relationships and depend on the social status of the communicators (Hawamdeh, 2002). Indirect communication can be used by Arabs to avoid possible offense and stressful interpersonal conflicts. Non-verbally, Arab communicators tend to stand close together, maintain eye-contact, and touch the other's hand or shoulder if they are of the same sex (Hawamdeh). Eye-contact may also be a sign of power; that is, people from lower social status or younger in age may not maintain eye-contact to show respect for the other party. Non-verbal communication has been widely studied internationally, with touch being the most frequently studied aspect in nursing research (McCann McKenna, 1993, Routasalo, 1999, Fleischer, et al. 2009). However, there is a lack of studies



addressing the non-Western context of using non-verbal communication skills within the nurse-client relationship. If we are to better understand nurse-client relationships to promote therapeutic relationships, we need to better understand the meaning and uses of verbal and non-verbal communication skills within the Jordanian culture.

In a Jordanian study, Hamdan-Mansour and Wardam (2009) examined Jordanian mental health nurses' attitudes toward mental illness and clients with mental illness. The research was conducted using a descriptive correlational design. The sample included 92 mental health nurses representing all nurses working at the acute and chronic inpatient and outpatient mental health agencies in the Jordanian governmental (79%) and private health care (21%) sectors. Data were collected about nurses' attitudes toward mental illness and clients with mental disorders and their satisfaction with nursing care delivery. Among the participants, only 21% of the nurses had specialized training in psychiatric mental health nursing. The study also revealed that participants had negative attitudes toward mental illness and toward clients with mental disorders. About 60% of the mental health nurses had perceived clients with mental illness to be dangerous, immature, dirty, cold-hearted, harmful, and pessimistic. However, nurses who received specialized training were more positive in their attitudes than those who did not. The previously mentioned quantitative study did not provide in-depth analysis on perceptions and attitudes about mental health issues in Jordan. Further qualitative studies are needed to provide more in-depth investigations on the topic.

There is emphasis on the importance of and connection between attitudes of nurses toward mental illness and nursing care delivery. Baker (2000) noted that attitudes of mental health nurses toward inpatients' mental health influenced the quality of mental health nursing care provided, and negatively influenced nurses' interactions with clients. Although nurses'

perceptions and attitudes are considered to be relevant to the nurse-client relationship, none of these research studies on the nurse-client relationship investigated the relationship from the perspective of health care recipients.

However, Coatsworth-Puspoky, Forchuk, and Ward-Griffin (2006) noted limitation of the published studies in relation to clients' perceptions of the nurse-client relationship, how relationships improve or deteriorate, from clients' perceptions of how these relationships influence their health. They, therefore, attempted to explore and describe nursing support relationships, using an ethnonursing approach focusing on the recipients' perspectives, within a Canadian mental health subculture. Fourteen participants were interviewed and field notes were used to capture issues associated with nurse-client interactions. The study authors' found two types of relationships, one that positively developed and the other began positively and then deteriorated. In both, there were three phases of the relationships; beginning, middle, and end. The positive side of the relationship process was summarized as perceiving a glimmer of help, exploring, and problem-solving and saying goodbye, which parallel Peplau's phases of the relationship. Nurses in this type of relationship were described as nice, friendly, and good listeners. In the non-therapeutic type of relationship, clients experienced lack of trust toward nurses who were perceived to be unhelpful. The nurse-client relationship was perceived to deteriorate starting from the first phase and continued to deteriorate through ignoring and avoiding support to the client until the end of the relationship.

## **Discussion**

One of the major gaps in the literature is the focus on one perspective of relationships that is, either from the nurse's or the client's perspective. Forchuk and colleagues suggested that studies, using either individuals or dyads, are necessary to explore concepts and processes within

nurse-client relationship processes (Forchuk, 1993; Forchuk, et al., 2000; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Due to the interactive nature of the relationship, Peplau (1997) argued that “the nurse-patient relationship is an interpersonal field, the data of which can be examined within the dyad as a basis for greater self-understanding and learning” (p.162).

The dyadic interactions between nurses and clients need to be investigated within its practice context, addressing the cultural values, beliefs, and norms that shape the interaction. Peplau (1997) suggested that multi-ethnicity is very much an attribute of the modern world and today’s healthcare systems increasing the need for research about different cultures. Leininger (1995) also emphasized the importance of studying and practicing cultural care that is congruent with the values, beliefs, and practices of individuals or groups of an identified culture. Therefore, research studies relevant to nursing practice need to address cultural dynamics that shape the nurse-client relationship.

## **Conclusion**

Knowledge about the relationship established between psychiatric nurses and clients is essential to the nursing process in psychiatric mental health settings. Studies on nurse-client relationships have been well established in Western countries such as USA, and Canada. However, very limited literature is available in Arab countries such as Jordan. Theories of nurse-client relationships, such as Orlando’s theory and Peplau’s theory, investigated the processes on nurse-client interactions as well as the roles nurses may utilize to enact therapeutic relationships. Therapeutic qualities of nurse-client relationships such as active listening, trust, respect, genuineness, and empathy were discussed in this chapter. Nevertheless, Leininger stressed the importance of considering the cultural context in order to provide culturally proficient nursing care.

In summary, we know from the literature about the processes of nurse-client interaction and the development of relationships from the perspective of either the nurse or the client, but there is lack of research that addresses the perspectives of the interacting dyad to afford a more holistic understanding of these interactions. We also know about the attitudes that are shaped by peoples' beliefs and values that may enter into nurse-client relationships within the Jordanian cultures, but we do not know about the behavioral enactment of nurse-client relationship through verbal and non-verbal communication in the Jordanian context. Currently, there is an absence of Jordanian studies on how this cultural context shapes nurse-client relationships in mental health care settings.

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### **Chapter 3 - Ethnonursing: An Innovative Way of Researching Transcultural Nursing**

*“To care for someone, I must know who I am.*

*To care for someone, I must know who the other is.*

*To care for someone, I must be able to bridge  
the gap between myself and the other”*

Jean Watson

#### **Introduction and Background**

“Nursing is a transcultural phenomenon requiring knowledge of different cultures to provide care that is congruent with the clients’ lifeways, social structure, and environmental context” (Leininger, 1988, p. 156). Accordingly, nurses need to understand what culture is, and how culture is viewed from nursing perspective. In addition, nurses are required to seek cultural care inquiry in order to provide optimum care for people from diverse cultures, and to be able to translate nursing knowledge globally. Nursing literature nowadays is increasingly debating the conceptualization of culture in nursing, and offering various models and research methodologies for studying cultural care.

*In this chapter*, discussions will be provided on the conceptualization of culture in nursing literature, and the philosophical assumptions on culture from a nursing perspective. This chapter will also discuss the role of ethnonursing, as a research method, in inquiring transcultural nursing care, and the use of Leininger’s “Sunrise Enabler: Culture Care Theory” as a means of studying nursing care practices within its cultural context.

Leininger (1991, 1997, p.13) defined culture as “the learned, shared and transmitted values, beliefs , norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally”. Leininger views cultural

values as long-term and very stable (Dayer-Berenson, 2011). However, the argument, which will be discussed further later in this chapter, is on the stability of culture based on the dynamicity of the life experiences that shapes one's own culture. For example, when people travel from country to another, their experiences will directly or indirectly influence their way of thinking. Therefore, the definition of culture, from my point of view, can extend to the lived experience of learning, sharing and transmitting values, beliefs, norms, and lifeways that creates similarities and differences among people of a particular culture.

Culture is also deeply shaped by multiple factors such as societal, economic, and political structure which makes culture not always obvious to outsiders. According to Hall (1984), there are three levels of culture; primary, secondary, and tertiary. Tertiary level of culture is the explicit aspects of culture which are usually visible to outsiders such as dress and rituals, whereas secondary level has to do with the underlying rules and assumptions that are rarely shared with outsiders. Primary level of culture is related to the deepest implicit rules of the group that are followed by members but rarely shared with others.

Culture can be linked to race, ethnicity, religion, gender, educational status, marital status, medical illness, sexual orientation ...etc. This way of referring to culture seems to classify people into discrete groups, but it is not necessarily applicable in the reality. For example, a person may have affiliations to multi-cultural positions according to how they describe their culture. In addition, the cultural boundaries are not necessarily clear as there are many blurred areas between "theoretically" cultural groups. There are also huge individual variations that can be found among people within the same cultural group. This makes understanding cultures a complex process that requires nurses to breakdown culture

to what shapes it and to the processes within it, then re-synthesise it to approach individuals, families or communities that require nursing care.

### **Conceptualizing Cultural Care**

Many different understandings of culture have been articulated in the literature. In this section, I present and critique several of these, with the importance of Leininger's *transcultural nursing* conceptualization as a means of analyzing nursing practices to promote culturally proficient nursing care.

**Cultural safety.** The concept of cultural safety is a relatively new concept that was conceptualized in New Zealand where there is bicultural orientation of Maori and Crown people (Browne, et al., 2009). "Cultural safety aims to counter tendencies in health care that create cultural risk (unsafety)" (Browne, et al., p. 169). Therefore, using this concept leads to the assumption of disempowerment and disadvantages among certain ethnocultural groups as related to the predominant culture of the area. While the concept of cultural safety is highly compatible with critical theoretical perspectives, its use can be limited in other theoretical perspectives such as in interpretive research which aims to gain understanding and description. Moreover, there are some ambiguity and lack of clarity in the terms, "culture" and "safety", limiting its utility and relevance in research and practice.

**Ethnocentrism.** Ethnocentrism refers to the approach of comprehending and judging the world from the perspective of one's own culture; in which the person evaluates other cultures by one's own cultural group standards, values and practices resulting in confusion or bias with truth (de Chesnay & Anderson, 2008). Ethnocentrism, therefore, assumes the centrality and superiority of one's own cultural group over another (Andrews, et al., 2010) which contributes to racism, stereotyping, and prejudice.

**Cultural sensitivity.** Cultural sensitivity in nursing reflects the awareness of cultural differences between the nurse and the client. However, Doane and Varcoe (2005) highlighted that cultural sensitivity served to emphasize differences at the expense of similarities. Moreover, Turner (2005) argued that cultural sensitivity, if used inappropriately, will serve as a barrier instead of a bridge to understanding, such as when health care professionals slot clients into generalized cultural stereotypes. While they are trying to provide culturally sensitive care, nurses may be insensitive to individual differences between clients of “apparently” the same culture.

**Cultural competence.** Cultural competence is a more comprehensive concept that requires the synthesis of previously gained awareness, knowledge, and sensitivity, and its application in providing nursing care (Andrews, et al., 2010). Cultural competence reflects culturally appropriate nursing by keeping the client central to the planning process and ensuring that cultural beliefs are incorporated into the client’s plan of care (Dayer-Berenson, 2011). The integration of cultural competence into primary care practice has been utilized by several nursing organizations such as National Organization of Nurses Practitioner Facilities (NONPF) (Green-Hernandez, et al., 2004), and Registered Nurses’ Association of Ontario (RNAO, 2007).

Nursing organizations have recommended training and education for all team members, including nurses and other health care professionals, on how to provide culturally appropriate care in the 21st century health care environment (Dayer-Berenson, 2011). Cultural competency means that nurses and other health care team members need to know about different cultural practices their clients may present. However, it is not feasible to teach nurses about all possible cultures; in addition, teaching nurses about cultures represents an oversimplification of cultural norms through the process of generalization. Therefore, nurses need an innovative way for learning and providing culturally competent care.

**Transcultural nursing.** Transcultural nursing is defined as “a discipline with a body of knowledge and practices to attain and maintain the goal of culturally congruent care for health and well-being” (Leininger & McFarland, 2006, p.19). It is one of the earliest terms linking care with culture that was developed by Leininger (1988) and still being used as an overarching concept. Transcultural nursing is created to help nurses recognize and understand cultural differences and its emerging differences in behaviors and needs (Leininger, 1988), which basically counteracts existing ethnocentrism in the favor of increasing cultural awareness and tolerance.

In transcultural nursing, Leininger (2006) stresses the importance of “obtaining in-depth knowledge of care and cultural constructs from key and general informants related to health or wellbeing” (p.6). Therefore, the focus in Leininger’s view of transcultural nursing is discovering and generating new knowledge about cultural care rather than only quantitatively testing theories.

### **Leininger’s Transcultural Care Theory**

Leininger advanced nursing knowledge on cultural care through her theory and research contributions on cultural care as a determinant of the advancement of quality nursing care individual clients receive. Leininger believes that cultural care is the synthesis of the two major constructs; *culture* and *care* that guide the researcher to discover, explain and account for health, wellbeing and other human conditions. Leininger (2006) challenged nurses to discover both the cultural diversity and universality regarding care worldwide. Transcultural nursing, therefore, focuses on the universality of human caring, and the comparative study and analysis of the diversity and dynamics of world cultures in relation to human caring values, beliefs, and behaviours (Leininger & McFarland, 2006).

## **Ethnonursing: A Method of Researching Transcultural Nursing**

Ethnonursing is a naturalistic research inquiry approach developed by Madeline Leininger (Leininger, 1995; 1997, 2002). Ethnonursing is a mini-ethnography, also referred to as focused ethnography (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Leininger & McFarland, 2006), that is characterized by reflecting on specific elements of one's own society (Knoblauch, 2005). It differs from the conventional/ classic ethnography mainly in terms of demands on time, which focused ethnography uses intensively (shorter period of times with more focus on the research purpose) rather than extensively (usually one year or more of observation). Systematic and reflective processes are employed directly on the cultural context to illuminate lifeways and understand their meaning for participants (Mixer, et al., 2009). Ethnonursing is based on a holistic framework that uses the techniques of purposeful sampling, observation, and in-depth interviewing to reveal participant's experiences (Miller & Petro-Nustas, 2002). Accordingly, key participants were selected because of their expertise related to the domain of inquiry, whereas general participants were selected from the community to reflect the views of the key participants (Leininger, 2002).

Ethnonursing approach aims to understand the diversity and universality of care, and for that purpose, it is imperative to distinguish between *emic* and *etic* data. Emic refers to the insider's viewpoint of the culture, while etic means the outsider's viewpoints of the culture (Leininger 1988, 1991).

**The role of theory in ethnography.** There is an ongoing debate among scholars on the role of theory in qualitative research in general and in ethnographic research in particular. Wilson and Chaddha (2010) summarized the argument in two main ways of incorporating theory in ethnographic research. The first way is the deductive approach in which ethnographic research



is conducted to “validate” theory. In the context of validation, ethnographic research can be used to test, advance or explain assumptions derived from theoretical arguments. The second way is the inductive approach, also referred to as “the context of discovery”. In the context of discovery, it is generally acknowledged that ethnography enables researchers to uncover relationships that have not been explicitly clarified in theoretical formulations. These discoveries often lead to the development of hypotheses that may provide direction for further research.

There is another inductive way in which theory may play a role in ethnographic research. That is to obtain theoretical insights from the interpretation of data uncovered in the context of discovery. In inductive approach, the researcher integrates new ethnographic findings with theoretical arguments, not in the sense of testing prior theoretically driven hypotheses, but in using theoretical knowledge to make sense of the new data uncovered in the field research (Wilson, & Chaddha, 2010). This latter inductive approach was used in this research. More specifically, Peplau’s Theory of Interpersonal Relations and Leininger’s Theory of Cultural Care provided theoretical lenses to inform the analyses of my research data as presented in the chapters four and five.

**Cultural care perspectives.** To specifically shed light on the cultural aspect of the nursing practices, Leininger’s theory of cultural care provided a theoretical lens to enhance a deeper understanding of the topic. However, to better understand the connection between culture and care, we need to uncover the most commonly used cultural care-related concepts.

As a way to graphically present her theory, Leininger developed the Sunrise Enabler to Discover Culture Care model to enhance examining cultural care-related phenomena. *See Figure 1.* The Sunrise Enabler to Discover Culture Care model is developed to be a cognitive map that helps investigating cultural care phenomena from a holistic perspective of multiple influences

that can potentially influence care and the well-being of people (Leininger, 1995). The Sunrise Model is organized from top to bottom in three layers. The top layer is the most abstract, and the most challenging to depict. It represents the worldview, cultural and social structure dimensions that constitute the knowledge about cultures, peoples, and care systems. The middle layer has to do with the influences of a culture on health care. These influences include cultural values, beliefs and lifeways, kinship and social, religious and philosophical, political and legal, technological, economic, and educational factors, in addition to the environmental context, language and ethnohistory. The bottom layer explains how care decisions are affected by culture through care expressions, patterns and practices. The arrows in the model indicate influences but not necessarily relationships.

The Sunrise Enabler to Discover Culture Care model summarizes all potential influences that may interactively shape culture and consequently, the interactions within the culture, including technological, social, economic, and educational factors. Health care expressions, patterns, and practices in this model can be seen to be interactive in nature and highly individualized within its unique contexts. The model presents influences as bidirectional, and emphasizes the interactive relational nature of factors, health care expressions and outcomes.

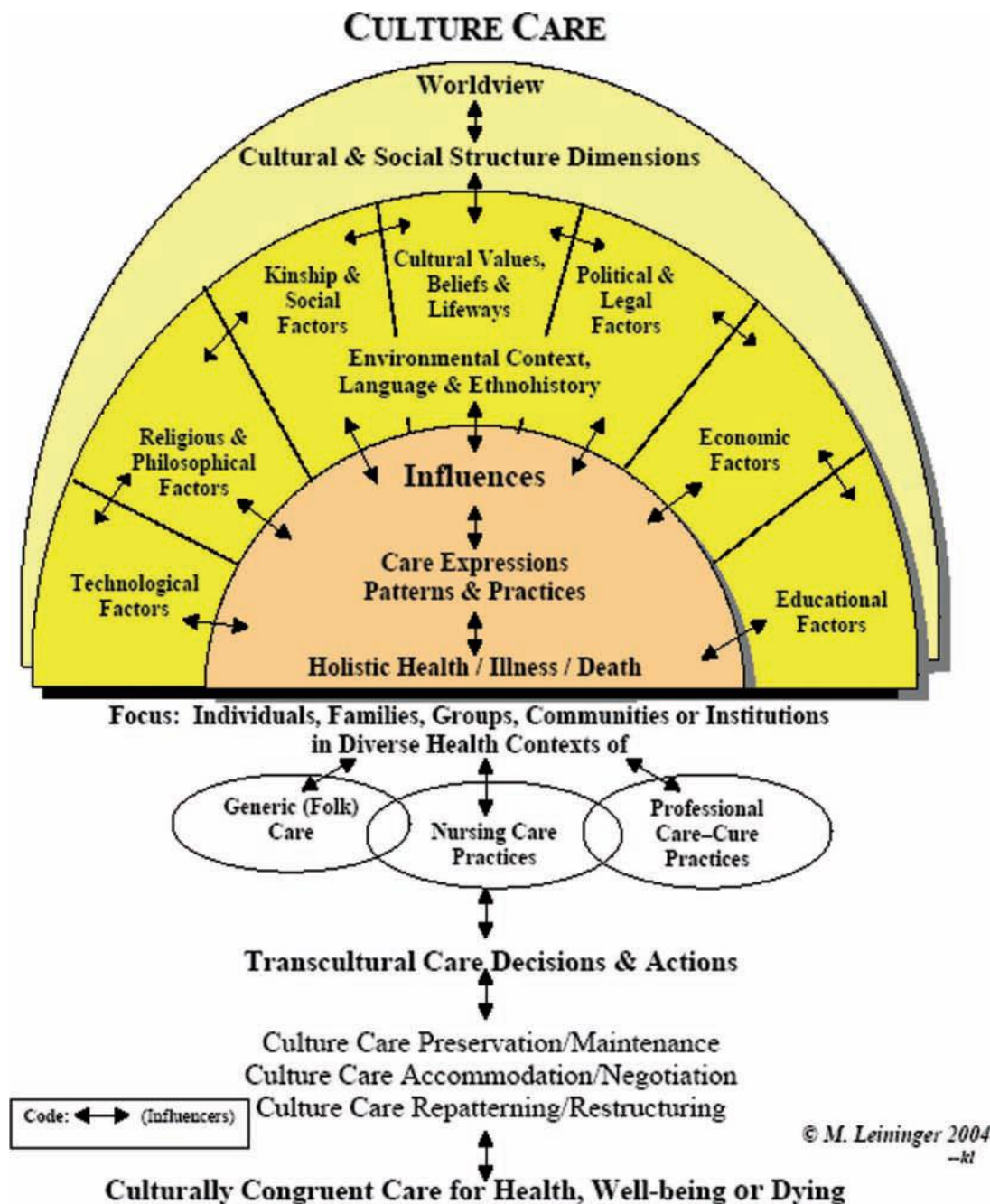


Figure 1. Leininger's Sunrise Enabler to Discover Culture Care (Leininger & McFarland, 2006, p.25)

**Critique of Leininger's Theory of Transcultural Care.** Although Leininger's contributions to cultural care have been highly recognized, there have been some criticisms for her work by nursing scholars. Leininger (1991, 1997, 2006, p.13) defined culture as "the learned,

shared and transmitted values, beliefs, norms, and lifeways of a particular culture that guide thinking, decisions, and actions in patterned ways and often intergenerationally”. Her anthropological perspective on culture raised the argument that Leininger views cultural values as long-term and very stable (Meleis, 1997; Boyle, 1999; Dayer-Berenson, 2011), which may result in a stereotypical view of a culture. This point may not be relevant if we consider the multiple realities existing in present day cultures (Juntunen, 2004).

Anthropology stresses understanding culture by stressing specific customs, folkways, and patterns... The fear of stereotyping is often cited as the major criticism of the cultural competency movement. It is important that this process of identifying the characteristics that may be associated with certain cultural groups be done with an extremely open mind and for the nurse to realize that, just like anything, exceptions can be found. It is important that we do not proceed with blinders on as the nurse must continually assess for affirmation or for exceptions (Dayer-Berenson, 2011, p. 16).

Although the stereotyping concern is an important one, other nurse scholars argue that the reliance on generalizations about cultures is necessary to expand nurses’ knowledge about a certain client population (Giger & Davidhizar, 2004; Dayer-Berenson, 2011; Giger, 2013). Considering the situation from both perspectives, it is clear that a nurse needs to be cautious when creating generalities and to be open and flexible to individualization of clients within any particular culture. The other criticism on Leininger’s theory that it does not consider the variation within cultures, including disability, socioeconomic status, gender, age, religion or education, which influence the ways in which people express their cultural orientation (Boyle, 1999; Lipson, 1999; Meleis, 1997; & Juntunen, 2004).

***Leininger's response to her theory's critique.*** In response to the critique of Leininger's transcultural theory and the Sunrise Enabler model, Leininger (2002) elucidated the embedded assumptions of her work. Leininger stated:

It is important to understand that gender, age, class, race, historical, and other features are usually embedded or related to social structure factors such as religion, kinship, politics, and economics. For example gender, age and race data, for example, are generally *embedded* in family ties, politics, and specific cultural norms and practices. In some families caring decisions and certain actions are related to male and female role, and often over generations. (p.81)

Although a number of nurse scholars have critiqued Leininger's theory/framework, her work is still one of the most essential contributions to the understanding of the concepts "culture" and "care" and the interrelation between them. For the last five decades, Leininger's theory has been well-recognized and utilized within nursing studies and research.

## **Conclusion**

In summary, several conceptualizations were introduced to facilitate studying nursing care in different cultures including the concepts of cultural safety, ethnocentrism, cultural sensitivity, cultural competence, and cultural care. Leininger's transcultural nursing theory of cultural care focused on discovering new knowledge about culture and care and how those concepts are determinant to advance nursing practices. Each term has been critiqued in the literature for its language, perspective, and scope of practical implication. Transcultural nursing, and cultural competency were found to be more comprehensive terms that are most commonly used within nursing.

Ethnonursing, as a qualitative research method, provides an open discovery process using diverse strategies and enablers to document, describe, and understand people's experiences, care meanings, and symbols of care related to their beliefs, values, health, and cultural lifeways. Utilizing ethnonursing require nurses to sincerely question how cultural care could be provided through self-reflection and based on the work of nursing theorists.

We never actually 'know' other human beings, not even ourselves, however, our inherent process in coming to know another person as fully as possible appears to be naturally characterized by that delicate balance between knowing parts and apprehending wholes (Thorne, 2001). As an attempt to develop nursing knowledge on cultural care, Leininger's ethnonursing approach and the Sunrise Enabler Model is suggested to be utilized when inquiring all nursing fields in which the nurse can constantly reflect on the interactive processes of providing, teaching/learning, and researching cultural care.

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## **Chapter 4 - Jordanian Mental Health Nursing Care: The State of the Art**

### **Introduction**

Florence Nightingale described nursing as a unique profession that is both *art* and *science*. Hildegard Peplau described how this art and science in nursing was enacted through therapeutic relationships (Peplau, 1988). Currently, there is growing concern at an international level about the importance of increasing nurses' knowledge of the range of different communication styles of people of diverse cultures, awareness of the person's own style, and sensitivity to contextual issues (RNAO, 2007) all of which influence the enactment of therapeutic communication and providing quality nursing care. Therefore, developing and maintaining therapeutic relationships require an understanding of cultural values and beliefs and their impact within the context of providing nursing care. Peplau (1997) stressed that contemporary nursing practices need facts, theories, and methods to obtain information about the different cultures, which can increase the quality of care provided to people from multi-ethnicities. Thus, we need to understand how nursing is enacted in different cultures and countries. However, there is limited nursing research that has investigated how mental health nursing care is provided within the Jordanian cultural context.

### **Background and Significance**

The Hashemite Kingdom of Jordan is a small developing Arab Middle Eastern country. Jordan shares borders with Palestine/Israel, Syria, Iraq, and Saudi Arabia. The political dynamicity of the area has major influences on the history of Jordan at all levels including social, cultural, financial, and political, impacting the various functional systems in the country. The central location of Jordan in the Middle East has led to the migration of increasing number of refugees. People from neighbourhood war-torn countries, such as Iraq and Palestine, and Arab

spring-affected countries such as Syria, and Libya are moving to Jordan seeking a peaceful place to live. The estimated population of Jordan is 6.9 million of whom approximately 2 million are Palestinian refugees (UNRWA), 597,300 Syrian refugees, and 55,500 Iraqi refugees (CIA, 2014). The net result is greater diversity of the Jordanian population in terms of backgrounds and country of origin. Within the healthcare sector, the Jordanian system has been affected by increased demands on health care services by the migrants.

The nursing discipline in the Middle Eastern country of Jordan presents an interesting paradox; that is nursing students study Western texts and are taught Western nursing models, while the assumptions behind these concepts and models might be different from the cultural values and beliefs of Middle Eastern countries (Hawamdeh, 2002). Thorough understanding of how cultural values and beliefs shape nursing care is an essential step toward achieving culturally competent therapeutic care. However, there is a paucity of published research investigating the mental health nursing care in Jordanian mental health settings and the shaping role of cultural values and belief systems.

The goal of this ethnographic study is to explore the Jordanian mental health care structure and system, and explore nursing care from a cultural and societal point of view utilizing an ethnonursing approach. This study may enhance nurses' knowledge about their practices by critically questioning and challenging how nurses establish and maintain culturally appropriate nursing care practices with their clients.

### **Existing Knowledge**

A literature search was conducted mainly using the CINAHL, PsychINFO, and ProQuest Nursing Journal database. The keywords that were included in the search were: cultural nursing, psychiatric nursing, mental health nursing, cultural care, Jordan, and Jordanian health care. Other

search strategies included manual search for Jordanian grey literature and unpublished papers, research studies, and graduate students' theses.

**History of Mental Health Nursing in Jordan.** Nursing as a profession began in Jordan approximately 60 years ago. The number of nurses in Jordan is estimated to be 29.5 per 10,000 people. This number is considered to be relatively high in the region, but low compared to Western countries, which also suffer from a nursing shortage (Jrasat, Samawi, & Wilson, 2005). In Canada, for example, the estimated number of registered nurses between the years 2006 and 2010 is 78 per 10,000 people (CIHI, 2011).

The history of mental health care can be traced back to the establishment of the first psychiatric mental health care facility in Jordan in 1968 (Hawamdeh, 2002), which makes this facility quite young compared to mental health care facilities in other countries. Before that, Jordanians relied on neighbouring countries for mental health care, in addition to the commonly used traditional healing modalities such as visiting a religious person or a traditional healer (Benbow, Ta'an, Terp, Haspeslagh, & Forchuk, in press). Given that mental health care is relatively recent in Jordan compared to other Jordanian health care sectors, there is limited research available in the field of mental health care. Research programs that investigate nursing practices within Jordanian mental health care settings are needed to advance the delivery of quality nursing care.

The current Jordanian mental health system is composed of services provided by the government (Ministry of Health), university and private sectors, and the military services (Royal Medical Services). Mental health services in Jordan include hospitals, addiction centres, and outpatient mental health facilities. The major limitation of the Jordanian mental health care system is the absence of organized and accessible community-based psychiatric inpatient units or

community residential facilities in the country (Benbow, et al., in press). According to the WHO (2011) report, there are 8.27 beds per 100,000 people in Jordan's mental hospitals, with an occupancy rate of 97%. Exact numbers of health professionals for Jordanian mental health are unknown for both the public and private sectors. However, estimates based on existing data reveal relatively low numbers of mental health professionals per capita; there are an estimated 1.09 psychiatrists, 0.54 other medical doctors (not specialized in psychiatry), 3.95 nurses (both associated and registered nurses, not specialized in mental health), 0.27 psychologists, 0.3 social workers, and 0.09 occupational therapists per 100,000 population (WHO, 2011). Furthermore, human resources are disproportionately distributed, as a large percentage of mental health care professionals work in mental hospitals near Amman, the capital city, where only 36% of the population live.

**Conceptualizing cultural care.** Many different understandings of culture have been articulated in the literature through the history of nursing and social studies. Culture, earlier than 1960's, was viewed as socially constructed labels according to ethnicities (such as Canadian, British, or American), or physical characteristics that are represented in races, like Black, White, or Brown (Vandenberg, 2011). Nursing leaders such as Florence Nightingale was more focused on the sick client and the nurse; and on health, nature, and environment without paying a lot of attention to the concept of culture in nursing (Leininger, 1991). At that time there was lack of knowledge about culture in nursing education, which led the nurse Madeleine Leininger to pursue her academic doctoral program in anthropology in the early 1960's. After that, the concepts culture, culture care, transcultural nursing, and culture competence were formally popularized in the nursing literature (Vandenberg, 2011).

As discussed in the third chapter, several terminologies were used to link *culture* and *nursing* including cultural safety, ethnocentrism, cultural sensitivity, and transcultural nursing. Each of these conceptualizations has its own origin, use and critique. For example, “Cultural safety aims to counter tendencies in health care that create cultural risk (unsafety)” (Browne, et al., p. 169). The term was conceptualized in New Zealand where there is bicultural orientation of Maori and Crown people (Browne, et al., 2009). Therefore, using this concept leads to the assumption of disempowerment and disadvantages among certain ethnocultural groups as related to the predominant culture of the area. While the concept of cultural safety is highly compatible with critical theoretical perspectives, the proposed research is firmly situated within an interpretive tradition which aims to gain understanding and description. Although issues of power may emerge as important constructs, these are not central to this research.

***Transcultural nursing.*** Transcultural nursing is defined as “a discipline with a body of knowledge and practices to attain and maintain the goal of culturally congruent care for health and well-being” (Leininger & McFarland, 2006, p.19). It is one of the earliest terms linking care with culture that was developed by Leininger (1988) and still being used as an overarching concept. Transcultural nursing is created to help nurses recognize and understand cultural differences and its emerging differences in behaviors and needs (Leininger, 1988), which basically counteracts existing ethnocentrism in the favor of increasing cultural awareness and tolerance.

In transcultural nursing, Leininger (2006) stresses the importance of “obtaining in-depth knowledge of care and cultural constructs from key and general informants related to health or wellbeing” (p.6). Therefore, the focus in Leininger’s view of transcultural nursing is discovering and generating new knowledge about cultural care rather than only quantitatively testing

theories. Therefore, Leininger's conceptualization of transcultural nursing was utilized as the perspective that guided this research study.

**Jordanian health care culture and communication.** There is paucity of literature on the influence of culture on health care in Jordan, or more broadly, in the Middle East. This topic needs to be studied and explored to serve both nurses in Jordan, and furthermore nurses in countries such as USA and Canada, where there are large numbers of immigrant people from Middle Eastern countries (Faragallah, Schumm & Webb, 1997). As these Middle Eastern people accessing the healthcare system and interacting with healthcare providers, their needs for culturally sensitive care is key to quality client care. Although Jordanian cultural concepts may not holistically represent all features of Middle Eastern cultures, given the large number of migrants in the country this study can provide an example of the wider culture (Shuriqueie, While, & Fitzpatrick, 2008).

Gaining an understanding between nurses and clients necessitates nurses becoming aware of taken-for-granted connotations by seeking clarifications and exploring meanings associated with their cultural backgrounds as basic principles that can facilitate understanding between nurses and clients (Shattell & Hogan, 2005). Attaining a better understanding of cultural values, beliefs, and norms, and how they may or may not shape the nurse-client interactions can be a first step toward facilitating therapeutic relationships that are culturally meaningful and relevant. The literature reviewed attests to a growing attempt to increase internationally culturally competent healthcare services, and mental health care services in particular, for Middle Eastern people (Kakoti, 2012).

The reviewed literature revealed some cultural connotations among Jordanians that may have an impact on the interaction between healthcare providers and their clients and the

subsequent delivery of health care. There is a significant value related to the status of insiders (family members) and their privacy as compared with outsiders (everyone else) among Arabs. This is manifested by resistance to the disclosure of personal information outside the family (AbuGharbieh, 1998). Health-related concerns can be considered a private topic that is only discussed within the family. Thus, frank questions and open shared discussions of diagnosis and prognosis can elicit negative reactions within Arab families (Meleis & Jonsen, 1983). However, there is no literature that has examined the role of these values in shaping relationships between the clients and health care providers.

Therefore, Jordanians' communication patterns are influenced by a hierarchy of family relationships and depend on the social status within the family of the communicators (Hawamdeh, 2002). Indirect communication at times can be used by Arabs to avoid possible offense and stressful interpersonal conflicts. Non-verbally, Arab communicators tend to stand close together, maintain eye-contact, and touch the other's hand or shoulder if they are of the same sex (Hawamdeh). Eye-contact may also be a sign of power; that is, people from lower social status or younger in age may not maintain eye-contact to show respect to the other party. Non-verbal communication has been widely studied internationally, with touch being the most frequently studied in nursing research (McCann McKenna, 1993, Routasalo, 1999, Fleischer, et al. 2009). However, there is a lack of studies addressing the non-Western context of using non-verbal communication skills within the scope of Jordanian mental health nursing.

A further impediment to therapeutic relationships is associated with the stigma surrounding mental illness that is predominant among Arabs. This stigma may interfere with individual clients and/or their family seeking healthcare services and communicating signs and symptoms of mental illness (Al-Krenawi, et al., 2001; Hawamdeh, 2002; Kakoti, 2012). The



stigma of mental illness and people with mental illnesses can negatively alter nurses' attitudes toward their clients (Hamdan-Mansour & Wardam, 2009) and may lead to clients' perceptions of powerlessness. These issues have not been closely studied previously, although they are considered to be vital to providing mental health nursing care within its cultural context.

Cultural values and beliefs in any culture can have significant effects in shaping nurses' health care practices as well as the health-seeking behaviours of clients. In general, there is a negative attitude toward people with mental illness in Jordanian culture. This negative viewpoint is even more worrisome in as much as it exists among the sub-culture of mental health care professionals (Hawamdeh, 2002; Hamdan-Mansour & Wardam, 2009). It is alarming that mental health care providers themselves may stigmatize people with mental illnesses. Such stigmatization underscores the need to investigate the value system that underpins it and how values may shape nurse-client relationships and care.

In summary, several conceptualizations were introduced to facilitate studying nursing care in different cultures including the concepts of cultural safety, ethnocentrism, cultural sensitivity, cultural competence, and cultural care. Leininger's transcultural nursing theory of cultural care focused on discovering new knowledge about culture and care and how those concepts are determinant to advance nursing practices.

We have limited information from previous literature about attitudes that are shaped by peoples' beliefs and values, but there is an absence of Jordanian studies on how this cultural context shapes mental health nursing care from the perspectives of the nurses and clients. There is also lack of Jordanian research studies that address the structure and systems in which mental health clients receive care and how these contextual factors interrelate with the provision of culturally competent quality care.

## **Statement of Purpose**

The purpose of this study was to explore and describe the Jordanian mental health care system, and investigates how the cultural values and beliefs of Jordanians shape mental health nursing care. The study aims to answer the following research questions:

- 1- What is the current structure of Jordanian mental health care system?
- 2- What contextual and environmental factors impact nursing care in Jordanian mental health care settings?
- 3- How do Jordanian cultural values and beliefs shape mental health care practices?
- 4- How do cultural values and beliefs influence people with mental illness from the perspectives of mental health nurses and clients?

## **Methodology and Methods**

Ethnonursing is the methodology that is used in this research study; which is a naturalistic inquiry research approach developed by Madeline Leininger (Leininger, 1995; 1997, 2002). Ethnonursing is a mini-ethnography, also referred to as focused ethnography (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Leininger & McFarland, 2006), that is characterized by reflecting on specific elements of one's own society (Knoblauch, 2005). It differs from the conventional/ classic ethnography mainly in terms of demands on time, which focused ethnography uses intensively (shorter period of times with more focus on the research purpose) rather than extensively (usually one year or more of observation). Additionally, its specific focus is on the communicative activities between the participants (Knoblauch, 2005). Ethnonursing is based on a holistic framework that uses the techniques of purposeful sampling, observation, and in-depth interviewing to reveal participant's experiences (Miller & Petro-Nustas, 2002).

The goal of ethnonursing is to understand the diversity and universality of care, and for that purpose, it is imperative to distinguish between *emic* and *etic* data. Emic refers to the insider's viewpoint of the culture (which is the nurse's and client's perspective in this study), while etic means the outsider's viewpoints of the culture (which is the society in this study) (Leininger 1988, 1991). The purpose of using ethnonursing research approach is to explore cultural roles, norms, and values and how they are related to health and illness-related behavior' (Boyle, 1994). Therefore, ethnonursing approach fits well with studies related to cultural care. Ethnonursing design was utilized to explore mental health nursing care from the perspectives of the people (nurses and clients) who engage in the relationship and within its natural setting (Jordanian national center for mental health).

In this study, Leininger's sunrise enabler model, which was discussed in details in the third chapter, was utilized to guide in-depth understanding of how cultural care-related values, beliefs and practices shape the nurse care. To be more specific, Leininger's model (Appendix B) was used during the data analysis where the collected data was analyzed and organized, then examined in relation to Leininger's model. Relevance and/or irrelevance with Leininger's model are highlighted to inform future recommendations. Previous work utilizing this model focused on its use to create nursing curricula that teach nursing students or nurses in the field how to provide cultural care based on the similarities and differences among cultures.

**Ethical considerations.** Participants' experience and participation in research must be respected by the researcher (Munhall & Boyd, 1993). Ethical approval was obtained from the University of Western Ontario's Research Ethics Board to assure the ethical acceptability of the research proposal. Ethical approval was also obtained from research's ethics committee in the Jordanian Ministry of Health. Participants' voluntary participation in the study was key

(Rossman & Rallis, 1998); therefore, an informed consent was obtained from each participant before conducting the research. Participants were informed that participation was not obligatory, and they could refuse to answer any question and withdraw from the study at any time. Participants' privacy was respected (Rossman & Rallis, 1998) by promising them that their data will not be used except for the purpose of the study, and future potential secondary analyses. Anonymity was assured by guaranteeing that their personal identity would not be used (Sapsford & Abbott, 1992). Participants were informed that identifiable (or potentially identifiable) information would be kept separate from collected data in a secured (key-locked) cabinet. Digital recordings of the interviews would be saved on a password-protected computer. Collected data would be kept for five years for potential future studies, after that all data will be safely destroyed. The nature of the study also necessitated the researcher informing participants that if any life-threatening ideation occurred during the interviews these should be reported to the participant's care providers.

**Study participants and context.** The study took place in the acute and chronic mental health units of a major hospital in Jordan; namely, the National Center for Mental Health (NCMH) in Amman (the capital city of the country) commonly referred to as Al-Fuhais mental health care hospital, which is the largest public centre that is available to Jordanians seeking mental health care. A purposive sample of nurses and clients from both acute and chronic units were recruited for this study to seek a diverse sample of participants from different countries of origin, socioeconomic backgrounds, genders, and who have different psychiatric diagnoses, who were admitted for varying lengths of time (Patton, 2002).

A range of 30-50 interviews was suggested by Morse (1994) for ethnographic studies. For this study a total of 34 interviews were held with the participants. Nine nurses and nine

clients were recruited from a Jordanian mental health care setting. Open-ended semi-structured interviews were held with nurses and clients individually to explore their perceptions on receiving/delivering care at NCMH. Six follow-up interviews took place to ensure collecting data at more than one point in time during their hospital stay. After taking field notes and preliminarily analyzing them, some questions raised and needed to be clarified with the participants. Therefore, ten short informal interviews were conducted with participants to clarify and verify observations.

Intensive observation-participation was through three months of regularly visiting the institution and recording field notes. Three to four weekly visits took place; each visit lasted for at least five hours. Attending individual nurse-client interactions took place as frequently as possible after getting nurses' and clients' permission. Nurses and clients were observed while interacting with each other and with other people in their units to give both breadth and depth on the processes as well as the patterns of interactions that were occurring.

**Data collection methods.** Prior to data collection, the researcher's advisory committee agreed that being introduced to more than only one system allows researchers to critically analyze and widen their perspective on the health care system. Our assumption is; being in the same room for a while may decrease the ability to judge its brightness/darkness. However, going outside then coming back to the same room may give a better idea of describing its luminosity. Therefore, the primary author of this chapter got the chance to be introduced to health care systems of more than one country to enrich the analysis and discussion of the findings. The researcher took a clinical course within the Canadian mental health care system in which she had the chance to visit and observe what, where, when and how care activities are provided to people

with mental illness in Canada. This experience allowed for additional critical understanding of both the strengths and weaknesses of the Jordanian mental health care system.

Data collection included two main methods, open-ended semi-structured interviews and observations. The ethnonursing research method was specifically designed to provide in-depth study of covert and embedded care and culture data through “detailed observations, reflections, descriptions, participant experiences, and data derived from largely open-ended inquiries” (Leininger & McFarland, 2006, p. 54).

Open-ended interviews were conducted with participants in order to understand their experiences and interactions within the NCMH. It is imperative to actively listen with an open mind to the informant, learning from them, and not imposing the researcher’s ideas (Leininger, 2002). Individual semi-structured interviews with the participants were held to explore participants’ perceptions of the nurse-client interactions. According to Patton (2002), in-depth interview is the best data collection tool for gaining understanding of the people’s perceptions and the meaning of their experiences. Also, interview is the only way for us to know what another person feels or experiences (Patton, 2002). In other words, in-depth interview allows for deep understanding of the phenomenon from the nurses’ and clients’ perspectives.

The purpose of the semi-structured interview is to encourage study participants to talk freely about their experience and perceptions of the phenomena with some flexibility (Lowes & Gill, 2006). The main advantage of using an open-ended interview is that it allows all participants to share their unique experiences of the nurse-client relationship. This method was the most appropriate method according to the purpose of the study as it gives minimal guidance to participants. Also, it gives them the chance to express their perceptions openly in their own words.

Participants were interviewed individually in a private area of the hospital for 1-2 hours. Open-ended questions were used such as “What is it like to work/come here?”, and “Can you think of any stories that typify what it is like to provide/receive health care at this setting?”. In addition to questions like “I would appreciate it if you tell me more about \_\_\_\_\_” [specific issue that is being shared]. Basic demographic information was collected from participants at the end of the interview. See appendices D and E for guides of possible interview questions. All interviews except one were done in the Arabic language. One interview was conducted in English. The interviews were recorded using a digital recorder, and notes were taken after each interview to summarize observations and impressions about the previously held interview. Recorded interviews were then translated and transcribed verbatim.

Clinical observation took place in common areas over three months of intensive data collection through three to four weekly visits. Each visit lasted for at least five hours for a total of about 260 hours of observation. Attending dyadic nurse-client interactions took place more than ten times each time for 5-20 minutes duration after getting nurses’ and clients’ permission. Observation guide is presented in Appendix F.

The observation-participation reflection according to Leininger (2002) is crucial to obtaining holistic, specific, and accurate data. For ethnonursing, Leininger and McFarland (2006) suggested that, “the researcher moves from an observer and listener role to gradually a participant and reflector role with the informants... The researcher moves in slowly and politely after seeking permission to be with the informant” (pp.89-90). The gradual entry helps the researcher observing naturally occurring interactions. Observations and reflections on what is going on before, during and after the interaction were documented. Participants were encouraged to explain what was being observed, done, or experienced. Ethnographic observation provided a

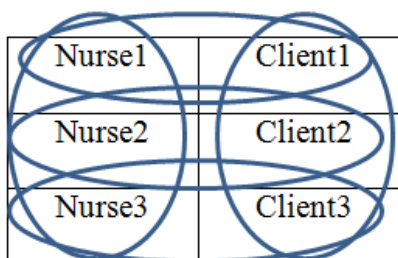
method to facilitate the description and reflection of the cultural dimensions on the people's interactive relationships (Angrosino, 2005).

**Data analysis.** Data from the individual interviews and observation field notes were analyzed using a thematic analysis approach. Thematic analysis seeks to unearth the themes embedded in a text at different levels (Attride-Stirling, 2001). Leininger (1997) suggested the following thematic analysis phases; collecting, describing and documenting data, identification and categorization of descriptors and components, conducting patterns and contextual analysis, generating themes, research findings, and recommendations. The analysis started simultaneously with the data collection, so that the interview questions could be further focused according to the themes of the analysis in subsequent interviews. Member checking was also performed to verify that the analyses actually reflect participants' experiences. Ethnographic data were analyzed utilizing Leininger's transcultural theory.

Interviews were analyzed at individual, dyadic, and group levels. Dyadic analysis assists in deriving themes related to the nature of relationships, which could otherwise not have been reached (Eisikovits, & Koren, 2010). The dyadic analysis was also used to increase trustworthiness (Lincoln & Guba, 1985) through use of triangulation (Denzin, 1989; Yardley, 2000). For the richest possible analysis, a hypothetical matrix (*Table 1*) is drawn below where data were analyzed at the individual level, showing separate columns of nurses and clients as well as their numbered dyads. The analysis presents common themes and findings among nurses as a group, clients as a group in addition to findings among dyads.



*Table 1. Data analysis matrix*



Nurse1	Client1
Nurse2	Client2
Nurse3	Client3

## Findings and Discussion

The main themes of study findings among nurses as a group, clients as a group, in addition to findings among dyads are; first theme: the journey from community to hospital and back to the community, second theme: the lack of resources: an obstacle to providing standard care, third theme: the establishment of the new model unit: a look into the future, and the fourth theme: the stigma of mental illness: societal responses and responsibilities. The research interviews and observations afforded a fairly comprehensive understanding of the context in which mental health nursing care takes place. A discussion of cultural care from the perspectives of Jordanian clients and nurses will be provided in this section.

**Pathways to psychiatric mental health care in Jordan.** According to Leininger's theory (Appendix B), care expressions, patterns, and practices are the core contributors to the world view of cultural care. Several professional and unprofessional health practices among Jordanians seeking mental health cure were depicted from the current study. Based on clients and nurses' perspectives, some mental health client does not seek specialized treatment at the onset of their symptoms. Clients often 'stop by' some alternative treatment options prior to reaching their professional destination. The journeys before and after admission to the NCMH are discussed herein.

***Theme 1: The Journey from Community to Hospital and Back to the Community.*** The majority of study participants were brought to mental health care hospital by a family member, relative or a friend. Typically, people with mental health concerns start their health seeking journey through primary health care centers showing health signs that a nurse and a general physician assess and refer to a psychiatric mental health care facility. However, there is always a possibility of overlooking mental health issues signs, confusing them with other medical non-mental health issues, or over-sensing mental health concerns (e.g. confusing symptoms of physical illness such as thyroid gland disorders with mental illness symptoms). People may also be referred to psychiatric mental health services by emergency services, or legal authorities due to reporting extraordinary behaviors or criminal activity. After referral to a mental health care facility, the nurse and the psychiatrist comprehensively assess the client's mental health status by conducting interviews with the client including performing a clinical assessment. Physical assessment and other tests may be performed depending on the client's condition. Accordingly the psychiatrist decides whether the client will be treated as an out-patient or be admitted as an in-patient in one of the public hospitals, university hospital, or private hospital based on the client's preference and ability to pay.

Jordanian public mental health hospitals are affiliated with the Jordanian Ministry of Health (MOH) and accessible to all citizens who are majorly insured and to non-citizens at affordable rates. A client's admission is conditional upon the presence of a referral document or being accompanied by a family member and having a proof of identity. However, the availability of beds is a condition for admission.

Culturally speaking, people with psychiatric disorders in Jordan usually live with their family members and are taken care of by them. Group homes and supported mental health

housing are not available in Jordan. People with psychiatric disorders do not live independently, which is congruent with the general cultural norms that children live with their parents and are taken care of by them until their marriage. Jordanian parents provide their children with a place to live, provide food and home necessities, and are financially responsible for their children until marriage. Males and females are not expected to work until they graduate from university. Therefore, clients are highly dependent on their families. This dependency extends to health care settings replacing family members with health care teams (primarily nurses) which add challenges to their work.

Although there is a very high level of education and a continuous increase in the percentage of university and diploma degree holders among the Jordanian population, there is still lack of awareness about mental health. The vast majority of study participants (clients) reported that they sought at least one conventional, religious, or traditional healer. In congruence with findings from Hawamdeh's (2002) study, most clients who participated in this study reported that either they or their family members believed in supernatural causation, such as evil eye (envy from jealous people) or Jinn (demons), for their psychiatric illness, neither of which held the client responsibility for his/her illness. Signs and symptoms of mental illness were referred to as unreasonable and unexpected behaviors that existed due to the presence of Jinn in the affected person. Therefore, seeing healers were thought to help by purging Jinn from the person. Most clients and all nurses who participated in this study agreed that these alternative healing modalities had failed to cure them; otherwise they would not be at the mental health facility at the time of this study. Nurse participants added that trying these alternative pathways delayed accessing the professional mental health care in addition to worsening their situations and increasing the severity of their signs and symptoms upon admission.

Psychiatric in-patient units in Jordanian hospitals are divided into acute or chronic units, some for male clients and others for female clients. There are no mixed sex units. Also, units are not divided by the mental health diagnoses, and there is no division of units by age. Geriatric clients are integrated with other clients from all age groups. There are no specialized units for children and adolescent. Adolescents are admitted to the regular units, and there are no admissions for children under the age of 16 because of lack of specialized care for children and because of assuming that parents could take care of them.

Nurses then establish the client's file, perform regular assessments, provide interventions, and keep track of the documentation. New clients are given tours to the ward and its staff in addition to the system and routine of the unit. Social workers are also included in the plan of care. However, there is a clear shortage of the number of social workers in Jordanian health system. One psychiatric hospital of eight units might have as few as two social workers.

During hospitalization, mental health clients receive continuous follow-up on their conditions from teams of psychiatrists and nurses, get counseling and pharmacological treatments as prescribed, and undergo several assessment tests for both mental and physical status as needed. These tests include psychosocial tests, electroencephalogram, laboratory tests, and X-ray. Nurses set schedules for giving medications, meals, smoking breaks, organizing family visit time, and social and recreational activities, in addition to monitoring bedtime and bathing routines. Social workers perform complete case studies through interviewing the clients as well as their parents/caregiver. Social workers also follow up with the clients after their discharge. However, after discharge follow-up is very limited due to the severe shortage of social workers.

During the clients' journey from admission to discharge, nurse-client interactions seemed to be congruent with Peplau's phases of nurse-client relationships, in which the nursing care evolves through identifiable, overlapping phases (orientation, working and resolution) (Peplau, 1952). However, the Jordanian current practice focuses mostly on the working phase with limitations in providing comprehensive orientation and proper follow up. Therefore, the concern is, if the orientation phase is not fully implemented, this might have consequences on the working phase. According to Peplau (1952), in orientation phase, trust is established, and issues to work on are identified. Therefore, delays and challenges in implementing plans in the working phase could be related to the lack of fully employing the orientation phase. In addition, the phase "prior to admission", which was not highlighted in the previous literature, was found to be crucial within the Jordanian culture, in which the client (or his/her family) seek alternative ways of healing and delay access to professional care which deteriorate their conditions as a result.

**The people and facilities of the national center for mental health (NCMH).** The National Center for Mental Health (main center) has a capacity of 260 beds divided into 8 units in addition to one forensic unit. An affiliated center (Alkarameh) has a capacity of 150 beds and serves as a tertiary mental health care hospital although it is not labeled as such. The occupancy rate is about 97% for both NCMH and Alkarameh. An addiction center is also available with a 46-bed capacity. According to the NCMH's records of 2013, there were 2089 admissions during the year from which 1434 (68.6%) are male clients. See

*Table 2.*

*Table 2. National Center for Mental Health (NCMH) client admission statistics 2013*

Number of admissions (year: 2013)	Male (%)	Female (%)	New clients admission	Male (%)	Female (%)
2089	1434 (68.6)	655 (31.4)	614	420 (68.4)	194 (31.6)

The high percentage of male clients compared to female clients could be explained by the mental health stigma that is more seen to affect females in the society. Female clients were hidden and hesitated to seek help because of social stigma that not only affecting them but also affecting their family members' (especially sisters), social relationships, job opportunities, and marriage options. Clients who have participated in this study expressed their fears of accessing mental health services due to being negatively viewed by the society which in turn caused their mental health status to deteriorate and ultimately reach out for care in critical situations. From another perspective, nurses in this study were concerned that their work with clients is extremely challenging when clients come to receive care in crisis which makes establishing therapeutic relationship and providing care more challenging. The nurses stressed that if clients seek professional care upon onset of symptoms, treatment would be more effective.

The most common psychiatric diagnoses at NCMH were schizophrenia (69.9%) and depression (13.2%). Detailed numbers and percentages on clients' visits to the center are provided in *Table 3*.

*Table 3. Client-visit statistics and diagnoses NCMH 2013*

Diagnosis	Number of visits (%)	Male	Female
Schizophrenia	12317 (69.9)	9471	2846

Depression	2329 (13.2)	1783	546
Epilepsy	802 (4.5)	524	278
Obsessive Compulsive Disorders	739 (4.2)	446	293
Mental Retardation	589 (3.3)	362	227
Anxiety	324 (1.8)	188	136
Addiction	5 (0.02)	5	0
Other disorders	508 (2.9)	287	221
Total	17613	13066	4547

**Theme 2: the lack of resources: an obstacle to providing standard care.** As shown in the table below (*Table 4*), there is a clear shortage of the human resources at the mental health care facilities in comparison to the number of clients/admissions. The shortage of human resources stemmed from the very limited resources provided to the Jordanian mental health care due to the economic status of Jordan as a developing country. Nurses expressed their concerns about the work load. Observational data revealed that very limited amount of time nurses can spend with their clients due to being primarily busy with scheduled tasks such as administering medications, checking on client, and supervising meals and smoking.

*Table 4. Health care professionals' statistics NCMH 2013*

Occupation	Numbers at NMHC	Alkarameh	Addiction center	Total
Psychiatrist	14	2	2	18
Psychiatric resident	16	0	0	16



Medical doctor	1	0	<i>1</i>	2
Pharmacist	4	2	2	8
Registered nurse	103	21	24	148
Licensed practical nurse	27	5	2	34
support worker	24	4	3	31
Social worker	16	1	3	20
Occupational therapist	2	0	0	2
Public health supervisor	1	0	0	1

Nurses constitute the largest number of health care professionals in mental health settings. According to the Jordanian Nursing Council (2006a), nurses in Jordan are classified as support worker, enrolled nurse, registered nurse, specialist nurse, and advanced practice nurse. Support workers are also referred to as nursing assistant, auxiliary, and personal care worker. This term is applied to workers who assist directly in nursing care under the direct or indirect supervision of nurses. They are paid providers who are neither registered nor licensed by a regulatory body.

An enrolled nurse or licensed practical nurse (LPN) is a nurse authorized to provide limited nursing care under the supervision of a registered nurse. A registered nurse, qualified, or licensed nurse is a self-regulated care professional who has successfully completed an education program approved by the nursing council. A specialist nurse is the nurse with advanced expertise in a branch of the nursing field including clinical, teaching, administration, research and consultant roles. Advanced practice nurse or clinical nurse specialist is a registered nurse who has developed expert knowledge and clinical competencies for expanded practice through getting

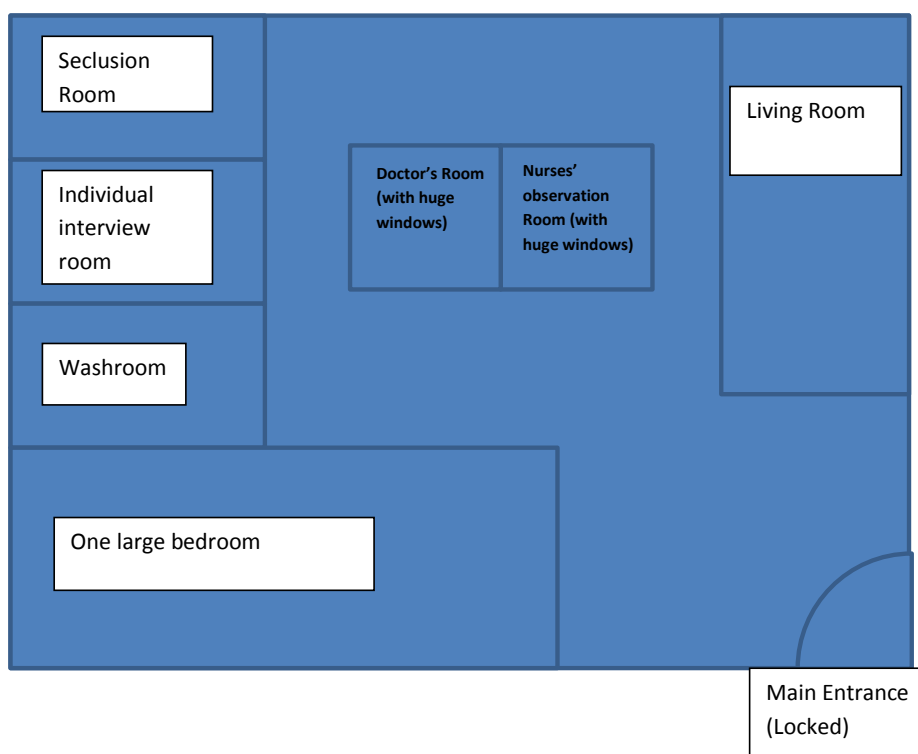
a Master's degree in nursing and specialized clinical experience. Different expectations and scopes of practice are identified for each group of nurses in regard to quality improvement, continuing education, enhancement of the profession, leadership and management, and therapeutic communication and interpersonal relationships.

The NCMH lacks specialist nurses and advance practice nurses. This could be one of the reasons for the limited continuity of education in the field of mental health nursing. Developing and advancing nursing care requires continuous effort and dedicating time of qualified people to achieving high standard care. According to one of the administrator nurses, most of the studies in the field are done by students in nursing, and psychology MSc programs at Jordanian universities and their work remains unpublished and inaccessible due to the lack of databases to store their work. Other work is done by the World Health Organization (WHO) in alliance with the Ministry of Health (MOH) and their work is published on the internet, but it is not specific to nursing.

### **Environmental context, unit structure, and the establishment of the new model Unit.**

According to Leininger, environmental context is a major influence on health and caring that refers to the totality of geophysical situation, and about the live-in setting of the culture (Leininger & McFarland, 2006). This section provides a comprehensive overview of the caring environment in which caring practices take place. Mental health care hospitals in public sector are not well developed compared to other areas of health care in Jordan and severely suffer from staff shortage (Jrasat, Samawi, & Wilson, 2005). However, there is a current effort to reform mental health units into more developed professional standards units called "*model units*". Other units will be referred to as "*regular units*". In this section, both types of units will be described, critiqued, and discussed.

**Regular unit's layout.** The regular unit in the hospital comprises the majority of the hospital units. See *Figure 2*. Each unit has one locked entrance with a security guard located outside the unit by the door to make sure that only authorized people can access the unit, protect the safety of the clients, and help the nurses in case of having any unexpected aggressive behaviors of clients.



*Figure 2. Regular unit's layout at NCMH*

The unit includes one large bedroom with 20-25 beds. Bedrooms meet the safety requirements, but lack privacy, character, art, or any entertainment avenue although some clients spend most of the day in this room. The living room only has chairs and in some units has TV's and other units lack it – that is if the device got broken, it is hard to replace it due to the limited

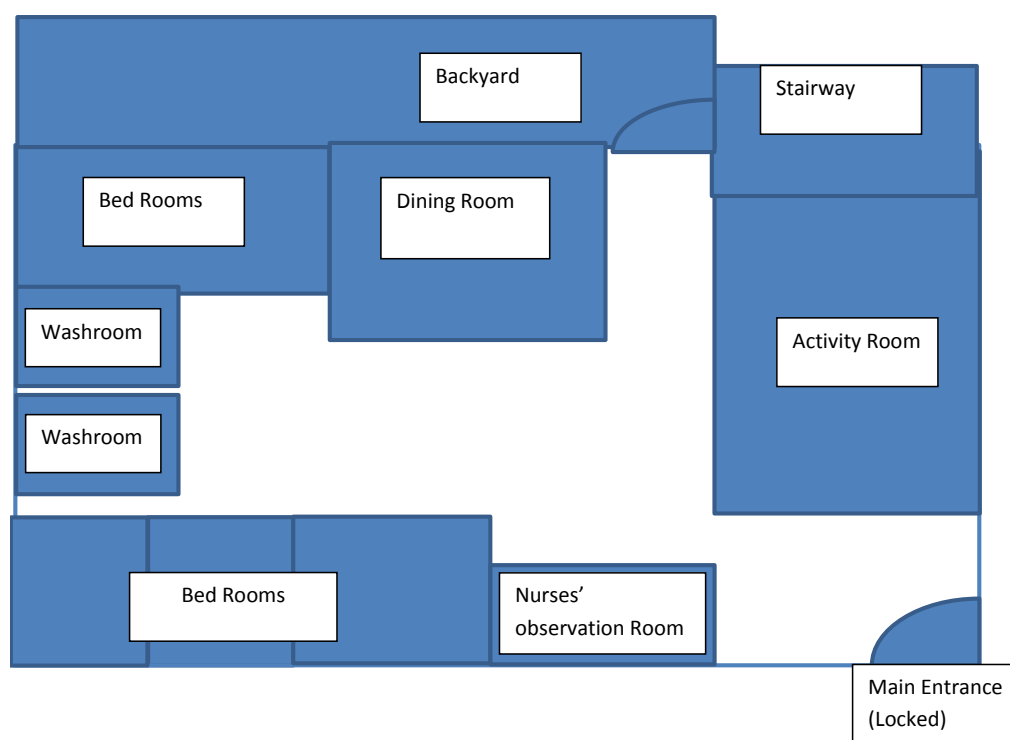
budget of the hospital. No other entertainment is provided in regular units. Nurses' and doctors' rooms are located in the center of the unit with huge glass windows (very hard glass-cannot be broken) to keep observing clients during their shifts. Units also include seclusion room (a secured room with a window), individual interview room and bathrooms. No dining room, therefore, clients usually have their meals in their bedroom or the living room. One of the clients commented "I feel very bored here... I wish if I can practice some exercises here or sports. I love to play basketball and I like swimming, but such activities are not possible here. There are no facilities". A nurse added "this is one of the difficulties; the shortage in tools and supplies [for activities]. There should be support systems available to help me perform my job... There are not many things that we can use for activities with the clients. If we want to plan activities, we need material."

***Theme 3: the establishment of the new model unit: a look into the future.*** Started in 2010, Ministry of health, WHO, and Jordanian Nursing Council established a *model admission unit* (male acute unit) in The National Center for Mental Health as a start. According to mental health administrative nurses, The aims behind the establishment of model units are:

- Shifting from a biological approach to the comprehensive bio-psychosocial approach
- Utilizing multi-disciplinary health care teams, rather than relying mainly on medical teams as it used to be
- Deinstitutionalizing mental health care
- Improving the quality of care

***Model unit's layout.*** The model unit in contrast has a large activity room with couches in it, and designated to be the main location where nurses and clients spend most of their day together as a family. See *Figure 3*. Games and books are also available at the unit. Multiple bedrooms are

established each bedroom has a capacity of 2-4 beds. There is also a dining room where clients can have their meals and in the same time have the chance to communicate with the staff. The space is decorated with fiberglass characters and the environment is very welcoming. A wall-fenced backyard is attached to the unit and accessible to clients all day. Main entrance is locked and controlled by an intercom connected to the nurses' room. Security guard is also available always near the door.



*Figure 3. Model unit's layout at NCMH*

The structure of the unit is clearly more welcoming and maintaining positive recovery environment. Nurse-client interaction takes place very frequently with all clients most of the time. Nurses and clients agreed that relationships between clients and nurses seem to be very friendly and more therapeutic than the rest of the hospital units. A client commented "I like the

environment here, people are very cooperative and I am receiving very good treatment. I am receiving good care and all necessary treatment free of charge.” Another client commented “model unit is much better than other units. There are more dialogues between the nurses and the clients, also, more attention to clients, more cigarettes, and activities. In other units there is no T.V., books, or games.” A nurse added “at every shift I sit with all clients and we chat about different topics, sometimes clients pick the topic and other time I pick it. We talk about addictions, peer support, spirituality, sexuality, and other topics they find interesting. Usually, by the end of the session, I encourage clients to come for an individual session with me or any other nurse to talk specifically about concerns they were not comfortable sharing within the group.”

Most nurses working in the model unit were recruited with no previous experience in mental health units. This purposeful selection was made to avoid the effect of past experiences from interfering with the new experience. Although experience is important in providing help for psychiatric clients, there was an assumption of negative past experience in working with psychiatric clients. This is congruent with findings from the literature where some health care professionals were having stigmatizing attitudes toward people with mental illnesses (Hawamdeh, 2002; Hamdan-Mansour & Wardam, 2009).

Upon the establishment of the unit, nurses had received a nine-month training course that included travelling to Spain and being introduced to a European mental health care hospital to benefit from their experience and apply in Jordan. Policies and procedures manual was adapted from there to be applied in Jordanian mental health care units. Continuous evaluation and follow up to the efficacy of the unit are maintained. Another model unit for females with acute conditions is currently in the process of being established. The vision of the hospital is to transform the whole mental health system into a new system exemplified by the model unit.

However, the very limited resources of the Jordanian mental health care field hinder the development and delay the progress of reforming mental health care.

Most of the clients who were admitted to the model unit were purposefully selected with no past admissions which will help in evaluating the effectiveness of the model unit and prevent the interference of negative experiences in the new setting. However, in 2013, they started admitting clients who have had previous admissions to other units. Most clients are admitted involuntarily and are usually brought by a family member with referral from out-patient clinics. The capacity of the model unit is 14 male nurses with an occupancy rate of 95%. The staffing of the unit is composed of 16 nurses including the head nurse. The nurse-client ratio is 1: 4 compared to 1:12 in other regular units in the hospital. There are 3 teams of doctors supervising the unit. Each team supervises 2-6 clients. Units' structures are presented in figures3. Describing the model unit compared to the other units:

I find the unit to be modern and suitable for delivering care in a way that is close to the Western world... there were some cons to other units. For example, the staff members were moody and not appropriately trained. The clients were in a very bad psychological status.

**The emic and etic influences on people with mental illness.** Congruent to Leininger's theory, culture and society were found to intensely influence nursing practices. Leininger's theory of cultural care emphasizes that in order to provide culturally competent care, nurses need to explore cultural care meanings, practices, and factors influencing care including educational, social, political, economic, religious, and technological factors (Leininger, & McFarland, 2006). Findings of this study revealed multiple influences affecting people with mental illness. Some of

those influences are perceived internally (emic) from the people with direct contact with the experience- in this study both clients and nurses, while outsider influences (etic) can be detected from the society, and family members (Leininger, & McFarland, 2006).

***Clients' perspectives.*** Client participants of this study highlighted the tension they experienced between receiving therapeutic care and its positive consequences on health on the one hand, and perceiving societal stigma as a main barrier to achieve their life goals, on the other hand. A client said: "In the hospital, staff treats us very kindly. They support us and deal with us just like a normal person. I feel progressing in the hospital. When they discharged me last time, I felt terrible at home. My brothers were calling me 'nuts' and people always treat me as a mad person because I was admitted to this hospital. My situation worsened and I felt I will never be capable of living normal life".

Analysis of data within the clients group showed a huge difference in how nurses and other staff members used to treat psychiatric mental health clients in the past and their current practices. Some clients, who have visited the center over several years, mentioned that staff were sometimes aggressive in treating them especially during times of severe episodes or non-compliance with the routine and medication. However, a change was perceived around 2006 when nurses started using more therapeutic approaches in dealing with clients. These practices utilized client-centered approaches and respected clients' autonomy. These changes happened gradually and ongoing transitioning is still in progress. The possible explanation for the change is the increased awareness of the lack of professional treatment in Jordanian psychiatric mental health hospitals that was brought to the public's attention through the media beginning in 2006. In addition, more focus was paid to mental health care by agencies such as the WHO, JNC, MOH, and universities.



*Nurses' perspectives.* Nurses expressed their gratitude for working with mental health clients particularly when they feel that their work had yielded positive consequences and they received positive feedback from their clients for their continuous care and support. However, there is some confusion regarding the boundaries of keeping professional empathy within its therapeutic limits. A nurse participant said: "I love my clients and they love me. Every time I take a leave, many of them ask about me just like asking about a family member. I am very compassionate with them to a degree that other nurses think I spoil them. However, I feel they are more demanding because I spoil them. My feeling toward my clients is the same I feel toward kids. They are very appreciative to kind words, respect and care, but they are very demanding."

Nurse participants of this study have identified several merits and challenges for working with mental health clients. Nurses devote great effort to establish and maintain positive supportive recovery environment for their clients. Unfortunately transitions beyond the hospital setting to support their continued improvement is limited due to the lack of community care services. Nurses, therefore, provide an experience that is non-stigmatizing to show their compassion and caring. A nurse said:

I like the environment. For me personally, I truly believe it offers help for people; to be more specific, for the client and his/her family. Clients need advocacy. We try to support and advocate for clients so they don't feel stigmatized by the society. When the client first is admitted, he/she has a chance of recovering and not developing a chronic/ long time disorder if he/she receives the proper help. Our strategy is to help the client blend and integrate within his/her own family or society to feel as a contributing member.

***The stigma on mental health care providers.*** Nurses expressed their concerns for being stigmatized for working with people with mental illness by the society members. A nurse said:

I feel that people in the Jordanian society still have stigma for people with mental illnesses as well as for staff working with them. For instance, I was in a meeting with my kid's school teacher. She was impressed that I am a nurse. She asked where I work. I answered in the national center. She said WOW, and then I continued my statement 'for mental health'. The teacher's facial expression immediately changed and said "so you work with crazy people!". I felt the stigma society put on even the staff working in mental health care. However, I did what I always do: trying to increase people's awareness toward mental illness.

These findings are congruent with Oweis (2005) who highlighted the challenges Jordanian nurses face regarding bringing their professional status to light [that is even more pervasive among psychiatric mental health nurses]. The author warned that this condition contributes to dissatisfaction, burnout, and higher rates of turnover among Jordanian nurses.

***Theme 4: the stigma of mental illness: societal responses and responsibilities.*** Stigma against mental illness; and more specifically, against people who have mental illness, is common among people of Western and non-western cultures (Canadian Mental Health Association, 1994). However, it is more pervasive among Arab cultures (Meleis, 1992, Hawamdeh, 2002). The stigma of mental illness is a multifaceted phenomenon with several contributing factors and associated consequences that not only affect the individual, but also rather extend to the family and broader community as well. Mental health stigma is mainly experienced through three vital

aspects of a person's life, namely; social life, employment, and housing (Canadian Mental Health Association, 1994; Nelson, Hall, & Forchuk, 2011). People with serious mental illnesses are more likely to be unemployed or to be underemployed in inferior positions that are inconsistent with their skills and/or training (Stuart, 2004). Although this study focused only on nurses and clients, the issue of societal stigma was raised in every interview. Several contributing factors and consequences of stigma were highlighted. Lack of societal awareness, lack of education on mental health and illness and the absence of anti-stigma campaigns were all contributing factors influencing stigmatization.

Clients in this study expressed their view that society stereotypes every person who visits a mental health institution as crazy, dependent, aggressive, and incapable of living a successful life as stated by one client:

“My family members do not treat me well; they always make fun of me because of my illness. They say you are crazy. All the society deals with me like this. If somebody has a broken arm, all will sympathize with him and will direct him to health services, but with mental illness, there is huge lack of awareness.”

Findings of this study are consistent with literature on Expressed Emotions (EE). Expressed Emotions can be applied to mental health clients' family environment based on how the relatives of these psychiatric clients spontaneously talk about their client relative. The three dimensions of high EE are hostility, emotional over-involvement and critical comments (Butzlaff, & Hooley, 1998; Leff, 2013). Family members with high expressed emotion are hostile, very critical and not tolerant of their client relative. They do not only criticize behaviors relating to their disorder but also other behaviors that are unique to the client's personality not

associated with their illness. High EE is more likely to cause deterioration of mental health status than low EE.

The Jordanian and family cultural and value systems do not only stigmatize the person who has a mental illness, but extends to their family members, which is referred to as ‘stigma by association’ (Lefley, 1987; Phelan et al, 1998; Byrne, 2001; & Struening et al, 2001). As an example, brothers and sisters of a person with mental illness usually face challenges when proposing to marry another person. It may be assumed that the mentally ill person will be a burden to them, or create fear that future children will also have mental illnesses due to genetic predispositions for mental illness. Some people therefore, choose to hide their child /sibling who have a mental disorder and isolate them from the broader society. One of the clients said: “My 18 year old son asked me not to go to the hospital; he said what people would say about you. I said if anyone asked about me tell them I am out of town for work... I blame the media for not introducing society to mental illnesses properly.”

A nurse participant summarized the lack of family and societal support by stating the following:

... another aspect is the support for families. Some clients have mental health issues due to mistreatment by their family. The client may have some genetic predisposition to mental health disorders; however, the family sometimes acts as a fueling agent to trigger such issues. We try to reduce the stigmatization of clients who suffer from mental health issues in the society. We try to help the client be a productive and contributing member. Sometimes, clients who have been able to live stable lives were able to get rid of their mental health issues.

The main challenge to clients after discharge is the absence of community services for mental illness, housing options, and ongoing supportive follow up. Nurses in the model unit, however, give their direct phone number to their clients so clients can call and keep in touch with their previous nurses after discharge but, there is a gap in professional systems or protocols for clients' follow up.

### **Conclusion and Recommendations**

This study afforded a fairly comprehensive understanding of the Jordanian mental health care system particularly at the NCMH. The study utilized an ethnonursing approach to investigate the topic from a cultural perspective. Congruent to Leininger's theory, culture and society were found to intensely influence nursing practices. Leininger's theory of cultural care emphasizes that in order to provide culturally competent care, nurses need to explore cultural care meanings, practices, and factors influencing care including educational, social, political, economic, religious, and technological factors (Leininger, & McFarland, 2006).

Several themes were generated through this study discussing the journey from community to hospital and back to the community, the lack of resources as an obstacle to providing standard care, the establishment of the new model unit, and societal responses and responsibilities toward the stigma of mental illness. Pathways to psychiatric mental health care were explored among the Jordanian people with mental illness including, traditional and professional views on health practices and believes. A description of the people, facilities, and the environmental context at the NCMH was provided. Strengths and weaknesses of the system were identified as well. The emic and etic perspectives toward people with mental illness were also analyzed from clients' perspectives, nurses' perspectives, and from societal point of view as participants see it. The theme of mental health stigma was strong among all participants.

Discriminatory attitudes and behaviours on the part of family members and society were found to be persistent in Jordanian society.

Based on the study findings, several recommendations for research, practice, policy, and education may be proposed. Further research is necessary to compare clients' outcomes and nurses' satisfaction between the regular and model units, and evaluate the effectiveness (including cost-effectiveness) of the model unit. Research in the field of mental health stigma in Jordan and family concerns and conflicts is also highly needed to study discriminatory behaviours including verbal and non-verbal behaviours. For practice, and education, nurses and other health care providers need to receive continuous education that is systematic and target all healthcare workers each based on their needs areas. There is an immense need to recognizing the profession of nursing from high level organizations.

Policy makers need to increase budget for mental health and allocate external resources to fund mental health projects internally and externally. To increase mental health awareness, anti-stigma campaigns should be started. In addition, establishing mental health-family association is essential to start educating family members on the different topics under the umbrella of supporting their beloved one who are affected by mental illness.

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## **Chapter 5 - Nurse-Client Relationships in Jordanian Mental Health Settings: An Ethnographic Study**

### **Introduction**

Building a therapeutic nurse-client relationship does not only facilitate interactions, but also improve outcomes of care (Peplau, 1952, 1997). It is considered to be a fundamental requirement for all nursing interactions and a primary intervention in psychiatric mental health nursing (Registered Nurses Association of Ontario [RNAO], 2002). The nurse-client relationship facilitates collaboration between the nurse and the client to facilitate both recovery and promotion of health (Peplau, 1997; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). However, there is limited knowledge about the cultural meanings of nurse-client relationships in non-Western countries, including Jordan.

A thorough understanding of how cultural values and beliefs shape the nurse-client relationship is an essential step toward achieving culturally competent nurse-client relationships. However, there has been no previous research investigating the nurse-client relationship in Jordanian mental health settings and the role of cultural values and belief systems in shaping this unique relationship. The overall goal of this ethnographic study was to explore and describe nurse-client relationships within Jordanian mental health care utilizing an ethnonursing approach. This study may enhance nurses' ability to critically question and challenge their practices to establish and maintain culturally appropriate relationships with their clients.

### **Background and Significance**

The Hashemite Kingdom of Jordan is a small developing Arab Middle Eastern country. Jordan shares borders with Palestine/Israel, Syria, Iraq, and Saudi Arabia. The political dynamics of the area has influenced Jordan's history; socially, culturally, financially, and politically,

impacting on the various functional systems in the country. The central location of Jordan in the Middle East has led to the migration of increasing number of refugees as an outcome of civil unrest in bordering countries such as Syria, and Libya, Iraq and Palestine seeking a peaceful place to live. The estimated population of Jordan is 6.9 million of whom approximately 2 million are Palestinian refugees (UNRWA), 597,300 Syrian refugees, and 55,500 Iraqi refugees (CIA, 2014). The net result is a diversity of the Jordanian population in terms of backgrounds and country of origin. Within the healthcare sector, the Jordanian system has been affected by increased demands by the migrants on health care services.

Cultural values and beliefs in any culture can have significant effects in shaping the health care practices of nurses as well as the health-seeking behaviors of clients. In general, there is a negative attitude toward mental illness and people with mental illness in the Jordanian culture. This negative image is even more worrisome in as it exists among mental health care professionals (Hawamdeh, 2002; Hamdan-Mansour & Wardam, 2009). It is alarming that mental health care providers themselves may stigmatize people with mental illnesses. Such stigmatization underscores the need to investigate the value system that underpins and may shape nurses values within their client relationships.

Research is needed to explore concepts and processes in the nurse-client relationship (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Although nurse-client interactions and relationship are well-studied in Western countries, very little understanding about the concepts and processes associated with nurse-client relationships in developing countries like Jordan. Understanding the values and belief systems in a culture can enhance nurses' understanding of health care-related behaviors and practices, which in turn can improve the nurse-client relationship, and eventually promote the quality of nursing care. The nurse-client relationship

cannot be holistically understood without understanding the cultural context that shapes the relationship between nurses and clients. Studying the values and belief systems that shape the nurse-client relationship may facilitate provision of culturally competent quality care for people with mental illnesses in Jordan and in Middle Eastern communities in a broader degree. Moreover, investigating the nurse-client relationship within the context of its culture will provide nurse educators and researchers with information that may facilitate assessment of the appropriateness of available teaching models and resources within Jordanian nursing.

### **Existing Knowledge**

A literature search using the online resources of University of Western Ontario Off-Campus online library was conducted using the CINHALL, PsychINFO, and ProQuest Nursing Journal database. The keywords included in the search were: nurse-client relationship, nurse-client interaction, nurse-client communication, psychiatric nursing, mental health nursing, mental health and Jordan, psychiatric nursing and Jordan, mental health nursing and Middle East, and psychiatric nursing and Middle East. The literature review covered the time period between 1946 and the present.

This literature review also included reports and publications from highly reputable associations and organizations, including the World Health Organization (WHO) and the Registered Nurses Association of Ontario (RNAO). The vast majority of research studies have been conducted in Western countries. This literature search was also extended to include research articles published in Arabic without locating any studies. To date, no studies were found that holistically investigated the nurse-client relationship within the Middle Eastern or Jordanian mental health care. The main findings from the literature review are summarized herein.

Most of the early studies on the topic of nurse-client relationships tended to apply quantitative research methods using mainly surveys and interviews. More recent literature, however, reflects the use of qualitative methods to achieve in-depth understanding of the different aspects of this relationship. The shift toward using qualitative methods in studying the nurse-client relationship occurred from the desire to investigate in-depth the nature and reality of the relationship without detaching it from the complex context in which it takes place.

Main issues addressed in the literature included the historical and notable events affecting the nurse-client relationship, its definition, and characteristics of nurse-client relationships, factors influencing the relationship, Peplau's theory of interpersonal relations, communication patterns and barriers to its enactment, perceptions about theories and theoretical issues related to interactions. Several studies addressed these topics; *the history and events affecting the nurse-client relationship* (Group for the Advancement of Psychiatry, 1952; Lego, 1975; Orlando, 1961; Naranick, 1947; Peplau, 1952; Tudor, 1952), *its definition* (Beeber, 1995; Hewitt & Coffey, 2005; Howgego et al., 2003; Martin, Garske, & Davis, 2000; RNAO, 2002, 2006; Saunders, 2001; Spiers & Wood, 2010), *characteristics of nurse-client relationships, and factors influencing the relationship* (Brunero, Lamont, & Coates, 2010; Cleary, Edwards, & Meehan, 1999; Hewitt & Coffey, 2005; Ketola & Stein, 2013; Kunyk & Olson, 2001; Morse, et al., 1992; Olsen, 1991, 1995; Reynolds & Scott, 1999; Reynolds & Scott, 2000; RNAO, 2002, 2006), and *Peplau's theory of interpersonal relations* (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Forchuk & Brown, 1989; Forchuk, Beaton, Crawford, Ide, Voorberg, & Bethune, 1989; Forchuk, 1991a, 1991b; Forchuk & Voorberg, 1991; Forchuk, 1992; 1993; 1994; Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998; Forchuk, Westwell, Martin, Azzopardi, Kosterewa-Tolman, & Hux, 1998). Detailed findings from these resources are discussed in chapter 2.

The literature shows that the central emphasis of nurse-client relationships approaches is on establishing a helping working relationship with clients. Saunders (2001) defined “therapeutic alliance” as the mutual experience and expression of feelings, attitudes, thoughts, and behaviors between the client and the therapist during the therapeutic encounter. In the same vein, Beeber (1995) had conducted an integrated literature review on the “one-to-one relationship” in the psychiatric mental health nursing practice context. She defined the relationship as “the systematic interaction of a psychiatric nurse and an individual client for the purpose of providing PMH [psychiatric mental health] nursing care” (p.9). Both definitions stress the importance of focusing on the dyad as a unit of interaction.

The therapeutic qualities of the nurse client relationship are among the most important aspects of the relationship discussed in the literature. The Registered Nurses Association of Ontario (RNAO, 2002, 2006) best practice guidelines summarize the qualities of the therapeutic relationship as: active listening, trust, respect, genuineness, empathy, and responding to client concerns. Most research, however, has focused on the quality of empathy in such relationships (Olsen, 1991; Morse, et al., 1992; Olsen, 1995; Reynolds & Scott, 1999; Reynolds & Scott, 2000; Kunyk & Olson, 2001, Hewitt & Coffey, 2005; Brunero, Lamont, & Coates, 2010).

There is emphasis on the importance of and connection between attitudes of nurses toward mental illness and nursing care delivery. Baker (2000) noted that attitudes of mental health nurses toward inpatients’ mental health influenced the quality of mental health nursing care provided, and negatively influenced nurses’ interactions with clients.

In a Jordanian study, Hamdan-Mansour and Wardam (2009) examined Jordanian mental health nurses’ attitudes toward mental illness and clients with mental illness. The research was conducted using a descriptive correlational design. The sample included 92 mental health nurses



representing all nurses working at the acute and chronic inpatient and outpatient mental health agencies in the Jordanian governmental (79%) and private health care (21%) sectors. Data were collected about nurses' attitudes toward mental illness and clients with mental disorders and their satisfaction with nursing care delivery. Among the participants, only 21% of the nurses had specialized training in psychiatric mental health nursing. The study also revealed that participants had negative attitudes toward mental illness and toward clients with mental disorders. About 60% of the mental health nurses had perceived clients with mental illness to be dangerous, immature, dirty, cold-hearted, harmful, and pessimistic. However, nurses who received specialized training were more positive in their attitudes than those who did not. The previously mentioned quantitative study did not provide in-depth analysis on perceptions and attitudes about mental health issues in Jordan. Further qualitative studies are needed to provide more in-depth investigations on the topic.

As noted in the second chapter, one of the major gaps in the literature is the focus on one perspective of relationships that is, either from the nurse's or the client's perspective. Forchuk and colleagues suggested that studies, using either individuals or dyads, are necessary to explore concepts and processes within nurse-client relationship processes (Forchuk, 1993; Forchuk, et al., 2000; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Due to the interactive nature of the relationship, Peplau (1997) argued that "the nurse-patient relationship is an interpersonal field, the data of which can be examined within the dyad as a basis for greater self-understanding and learning" (p.162).

Furthermore, the dyadic interactions between nurses and clients need to be investigated within its practice context, addressing the cultural values, beliefs, and norms that shape the interaction. Peplau (1997) suggested that multi-ethnicity is very much an attribute of the modern

world and today's healthcare systems increasing the need for research about different cultures. Leininger (1995) also emphasized the importance of studying and practicing cultural care that is congruent with the values, beliefs, and practices of individuals or groups of an identified culture. Therefore, research studies relevant to nursing practice need to address cultural dynamics that shape the nurse-client relationship.

In summary, we know from the literature about the processes of nurse-client interaction and the development of relationships from the perspective of either the nurse or the client, but there is lack of research that addresses the perspectives of the interacting dyad to afford a more holistic understanding of these interactions. We also know about the attitudes that are shaped by peoples' beliefs and values that may enter into nurse-client relationships within the Jordanian cultures, but we do not know about the behavioral enactment of nurse-client relationship through verbal and non-verbal communication in the Jordanian context. Currently there is an absence of Jordanian studies on how this cultural context shapes nurse-client relationships in mental health care settings.

### **Statement of Purpose**

The purpose of this study is to explore and describe the nurse-client relationship within the Jordanian culture's mental health care utilizing an ethnonursing approach. The study investigates dyadic relationships to provide a deeper understanding of the interaction from the perspective of both nurses and clients. The study also examines how the cultural values and beliefs of Jordanians shape the nurse-client relationship in Jordanian mental health care. The processes of the interaction will be addressed, as well as the communication patterns that are used to promote culturally therapeutic nurse-client relationships.

## Research Questions

1. How do mental health nurses employed in a Jordanian mental health center describe nurse–client relationships?
2. How do clients describe nurse–client relationships within a mental health care environment?
3. How do Jordanian cultural values, beliefs, and practices shape nurse-client relationships in mental health care settings?
4. What are the facilitators, and/or barriers to developing therapeutic nurse-client relationships?

## Methodology and Methods

Ethnonursing is the methodology that is used in this research study. Ethnonursing is a naturalistic inquiry research method developed by Madeline Leininger (Leininger, 1995; 1997, 2002). Ethnonursing is a mini-ethnography, also referred to as focused ethnography (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Leininger & McFarland, 2006), that is characterized by focusing on specific elements of one's own society (Knoblauch, 2005). It differs from the conventional/ classic ethnography mainly in terms of demands on time, which focused ethnography uses intensively (shorter period of times with more focus on the research purpose) rather than extensively (usually one year or more of observation), in addition to its specific focus on the communicative activities between the participants (nurses and clients) (Knoblauch, 2005). In ethnonursing, systematic and reflective processes are employed while focusing on the cultural context to illuminate lifeways and understand their meaning for informants (Mixer, et al., 2009). Ethnonursing is based on a holistic framework that uses the

techniques of purposeful sampling, observation, and in-depth interviewing to reveal participant's experiences (Miller & Petro-Nustas, 2002).

The goal of ethnonursing is to understand the diversity and universality of care, and for that purpose, it is imperative to distinguish between emic and etic data. Emic refers to the insider's viewpoint of the culture (which is the client's and nurse's perspective in this study), while etic means the outsider's viewpoints of the culture such as the society and family members (Leininger 1988, 1991). The purpose of using ethnonursing research approach is to explore cultural roles, norms, and values and how they are related to health and illness-related behavior' (Boyle, 1994) specifically, nurse-client interactions. Therefore, ethnonursing approach fits well with studies related to cultural care. An ethnonursing approach was utilized to explore mental health nursing care from the perspectives of the people who engage in the relationship (nurse and client) and within its natural setting (mental health).

**Ethical considerations.** Participants' experience and participation in research must be respected by the researcher (Munhall & Boyd, 1993). Ethical approval was obtained from the University of Western Ontario's Research Ethics Board to assure the ethical acceptability of the research proposal. Ethical approval was also obtained from research's ethics committee in the Jordanian Ministry of Health. Participants' voluntary participation in the study was key (Rossman & Rallis, 1998); therefore, an informed consent was obtained from each participant before conducting the research. Participants were informed that participation was not obligatory, and they could refuse to answer any question and withdraw from the study at any time. Participants' privacy was respected (Rossman & Rallis, 1998) by promising their data will not be used except for the purpose of the study, and future potential secondary analyses. Anonymity was assured by guaranteeing their personal identity would not be used (Sapsford, & Abbott,

1992). Participants were informed that identifiable (or potentially identifiable) information would be kept separate from collected data in a secured (key-locked) cabinet. Digital recordings of the interviews would be saved on a password-protected computer. Collected data would be kept for five years for potential future studies, after that all data will be safely destroyed. The nature of the study also necessitated the researcher informing participants that if any life-threatening ideation occurred during the interviews these should be reported to the participant's care providers.

**Study participants and context.** The study took place in a major hospital in Jordan; namely, the National Center for Mental Health (NCMH) commonly referred to as Al-Fuhais mental health care hospital, which is the largest public centre available to Jordanians seeking mental health care. It is located in the capital of Jordan, Amman, and is accessible to the majority of the population. Nurses and clients from both acute and chronic psychiatric mental health care settings were recruited for this study.

According to Patton (2002), purposive sampling is the underlying strategy for gaining the rich, in-depth understanding in undertaking qualitative research. A purposeful sampling technique was used to select participants who could provide a variety of experiences to enhance a deep understanding of the nurse-client relationship. More specifically, the purpose was to obtain a diverse sample by recruiting participants from different countries of origin, socioeconomic backgrounds, genders, and who have different psychiatric diagnoses who have been admitted to the hospital for varying lengths of time.

A range of 30-50 interviews was suggested by Morse (1994) for ethnographic studies. For this study nine nurse-client dyads were purposefully recruited from a Jordanian mental health care setting. Open-ended semi-structured interviews were held with nurses and clients

individually to explore their perceptions of nurse-client interactions. In addition, six follow-up interviews took place to ensure data were collected at more than one point in time during the nurse-client relationship. After taking field notes and preliminarily analyzing them, some questions raised and needed to be clarified with the participants. Ten short informal interviews were conducted with participants to clarify and verify observations.

Intensive observation-participation was conducted through three months of regularly visiting the institution and recording field notes. Three to four weekly visits took place; each visit lasted for at least five hours. Attending individual nurse-client interactions took place as frequently as possible after getting nurses' and clients' permission. Nurses and clients were observed while interacting with each other and with other people in their units to give both breadth and depth on the processes as well as the patterns of interactions that were occurring. Data collection was continued until saturation of themes was achieved as suggested by Morse (1995).

**Data collection methods.** Prior to data collection, the researcher's advisory committee agreed that being introduced to more than only one system allows researchers to critically analyze and widen their perspective on the health care system. Our assumption is; being in the same room for a while may decrease the ability to judge its brightness/darkness. However, going outside then coming back to the same room may give a better idea of describing its luminosity. Therefore, the primary author of this chapter got the chance to be introduced to health care systems of more than one country to enrich the analysis and discussion of the findings. The researcher took a clinical course within the Canadian mental health care system in which she had the chance to visit and observe what, where, when and how care activities are provided to people

with mental illness in Canada. This experience allowed for additional critical understanding of both the strengths and weaknesses of the Jordanian mental health care system.

Data collection included two main methods, open-ended semi-structured interviews and observations. The ethnonursing research method was specifically designed to provide in-depth study of covert and embedded care and culture data through “detailed observations, reflections, descriptions, participant experiences, and data derived from largely open-ended inquiries” (Leininger & McFarland, 2006, p. 54).

Open-ended interviews were conducted with participants in order to understand their experiences and enactment of the nurse-client relationship. It is imperative to actively listen with an open mind to the informants, learning from them, and not imposing the researcher’s ideas (Leininger, 2002). Individual semi-structured interviews with the participants were held to explore participants’ perceptions of the nurse-client interactions. According to Patton (2002), in-depth interview is the best data collection tool for gaining understanding of peoples’ perceptions and meaning of their experiences. Also, interviewing is the only way for us to know what another person feels or experiences (Patton, 2002). In other words, in-depth interviewing allows for deeper understanding of the phenomenon from the nurses’ and clients’ perspectives.

The purpose of the semi-structured interviews was to encourage study participants (nurses and clients) to talk freely about their experiences and perceptions of the phenomena with some flexibility (Lowes & Gill, 2006). The main advantage of using open-ended interviewing was to allow all participants to share their unique experiences of the nurse-client relationship. This method was the most appropriate method according to the purpose of the study as it provides minimal guidance to participants. Also, it gave them the opportunity to express their perceptions openly in their own words.

Participants were interviewed individually in a private area of the hospital for 1-2 hours. Open-ended statements such as “I would like to learn about experiences about the nurse-client relationship” were used. In addition to questions like “I would appreciate it if you tell me more about \_\_\_\_\_” [specific issue that is being shared]. Basic demographic information was collected from participants at the end of the interview. See appendices D and E for guides of possible interview questions. All interviews were done in the Arabic language except one (in English). The interviews were recorded using a digital recorder, and notes were taken after each interview to summarize observations and impressions about the previously held interview. Recorded interviews were then translated and transcribed verbatim.

Clinical observation took place in common areas over three months of intensive data collection through three to four weekly visits. Each visit lasted for at least five hours for a total of about 260 hours of observation. Attending individual nurse-client interactions took place more than ten times each time for 5-20 minutes duration after getting nurses’ and clients’ permission. Observation guide is presented in Appendix F.

The observation-participation reflections according to Leininger (2002) are crucial for obtaining holistic, specific, and accurate data. For ethnonursing, Leininger and McFarland (2006) suggested that, “the researcher moves from an observer and listener role to gradually a participant and reflector role with the informants... The researcher moves in slowly and politely after seeking permission to be with the informant” (pp.89-90). The gradual entry helps the researcher observing naturally occurring interactions. Observations and reflections what is going on before, during and after the interaction were documented. Participants were encouraged to explain what was being observed, done, or experienced. Ethnographic observations provided a

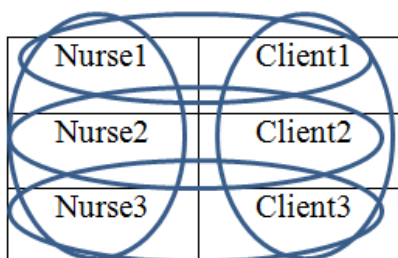


method to facilitate the description and reflection of the cultural dimensions on the people's interactive relationships (Angrosino, 2005).

**Data analysis.** Data from the individual interviews and observation field notes were analyzed using thematic analysis approach. Thematic analysis seeks to unearth the themes embedded in text at different levels (Attride-Stirling, 2001). Leininger (1997) suggested the following thematic analysis phases; collecting, describing and documenting data, identification and categorization of descriptors and components, conducting patterns and contextual analysis, generating themes, research findings, and recommendations. The analysis started simultaneously with the data collection, so that the interview questions could be focused according to the themes of the analysis. Member checking was also performed to verify that the analyses actually reflected participants' experiences. Ethnographic data were analyzed in relation to Peplau's theory of interpersonal relations (Appendix A) and Leininger's transcultural theory that is presented in the sunrise enabler model (Appendix B).

Interviews were analyzed at individual dyadic, and group levels. Dyadic analysis assists in deriving themes related to the nature of relationships, which could otherwise not have been reached (Eisikovits, & Koren, 2010). The dyadic analysis may also increase trustworthiness (Lincoln & Guba, 1985) by triangulation (Denzin, 1989; Yardley, 2000). For the richest possible analysis, a hypothetical matrix (*Table 1*) is drawn below where data were analyzed at individual level, in columns of nurses or clients as well as in rows of dyads. The analysis presents common themes and findings among nurses as a group, clients as a group in addition to findings among dyads.

*Table 5. Data analysis matrix*

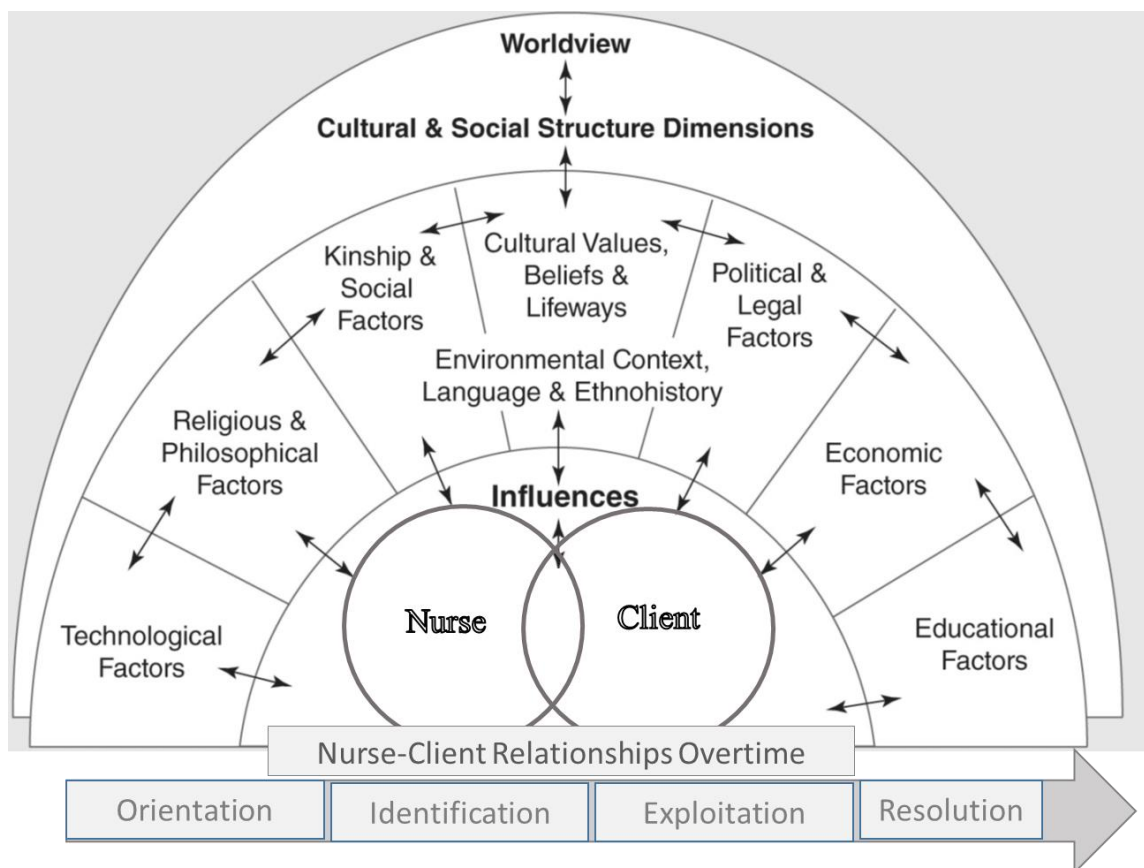


## Findings and Discussion

We need to understand who are the clients, who are the nurses, what is the system, and how did they come to this setting in order to understand the relationship between the nurse and the client in the context of Jordanian mental health care setting. The research observations and interviews afforded a fairly comprehensive understanding of the context in which nurse-client interactions took place, as well as the processes of nurse-client relationships. A comprehensive discussion of cultural care from the perspectives of Jordanian clients and nurses is provided.

Peplau's theory of interpersonal relations provided a framework for the analysis and the presentation of the findings. Peplau's theory afforded a guideline for understanding the nurse-client interpersonal processes including the influences on the relationships that are related to both the nurse and client and their interactions along the phases of their relationships (Forchuk, 1993). However, Peplau did not specifically discuss the contextual factors including the cultural and social factors that may interfere with nurse-client relationships. Therefore, Leininger's sunrise enabler model was used as another lens to frame the findings about nurse-client relationships within its cultural context. Leininger's theory of cultural care emphasizes that in order to provide culturally competent care, nurses need to explore cultural care meanings, practices, and factors (educational, social, political, economic, religious, and technological) influencing care (Leininger, & McFarland, 2006). To incorporate Peplau's theory with Leininger's model, I

integrated the two models in the model below (*Figure 4*) to represent a visual presentation to nurse-client interactions that take in consideration the contextual dimensions of the relationship.



*Figure 4. Peplau and Leininger Theories Integration Model*

**Description of the dyads.** The nine nurse-client dyads participated in this study represented an example of the composition of nurse-client dyads in the hospital. Clients' age ranged between 18 and 64 years. Three had only primary education, 3 finished their high school, 2 were college degree holders, and 1 had a Master degree. In terms of clients' countries of origin, the majority of clients were Jordanians (5 clients), 2 were Jordanians from Palestinian origins, 1 was Syrian refugee, and 1 self-identified as Middle Eastern because he was born, raised and lived in different Middle Eastern countries during his life. Five nurses were Jordanians and four

were Jordanians from Palestinian origins. Nurses' experiences in psychiatric care ranged from 6 months to 15 years. Seven of the nurses were bachelor degree holders, one nurse had a master degree, and one was with diploma. The composition of the nurse-client dyads were as the following: 3 female nurse-female client, 2 female nurse-male client, and 2 male nurse-male client. From cultural point of view, male clients can have male or female nurses; however, female mental health units are usually staffed by female nurses only for clients' comfort.

**Views on the progress of nurse-client relationships.** Both nurses and clients who participated in this study expressed mixed responses to how they described their nurse-client relationships. Several qualities, facilitators, and barriers to their relationships were identified. In addition, different views on 'the same relationship' were sometimes depicted. Some variations were also portrayed when collected data in regular units in the center versus the 'model unit'. The 'model unit' is a newly developed standard care unit that was established in 2010 at NCMH by the Jordanian Ministry of Health, WHO, and Jordanian Nursing Council. Extensive discussion on the model unit is provided in Chapter 4.

The data revealed that nurse-client relationships were developing over time. Both nurses and clients agreed that their relationships went through phases that are congruent with Peplau's interpersonal nursing theory. Those phases included orientation, identification, exploitation, and resolution. In our study, conversations with participants explored thoughts and feelings regarding their nurse-client relationships. Data showed that the initial phase of the relationship was very brief most of time with insufficient orientation of the client to the people, resources, routines, rights, responsibilities, and expectations.

Upon admission my nurse introduced me to the staff and unit facilities in a quick round. I felt welcomed. Anyways, I learned about the unit routine from the other clients. This created some conflicts as I did not know the system of the unit until I actually lived in the unit.... While in the unit, I felt comfortable expressing my concerns to the nurse... The good thing here is that you can talk to the nurse you feel more comfortable with; even if he is not your assigned nurse ... I feel we [staff and clients] became a family in the unit...Now as I am being discharged, the nurse encouraged me to call the unit for any concerns.

From nurses' perspective nurse-client relationships were mostly positively developing during the time from admission to discharge. Some clients agreed with this viewpoint whereas others expressed a different perspective stressing relationships positively develop over time to a limit where it starts to stabilize or deteriorate. For example when a nurse believes that a client's needs are met or almost met near the termination phase, the nurse starts to spend less time with the client in order to be able to serve other clients with greater needs. On the other hand the client may believe that the nurse is ignoring or less empathetic with them near the termination of their relationships. A participant expressed, "in the beginning, the nurse was very nice with me and always there for me when I needed him, but now [in the termination phase] he is dealing less with me and does not care as much." This example portrays a typical situation that was frequently encountered by clients where there is an absence of discussion around their perceptions about the relationship which can lead to misunderstandings about the termination phase as a deterioration of the relationship by clients. Analyzing similar situations based on both

interview and observation data showed that there is lack of identifying nurses' and clients' responsibilities and expectations within the relationships early in the orientation phase.

**Perceptions on the qualities and challenges of nurse-client relationships.** Both nurses and clients in this study emphasized the importance of developing and having therapeutic nurse-client relationships. Participants during interviews identified genuineness and friendliness among the most vital qualities of the therapeutic relationship. Mental health nurses stressed the importance of being authentic with their clients to establish and maintain therapeutic relationships. "I believe the nurse-client relationship should be genuine and friendly because if the client doesn't feel comfortable around you, interaction becomes hard; the client will not look up to you as a role model; will not cooperate with you; and may cause you even problems. You may lose control over your shift."

Nurses expressed that sometimes a very simple gesture may show clients that they truly care about their situation and they want them to get better and feel more comfortable. Clients were referred to as "very smart" and very attentive to what you do and say. Clients want to see congruency between nurses' verbal and nonverbal messages. A nurse gave an example of how to validate the verbal message of being truly concerned of clients' feelings into demonstrating caring. "I may ask him what he likes to do the most. If it is available, I make sure that he gets it. For example, lots of clients like to play cards so I learned how to play cards here so I can play it with them. I noticed that my clients feel very happy when we engage with them in their favorite activities." Clients also described the staff in the model unit as being friendly "Thank God, here, the staff are friendly. Thank God, everything is good. They know God". They know God culturally means they treat people ethically and morally because God's worship is best exemplified by being fair, honest, and respectful to others.

Clients mostly shared positive feelings regarding their interactions with the nurses in their units. Some clients however were not comfortable with their relationships with their nurses. However, responses were circumscribed with the unit they were in. Clients who were admitted to the model unit showed more satisfaction than those in the regular units. An explanation might be related to the very high number of clients assigned to each nurse in regular units compared to the model unit. The nurse: client ratio in regular units is 1:12 whereas it is 1:4 in model unit. The latter allows the nurses to invest more time and effort in their relationships with clients. In addition, the structure, nurses' preparedness and commitment to standards of care, and resources of the model unit can contribute to the development of therapeutic nurse-client relationships.

As a client in the model unit shared: "I like the environment here, people are very cooperative and I am receiving very good treatment. I am receiving good care and all necessary treatment free of charge." Another client who was admitted to a regular unit shared an opposing view: "I don't like the way nurses deal with us. They always give us orders and do not ask for our opinions. We do not have a say on what or when we eat, we do not have access to the phone to talk with our families except once a week, and if I did not get hold of them then I lose my chance. We have no books, no TV, no activities here."

From a client's perspective, who experienced care in both units, "the model unit is much better than other units. There are more dialogues between the nurses and the clients, also, more attention to clients, more cigarettes, and activities. In other units there is no T.V., books, or games." Model unit nurses also agreed that differences in communications are present between the regular and model units. The nurse M gave an example of unfriendly communication as "...give orders in an authoritative way. Clients with mental health issues are usually more sensitive than others. They appreciate good treatment, while bad treatment makes their situation

worse.” Nurses supported the idea of involving clients in making decisions and conducting group and individual sessions to evaluate their clients. For example, a nurse verbalized: “I usually involve the clients in group discussions in addition to the individual assessments. Based on that, I have a better sense of clients’ needs and how to talk to the client about a certain subject. Based on my one hour group therapy session, I can make a judgment of who needs one to one therapy session, and who benefits from a group therapy session. I usually ask the client’s permission to conduct one to one therapy sessions.”

Both nurses and clients in this study stressed the importance of building mutual trust between communicators. One of the nurses gave an example: “another thing about the client care is being truthful because once you lie to the client, he/she will never believe you again, you lose their trust forever. It is impossible to build trust again. The client also monitors how you treat other clients. If you show authority and violent behavior towards a certain client, you also lose the relationship with the other client.” However, obstacles to building trust relationships exist. For example, in following up one of the nurse-client dyads, the client verbalized: “I don’t trust my nurse because she told me one week ago that my condition is stable and I may go home. Since last week, every day they tell me you will be discharged tomorrow, but I am still here.” Following up on the case showed that the family of that client had a situation in which they cannot come to the hospital to discharge their son/daughter. Lack of transparency in communication may lead to negative perceptions about the other party and may lead to challenges in communication.

Challenges to defining boundaries were common among participants at different levels. First, there was lack of continuous education and evaluation of the nurses to therapeutic communication except for the nurses in the model unit. Nurses need re-orientation to care



standards and practice guidelines. Second, participants may mix the concept of being friendly with boundary violations. For example, some clients perceived nurses as “friendly” because they offered off-schedule cigarettes, or allowed them to use the nurse’s personal cellphones. “Due to conflict and high degree of stress, I noticed high tension in a shift usually occurs because of the strict nature between the nurse and the client and having so many boundaries/barriers to the relationship. On the other hand, when a nurse identified boundaries yet made the relationship friendly, the shift goes smoother.” However, lack of identifying boundaries may lead to abusing relationships which has occurred in the shape of verbal and physical violence. Third, there are systematic problems in omitting reported abuse and/or boundary violations. Reporting such cases will help learn what leads to such issues and the means to prevent it in future. In addition, some nurses reported being victims of physical abuse from some clients, and avoidance of completing incident report led to the understudy of a real concern that needs to be further investigated and prevented.

**Contextual factors.** Cultural care expressions, such as nurse-client relationships, according to Leininger and McFarland (2006) are shaped by dimensions of the cultural context. Examples of those contextual influences include educational, social, political, economic, religious, and technological factors. The table below (*Table 6*) provides an integration of how literature described those influences in relation to shaping nurse-client relationships and findings from the current study on Jordanian mental health care settings. Examples are also provided from study interviews and ethnographic data.

*Table 6. Sub-items for the cultural and social Structure dimensions of the Leininger’s Sunrise Enabler Model*

Dimension: Technological factors:
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Description	Examples from Jordanian context
Access to information technologies, communication means, media, electronic services, and others.	Very limited information resources are provided to both nurses and clients. Clients have access to TV as the main mass media technology with limited authority to control what to watch. Clients are allowed to use the phone only once a week through the unit's landline. Clients are not allowed to use their cell phones, laptops, or any electronic device while admitted to hospital units.
Dimension: Religious and Philosophical Factors	
Religious practices, consultation to traditional healers, meanings of life, individual strength, beliefs, spirituality and health, personal values, norms and religious beliefs, freedom of thinking and expression, and others.	During this study, all participants were Muslims except one client. Religious and spiritual affiliations are highly respected and participants were given freedom to practice religious activities. Clients expressed their appreciation when nurses were utilizing spirituality as a means of relaxation. Most of interviewed clients have visited traditional healers and expressed their disappointment which lead them to access professional healthcare system. Nurses were utilizing quotes from Quran and Hadith to encourage people to adhere to their medical treatment and improve their compliance with modern medicine versus relying on culturally common traditional healers. Traditional healers were commonly visited by psychiatric clients or their families, but not for other physical illnesses.
Dimension: Kinship and Social Factors	
Familiar structure, birth position in the family, family values, roles of the aged, head of household, composition of family, developmental tasks, social status, bereavement of parents, family disease, family kinship/relations, friendship relations, emotional-sexual relationships, emotional situation, networks and social supports, access to culture, leisure and sports, migration, gender relations, social norms, public security, citizenship, access to means of transportation, conjugality, violence, and others.	Mixed responses were depicted from the participants regarding the roles of family members. In general, culturally known that family members of a sick person are primarily responsible of taking care of him/her. Leaving a sick person to live in an institution is stigmatized in the society, but due to the lack of community institutions for people with mental illnesses, clients are left with only two options; either to live permanently with other family member or to stay in hospital. Alkarameh (a tertiary mental health hospital) is used as a group home for clients with chronic illnesses although it is referred to in the society as a

	<p>hospital. The rough estimation for the length of stay for clients in Alkaramah is more than 10 years. People with mental illnesses are highly stigmatized in the society to a degree in which some families literally hide their sick child as long as they can. One of the interviewed clients with a high level of education were advised by his son to say that he was out of town for business to hide the fact that he is admitted to psychiatric hospital.</p>
Dimension: Cultural Values, Beliefs and Ways of Living	
<p>Description: Beliefs, responsibility for health, folk practices of cure and care, perception of official health system, perception of health professionals, spirituality and health, cultural references, access to culture and information, knowledge, attitudes, behavior, tobacco, alcohol, recreational drugs, physical activities, safety, interests, common foods, hygiene, world views, entertainment and leisure, alternative lifestyles, and others.</p>	<p>In regarding to historic views on mental illness, there is disparity between how people culturally interpret mental illness, how religion views it, how people understand religious view, and the professional understanding of mental illness. One of the therapy groups with the clients that I attended aimed to emphasize how Islam as a religion asks people to take care about him/herself and seek professional treatment when they are sick and that Islam views health holistically in body, mind, and soul. Details on traditional healers, interpretations of mental illness, and access to health care and other healing modalities are provided in chapter 4.</p> <p>Smoking, alcohol, and drug abuse are prohibited in Islam, however; smoking is culturally very common and accepted but alcohol and drugs are not.</p>
Dimension: Political and Legal Factors	
<p>Description: Access to public policies (security, health, education, environment, job, transports, social), access to justice, citizenship, political participation, freedom to think and express, institutional communication, and others.</p>	<p>Mental health nursing policies are being established with support from WHO, Ministry of health, and Jordanian Nursing Council. Access to health care is available to every person in the country. Health care services are provided at affordable costs, however; most of the people residing in Jordan have health insurance that covers health care services and treatment including medications.</p>
Dimension: Economic Factors	
<p>Description: Familiar outcomes, informal job, formal job, outcome, social class, material situation (goods), work conditions,</p>	<p>At the institutional level, economic challenges are present. At the personal level, all client participants self-identified their economic status</p>

housing conditions, occupation/profession, buyout of clients' goods, cost of living, and others.	as low to middle income. Generally, people with high income tend to access centers in private health care sector where 'luxury' services are provided as clients described. Job opportunities are very limited to people with mental illness. No support is provided to employment agencies to hire people with mental illnesses. Societal stigma and/or fear of it also hinder clients' employment opportunities. Nurses self-identified their economic status as middle income. Most nurses verbalized their dissatisfaction with their salary compared to the challenges and nature of their work. They indicated the high need for a raise in their salary in addition to considering adding financial incentives.
Dimension: Educational Factors	
Description: Knowledge, access to education, literacy (read and write), reading and writing habits, type of school (private or public), schooling, access to information, school violence, intellectual performance, solution of problems, attention, and others.	Clients' education ranged from preliminary education to graduate level with the majority having secondary education. All interviewed clients were able to read and write in Arabic, and two clients were able to communicate in English. Education in Jordan is compulsory to 12 <sup>th</sup> grade in the current system. Most of nurses have BSc level in Nursing, some had diplomas. Two nurses were holding Master degrees.
Dimension: Environmental Context	
Description: Destination of waste, public illumination, access to electricity grid, natural ventilation, drain, asphalt/pavement, septic tank, drinkable water, pollution (air, water, visual, noise), access to drinking fountain, exposition to pesticide or fertilizers, exposition to chemical, physical agents etc., and others.	<p>Units were well-ventilated and always kept clean. Drinkable water was accessible all the time. Challenges were noticed with providing cold water as some clients were breaking the water cooler when aggressive crises were present. Nurses teamed to get innovated ideas to provide cold water that cannot be destroyed at affordable cost by installing a cooling unit behind the wall and connected to a fountain in the unit. At one of the units, nurses worked collaboratively with the client to implement this idea and they actually achieved their goal at minimal cost. Now, they aim to communicate their experience to the other units as a role model.</p> <p>In relation to unit structure, there is a huge improvement in the newly renovated "model</p>

	unit” which simulates the standard environment to providing mental health care at many levels, such as the unit structure, nurse: client ratio, and implementing standards of care. For further details see chapter 4.
Dimension: Language	
Description: Dominant language, contextual use, tone/volume, spatial distancing, eye contact, facial expressions, greetings, touch, language, dialect, and others.	Arabic is the dominant language in Jordan. English is widely understood by professionals as Jordanian universities use both an English curriculum as well as Arabic. High volume of voice is common among males. Occasional interruption of speech is widely accepted and does not carry negative connotation for most people. The use of touch in hand shaking, shoulder tapping, and sometimes hugging when needed is accepted between same sex communicators. Touch, such as in hand shaking, is not allowed between people of opposite sex except immediate family members for religious reasons. Some people are not as restrictive. However, Instrumental touch (such as pulse checking, and while performing a nursing procedure) is accepted. Culturally, some people link eye contact to power. Power is considered higher for older people and highly educated people. Failure to maintain eye contact was noticed among some clients when dealing with their health care providers or during interaction with a parent for example.
Dimension: Ethnohistory	
Description: Community history, population history, life history, total time living in the community, sense of belonging, social participation in the community, and others.	Participants presented high sense of belonging to their community, families, and the area of living. For example, almost all nurses chose to work at NCMH because of the convenient commuting distance between where they live and the center.

The main themes of these findings included, the presence of strong family relationships, the strong reliance on traditional healing modalities for treating mental illnesses within Jordanian cultures, the disappointment of traditional healing modalities in treating mental illnesses, the

limited resources for the mental health care system, the strong presence of stigma against mental illness, and the various connotations to the use of nonverbal communication skills.

**Truthfulness and credibility strategies.** To maintain the research's truthfulness and credibility, all data collected were thoughtfully examined with the Leininger's six qualitative criteria: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability (Leininger, 1995, 1997, 2002, 2006). According to Leininger (2006, p.22) credibility refers to the accuracy, believability, and truths of findings from participants. Confirmability refers to repeated direct and documented data confirmed with the participants. Meaning-in-context refers to findings that are understandable to participants studied within their natural and familiar environmental context. Recurrent patterning refers to the repeated instances, patterns of expressions, and patterned occurrences over time. Saturation refers to the exhaustive search from participants to the research topic in which no new findings were forthcoming from participants. Transferability refers to whether the findings from a particular qualitative study can be transferred to or appropriately used in another similar culture(s) within their context.

These truthfulness and credibility criteria was taken into consideration during both of data collection and analysis as they were intertwined to produce rigorous findings that actually reflect the participants' experiences and point of views, in conjunction with the researcher perspective of reflective interpretation. Preliminary research findings were discussed with the participants including checking and rechecking ideas for accuracy with participants to ensure research truthfulness.

## **Discussion, Conclusion and Recommendations**

The Jordanian system is moving forward toward providing professional care that meets global standards. Efforts at personal, institutional, and governmental levels are being devoted to

improve the provision of mental health care. The combination of Peplau's theory of interpersonal relations (Peplau, 1952) and Leininger's sunrise enabler model (Leininger, & McFarland, 2006) were found to be successful in exploring nurse-client relationships within the Jordanian mental health care system considering the contextual factors that may interfere with nurse-client relationships.

There are massive limitations in the resources that hinder the progress of the development process. Nurse-client relationship as a primary therapeutic intervention in mental health nursing is shaped by its context. In this study, we provided description, analysis and examples of how Jordanian cultural influences directly or indirectly shape the nurse-client interaction. Staff continuous education is very important to the delivery of care, nevertheless; careful consideration of cultural contextual dimensions is determinant to establishing and maintaining therapeutic relationships.

The vision for future Jordanian mental health includes "the provision of quality community mental health services that are equitable, cost-effective and accessible to all people... [and that] reflect the comprehensive bio-psychosocial approach through multidisciplinary interventions, with emphasis on human rights, participatory approach and cultural relevance" (WHO, 2013).

Previous literature emphasized that the therapeutic relationship is as the mutual experience and expression of feelings, attitudes, thoughts, and behaviors between the client and the health care provider during the therapeutic encounter (Saunders, 2001). Opposite to findings from Hamdan-Mansour and Wardam (2009), nurses and clients in this study expressed agreement on the importance and demonstration of therapeutic empathy among nurses in their

relationships. This discrepancy can be interpreted by the improvement in care quality provided in Jordanian mental health care settings and the increased attentiveness to professional care.

Congruent with Peplau's theory, Forchuk (1994) stated that the progress of the initial phase of the relationship is the determinant to relationship outcomes, and the use of awareness of self and self-reflection is imperative to the achievement of therapeutic relationships. Findings in this study revealed that there is an inadequacy of orienting clients to their new setting and the system of the unit, which may cause conflicts and misunderstandings during their relationship.

Nursing literature also highlighted that certain qualities are essential for all nurse-client interactions. Therefore, RNAO (2006) established the best practice guideline with active listening, trust, respect, genuineness, empathy, and responding to clients' needs as the most imperative qualities to therapeutic nurse-client relationships. Trust is critical in the nurse-client relationship especially in mental health care because the client is in a vulnerable position. Initially, trust in a relationship is fragile, and so it's particularly important that a nurse keeps promises to a client. If trust is breached, it becomes difficult to re-establish (Hupcey, et al., 2001; CNO, 2013). This study highlighted the concept of 'trust' as an extremely imperative quality to therapeutic relationships. However, maintaining trust between communicators in this setting was not easy due to other contributing contextual factors. More work on educating nurses on establishing and maintaining therapeutic relationships is essential keeping in mind the cultural challenges.

Maintaining boundaries when providing care can be attained by being aware of the boundary between professional and personal roles, clarifying boundaries to client, developing and following a plan of care, and meeting personal needs outside the relationship (CNO, 2013).



The lack of studies addressing professional boundaries in Jordanian culture; in addition to the absence of regulations for guiding professional relationships contributes to the challenges to establishing and preserving professional boundaries. Clients tended to classify boundary violation as either to the positive side “being friendly” or to the negative side as “being abusive.” More research and education are urgently needed to overcome these challenges.

With cultural and social structure dimensions in mind, and the assumption that nurse-client relations take place into multidimensional levels (global society, community, family, and interpersonal) (Leininger, 1997), nurses are encouraged to develop and utilize abilities and competencies to incorporate the multiple factors that influence care (Melo, 2013). The previous section highlighted how nurse-client relationships are shaped by the values and beliefs held by people in Jordan. There is high value to family and society among Jordanians, in addition to the pervasive stigma associated with mental illnesses. This can be utilized to establish campaigns that aim to eliminate stigma toward mental illnesses and help integrate people with mental illnesses in the society. Religion was highly valued by participants and can be used as a means of increasing awareness toward mental illness and accessing professional care when needed. Careful attention to cultural contextual factors should be always taken in consideration when implementing or practicing nursing care for achieving the best outcomes.

Research is also highly needed to further investigate specific aspects of nurse-client interactions within Jordanian mental health settings. For example quantitative studies that compare the effectiveness of care and the satisfaction of both nurses and clients between the regular units and model unit can help evaluate its effectiveness. Financial resources need to be pursued to further develop mental health care in Jordan. Staffing also needs to be increased to allow for continuous education and clients’ appropriate comprehensive orientation. The nurse to

client ratio of 1:12 is alarming and could be a massive barrier to the delivery of professional care. Findings from this study support the utilization of Peplau and Leininger's theories to studying interpersonal nursing practices within their cultural orientation. Future studies are recommended to further investigate each phase of nurse-client relationships in order to improve nursing care in Jordanian mental healthcare setting. In addition, findings related cultural context of nursing care identified the shaping role of Jordanian culture in forming and influencing nurse-client relationships. Findings from this study can be utilized to allocate resources to improve the health care services and practices.

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## **Chapter 6 - Conclusion**

This chapter concludes the key findings of the study and addresses their recommended implications for future research and practice in promoting the delivery of mental health care in Jordan. This study investigated the structure and system of the mental health care, and explored nurse-client relationships in Jordanian mental health care settings utilizing an ethnonursing approach. This chapter will start with a brief description of the study background, the purpose and research questions, the methodology and methods, then present a summary of the findings and recommendations.

### **Summary of the Study**

The nurse-client relationship is viewed as the primary human contact that is crucial to providing nursing care. Interaction processes need to be investigated within their cultural context in order for the nurses to establish a therapeutic nurse-client communication that is congruent with the culture in which it takes place. The nursing discipline in the Middle Eastern country of Jordan presents an interesting paradox; that is, nursing students study Western texts and are taught Western nursing models. However, the assumptions behind these concepts might be different from the cultural values and beliefs of Middle Eastern countries (Hawamdeh, 2002). Thorough understanding of how cultural values and beliefs shape the nursing care is an essential step toward achieving a culturally competent therapeutic care. However, there is a paucity of published research to investigate the mental health nursing care in Jordanian mental health settings and the role of cultural values and belief systems in shaping it.

### **Study Purpose and Questions**

The purpose of this study was to explore and describe the Jordanian mental health care system, and investigate the cultural meanings of nurse-client relationships and how the cultural

values and beliefs of Jordanians shape mental health nursing care in general and the nurse-client relationship in particular. The study utilized an ethnonursing approach. This research pursued answers to the following research questions: 1) What is the current structure of the Jordanian mental health care system? 2) What contextual and environmental factors impact nursing care in Jordanian mental health care settings? 3) How do Jordanian cultural values and beliefs shape mental health care practices? 4) How do cultural values and beliefs influence people with mental illness from the perspectives of mental health nurses and clients? 5) How do mental health *nurses* employed in a Jordanian mental health center describe nurse-client relationships? 6) How do mental health *clients* admitted to a Jordanian mental health center describe nurse-client relationships? 7) How do Jordanian cultural values and beliefs shape mental health care practices including nurse-client relationships? 8) What are the facilitators, and/or barriers to developing therapeutic nurse-client relationships within the Jordanian mental health care system?

### **Methodology and Methods**

Ethnonursing is the methodology that is used in this research study; which is a naturalistic inquiry research approach developed by Madeline Leininger (Leininger, 1995; 1997, 2002). Ethnonursing is a mini-ethnography, also referred to as focused ethnography (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Leininger & McFarland, 2006), that is characterized by reflecting on specific elements of one's own society (Knoblauch, 2005). It differs from the conventional/ classic ethnography mainly in terms of demands on time, which focused ethnography uses intensively (shorter period of times with more focus on the research purpose) rather than extensively (usually one year or more of observation). Additionally, its specific focus is on the communicative activities between the participants (Knoblauch, 2005). Ethnonursing is based on a holistic framework that uses the techniques of purposeful sampling,

observation, and in-depth interviewing to reveal participant's experiences (Miller & Petro-Nustas, 2002). An ethnonursing approach was utilized to explore mental health nursing care from the perspectives of the people who engage in the relationship (nurse and client) and within its natural setting (mental health care units).

**Study participants and context.** The study took place in the acute and chronic mental health units of a major hospital in Jordan; namely, the National Center for Mental Health (NCMH) in Amman (the capital city of the country) commonly referred to as Al-Fuhais mental health care hospital, which is the largest public centre that is available to Jordanians seeking mental health care. A purposive sample of nurses and clients from acute and chronic care units were recruited for this study to seek a diverse sample of participants from different countries of origin, socioeconomic backgrounds, genders, and who have different psychiatric diagnoses, who were admitted for varying lengths of time (Patton, 2002).

**Data collection.** Nine nurse-client dyads were purposefully recruited from a Jordanian mental health care setting. Open-ended semi-structured interviews were held with nurses and clients individually to explore their perceptions of nurse-client interactions. In addition, six follow-up interviews took place to ensure data were collected at more than one point in time during the nurse-client relationship. After taking field notes and preliminarily analyzing them, some questions raised and needed to be clarified with the participants. Ten short informal interviews were conducted with participants to clarify and verify observations.

Participant observation took place in common areas over three months of intensive data collection through three to four weekly visits. Each visit lasted for at least five hours for a total of about 260 hours of observation. Attending individual nurse-client interactions took place more than ten times each time for 5-20 minutes duration after getting nurses' and clients' permission.

Data collection was continued until saturation of themes was achieved as suggested by Morse (1994).

**Data analysis.** Peplau's (1952) theory of interpersonal relations, and Leininger's (1997) theory of cultural care and her sunrise enabler model provided the theoretical lens that frames the research inquiry. Data from the individual interviews and observation field notes were analyzed using a thematic analysis approach. Thematic analysis seeks to unearth the themes embedded in a text at different levels (Attride-Stirling, 2001). Leininger (1997) suggested the following thematic analysis phases; collecting, describing and documenting data, identification and categorization of descriptors and components, conducting patterns and contextual analysis, generating themes, research findings, and recommendations.

## **Key Findings**

**Chapter 4: “Jordanian Mental Health Nursing Care: The State of the Art”.** The findings of this study addressed the following areas: pathways to psychiatric mental health care in Jordan; the people and facilities of the National Center for Mental Health (NCMH); environmental context, unit structure, and the establishment of the new model unit; the emic and etic influences on people with mental illness including nurses' and clients' perspectives in addition to societal responses and responsibilities. The main themes of study findings among nurses as a group, clients as a group, in addition to findings among dyads were; first theme, the journey from community to hospital and back to the community; second theme, the lack of resources: an obstacle to providing standard care; third theme, the establishment of the new model unit: a look into the future; and the fourth theme, the stigma of mental illness: societal responses and responsibilities.

Mental health care hospitals in public sector are not well developed compared to other areas of health care in Jordan and severely suffer from staff shortage (Jrasat, Samawi, & Wilson, 2005). However, there is a current effort to reform mental health units into more developed professional standards units called “*model units*”. The aims behind the establishment of model units are: shifting from a biological approach to the comprehensive bio-psychosocial approach, utilizing multi-disciplinary health care teams, rather than relying mainly on medical teams as it used to be, deinstitutionalizing mental health care, and improving the quality of care. Although these aims were not fully achieved, this study supports the investment in the model units evidenced by the expressions of improvement of care and hence the satisfaction of both clients and nurses in the model unit compared to the regular units.

The Jordanian National Center for Mental Health (NCMH) lacks specialist nurses and advance practice nurses. This could be one of the reasons for the limited continuity of education in the field of mental health nursing. Developing and advancing nursing care requires continuous effort and dedicating time of qualified people to achieving high standard care. According to one of the administrator nurses, most of the studies in the field are done by students in nursing, and psychology MSc programs at Jordanian universities and their work remains unpublished and inaccessible due to the lack of databases to store their work. Other work is done by the World Health Organization (WHO) in alliance with the Ministry of Health (MOH) and their work is published on the internet, but it is not specific to nursing.

**Chapter 5: “Nurse-Client Relationships in Jordanian Mental Health Settings: An Ethnographic Study”.** Peplau’s theory of interpersonal relations afforded a guideline for understanding the nurse-client interpersonal processes including the influences on the relationships that are related to both the nurse and client and their interactions along the phases

of their relationships (Forchuk, 1993). However, Peplau did not specifically discuss the contextual factors including the cultural and social factors that may interfere with nurse-client relationships. Therefore, Leininger's sunrise enabler model was used as another lens to frame the findings about nurse-client relationships within its cultural context. Leininger's theory of cultural care emphasizes that in order to provide culturally competent care, nurses need to explore cultural care meanings, practices, and factors (educational, social, political, economic, religious, and technological) influencing care (Leininger, & McFarland, 2006). Hence, *Peplau and Leininger Theories Integration Model* (Figure 4) was developed in this research to visually present nurse-client interactions that take in consideration the contextual dimensions of the relationship which is basically an integration between Peplau's and Leininger's models.

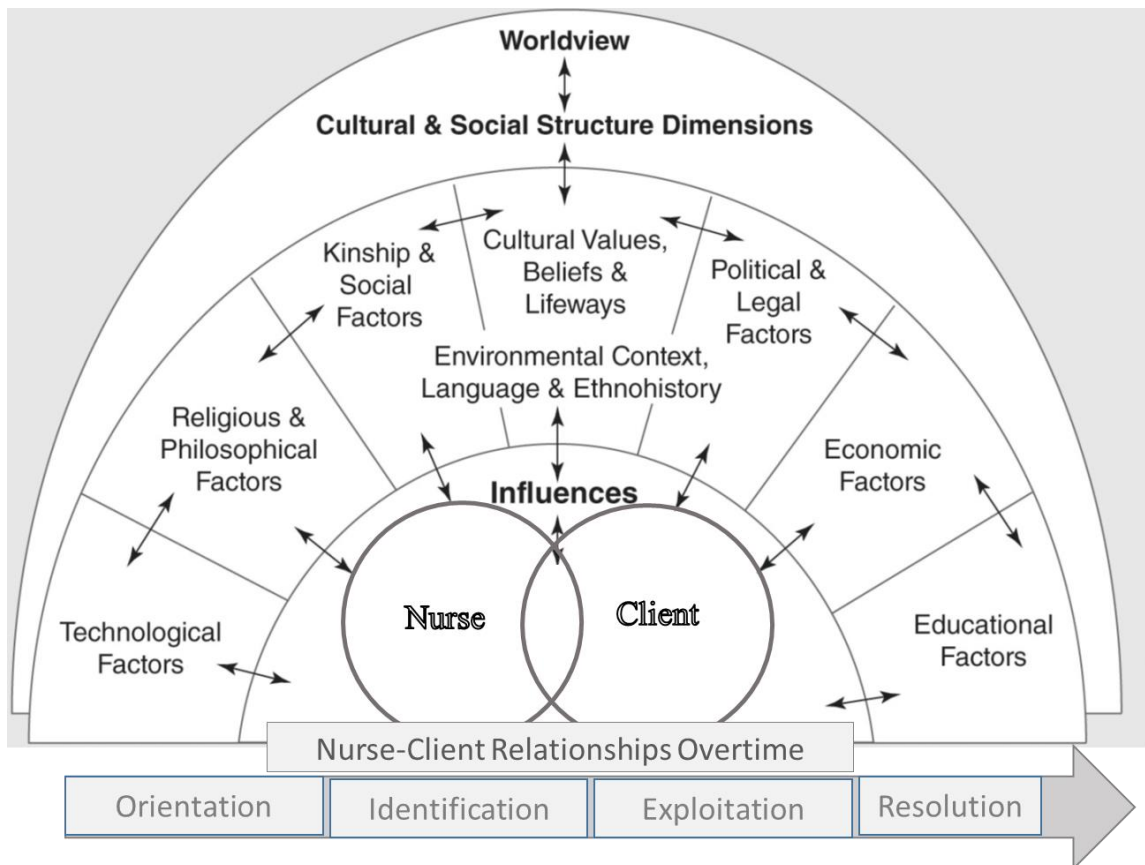


Figure 5. *Peplau and Leininger Theories Integration Model*

Findings of this study revealed diverse views on the progress of nurse-client relationships. Both nurses and clients who participated in this study expressed mixed responses to how they described their nurse-client relationships. Several qualities, facilitators, and barriers to their relationships were identified. In addition, different views on 'the same relationship' were sometimes depicted. Variations were also portrayed with collected data in regular units in the center versus the 'model unit'.

Both nurses and clients in this study emphasized the importance of developing and maintaining therapeutic nurse-client relationships. Participants identified genuineness and friendliness among the most frequently mentioned concepts during interviews. Mental health nurses stressed the importance of being authentic with their clients to establish and maintain therapeutic relationships. However, Challenges to defining boundaries were common among participants. Confusing 'being therapeutically friendly' with boundary violations were noticed at occasions.

The study discussed how the multiple contextual influences, such as educational, social, economic, and religious factors, identified in Figure 4, may contribute to shaping nurse-client relationships within the Jordanian mental health nursing setting. The main themes of these findings included; the presence of strong family relationships, the strong reliance on traditional healing modalities for treating mental illnesses within Jordanian cultures, the disappointment of traditional healing modalities in treating mental illnesses, the limited resources for the mental health care system, the strong presence of stigma against mental illness, and the various connotations to the use of nonverbal communication skills.



There are massive limitations in the resources that hinder the progress of the development process. Nurse-client relationship as a primary therapeutic intervention in mental health nursing is shaped by its context. In this study, we provided description, analysis and examples of how Jordanian cultural influences directly or indirectly shape the nurse-client interaction. Staff continuous education is very important to the delivery of care, nevertheless; careful consideration of cultural contextual dimensions is determinant to establishing and maintaining therapeutic relationships.

### **Implications**

The vision for future Jordanian mental health includes “the provision of quality community mental health services that are equitable, cost-effective and accessible to all people... [and that] reflect the comprehensive bio-psychosocial approach through multidisciplinary interventions, with emphasis on human rights, participatory approach and cultural relevance" (WHO, 2013). Several recommendations were derived from this study to facilitate the achievement of the Jordanian future vision of a contemporary and culturally compatible mental health care.

**Implications for practice.** As Canadian Mental Health Association (CMHA, 2015) highlighted, “we all have mental health, just as we all have physical health. Mental health is more than the absence of mental illness. It’s a state of well-being”. Findings revealed that mental illness stigma is highly prevalent in the society and within families, and plays a significant role in the client’s ability to access health care services and manage their conditions.

This study invites Jordanian communities to establish initiatives to increase mental health awareness at all levels. School education, local events, and national anti-stigma campaigns need

to be established to reduce the stigma associated with mental illness and provide insight into the services and support available to those living with mental illness. In addition, there is a massive need to educate family members of the person with mental illness about the importance and avenues for creating recovery environment.

This study highlighted the very limited availability of community services for people with mental illnesses and the absence of support for their families. Adapting other countries' experiences in improving community health and establishing organizations for families of people with mental illness should be considered such as the Canadian organization "Family Association for Mental Health Everywhere (FAME)", which offers support education, resources and coping strategies to families where there is a mental health concern. Mental health helplines, anonymous groups, and one-to-one services are some strategies that can be culturally acceptable while working on reducing mental health stigma. Literature on Expressed Emotions (EE) can also be invested in educating families about their roles in establishing and maintaining recovery environments (Butzlaff, & Hooley, 1998; Leff, 2013).

One model unit was established at the NCMH that aims to reform mental health care and purposes to provide standard care. Nurses and clients in the model unit agreed that model unit provides higher quality of services and can result in more nurses' and clients' satisfaction. In the model unit, where the nurse to client ratio is 1:4, nurse-client interactions happens spontaneously and very often, and building therapeutic relationships were facilitated. On the other hand, in all other units the nurse to client ratio is 1:12, which is alarming and could be a massive barrier to the delivery of professional care and a hindrance to building therapeutic relationships. This study, therefore, supports the investment in creating more *model units* as a first step toward

improving mental health care in Jordan. Staffing also needs to be increased to allow for enhancing nurse-client relationships and improving the quality of nursing care in general.

Findings of this study also showed that there are deficits in the orientation phase within establishing nurse-client relationships. Clients were very briefly oriented to their admittance unit and their assigned nurse, and then the nurse starts working with the client toward achieving the nurse's pre-set goals that ally with the doctor's recommendations. Clients are not always effective contributors in making decisions regarding their treatment plans. Scholars in the field of nurse-client relationships such as Peplau, and Forchuk stressed the importance of establishing trust during the orientation phase of the therapeutic relationship. Multiple influences may contribute to the orientation phase, such as the nurse's and the client's values, cultural beliefs, past experiences, expectations, and preconceived ideas. Consequently, deficits in appropriately exploiting this phase can eventually deteriorate the nurse-client relationship.

Therefore, this study recommends nurses to allocate more time establishing therapeutic relationships with their clients, including clients to be active participants in their treatment plans, and take the time to 'get to know each other' and each other's background and expectations so that conflicts and challenges could be less evident in the processes of their interactions. This needs to happen prior to establishing therapeutic goals (Forchuk, 1991; Forchuk, 1993; Peplau, 1952).

**Implications for education.** Continuous education for mental health nurses has been already started, and needs to be maintained and further developed. This study supports educating mental health nurses on utilizing contemporary nursing practices while critically questioning

their cultural compatibility. A previous thoughtful exploitation of Western experiences were initiated and found to facilitate improving the quality of mental health care in Jordan

The establishment of the model unit required nurses to receive nine-month training course in Spain to give nurses the opportunity to observe Western experiences in mental health nursing. This training resulted in improvement of nursing care and high satisfaction as reported by both clients and nurses. This study encourages nurses from other units to undergo similar training programs to update their knowledge and widen their perspectives. However, due to the financial restrains, model unit-trained nurses are recommended to establish local training programs that aim to communicate their experiences and update other nurses' knowledge. Another suggestion is making the 'model unit' a 'model' for future units. This could be applied by conducting internal staff training/rotation, in which nurses from other units work in the model unit for a period of time to learn and benefit from the experience of the previously trained nurses.

Establishing an organized and accessible mental health community services is essential to improving mental health services. At universities and collages' level, proper educational programs on *psychiatric* community health nursing needs to be established to graduate qualified nurses that are capable of creating change in people's life and help them integrate within their society. For example, the current community health nursing courses in Jordanian universities focus only in physical health concerns and omit psychiatric mental health topics. This study recommends nursing educators to integrate mental health topics in teaching community health nursing. Educators in community health courses may highlight mental health areas such as mental illness prevention, increased awareness, mental health assessment, early access to professional care, and creating recovery environment as areas of interest for nursing students.

Mental health educational sessions can also be held with individuals, families, in schools, and primary health care centers.

**Implications for policy.** Strategies to attract internal and external funds need to be established to further develop mental health care in Jordan. For example, *Policy makers* need to increase budget for mental health and allocate additional internal and external resources to fund national mental health projects. One of the possible interpretations for the shortage of financial resources to develop mental health services is the poor understanding of the cost of mental illness left untreated or poorly treated. Proper economic evaluation at governmental level is necessary to address the cost effectiveness of providing high quality mental health care at hospitals and within communities.

National programs and policies should be designed and established to integrate people with mental illnesses in the community and the work force such as providing governmental support to rehabilitate and employ people living with mental health conditions. It is also very important to integrate mental health care in primary health care, and increase community services such as community mental health care and social services to allow for proper de-institutionalization of mental health care.

**Implications for future research.** Future qualitative and quantitative research studies on the field can help evaluating the current system and highlight areas of improvement. For example quantitative studies that compare the effectiveness of care and the satisfaction of both nurses and clients between the regular units and model unit can help evaluate its effectiveness. Research is also highly needed to further investigate specific aspects of nurse-client interactions within

Jordanian mental health settings. Additionally, further studies in other Arab countries/Middle Eastern countries are needed to see if similar themes emerge.

Future studies that utilize the current study's model "Peplau and Leininger Theories Integration Model" (Figure 4) can be very beneficial in further exploring aspects of nurse-client interactions within its cultural context. Each phase of nurse-client relationships should be investigated in order to improve therapeutic nursing care in Jordanian mental healthcare setting. For example, quantitative experimental research can be conducted to study the effect of the therapeutic use of the orientation phase on the progress of nurse-client relationships.

With cultural and social structure dimensions in mind, and the assumption that nurse-client relations take place into multidimensional levels (global society, community, family, and interpersonal) (Leininger, 1997), nurses are encouraged to develop and utilize abilities and competencies to incorporate the multiple factors that influence care (Melo, 2013). Findings related cultural context of nursing care identified the shaping role of Jordanian culture in forming and influencing nurse-client relationships. This study identified some of the areas were nurses and clients can address to improve their relationships, such as increasing the level of clients' independence, respecting autonomy, and avoiding boundary violations. Future ethnographic research is needed to focus on the different perceptions and enactments of "boundaries" within Jordanian nurse-client relationships to guide its therapeutic use within its cultural context.

In conclusion, this study highlighted areas where initiatives and improvements are needed to enhance building therapeutic nurse-client relationships and advance the delivery of mental health care in the Middle Eastern country of Jordan. Changing the current 'state of the art' requires collaborative work from individuals (nurses, and clients), families, educators, policy

makers, and governmental agencies. This study provided recommendations and suggestions for future practice, education, policy and research in the field of Jordanian mental health nursing care, and there is no limit to what can be achieved as long as we take the first step.

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## **Appendices**

Appendix A: Peplau's Theory of Interpersonal Relations: Concepts and Relations

Appendix B. Leininger's Sunrise Enabler to Discover Culture Care

Appendix C: Letter of Information for Study Participants

Appendix D: Interview Questions Guide (for Nurses)

Appendix E: Interview Questions Guide (for Clients)

Appendix F: Guide for Recording Fieldnotes

Appendix G: Ethics Approval

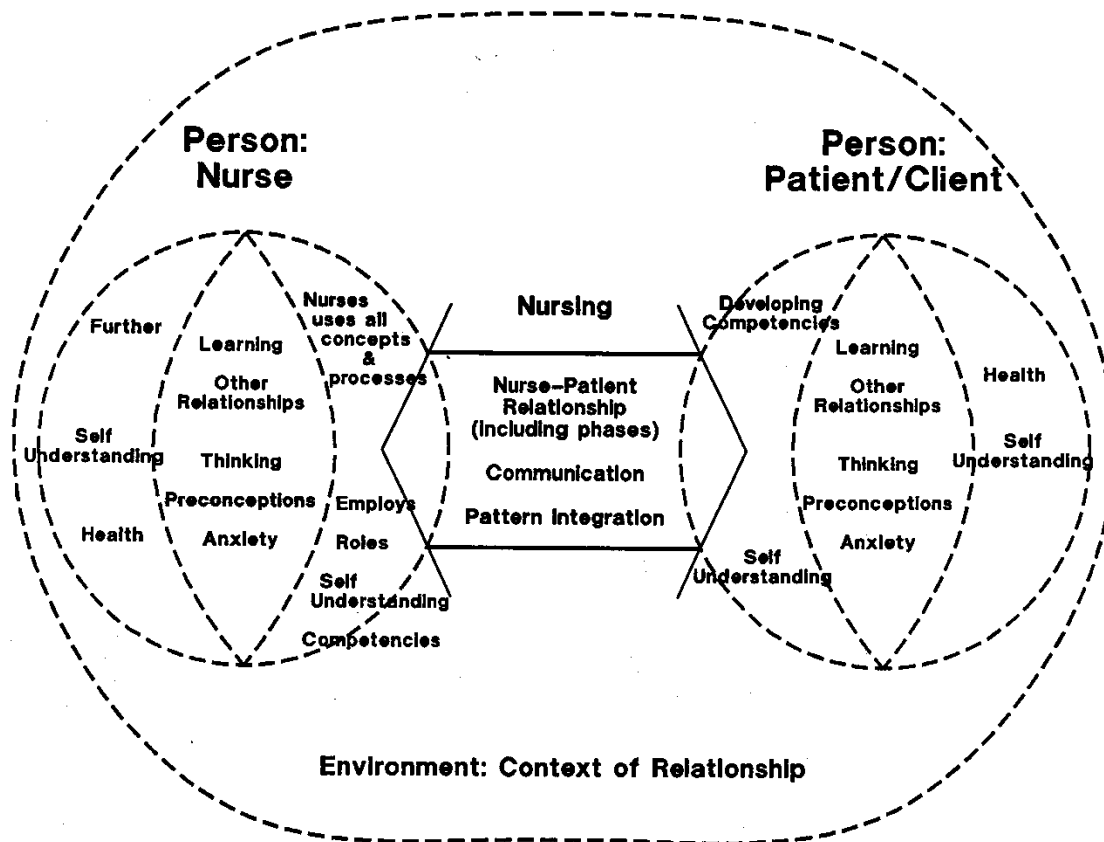
Appendix H: Ethics Approval – Jordan

Appendix I: Letter of Information and Consent Form - Arabic

Appendix J: Notice Re Observations on Ward

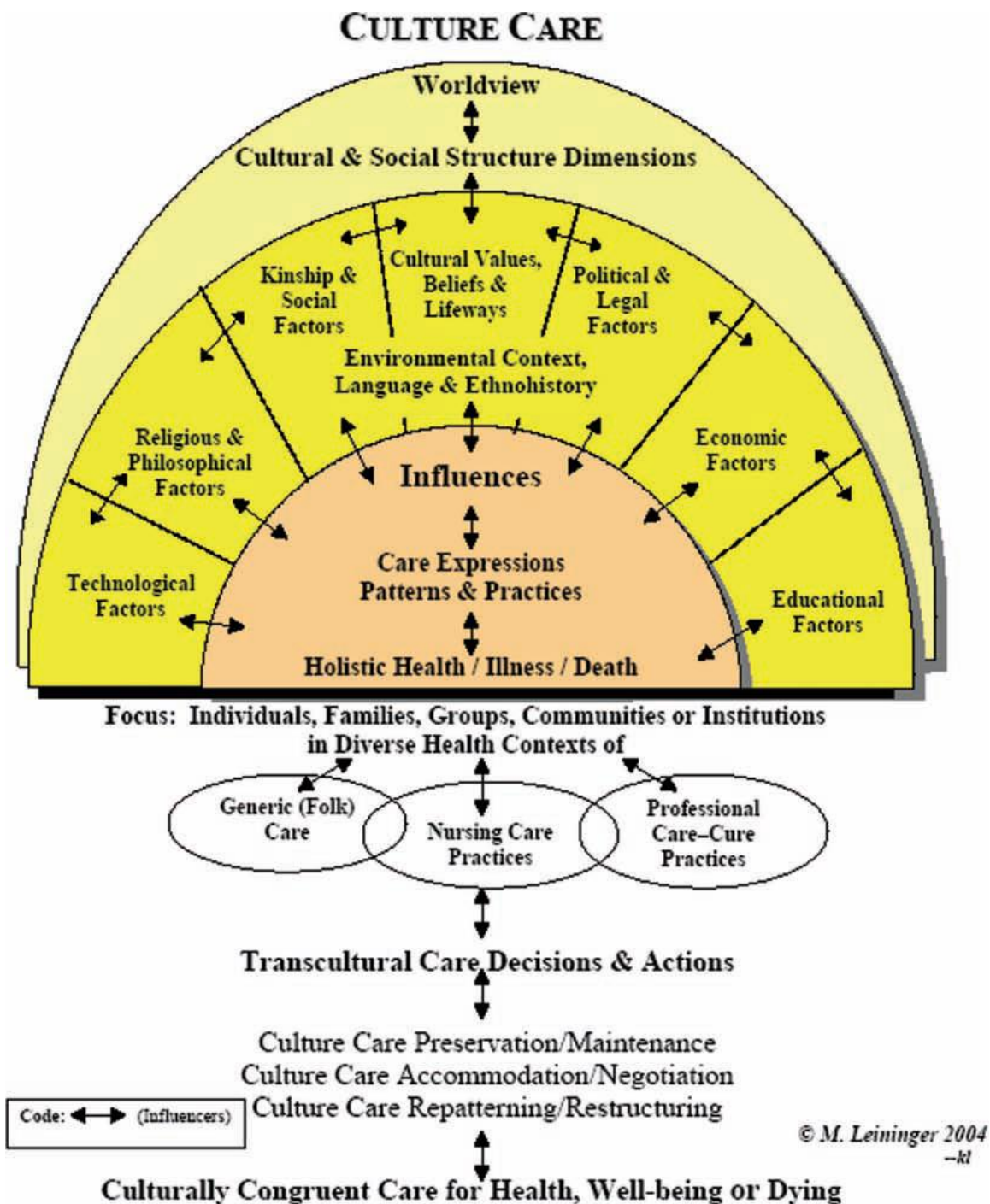
Appendix K: Notice Re Observation on Ward - Arabic

## Appendix A: Peplau's Theory of Interpersonal Relations: Concepts and Relations



Forchuk C. (1989). Peplau's Framework: Major Concepts and their Inter-Relationships. Hamilton Psychiatric Hospital, Hamilton, Ontario, Canada. Reprinted with permission.

**Appendix B. Leininger's Sunrise Enabler to Discover Culture Care (Leininger & McFarland, 2006, p.25).**



## **Appendix C: Letter of Information for Study Participants**

March 14, 2013

**Study Title:** Nurse-client relationships in Jordanian mental health settings: an ethnographic study

**Study Investigators:**

Wafa'a Ta'an, MScN, RN

PhD Student

Arthur Labatt Family School of Nursing

University of Western Ontario

Dr. Cheryl Forchuk, PhD, RN

Full Professor

Arthur Labatt Family School of Nursing

University of Western Ontario

**Introduction**

You are being invited to take part in a study being conducted by researchers from the University of Western Ontario. These researchers are studying nurse-client relationships in Jordanian mental health settings. People who are admitted to psychiatric mental health care facilities at the National Center for Mental Health (NCMH) care hospital in Jordan, and nurses who are working with those clients are invited to participate in the study.

**Description of the study**

The study will investigate professional relationships between the nurse and the client. The study will explore issues like how relationships develop, what things are helpful in developing the relationship, what things cause problems in the development of these relationships, and how cultural values and beliefs shape the relationship. In addition, communication styles and pattern will be examined. Conducting this study will provide a deeper understanding of the interaction from both nurses' and clients' point of views.

**What will I have to do if I choose to take part?**

If you agree to participate, you will be initially interviewed for one to two hours. The interview will be audiotape-recorded. The researcher will describe the research purpose, obtain your written consent, and then ask you some questions about your experience of interacting with mental health nurses/clients. A follow-up interview will be held sometime after the first interview. At the end of the interview, you will be asked to provide information about your age, sex, psychiatric mental health history/diagnosis (for clients), and psychiatric mental health work experience (for nurses).

**Are there any risks or discomforts?**

There are no known risks to participating in this research. However, if any emotional distress arises while clients are talking about their mental health experiences, they will be asked if they would like to stop the interview and be referred to their health care providers.

**What are the benefits of taking part?**

Your experience and perspectives on the nurse-client relationship is very important information that only you have. With your permission, the information you share may be presented to others through journals, publications, and at conferences and meetings. Your views may help to influence the future nursing research, education, and practice. You may benefit personally from

your participation by gaining more insight about the topic and gain sense of empowerment by being part of the research.

### **Compensation**

At the end of each interview, you will receive \$15 ( $\approx$  10 Jordanian Dinars) to compensate you for your time, and to thank you for participating in the research. You must complete the entire study to receive the \$15 for compensation. If you withdraw from the study prior to its completion, you will be offered \$10 compensation. Participants who withdraw prior to the individual interview will not be compensated.

### **What happens to the information that I tell you?**

The interviews will be audiotape recorded. What you say on the tape will be typed out. The only people who will listen to the tapes will be the researchers and the person who transcribes or types out the tapes. To protect your identity, only numbers will be used to identify pictures, tapes, and transcripts of the tapes. The consent form, tapes, and transcripts will be locked in a secure place at University of Western Ontario and kept for future consultation by the researchers, and possible future studies for five-year period. Absolute confidentiality cannot be granted, that means if you share information about suicidal ideation or life-threatening situation- by law it must be reported to the health care provider.

Representatives of the University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research. If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your permission.

### **Other Information about this Study:**

Your participation in this study is entirely voluntary, and you may withdraw from the study at any time you wish. You also can refuse answering any question if you want. If you decide to discontinue your participation in this study, you will continue to be treated in the usual and customary fashion.

This letter is for you to keep. If you have any questions about this study, please contact the supervisor. If you have any questions about the conduct of this study or your rights as a research participant, please contact the Director, Office of Research Ethics, The University of Western Ontario.

## Consent Form for Study Participation

### Nurse-client relationships in Jordanian mental health settings: an ethnographic study

**Research Supervisor:** Dr. Cheryl Forchuk

**Investigator :** Wafa'a Ta'an

I have read the Letter of Information and I agree to participate in this study. All questions have been answered to my satisfaction.

---

Signature of Participant

---

Date

---

Printed Name of Participant

---

Signature of Person Obtaining Consent

---

Date

---

Printed Name of Person Obtaining Consent

## **Appendix D: Interview Questions Guide (for Nurses)**

### **Nurse-client relationships in Jordanian mental health settings: an ethnographic study**

1. What is it like to work here?
2. Can you think of any stories that typify to you what it is like to provide mental health nursing care?

Probes:

What are the benefits?

What are the challenges?

Why did you choose to work in this setting?

What is your role? How would you change this role?

3. Tell me about a time when you felt good about an interaction with a client?

Probes:

Do relationships change over time? How?

What words would you use to describe your relationships with clients?

What constitutes a healthy relationship, what does it look like?

How do you decide on the care you provide with clients?

What helps your relationships with clients?

4. Tell me about a particularly challenging interaction with a client?

Probes:

Do you ever have disagreements with clients? How are these solved?

What hinders your relationships with clients?

5. What other factors impact nurse-client relationships in this setting?

Probes:

What are personal factors, work environment factors, societal factors?



6. Tell me about your values and beliefs about the nurse-client relationship?

Probes:

Can you tell me some of the things that you really liked about your interactions with your client, and why these were important to you?

7. Tell me a bit about yourself?

Probes:

Educational background.

Financial background.

Family background.

Experiences with mental health nursing.

How long they have been working in this setting.

Racial/ethnic background.

8. Has my presence here impacted the setting? How?

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\*This Guide is adapted from Oudshroon (2011) with permission.

## **Appendix E: Interview Questions Guide (for Clients)**

### **Nurse-client relationships in Jordanian mental health settings: an ethnographic study**

1. What is it like to come here?
2. Can you think of any stories that typify what it is like to receive health care at this setting?  
 Probes:  
 What is the quality of the care you are receiving?  
 What changes would you make to your care?  
 Why did you choose to come here for your care?
3. Tell me about a time when you felt particularly good about an interaction with a nurse?  
 Probes:  
 Do relationships change over time? How?  
 What words would you use to describe your relationships with nurses?  
 What constitutes a healthy relationship, what does it look like?  
 How do you decide on the care you receive?  
 What helps your relationships with nurses?
4. Tell me about a particularly challenging interaction with a nurse?  
 Probes:  
 Do you ever have disagreements with nurses? How are these solved?  
 What hinders your relationships with providers?
5. What other factors impact nurse-client relationships in this setting?  
 Probes:  
 What are personal factors, environment factors, and societal factors?
6. Tell me about healthy relationships in your life?
7. Tell me about your values and beliefs about the nurse-client relationship?  
 Probes:  
 Can you tell me some of the things that you really liked about your interactions with your client, and why these were important to you?

8. Tell me a bit about yourself?

Probes:

Educational background.

Financial background.

Family background.

Experiences with psychiatric/mental health issues.

How long they have been coming here.

Racial/ethnic background.

9. Has my presence here impacted the setting? How?

## **Appendix F: Guide for Recording Fieldnotes**

### **Nurse-client relationships in Jordanian mental health settings: an ethnographic study**

1. What is the atmosphere in the ward today?
2. What interesting occurrences were there today?
3. What values were displayed today?
4. What behaviours were demonstrated today?
5. What beliefs were demonstrated today?
6. Describe nurse-client interactions.
  - a. Reflect on social locations.
  - b. Reflect on barriers.
  - c. Reflect on facilitators.
9. Describe my interactions with clients.
  - a. Reflect on social locations.
  - b. Reflect on barriers.
  - c. Reflect on facilitators.
10. Describe my interactions with providers.
  - a. Reflect on social locations.
  - b. Reflect on barriers.
  - c. Reflect on facilitators.
11. Initial analysis of the nurse-client relationship.
12. What was unsettling/challenging in what I saw today?
13. What were the paradoxes and contradictions in what I saw today?

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\*This Guide is adapted from Oudshoorn (2011) with permission.

## Appendix G: Ethics Approval



Research Ethics

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Cheryl Forchuk

File Number:

Review Level: Delegated

Approved Local Adult Participants: 0

Approved Local Minor Participants: 0

Protocol Title: Nurse-Client Relationships in Jordanian Mental Health Settings: An Ethnographic Study

Department & Institution: Health Sciences/Nursing, Western University

Sponsor:

Ethics Approval Date: June 18, 2013 Expiry Date: September 30, 2016

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Other	References	
Letter of Information	Consent form and Interview and observation guides.	2013/04/24
Advertisement	Sign Arabic	
Advertisement	Sign English	
Letter of Information & Consent	LOI_Arabic	
	References	
Letter of Information & Consent	Informed Consent_Arabic	
Instruments	Field notes guide	
Instruments	Interview guide_Nurses	
Instruments	Interview guide_Clients	
Letter of Information	Consent Form	
Letter of Information	LOI_clients	
Letter of Information	LOI-Nurses	
	Response to REB recommendations	

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the University of Western Ontario Updated Approval Request Form.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Joseph Gilbert. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB


Ethics Officer to Contact for Further Information

Erika Rasile	Erin Kelly	Vikki Tran	Shantel Walcott
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This is an official document. Please retain the original in your files.

## Appendix H: Ethics Approval – Jordan

### Ethical approval from the Jordanian Ministry of Health (MOH) - Ethics Committee



الرقم .....  
التاريخ .....  
الموافق ..... م ب ١ / لجنة أخلاقيات

مدير تطوير الموارد البشرية

تحية طيبة وبعد ،،،

شماره لکتایکم رقم تطویر / خط ط / تاریخ ٢٠١٣/٦/٢٦  
بخصوص البحث المقدم من طالبة الدكتوراه /وفاء فلاح طالب طعان .

بعنوان :

(Nurse –client Relationships in Jordanian mental Health settings  
:An Ethnographic study )

یرجى التكرم بالعلم بأنه تم عرض البحث على لجنة الأخلاقيات البحث العلمي  
وقد قررت اللجنة الموافقة على اجراء البحث المشار اليه اعلاه .

للتكرم بالاطلاع واجراءاتكم لطفا .

واقبلوا الاحترام

مدير مستشفى البشير

ص ب /رس

## Appendix I: Letter of Information and Consent Form - Arabic

### Arabic translation of the letter of information and the consent form

معلومات حول البحث لمن يريد الاشتراك

عنوان الدراسة: علاقة الممرض بالمريض في مستشفيات الصحة النفسية الاردنية: دراسته ميدانية

معلومات الباحث:

وفاء فلاح طعان

طالبة دكتوراه في التمريض

جامعة وسترن أونتاريو الكنديه

معلومات المشرف:

الاستاذة: شيريل فورشك

جامعة وسترن أونتاريو الكنديه

### مقدمة:

أنت مدعو للمشاركة في دراسة من جامعة وسترن أونتاريو الكندية. هذه الدراسة بعنوان "علاقة الممرض بالمريض في مستشفيات الصحة النفسية الأردنية: دراسة ميدانية".

الأشخاص المدخلين في أقسام الحالات الحادة أو المزمنة و الممرضين العاملين في هذه الأقسام مدعويين للمشاركة.

### وصف الدراسة:

هذه الدراسة تتناول موضوع علاقة المريض بالممرض ضمن الاطار المهني و تتناول مواضيع مثل كيف تبني العلاقات و ما هي الامور التي تفيد المريض و الممرض في بناء علاقة علاجية ناجحة و ما هي المعوقات لذلك.

أيضاً تتناول الدراسة موضوعات تخص المضمون الثقافي لهذا الموضوع و مدى تأثيره على بناء هذه العلاقات العلاجية من وجهة نظر كل من المريض و الممرض.

### ماذا يجب أن أفعل إذا اخترت أن اشارك في الدراسة؟

إذا اخترت أن اشارك في الدراسة، سوف يتم مقابلتك لمرة كل مقابلته تستمر حوالي ساعة. سوف يتم شرح موضوع البحث و أخذ توقيعك على الموافقة و طرح عدد من الأسئلة حول خبرتك في الموضوع. بالإضافة إلى اسئلة عن عمرك وتشخيصك وتاريخك المرضي (للمريض) وخبرتك المهنية (للممرض).

### هل هناك أي اضرار من المشاركة في هذه الدراسة؟

ليس هناك أي اضرار متوقعة من المشاركة في هذه الدراسة. إذا تعرض المريض إلى إنفعالات نفسيه من التحدث عن المرض. سوف يتم وقف المقابلة وتحويل المريض إلى معالجه.

### هل هناك أي فوائد من المشاركة في هذه الدراسة؟

خبرتك ورأيك في موضوع علاقة المريض بالممرض ذو اهمية كبيره وانت وحدك تستطيع تقديم مثل هذه المعلومات. بعد موافقتك، سوف يتم عرض نتائج هذا البحث في مجلات واجتماعات على مستوى عالمي. مشاركتك أيضاً ممكن أن تزيد من وعيك تجاه هذا الموضوع.



### عوائد مالية:

سوف يتم مكافأتك على الوقت الذي قضيتَه في المقابل بمبلغ 10 دينار أردني بعد إنهاء كل من المقابلتين.

### ماذا بخصوص المعلومات التي تسمعها مني؟

سوف يتم تسجيل المقابلة ثم طباعتها إلى ملف. أي معلومات شخصيه سوف يتم ازالته من الملف. فريق البحث وحده سوف يكن مطلع على معلوماتك. أي ورقة ممكن أن تدل على شخصيتك سوف يتم فصلها عن المعلومات التي تشارك فيها وسوف يتم حفظها في خزانه مغلقة. سوف يتم حفظ معلومات البحث لمدة 5 سنوات ومن ثم شطبها وتدميرها بطرق آمنة. السريه المطلقة يستحيل تطبيقها، أي معلومات من الممكن أن تشكل خطر على حياتك أو حياة الآخرين سوف يتم احالتها إلى الفريق المشرف على علاجك.

في أي وقت من المحتمل أن يتصل بك أحد المشرفين على الموافقة الاخلاقيه لإجراء البحوثات من جامعة وسترن اونتااريو للتأكد بأن البحث يجري بطريقة سليمة.

### معلومات اضافيه عن هذه الدراسة:

مشاركتك في هذه الدراسه هو حتماً موضوع اختياري وتستطيع أن توقف مشاركتك في أي وقت، إذا كنت لا ترغب بإجابة أي سؤال حتماً لك كل الحق بالإمتناع عن الاجابه.

هذه الورقة لك، يمكنك الاحتفاظ بها وإذا كان عندك أي إستفسار عن البحث بإمكانك الاتصال بمشرفة الدراسة و بخصوص الممارسة الاخلاقيه للبحث يمكنك الاتصال على المكتب المشرف على أخلاقيه ابحاث جامعة وسترن أونتااريو الكنديه

### الموافقة على الاشتراك في البحث

عنوان الدراسة: علاقة الممرض بالمريض في مستشفيات الصحة النفسية الاردنية: دراسته ميدانية

إسم الباحث: وفاء فلاح طعان

إسم المشرف: الاستاذة: شيريل فورتشك

لقد قرأت الرسالة المرفقة حول البحث و أوافق على المشاركة في هذه الدراسة. تمت الاجابه عن جيع تساؤلاتي بطريقة مناسبة

.

توقيع المشارك: \_\_\_\_\_ التاريخ: \_\_\_\_\_

إسم المشارك: \_\_\_\_\_

توقيع الباحث: \_\_\_\_\_ التاريخ: \_\_\_\_\_

إسم الباحث: \_\_\_\_\_

## Appendix J: Notice Re Observations on Ward

### Nurse-Client relationships in Jordanian Mental Health Settings: An Ethnographic Study

#### **NOTICE RE OBSERVATIONS ON WARD**

I am a nursing PhD student who is doing a research study on nurse-client relationships. I will be observing nurse-client interactions on the ward but **will not** be including any identifying information.

Feel free to speak to me on the ward or contact me if you need any further information about the study. If you do not want me to make any observations involving you, feel free to contact me, or speak to me or your nurse on the ward.

Thank you,

Wafa'a Ta'an

## Appendix K: Notice Re Observation on Ward - Arabic

### Arabic translation of the notice re observation on ward

عنوان الدراسة: علاقة الممرض بالمريض في مستشفيات الصحة النفسية الاردنية: دراسة ميدانية

يتم حالياً إجراء دراسته ميدانية في القسم

أنا طالبة دكتوراه أقوم بعمل بحث حول موضوع العلاقة المهنية العلاجية بين الممرض و المريض سوف أقوم بتدوين ملاحظات من القسم حول الموضوع لكن لن يتم عرض أي معلومات تدل على هوية الأشخاص.

إذا كان لديك أي إستفسار الرجاء التكلم معي في القسم أو ارسال بريد إلكتروني. و إذا كنت لا ترغب بأن أدون ملاحظات تشملك أرجو ابلاغي مباشرة أو إبلاغ الممرض/الممرضة المسؤولة.

و شكراً جزيلاً

وفاء طعان

## Curriculum Vitae

### Ta'an, Wafa'a Falah

<b>Personal Information</b>	<p>Name: Wafa'a Ta'an, RN, MSc, PhD</p> <p>Gender: Female</p> <p>Nation of Citizenship: Jordanian</p>
<b>Education</b>	<p>Nursing PhD at Western University, London, Ontario, Canada (Sep, 2009-Dec, 2015)</p> <p>Got Scholarship from Jordan University of Science and Technology, Jordan for the period (Sep. 2009-Aug. 2013).</p> <p>Also got a scholarship from University of Western Ontario (2011-2013).</p> <p>Master of Nursing, Queen's university Belfast, UK (2006-2007).</p> <p>Got a scholarship from TEMPUS project (A European Union's program) for the period (Jan, 2006-Aug, 2006).</p> <p>Bachelor of Nursing, Jordan University of Science and Technology, Jordan (2001-2005), (One of the top ten graduated students)</p> <p>Tawjihi (Post-secondary certificate) from Jubilee school (for gifted students), Amman, Jordan. (2000-2001)</p>
<b>Languages</b>	<ul style="list-style-type: none"> <li>• English Language (fluent speaker)</li> <li>• Arabic Language (fluent speaker)</li> </ul>
<b>Publications</b>	<ul style="list-style-type: none"> <li>• 2014/2015 Mental Health Care Nursing Standards: International Perspectives chapter in the book Routledge Handbook of Global Mental Health Nursing_ in press</li> <li>• 2014/2015 An Assessment and Evaluation of London CARES: Facilitating Service Integration through Collaborative Best Practices (book chapter). In press.</li> <li>• Ta'an, W. and Forchuk, C., Berman, H., Orchard, C., Alzoubi, F. (2015). Nurse-Client Relationships in Jordanian Mental Health Settings: An Ethnographic Study. <i>London Health Research Day</i>. April 1<sup>st</sup>, 2015. London Ontario: Canada.</li> <li>• Ray, S. L., Ta'an, W., Bamford, M., Forchuk, C., &amp; Acosta, N. (2011). A downward spiral: Homelessness among Canadian Forces and Allied Forces veterans. <i>Esprit de Corps</i>, 18(10), 42-59.</li> <li>• Ta'an, W. and Forchuk, C., Berman, H., Orchard, C., Alzoubi, F. (2015). Jordanian Mental Health Care: An Ethnographic Study Investigating Nurse-Client Relationships. STTI Iota Omicron Chapter 28th Annual Research Conference. May 2015.</li> </ul>

	<ul style="list-style-type: none"> <li>• Forchuk, C., Ta'an, W., Reiss, J.P., Smith-Carrier, T., Edwards, B. (2015). The Experience of Stigma and Poverty for People with Mental Illness. STTI Iota Omicron Chapter 28th Annual Research Conference. May 2015.</li> <li>• Ta'an, W. and Forchuk, C., Berman, H., Orchard, C., Alzoubi, F. (2015). Jordanian Mental Health Nursing Care: The State of the Art. CURA 2 Conference: Poverty and Social Inclusion. October 2015. <i>Received the best student presentation award</i></li> </ul>
<b>Workshops and Participation</b>	<ul style="list-style-type: none"> <li>• "Participating in Research When It is Not Your Primary Focus" Workshop by LAWSON &amp;UWO. August 2014.</li> <li>• "Knowledge Translation" Workshop by LAWSON &amp;UWO. March 2014</li> <li>• "Poverty and Social Inclusion 3rd Annual Forum" by LAWSON &amp;UWO October 23-24, 2013</li> <li>• "A Practical Introduction to Content Analysis" workshop by UWO. January, 2013.</li> <li>• Youth matters in London: Homelessness, mental health and addiction conference" by LAWSON and Youth Opportunities Unlimited. April, 2012.</li> <li>• Basic and advanced NVivo 9 workshop by Form &amp; Kunskap Stockholm AB. January, 2011.</li> <li>• "Forging your way through the literature jungle" workshop by UWO. November, 2010.</li> <li>• "Systematic literature review workshop" by LAWSON &amp;UWO. November, 2010.</li> <li>• Proposal development workshop organized by LAWSON &amp;UWO, London, Ontario, Canada. April, 2010.</li> <li>• Research ethics workshop organized by LAWSON &amp;UWO, London, Ontario, Canada. March, 2010.</li> <li>• Youth matters in London: Mental health, addiction and homelessness workshop organized by LAWSON &amp;UWO, London, Ontario, Canada. January, 2010.</li> <li>• SPSS training course organized by The Consultative Center for Science and Technology/ Jordan University of Science &amp; Technology, Jordan. February 2008.</li> <li>• Creative thinking, Decision making, and Problem solving organized by the civil society Development center/ Jordan University of Science &amp; Technology, Jordan. (2005).</li> <li>• Communication skills workshop, organized by civil society development center / Jordan University of Science &amp; Technology (2005).</li> <li>• Participation in community health services as free medical open days in poor areas in Jordan.</li> <li>• Think Tank: The Potential of the Ontario Common Assessment of Need (OCAN) to Advance Health Equity- by The Racialized Populations and</li> </ul>

	<p>Mental Health and Addictions Community of Interest. March 2015. Toronto ON.</p> <ul style="list-style-type: none"> <li>• Nursing Network on Violence against Women International (NNVAWI) conference. April 2015. Atlanta, GA.</li> <li>• 28th Annual Research Conference- Building Leadership in Nurses Everywhere from the Bedside to the Boardroom. May 2015. By The Arthur Labatt Family School of Nursing Faculty of Health Sciences &amp; Iota Omicron Chapter Sigma Theta Tau International Honor Society of Nursing. London ON.</li> <li>• London Health Research Day. April 1st, 2015. London Ontario: Canada.</li> <li>• Faculty of Health Science Research Day. March 2015. UWO: London ON.</li> <li>• Poverty and Social Inclusion 5<sup>th</sup> Annual Forum. CURA 2. October 28-29 2015. London ON. Received best student presentation award.</li> </ul>
<b>Experiences</b>	<p>Part-time research assistant and research coordinator, UWO (Jan, 2010-present).</p> <p>Part-time teacher assistant, UWO (Jan, 2010-Present).</p> <p>Full-Time Lecturer at Jordan University of science and technology, faculty of nursing, community and mental health nursing department) (Jul. 2007- Aug. 2009) in the following courses:</p> <ul style="list-style-type: none"> <li>Community health nursing.</li> <li>Mental health nursing.</li> <li>Communication skills for nursing students.</li> <li>Ethics in nursing.</li> <li>Clinical Community health nursing.</li> <li>Clinical mental health nursing.</li> <li>Clinical Training course for fourth year nursing students.</li> </ul> <p>Clinical trainer in Jordan University of science and technology (Oct. 2005- Jan. 2006), In faculty of nursing (community and mental health department) in the following courses:</p> <ul style="list-style-type: none"> <li>Clinical Physical examination course.</li> <li>Clinical fundamentals course.</li> <li>Clinical mental health nursing course.</li> </ul> <p>Staff Nurse in medical and surgical wards in King Abdullah University Hospital (KAUH) (Aug, 2005- Sep, 2005).</p>