

PERCEPTIONS OF REGISTERED NURSES ON EMOTIONAL NEEDS AND THEIR  
ROLE IN MEETING EMOTIONAL NEEDS OF PATIENTS AT ENGELA  
HOSPITAL, OHANGWENA REGION, NAMIBIA

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## ABSTRACT

Meeting emotional needs is considered a central component of nursing care. Nurses today are expected to meet emotional needs of patients. It is however not clear whether nurses perceive their role in meeting the emotional needs of patients rather than physical needs only. Therefore, the study titled: "The perceptions of registered nurses on their role in meeting emotional needs of patients at Engela Hospital, Ohangwena region, Namibia" was conducted. The aim was to explore and describe the perceptions of registered nurses on their role in meeting emotional needs of patients at Engela Hospital, Ohangwena Region, in order to make recommendations for the reinforcement of emotional support for patients.

In order to meet the aims and objectives, this study has used the qualitative, exploratory, descriptive research design to determine the perceptions of registered nurses on their role in meeting the emotional needs of patients at Engela Hospital. In-depth face-to-face interviews were conducted at Engela hospital. Twenty (20) registered nurses employed at Engela hospital and purposively sampled, participated in this study. The interviews were conducted until data saturation. Interviews were recorded with audio-recorder and transcribed verbatim. Data was analysed following the methodology provided by Botma et al (2010).

The study identified four (4) themes and several sub-themes forming part of the findings of the study. The four identified themes were: Participants perceived different negative emotions during patient's hospitalisation that needs to be met such as anger, anxiety, fear, stigma and depression. Participants perceived psycho-social and physical factors that contribute to patient's emotions such as pain, diagnosis, isolation, relationships, and

cultural and spiritual factors. Participant perceived their roles in meeting emotional needs such as reassuring, referring, counseling, rendering holistic care and allowing personal preferences. Finally, Participants perceived barriers to fulfill their role in meeting emotional needs of patients such as shortage of staff, lack of privacy and lack of freedom in patients they express their feelings. Therefore, the study concluded that registered nurses perceived their role in meeting patient's emotional needs. However, the study has also identified barriers that affect the registered nurses from meeting the emotional needs of patients at Engela hospital. Finally, the study recommends supervision by management on emotional support by nurses, nurse educators emphasise on emotional care and further methodological sound research obtaining the views of both parties involved.

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## DEDICATION

Firstly, I dedicate my thesis work to God Almighty who has been there for me guiding me throughout the study. Secondly, I dedicate this study to my dear wife Beatrix. This is the result of your perseverance and encouragement.

Thirdly, I would love to dedicate this thesis to all the registered nurses willing to render holistic care to patients. Those registered nurses who have a passion to care for their patients. In the same accord, I would love to dedicate the thesis to the Engela nurses. This study is dedicated to all the effort you put on the caring of patients despite evident challenges in health fraternity. Lastly, I dedicate this study to all the patients going through emotional distress. The love and care that nurses have for you is evident and prompt this and other studies.

## DECLARATIONS

I, Rainhold Vatilifa Ndaikile, declare that the study titled “PERCEPTIONS OF REGISTERED NURSES ON EMOTIONAL NEEDS AND THEIR ROLE IN MEETING EMOTIONAL NEEDS OF PATIENTS AT ENGELA HOSPITAL, OHANGWENA REGION, NAMIBIA” is my own work. Researchers or authors that have contributed to this study have been appropriately acknowledged within and on the bibliography. This version is an original work and has not previously been submitted in full or in part for a degree at any other university.

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**Signature of student**

OCTOBER 2022

**Date of signature**

## CHAPTER ONE

### INTRODUCTION AND BACKGROUND

#### 1.1. INTRODUCTION

Emotions, in this context are how individuals deal with matters or situations they find personally significant (UWA, 2019). Additionally, emotions are strong feelings such as fear, anger, grief, joy or love or aroused mental state recognised in ourselves by certain bodily change and in others by certain characteristic behavior (Freshwater & Maslin-Prothero, 2015). Emotions have both physical and psychological dimensions, they are reactions to the outside world, they express what is going on inside the body to the outside world, and they exist for a reason—each emotion has a purpose (MacIntyre & Vincze, 2017). Individual negative emotions can obliterate their mental energy, negatively affect the body, and lead to health problems (Lawson, 2016). This study highlighted negative emotions based on their effect to patient’s well-being.

Emotions can be caused by a triggering event such as an overwhelming workload (Scott, 2020). Generally, emotions can also be caused by life challenges such as family problems, poverty, relationship problems and ill-health (Kandola, 2020). Expansively, emotions can be caused by unresolved work-related issues such as concerns about job security, concerns about performance, long hours, low pay, poor working conditions, increasing responsibility, a lack of control over work, relationships with colleagues or managers (Kandola, 2020; Cherry, 2019). However, emotions can also be caused by home-related causes such as experiencing persistent relationship problems with partners, other family

members or friends, undergoing major life changes such as relocating or having a child, living in a neighborhood that faces inequity and a deprivation of resources, experiencing discrimination, feeling lonely or isolated, having debt and having an unhealthful lifestyle, which might involve smoking or low levels of exercise (Kandola, 2020). On the other hand, negative emotions are also the result of individual thoughts surrounding an event. Significantly, the way an individual interprets what happened can alter how he or she experiences the event and whether or not it causes emotional distress and becomes a need (Scott, 2020). Therefore, in order to achieve holistic wellbeing of people emotions should never be ignored (MacIntyre & Vincze, 2017).

This nature – emotional state – often yearns for fulfillment, which is termed as emotional need (Anåker et al., 2018). Emotional need is defined as emotional care and/or support necessary for survival (Freshwater and Maslin-Prothero, 2015). Moreover, emotional needs have the mental requirements of intrapsychic origin that usually centers on basic feelings as love, fear, anger, sorrow, anxiety, frustration and depression and involves the understanding, empathy and support of one person for another (Toole, 2013).

Patients' emotional needs and their effects are slightly different from ordinary emotional needs. The prevalence of emotional needs is higher in people with physical illness compared to the general population (Fellow-Smith, 2012; Taylor et al., 2016). Patient's emotional needs are identified as establishing relationship and improving the patient's mood, compassionate behaviour, informing, improving physical environment and considering companions needs (Apóstolo et al., 2011; Molazem & Ghadakpour, 2013).

These needs if not met sometimes manifest in physical forms such as difficult coping with diagnosis, withdrawal from treatment, poor medication or diet compliance, poor emotional adjustment and reduced quality of life (Taylor et al., 2016; Apóstolo et al., 2011).

While it is acknowledged that emotional needs occur in everyone and under normal circumstances, it usually intensifies during periods of excessive stress, physical and mental illness (Toole, 2013). Therefore, is arguable that sickness and hospitalisations makes the person more vulnerable and dependent on others. The major causes of emotional needs are unattended emotional distress and lack of emotional support (Chiesi et al., 2017). Undeniably, patients are more emotionally distressed because of pain, sometimes neglected, stigmatized and many times isolated from their loved families and friends during hospitalisations (Carter et al., 2021; Asghari & Arabi, 2019; Dueñas et al., 2016). Within the hospital, patients' emotional needs can be triggered by their illness, diagnosis or treatment (Taylor et al, 2016). Fellow-Smith (2012) indicated that in a study of more than 245,000 people in 60 countries, an average of between 9.3 per cent and 23 per cent of participants with one or more chronic physical disease had co-morbid depression. Moreover, their emotional needs can be elicited by isolation from family, boredom, changed lifestyle and inability to participate in cultural and spiritual/religious activities (Taylor et al, 2016; Chandramohan & Bhagwan, 2015). Therefore, nurses should treat patients with compassion, care and love.

Traditionally, nurses were employed to amongst others, offer holistic cares (physical and emotional). The provision of holistic care includes emotional needs of patients. Meeting emotional needs is considered an essential component of nursing care but it remains unclear as to exactly how this is implemented in practice (Hill et al., 2015). Nurses are believed to be in key positions to help reduce affective disorders and emotional and spiritual needs of the patients (Chandramohan & Bhagwan, 2015). Nurses are expected to meet emotional needs of patients using approaches such as building a positive nurse-patient relationship, understanding, talking and touching patients, providing seclusions, being kind and loving, providing answers to patients and providing music (Stroke Association, 2012; Asghari & Arabi, 2019). Furthermore, it is apparent that communication is one of the most important aspects of nursing care in improving outcomes for hospitalized patients with emotional distress (Chandramohan & Bhagwan, 2015).

Emotional needs have a profound effect on patient's health outcomes (Asghari & Arabi, 2019). Meeting patients' emotional needs improves the wellbeing and health status of patients. Furthermore, meeting patients' emotional needs accelerate prognosis, aid in coping, improve quality and meaning of life (Molazem & Ghadakpour, 2013). On the other hand, unmet emotional needs can have devastating results: exacerbate disease severity, cardiac reinfarction and at worse can result in cardiac arrest. Additionally, unmet emotional needs have been associated with desires to discontinue patronising a specific hospital as patients became disappointed about the services provided (Chiesi et al., 2011).

The Namibian government established the Nursing Act 28 of 1993, parallel to the National Health Policy, aimed at providing quality health care services to achieve health for all Namibians (Sherif, 2010). In this policy, the government committed itself to provide access to health services for all Namibians by the year 2000, through the adoption of the primary health care approach and principles. The Namibian health care policy is driven by the principles of equity, accessibility, affordability, community participation and empowerment, multi-sectorial collaboration, and the provision of quality health care services. The National Health Policy was reviewed in 1998 resulting in current policy that re-emphasizes the primary health care approach as the best strategy to address the citizens' health care needs (Sherif, 2010).

Regardless of the National Health Policy Framework in place patients continue to complain about lack of emotional support at hospitals. An article published in The Namibian by Ndeyanale, (2021) articulate how the Ministry of Health and Social Services condemned nurses for slapping patients at Oshakati State Hospital, the inhumane act was called out after a video circulated on social media of two nurses slapping a patient refusing to take medication who deserved emotional support. In conclusion, this study is aimed at tackling such issues, helping nurses understand their role in meeting emotional needs of patients as well as giving suggestions on how nurses can communicate with patients, keeping in mind the holistic view of health care.

## 1.2. BACKGROUND TO THE PROBLEM

Extensive studies on emotional needs of patients were done internationally by researchers such as (McCull-Kennedy et al, (2017); Taylor & Combes (2014). It is concluded by these researchers that negative emotions have a negative impact to the well-being of the people. Unmet emotional needs of patient may affect their prognosis, resulting in prolonged hospital admissions that may affect the economy (World Health Organisation , 2015). Therefore, as a matter-of-fact patients health need may get worse than how patients comes in the health facilities if their emotional needs are not met (International Council of Nurses, 2021). The United Kingdom scholars contributed to the argument of the impact of unmet emotional needs by emphasizing that physical illness triggers many distressing emotions such as feeling vulnerable, anxiety and depression (Currid, 2012).

The global community through researcher, organisations and governing bodies has provided minimum practices, policies and guidelines to ensure holistic health care to patients. There are guidelines in place supporting meeting emotional needs by registered nurses. The United Kingdom has drafted a guideline recognizing meeting of emotional needs to patients of different diseases. This guideline advocated that emotional support should be provided to all patients and nurses should be equipped with appropriate training to recognize the emotional needs of patients. According to the guidelines, clear information and appropriate sensitive communication skills are also recognised as vital aspects of meeting emotional needs (Sullivan & Mansour, 2015). Furthermore, the national leadership of the United Kingdom through its political governing body established a health committed to review challenges hindering delivery of holistic nursing

care (House of Common Health Committee, 2020). Additionally, the international health organisations continuously emphasised the inclusion of mental health as it contributes to the health status of the world (World Health Organisation, 2004; International Council of Nurses, 2021).

Challenges in implementing the guidelines and meeting emotional needs of patients have been observed. The Health Committee exposed that nurse are not able to deliver quality care and meet emotional needs of patients because of the shortage of staff among nurses (House of Common Health Committee, 2020). Nurses are a backbone of health care: therefore the shortage of nurses will halt the quality patient care (Heyhoe et al., 2016). On the other hand, some nurses have no knowledge on providing emotional support to patients (National Quality Board, 2014). Thus, the matter of continues professional development is suggested to be taken serious. Another barrier in implementing the holistic care is economic challenges especially in developing countries (World Health Organisation , 2015). The poor countries may not afford to employ enough staff and build favorable health facility suitable for mental wellness. Therefore, it is accepted that there has been challenges in meeting emotional needs of patients.

Even though there have been challenges or poor implementation in meeting emotional need of patients, some countries have implemented the holistic and mental health guidelines. The guidelines of the United Kingdoms on meeting emotional needs and training nurses on emotional support is reported to be successful and well implemented (Sullivan & Mansour, 2015). Furthermore, the House of Common which is a political

leading body appointed a committee to continuously oversee the delivery of holistic health care to patients (House of Common Health Committee, 2020). There was no other commitment found on meeting emotional needs of patients or direct emotional support guidelines from the World Health Organisation and other international health bodies.

In Africa research in the field of holistic nursing care patient's emotional needs is minimal. However, minimum interest is found in South Africa in the holistic view of health care, in which emotional and spiritual needs are considered inseparable from physical needs (Monareng, 2012; Chandramohan and Bhagwan, 2015). Patients in Africa react differently to similar events as a result of their cultures or religion (Monareng, 2012). Similarly, to other part of the world, patients with emotional distress take longer time to recover than the emotionally stable patients. There was no policy found in Africa as a guide to nurses in meeting emotional needs of patient.

Few studies have been conducted in the area of the health system in Namibia. A study conducted by Freeman et al., (2016) focuses on strengthening the Namibian health system through the integration of palliative care. The study illustrates how a country can implement the World Health Organisation's public health strategy for developing palliative care services, which recommends four pillars: government policy, education, drug availability, and implementation (Freeman et.al. 2016). Researchers such as Feivik and Backman, (2015) have also done research in the area health system in Namibia, focusing on the impact the relationship between nurses and patients have on adherence of patient's treatment plan. The study concluded that it is important for nurses to have two-

way communication with their patients as it help the two to understand each other better and make it easier for patients to adhere to medication regimens. As stated above by other researcher communication is vital in meeting emotional needs.

According to the National health Act of 2015 (Act no.2 of 2015), there exists a National Health Policy which is mandated to provide a framework for a structured uniform health system within Namibia; to consolidate the laws relating to state hospitals and state health services, and to regulate the conduct of state hospitals and state health services; to provide for financial assistance for special medical treatment of State patients; and to provide for incidental matters. In spite of the National Health Policy Framework in Place, reports of mistreatment in Namibia hospitals persists, which shows that there is a lack of understanding of holistic view of health care and need for guidelines and interventions regarding the emotional need of patients in Namibia.

There is no guideline found in Namibia on meeting emotional needs of patients, however, meeting emotional need is considered a central component of nursing care (Hill, Evan, & Forbat, 2015). Therefore, one of the main roles of registered nurse according to the government gazette is to provide holistic care to the patients (Government gazette of the republic of Namibia, 2014). Therefore, registered nurses in Namibia are expected to provide holistic care to the patients, which include physical, emotional, psychological and spiritual care.

Even though the Namibian Government published a National Health Policy Framework there are constant reported cases of mistreatment of patients in public health care. A study on provider and client perspectives on maternity care in Namibia by Wesson, et al., (2018) concluded that One-third (31%) of survey respondents reported witnessing or knowing of client mistreatment at their hospital, about half (49%) agreed that “sometimes you have to yell at a woman in labor,” and a third (30%) agreed that pinching or slapping a laboring woman can make her push harder. Nurses were much more likely to agree with these statements than medical officers. Health workers’ commitment to babies’ welfare and stressful workloads were the two primary reasons cited to justify “harsh” behaviors. Extensive research shows that there is little to no research found that focuses specifically on the perceptions of registered nurses on their role in meeting emotional needs of patients in Namibia, which prompted the reason for this study.

### 1.3. PROBLEM STATEMENT

Firstly, this study was necessitated by numerous reports of patient’s dissatisfactions, lack of literature and proper guidance to registered nurses on how to meet emotional needs of patient (Ndeyanale, 2021; Alkazemi et al., 2019). As mentioned earlier different researchers emphasised that nurses today are expected to have the knowledge, skills and competencies to meet the evolving holistic health needs of the patients they care for. However, it is not clear whether nurses perceive their role in meeting holistic needs of patients rather than physical needs (Currid, 2012). As a clinical registered nurse based at Engela Hospital, a researcher had an interaction with different patients daily. During the time of interaction the researcher observed different negative emotions in patients which the researcher identified as needs. In frequent conversation some patients expressed their

emotions resulted from the diagnosis, illnesses or other causes outside the hospital. Additionally, some patients characterised emotional needs as a burden to recovery. Even though patients appreciate the efforts on treating the physical pain, they judged the effort to care for emotional needs within the hospital fraternity. These raises questions as to whether nurses attend to the emotional needs of patients and whether they perceive meeting emotional need of patient as their roles. These questions thus accentuate the purpose of the study.

#### 1.4. AIM OF THE STUDY

The aim of this study was to explore and describe the perceptions of registered nurses on emotional needs and their role in meeting emotional needs of patients at Engela Hospital.

#### 1.5. OBJECTIVIES

The objectives of study were to:

- Explore the perceptions of registered nurses on emotional needs of patients at Engela hospital.
- Describe the perceptions of registered nurses on their role in meeting emotional needs of patients at Engela hospital.

#### 1.6. SIGNIFICANCE OF THE STUDY

This study was a great learning opportunity and self-discovery to the researcher and the participating nurses on their perceptions, roles and how they can meet patients' emotional needs. Therefore, sharing the findings of this study may help registered nurses gain

knowledge and understanding on the type of emotional needs identified by participants and on how to meet those needs. Furthermore, the content of the study may benefit the registered nurse to understand complications involved when emotional needs of patients are not met which will assist them in meeting them. Additionally, the findings of the study may assist the management and administrator to identify gaps and barriers existing in the hospital in implementing or meeting emotional needs and address them accordingly. Furthermore, the outcome of this study can be used as a guide for further research both by the University of Namibia (UNAM) and Ministry of Health and Social Services (MoHSS). In the case of UNAM, the finding might influence further studies specifically targeting the perceptions of its graduates on the topic and how the outcomes can map on areas of improvement of the undergraduate program. While in the case of MoHSS the outcome may act as guide in its planning and determination of the need and urgency to embark on similar studies for all other hospitals across the country as well as drafting guidelines, clear information and appropriate sensitive communication skills to help the nurses in meeting emotional needs. Moreover, the finding of this study might act as a basis of further research in developing a knowledge base on meeting emotional needs of patients in nursing.

#### 1.7. DELIMITATION

This study is limited to the population of Engela Hospital and by the aims and objectives of the study. This study focused on registered nurses at Engela Hospital only. Therefore, the findings cannot be generalized to other hospitals or to other studies.

## 1.8. PARADIGMATIC PERSPECTIVES

Paradigm is a theoretical perspective or approach to reality recognised by a community of scholars or a position that provides the researcher with a set of beliefs to guide the research (Holloway & Stephanie, 2010). It constitutes the abstract beliefs and principles that shape how a researcher sees the world, and how he interprets and acts within that world (Kivunja & Kuyini, 2017). Similarly, Brink et al (2012) outlined the functions of paradigm as to define how the world works, how knowledge is extracted from this world, and how one is to think, write, and talk about this knowledge. Additionally, paradigm also maintains consistency in research for example paradigm matches theory, matches design and matches findings. Brink et al., (2012) described paradigm as set of assumptions about the basic kinds of entities in the world, about how these entities interact, and about the proper methods to use for constructing and testing theories of these entities.

In this study, interpretive paradigms guided the researcher. Interpretive paradigm means that the approach seeks to understand people's lived experience from the perspective of people themselves (Hennink et al., 2012). This paradigm emphasizes the significance of interpretation and observation in the social world. Nevertheless, it acknowledges that people's perceptions of reality are subjective therefore; there can be multiple perspectives to reality. The paradigm for this study consisted of ontological, epistemological, axiological, methodological and rhetorical assumptions that are defined in the following sections.

### 1.8.1. Ontological assumptions

Ontology is a branch of philosophy concerned with the assumptions we make in order to believe that something makes sense or is real, or the very nature or essence of the social phenomenon we are investigating (Kivunja & Kuyini, 2017). Ontological assumptions are patterned set of assumptions about reality (Brink et al., 2012). Reality is subjective and multiple as seen by participant (Holloway & Stephanie, 2010 ; Hennink et al., 2012).

The research question that required to be answered was: “What is the nature of reality as perceived by the research participants on emotional needs and their role in meeting emotional needs of patients?” The reality of this study is the “perceptions” of registered nurses on their role in meeting emotional needs of patients.

Ontology enabled the researcher to examine his underlying belief system and philosophical assumptions as the researcher, about the nature of being, existence and reality. Furthermore, philosophical assumptions about the nature of reality are crucial to understand how the made meaning of the data gathered (Kivunja & Kuyini, 2017). The principal assumption of this study was that registered nurses have different perceptions on their role in meeting emotional needs of patients. In this study, various realities contained various perceptions such as the realities of the researcher, the participants, and the readers who are interpreting the study. Data that had been gained from observations and interactions during the interviews were divided into sets of themes and subthemes, and summarised in order to provide clear meanings that reflected the perceptions of registered nurses on their role in meeting emotional needs of patients (Botma et al., 2010). The researcher used direct quotations from interviews as supporting information. The

researcher used evidence of multiple realities by using direct quotations in the study reflecting the actual words of different participants who perceived different roles in meeting emotional needs of patients (Holloway & Stephanie, 2010).

#### 1.8.2. Epistemological assumptions

The word episteme means knowledge and epistemology is used to describe how we come to know something or how we know the truth or reality or what counts as knowledge within the world (Kivunja & Kuyini, 2017). The most important question is on the relationship between the inquirer and the phenomenon (what is being studied) (Brink et al., 2012). The researcher collaborated and spends time in the field at Engela hospital with participants and became an insider.

In this study, the researcher conducted the in-depth face-to-face interviews with open-ended questions in order to obtain rich information from participants. The purpose of the researcher was to gather information on the “perceptions of registered nurses on emotional needs and on their role in meeting the emotional needs of patients” in order to gain knowledge on how the registered nurses meet emotional needs of patients. Nevertheless, more knowledge on the study was also obtained from different literatures. Epistemology is important because, it helps the researcher to establish the faith you put in your data (Kivunja & Kuyini, 2017) .

### 1.8.3. Axiological assumptions

Axiology refers to the ethical issues that need to be considered when planning a research proposal (Kivunja & Kuyini, 2017). Axiology deals with the role of values. Therefore, the researcher acknowledges that research is value-laden and that biases are present.

In this study, the researcher openly discusses values that shaped the narratives and included own interpretation in conjunction with interpretation of participants. Ethical principles, such as autonomy, respect, beneficence and justice were maintained during the collection of qualitative data.

### 1.8.4. Methodological assumptions

Brink et al (2012) defined methodology as the particular ways of knowing about that reality. While, Kivunja and Kuyini (2017) defined methodology the research design, methods, approaches and procedures used in an investigation that is well planned to find out something. Methodology deals with how should the inquirer obtain knowledge (Brink et al, 2012). This study used qualitative method.

The researcher conducted in-depth face-to-face interviews to obtain data on the perceptions of registered nurses on their role in meeting emotional needs of patients. The findings were analysed qualitatively. The study concluded that registered nurses perceived their role in meeting emotional needs of patients.

#### 1.8.5. Rhetorical assumptions

Rhetorical deals with the question of language of research (Kaushik & Walsh, 2019). In this study, informal simple language was used during face-to-face interviews. Furthermore, data were literally transcribed, described and developed the theme and sub-themes. The findings of the study were presented using exact quotations of the participants.

#### 1.9. THEORETICAL PERSPECTIVE OF THE STUDY

Theoretical perspective is based on propositional statements from theory to theories (Brink et al., 2012). Therefore, theoretical foundation is found to be relevant since it can guide the researcher to enlighten and contemplate logical (Creswell & Plano, 2017). In this study the researcher has espoused Theory of Mind (ToM) of Premack and Woodruff (1978) and Theory of Motivation: Abraham Harold Maslow described as follow:

##### 1.9.1. Theory of mind: Premack and Woodruff's (1978)

The study adopted the Theory of Mind (ToM) of Premack and Woodruff (1978) as a theoretical guideline to identifying and understanding the emotions of patients. This theory is based on knowing that other people have mental states and using that knowledge to recognize another person mental state which is to infer what the person is feeling or thinking (Gazzaniga et al., 2010). Gross, (2010) concurred that the ability to read the minds of others and to use this knowledge about their intentions and beliefs to predict

what people are going to do next seems to be a uniquely human ability and thus a very important component of social cognition.

In this study, the Theory of Mind revealed the significance of reading the minds of patients and understand their emotional state. Furthermore, it emphasised on the important role of registered nurses of diagnosing the patients with emotional distress and provide relevant emotional support. Therefore, the ability of the registered nurses to read their patients minds and render emotional support is the main goal of the Theory of Mind.

#### 1.9.2. Theory of Motivation: Abraham Harold Maslow (1954)

Consequently, this study adopted a Theory of Motivational by Maslow Harold Abraham (1954) which is more interested on the ‘why’ and ‘how’ questions. Motivation is concerned about why people act or think the way they do-what is the cause of their actions and thoughts and how can the be assisted- what are the underlying mechanisms and processes (Gross, 2010). According to Maslow, we are subjected to two different sets of motivational states or forces.

- Those that ensure survival by satisfying basic physical and psychological needs (Physiological, safety, love and belongingness and esteem)
- Those that promote person self actualisations - that is realising one’s full potential especially in the intellectual and creative domain. (Gazzaniga et al, 2010; Gross, 2010)

In this study, Theory of Motivation was adopted to generate impact of emotional needs and act as a guide on how to meet the emotional needs of patients. According to Maslow, patients are subjected to those different sets of motivational states as follow.

- Some of the needs identified by Maslow's hierarchy of needs are physiological needs such as temperature regulation of patients' rooms, rest and activity. Furthermore, other needs to be considered by nurses are safety needs- needs to protect patients from dangerous objects or situations such as wrong operations. In addition, Love and belongingness- patients should receive love, affection, trust and acceptance and they should be allowed to affiliate or be part of groups. Finally, patients are subject to knowledge and understanding- they need meaning hence they have curiosity to know about their treatment.
- Self actualisation - patients should be assisted to realize their potential and become everything they want to become. (Gross, 2010)

#### 1.10. DEFINITION OF KEY CONCEPTS

The concepts defined in this study are obtained from the title of this thesis "Perceptions of registered nurses on their role in meeting emotional needs of patients at Engela hospital, Ohangwena region, Namibia".

##### 1.10.1. Perceptions

Perception is the way you think about something and your idea of what it is like (Longman Dictionary of Contemporary English, 2015). Therefore, this study adopts the aforementioned definition. The perceptions in this study are the ideas of registered nurses on their role in meeting emotional needs of the patients at Engela hospital.

#### 1.10.2. Registered nurses

The registered nurse in this study is meant to be any nurse registered with the health professions council of Namibia (Nursing council) with a four years Bachelor Degree in Nursing Sciences (Clinical) or a three years bachelor Degree of Nursing Sciences (Advanced practice) or a four year diploma in comprehensive nursing and Midwifery sciences or a three and half years diploma in General Nursing and Midwifery obtained at the University of Namibia or any other approved University by the council (The Nursing Council of Namibia , 2010). In this study, the registered nurses are nurses employed at Engela Hospital who met the nursing council criteria as mentioned above.

#### 1.10.3. Role

This study defined “role” as the kind of behaviour expected of a person because of his particular place in his or her social setting or situation ((Freshwater and Maslin-Prothero, 2005).). In this study, the role is behaviours and actions required from regitered nurses to meet emotional needs of patients.

#### 1.10.4. Emotional needs

In the context of this study, emotional need is defined as emotional care and/or support necessary for survival (Freshwater and Maslin-Prothero, 2005). In this study, emotional needs can be counseling, reassurance, kindness and love towards patients.

#### 1.10.5. Patients

This study defined the word ‘patient’ as a person who is physically or mentally ill or who is undergoing treatment for physical or mental illness (Freshwater & Maslin-Prothero, 2005). In this study, a patient is any person visited the hospital seeking health care.

#### 1.11. OUTLINE OF CHAPTERS

This thesis is presented in the following chapters.

Chapter 1: This chapter consists of the introduction and background of the study and thereby sets the scene for the research. The motivations for the researcher to conduct the study as well as the study’s objectives are described in this chapter. Furthermore, the chapter outlined the significance and delimitations of the study. Finally, the study concluded with the paradigmatic perspectives.

Chapter 2: This chapter presents the literature review. Different literatures are reviewed and are employed to guide the study.

Chapter 3: The research design and methods that the researcher adhered to during the study are described as well as ethical considerations, data collection methods and process followed. It also contains the measures employed to ensure trustworthiness during the study.

Chapter 4: this chapter analysed the data and presents the findings. Themes and sub-themes that emerged are outlined in this chapter. This chapter includes discussion of the

study's findings. Various similar findings obtained by other researchers are reflected on in this chapter, and the literature is integrated into the discussions to serve as additional evidence of the study's findings.

Chapter 5: As the study's last chapter, this chapter outlines the conclusion and the summary of the findings in context. In addition, it includes information on limitations and recommendations with regard to the perceptions of registered nurses on their role in meeting emotional needs of patients at Engela hospital, Oshana region, Namibia.

#### 1.12. SUMMARY

This chapter presents the introduction and background of the study. Furthermore, it covered the problem statement followed by the aim and objectives of the study, significance and delimitation of the study. Consequently, paradigmatic and theoretical perspectives were discussed. Finally, the chapter presented the definitions of the key concepts. The next chapter will cover the literature review.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1. INTRODUCTION

The previous chapter dealt with introduction and background of the study. Therefore, this chapter will look at the literature review. Literature reviews is designed to provide an overview of sources the researcher has explored while researching on the roles of registered nurses in meeting emotional needs of patients. The literature review of this study was guided by research topic of this study. The researcher reviewed different books and journal articles which represents background and research developments related to the research topic. The researcher searched for theories and books related to the topic, read to understand and form conclusions about the existing research and theory presenting them in an organised manner (Brink, Van der Walt, & Van Rensburg, 2012). Furthermore, the literature of this study is conducted to demonstrate to the readers how this research fits into the larger field of study (Ramdhani et al., 2014). This chapter presents the opportunity to show what research has already been done on the topic. Therefore, as part of this overview it has also highlighted areas which relate to the patient's emotional needs, but may not have had as much research carried out upon them.

#### 2.2. BACKGROUND OF EMOTIONAL NEEDS

Globally, is believed that almost every patient has emotional needs arising from the current illness, diagnosis and pressure of taking medication (Chiesi et al., 2017). Emotional needs arises from psychosocial problems which often lead to emotional

disorders such as distress, stress, anxiety and depression, resulting in decreased self-care, quality of life and disease control (Chew, et al., 2017). Chew et al (2017) further argued that for many patients, it is difficult to cope with their chronic disease in daily life. As a result, many are experiencing complications (cardiovascular diseases, nephropathy, retinopathy and neuropathy) and psychological problems. Therefore, the study conducted by Renn –Żurek et al, (2014) concluded that problems related to care over a patient in the last phase of cancer (uncontrollable pain, presence at the moment of death) raise psycho-emotional problems and have a negative impact on the emotional state of nursing personnel.

On the other hand, illness, poverty, stigma and neglect are believed to be major cause emotional distress in patients (Vries et al., 2013). Henceforth, emotional distress may lead to a downward spiral of poor adherence or prognosis, deterioration of the condition and decline in daily functioning (Vries et al., 2013). Despite evidence that patients' desire improved support, management of their psychosocial problems, particularly at the lower-level, remains sub-optimal (Taylor et al., 2016). Therefore, it is important to understand care from a patient perspective and meet emotional needs of patients (Parker et al., 2020).

In Iran the most imperative obligations of each health care system and treatment service is to deliver care on the basis of the patient's need and to satisfy their expectations (Molazem and Ghadakpour, 2013). They further maintained that meeting the patients caring needs results in the patient being comforted and satisfied, having increased of self-care, and pain adaptation. Furthermore, Lack of satisfaction of the physical and emotional needs of the patient results in feelings of anxiety, hesitation, loneliness as well as lack of attention or understanding in patients. Consequently, patients do not follow their

prescribed medicine properly and even show poor prognosis (Molazem & Ghadakpour, 2013). Therefore, it is argued that healthcare professionals should do emotional work; they should deal with pain, joy, anxiety, unhappiness, hope, loss, and anger of patients on a daily basis (Heyhoe et al., 2016).

Little regional data exists on the emotional needs of patients. South African scholars concurred with patient's emotional needs either during the period of hospitalisation, visitation or during palliative care (Mokwena & Ngoveni, 2020; Chandramohan, 2013). There is a rise in emotional concerns in Botswana nation caused by suffering related to illnesses (Philips & Lazenby, 2013). Different extensive studies were done internationally and regionally, however, there is little to no study done in Namibia focusing on emotional needs of patients.

### 2.3. TYPES OF EMOTIONS

There are several emotions in patients consequential from severe and dilapidating diseases that may result in psychiatric disorders (Asghari & Arabi, 2019). Schouten, et al., 2019 emphasised that patients are systematically queried about their well-being and needs related to several psychosocial aspects (e.g., cognitive functioning, emotions, relationships and communication with loved ones, sexuality, social participation, employment). Fellow-Smith (2012) pointed out different types of emotions patients encounter such as shock, fear, anger, resentment, denial, helplessness, sadness, anxiety and frustration. Furthermore, Chew, et al., (2017) illustrated a full cup of emotions such as pain, hurt, guilt, stress, condemnation and fear which might lead to physical illness as stomach ache, poor eating and sleeping appetite, headache and digestive problems.

Different types of emotions are discussed extensively as follow. Different types of emotions of patients in the hospital are discussed extensively as follow.

### 2.3.1. Fear

Fear is an emotional reaction in response to some threatening stimuli in the environment, which is typically characterized by the flight or fight reaction (Philips , 2020). Fear appears to be one of the major emotions in patient. Moreover, fear within the hospital can also be caused by different phobia such as needle phobia, hospital phobia or death phobia (NHS Foundation Trust, 2020). Many people with phobias might have previous experiences with the similar events. Thus, patients might feel accepting over time to these emotions but it is also common that these feelings might become stronger over time.

The causes of fear are non-specific and vary from patient to patient. Occasionally, fear arises before surgery and has multiple consequences such as anesthetic complications as a result of vital signs instabilities (Sepúlveda-Plata et al., 2016). However, fear can also be caused by past incidence or traumas, such as painful injections, rude nurses and doctors or death of a family member from same illness or health facilities (Mind, 2021). Sometimes fear stems from real threats, but it can also originate from imagined dangers. Finally, fear can also be a symptom of some mental health conditions including panic disorder, social anxiety disorder, phobias, and post-traumatic stress disorder (PTSD) (Fritscher, 2020).

### 2.3.2. Anxiety

In contrast to fear, anxiety is more of a cognitive process, where people are starting to worry about future situations that may involve some loss of control (Philips ,2020). The reaction to anxiety is more complex than simply fight and flight. It will lead to people's attention drifting and people having more negative thoughts. Anxiety is a physiologic response that can result from genetic vulnerabilities and psychosocial stressors which can cause feelings of dread, apprehension, and worry in response to a perceived fear or stressor (Fleming, 2020). Furthermore, patients with anxiety disorders may have anxious feelings that are so uncomfortable that they avoid daily routines and activities that might cause these feelings such as medicine or other activities that may lead to their healings (Rector et al., 2008). Therefore, the fear of anesthesia and the fear of errors during anesthetic-surgical procedure are set in predictors for moderate and severe anxiety in the preoperative period (Melchior et al., 2018).

Experiencing anxiety can affect how a patient functions on a daily basis and responds to care, affect a person's quality of life significantly and contributed to an increased risk of suicidal (Fleming, 2020; Milne, 2020). Moreover, anxiety can have a physiological impact on some patient test results, which may lead to complications or discrepancies in diagnosis and, ultimately, in treatment (Philips, 2020). Finally, anxiety was found to be associated with symptom severity and sleep quality (Cankurtaran et al, 2021)

### 2.3.3. Depression

Fried and Nesse, (2015) defined depression to be a severe or very severe impairment of functioning that highly compromises the capacity for self-care and independent living. It

should be noted that depression is underdiagnosed and under treated in clinical setting, therefore nurses should take note that depressed patients frequently present with somatic complaints to their primary care rather than complaining of depressed mood (Guidelines for Clinical Care Ambulatory, 2019). Depressive symptoms are described to be sad mood, insomnia, concentration problems, and suicidal ideation (Fried & Nesse, 2015).

Within the hospital facilities, depression can be caused by physical illnesses. To simplify, physical illness can lead to depression through the lowered mood that patients experience when they are unwell, in pain or discomfort, confined and less able to do the things we enjoy (Schimelpfening, 2020). Additionally, depression can be caused by genetic factors, change in the brain neurotransmitter levels, bipolar disorder and other psychological and social factors. Depression is unlikely to occur without stressful life events, but the risk of developing depression as a result of such an event is strongly genetically determined (Goldman, 2019). Furthermore, abuse, physical, sexual or emotional abuse can cause depression. Moreover, elderly patients are at higher risk of depression. That can be made worse by other factors, such as having a lack of social support. Finally, some drugs, such as isotretinoin (used to treat acne), the antiviral drug interferon-alpha, and corticosteroids, can increase patient's risk of depression (Bruce, 2021). Depression can, therefore, lead to poor mental and physical functioning, leaving the patients less likely to follow required medication and diet plans for their chronic condition (Razzak et al., 2019).

#### 2.3.4. Hopelessness

Hopelessness is characterized by persistently negative feelings and expectations about the future as well as loss of motivation (Sahin et al., 2013 (Sarabi, 2020). Furthermore,

Sahin et al (2013) indicated that the sense of hopelessness seems to lead to increasingly negative evaluations of new situations and less effective coping strategies; thus, the perception is that one will not accomplish anything meaningful. As a result, hopelessness is considered one of the most consistent and robust risk factors of suicide thoughts and attempts or treatment defaulter (Rodríguez et al., 2017).

Major chronic medical conditions and illness such as cancer serves to be a major cause of hopelessness in patients (Grassi, et al., 2010). Moreover, patients with contagious diseases and most discriminated diseases such as HIV/AIDS are having a potential risk of hopelessness (Aguglia, et al., 2021).

#### 2.3.5. Denial

Denial is described as the refusal to accept the existence of a distressing condition (Rawool, 2018). Asghari and Arabi (2019) indicated that the denial stage is created by the suspicion and unbelief of the patient. At this stage, by denying the disease, the patient tries to maintain the mental condition. Furthermore, Rawool explained that denial can present in a variety of forms, including implicit or explicit denial, and can range in severity from partial to complete denial. Consequently, denial can be motivated by psychodynamic factors, such as threat to self-esteem, fear of impaired body integrity, and exaggerated optimistic biases (Vuilleumier & Saj, 2013). On the other hand, studies agreed that denial delays seeking for treatments or taking measures to halt the condition (Vuilleumier & Saj, 2013; Rawool, 2018). Denial of illness has a profound impact on everyday life for the patients and it can significantly affect medical care by delaying appropriate consultation and limiting the acceptance of treatment (Vuilleumier & Saj, 2013).

Furthermore, the study done by Petty et al (2020) revealed that emotions in general were noticed from agitation, crying, and increased mobilizing of patients. Below table indicates the emotions identified from different sources as cited in this study and their descriptions.

**Table 1 Emotions derived from studies and their descriptions (Petty et al., 2020; Vuilleumier & Saj, 2013)**

Emotions	Descriptions of emotions
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Agitation	<input type="checkbox"/> The word “agitation” or “agitated”: verbal or physical agitation was noticed.
<input type="checkbox"/> crying	<input type="checkbox"/> Discriptions includes crying, tears or weeping
<input type="checkbox"/> Denial	<input type="checkbox"/> Denying diagnosis, denying treatment, denyig admission
<input type="checkbox"/> Sadness	<input type="checkbox"/>
<input type="checkbox"/> aggressions	<input type="checkbox"/> shouting, destroting things
<input type="checkbox"/> anger	<input type="checkbox"/> complaining, facial expression, aggressive
<input type="checkbox"/> hopelessness	<input type="checkbox"/> giving up on life, stop taking medication
<input type="checkbox"/> anxiety	<input type="checkbox"/> uneasy, worry, fear

#### 2.4. TYPES OF EMOTIONAL NEEDS IN PATIENTS

Providing emotional needs is aimed at emotional wellbeing among patients. Emotional well-being refers to the emotional quality of an individual's everyday experience, the frequency and intensity of experiences of joy, stress, sadness, anger, and affection that makes one's life pleasant or unpleasant (McColl-Kennedy et al., 2017). Emotional support,

in particular, may contribute to the mitigation of stress associated with significant illness and has been causally associated with improved long-term health-related quality of life among patients with chronic conditions (Kapadia et al, 2020). Patients can feel more cared for emotionally as result of certain behaviors and communications by their health caregivers (Taylor & Combes, 2014). Therefore, types of emotional needs of patients are discussed as follow.

#### 2.4.1. Nurse-patients trust relationship

The nurse patient relationship is of great significance for both nurses and patients. The nurse-patient relationship is characterized by nurses working with vulnerable individuals who are dependent on care in situations that are often intimate in nature (Hechinger et al, 2019). Patients find it a necessity for the nurses to establish a relationship with them because they considered it a basic factor for improving their mood and tolerating difficult condition of sickness (Molazem & Ghadakpour, 2013). The relationship of nurses and patients in healthcare settings has been central in ensuring good and efficient healthcare delivery which is a goal of nursing (Konlan, et al., 2021). This is a trusting relationship where values are respected as the nurse listens to the patient's concerns, provides information and advice,relieves distress by encouraging the expression of emotion improves morale through review of established outcomesand encourages the patient to practice self-help (George, 2021). Therefore, the general goal of nurse- patient interaction is to help patients grow and recover (George, 2021).

#### 2.4.2. Counseling

Counseling is process by means of which the nurse expresses care and concerns towards the patient and facilitates the patient's personal growth and brings about change through self-knowledge (Kamuzu College of Nursing, 2012). There are a number of broad interpersonal principles that all nurses are introduced to in their education and probably try to adhere to in their daily practice, therefore, all nurses are ought to counsel patients (Hardy & Winship, 2012). It is established that most important lifestyle risk factors causing chronic illnesses are unhealthy dietary habits, smoking, obesity, inadequate physical activity, and alcohol abuse. Thus, lifestyle counseling by nurses makes it possible to effectively influence the risk factors of chronic illnesses caused by lifestyle (Koop et al, 2017). Therefore, it should be understood by nurses that counseling helps patients develop their capacities to the full. These include intellectual, social, physical, and moral capacities (Kamuzu College of Nursing , 2012).

#### 2.4.3. Reassurance

Reassurance is the removal of fears and concerns about illness (Traege et al., 2017) while in children is a procedure-related comments that are directed toward the child with the intent of reassuring the child about his or her conditions, or the course of the procedure (Carter et al., 2021). Even though, some patients report not reassured they have a correct diagnosis or treatment, reassurance is perceived as essentially a psychotherapeutic technique rather than an inevitable byproduct of a medical consultation (Traege et al, 2017). Reassurance directed contemporaneously to both the child and parents or adult patients was achieved in four main ways: acknowledging pain is real/believed;

tailoring their approach to the individual child; presenting solutions and options; and using education or information (Carter et al., 2021). Furthermore, reassurance helps patients understand and accept their diagnosis, establish confidence and grow trust in the nursing and medical team (Carter et al., 2021; Cankurtaran et al., 2021). Therefore, nurses are encouraged to reassure patients on their interactions and be a medium of hope and courage.

#### 2.4.4. Allow religious and spiritual participation

Spirituality is an essential aspect of holistic nursing care that is commonly disregarded. This is because of difficulties in conceptualising spirituality and confusion about how it should be integrated into nursing care (Rogers & Wattis, 2015). Religious and spirituality are two different terms that need to be understood by nurses for them to avoid religious conflicts with patients. Spirituality is an individual's attitudes and beliefs related to transcendence (God) or to the nonmaterial forces of life and of nature. Religious practice or religiosity, however, relates to a person's beliefs and behaviors associated with a specific religious tradition or denomination (Jones & Bartlett Learning, 2012). Nurses need to have a clear understanding of this distinction or they may neglect spiritual needs in focusing only on a patient's religious practice

Every human is part of spirituality as it ensures one's identity and life meaning. Spiritual well-being ensures patients comfort, peacefulness, reassurance and hope to recovery (Ruder, 2013). All nurses are expected to render spiritual care to patients which is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to

express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener (Royal College of Nursing, 2011). Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires'. Spirituality is unique to each individual and that nurses should listen to patients to determine what is important to them (Rogers & Wattis, 2015).

Some spiritual needs of patients are the need for forgiveness, the need for a source of hope and strength, and the need for spiritual practices, such as expressions of belief in the concept of God or a deity. Furthermore, the least frequently identified spiritual needs were the need for creativity, the need for meaning and purpose and the need for love and harmonious relationships (Karnjuš et al, 2019). In response to aforementioned spiritual needs, patients establish relationships, listens to their patients, provide love and kindness and refer their patients according to their demand (Chandramohan, 2013).

As mentioned above, religiosity refers to beliefs and behaviors specific to religious or denomination. Religious care has a significant role, similarly to spiritual care, on the health outcome of individual patients. However, only by understanding the religious beliefs of individuals can medical practitioners effectively meet the health care needs of patients of diverse religious beliefs (Rumun, 2014). Furthermore, nurses need to understand the rationales supporting those beliefs because they can impact their patients' care plan (Timothy, 2021). Patients who demands religious care such as prayers or scripture readings can be assisted by calling their clergy or chaplain. However, nurses,

those who are able to lead patients in prayers or share similar beliefs can lead the patients in prayers and give some divine assurance (Chandramohan, 2013; Timothy, 2021).

#### 2.4.5. Compassionate behaviors

Compassionate is defined as a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action (Hofmeyer, et al., 2016).

Compassionate care is characterized by nurses' establishing special bonds with patients (Pehlivan & Güner, 2020). Furthermore, Pehlivan and Güner (2020) argues that compassionate care behavior requires understanding others' values, establishing relationships with them, and responding to them in meaningful ways. Likewise, nurse's compassionate care is associated with care, compassion, courage, communication, commitment and competence manners (Bivins et al., 2017). Therefore, it is argued that nursing care is synonymous with compassion (Mills et al., 2015)

Compassionate has profound benefits to patients and nurses. Firstly, it improves nurses' understanding of involving patients and families in care. Secondly, it improves nurses' ability to determine patients' and families' needs and use appropriate approaches. Lastly, positive effects on patient outcomes (Pehlivan & Güner, 2020). Therefore, it is advised for nurse educators is to create innovative online curricula to teach compassion and resilience that nurses need to practice effectively compassion in demanding healthcare environments (Hofmeyer, et al., 2016).

#### 2.4.6. Love

Love is an emotional state that is typically directed at another person (Emakpor & Nyback, 2010). Love is a basic need that is required for holistic wellness. Absence of being loved

may lead to severe emotional distress. Patients' healing and positive therapeutic outcomes believed to be essentially related to the level of intimacy between the nurses and patients (Stavropoulou et al., 2012). Nurses are the ultimate caretaker of patients in the hospital who are expected to show love to patients in absence of their loved ones in the hospital. Therefore, a nurse demonstrates love to patients by caring manners, understanding, listening and by having a good nurse-patient relationship (Bivins et al., 2017; Konlan, et al., 2021).

#### 2.4.7. Care

Professional nursing is based on caring which is a combination of love and respect in interacting with others (Adib-Hajbaghery & BolandianBafghi, 2020). Patients are vulnerable because of their illnesses. Majority of patients are unable to help themselves or make well informed decisions resulting in them depending into nurses as caregivers (Currid, 2012; Al Ubaidi, 2017). The nursing care is based on the art of caring for patients. Therefore, nursing care is significant for people as patients because in such a vulnerable condition of being sick and assuming the patient role, patients expect nurses to perform their functions to the best of their abilities to provide the utmost care (Murata, 2014).

#### 2.4.8. Listening

Listening is demarcated as a strategy of essential communication for understanding the other person; it is a positive attitude of warmth, interest and respect, therefore, being considered therapeutic (Mesquita & De Carvalho, 2014). Nurses have been observed avoiding emotional cues of patients. It should be noted that, poor listening can cause nurses to make wrong assumptions about patients needs (Griffiths et al., 2016). Nurses

listening has attributes with having good bedside manner,' 'friendliness,' 'encouraging,' and 'speaks frankly, honestly (Jagosh et al., 2011), and listening to the vital signs (Mesquita & De Carvalho, 2014). Listening matters to patient care because the quality of the interactions between health-care staff and patients has an impact on patients' psychological functioning, quality of life, adherence to treatment and information remembrance (Griffiths et al., 2016).

#### 2.4.9. Improving physical environment

Environmental and design-related factors are part of patient satisfaction and emotional wellness. The physical environment can be defined as a space that includes architectural features (layout and size), interior design features (colours and layout of furnishings) and ambient environment (lightning and noise levels) (Anåker et al., 2018). Architectural features are exceptional in nursing care, however, nurses are ought to ensure that the provided environment is conducive for patients recovery. To simplify nurses are to ensure clean beddings, clean environment such as rooms, medical equipment visibility and a quite environment free from noise (Alkazemi et al., 2019; Jamshidi et al., 2019). Environmental stimuli, such as noise or crowding stressors, may cause negative or positive stress reactions (Eijkelenboom & Bluysen, 2019). Therefore, stress is considered a hindrance to fast recovery.

#### 2.5. FACTORS INFLUENCING EMOTIONAL NEEDS IN HOSPITAL

Humans are emotional beings, whereby, in the face of danger a rational and slower considered response to a risk comes at a cost (Heyhoe et al, 2016). Emotional needs of patient are influenced by different physical and social factors. According to several

studies, physical illness, terminal illness, newly diagnosis, being neglected by families during hospitalization, separation from family, healthcare provider's attitude and coping can influence the patient emotions (Curie, 2019; Chiesi et al, 2017). Therefore, physical and social factors influencing emotional needs are discussed extensively below.

### 2.5.1. Physical factors/challenges

Physical factors are those factors that are associated with the body or material things (Freshwater & Maslin-Prothero, 2005). In this context, physical factors can be material things such as finance or body such as pain. Therefore, the physical challenges that influence the emotional needs of patients such as financial challenges and health challenges are discussed as follow.

#### 2.5.1.1. *Financial challenges*

Unmet financial needs moderated the relationship between psychological morbidity and quality of life (Pereira, et al., 2018). Financial stress is commonplace in today's society that arises from different sources, differs in intensity and contributes severely to the emotional needs of human beings (Witherspoon, 2017). Financial stressors can be caused by the ongoing financial strain, difficulty paying bills, carrying over credit card debt, bankruptcy, life events and ongoing problems. Furthermore, Witherspoon argues that potential long-term implications from an inability to cope with financial stressors may be problematic and lead to such things as poor physical health, diminished well-being, and reduced social functioning. A patient may start overthinking on how to pay bills become stressed and yearns for comfort and counseling (Apóstolo et al., 2011).

#### 2.5.1.2. *Health challenges*

There is a strong link between mental health and physical health, but little is known about the pathways from one to the other (Ohrnberger et al., 2017). Many patients with physical illness experience emotional distress. Furthermore, patients with chronic diseases such as cancer experience severe emotional distress and influences more emotional needs (Razzak et al., 2019). Moreover, a study done by Desouza institute (2013) on emotional needs to cancer patients supported that patients' emotions are affected by pain, cancer diagnosis and treatment. Besides, Dueñas et al (2016) in their study explained that negative repercussions of pain have contributed massively to the deterioration of patient's quality of life both emotional and physical. Henceforth, difficulties in coping effectively with diagnosis, physical symptoms and treatment, may result in emotional distress, poor emotional adjustment and reduced quality of life (Taylor et al., 2016).

#### 2.5.2. *Social factors*

Social factors represent an important set of influences on patient behavior by their cultural people, social class or families and friend. These factors can discourage patients in participating freely on their treatment or seek for treatment. Equally, the social factors can also encourage patients wellness if have support of the social people in their surroundings. Clearly, these factors can lead to emotional distress that may influence the emotional needs of patients. Therefore, social factors such as isolation and fear to stigma are discussed in detail on how they influence emotional needs of patients.

#### 2.5.2.1. *Isolation*

Absence of social links causes great emotional discomfort in their lives (Molina & Forastero, 2015). Molina and Farastero further explained that absence of social links is caused by stigma in the society that may cause depressions and anxiety in some patients. Other emotions such as low mood, stress, and anxiety may be attributed to difficult life circumstances such as marital problems (Parker et al., 2020). On the other hand, on their study Petty et al (2020) identified that the other main causes of distress were the unfamiliar hospital environment, not knowing what is happening being away from loved ones, not knowing where s/he is, wanting to go home, confusion, and strangers.

#### 2.5.2.2. *Fear of stigma*

Social stigma in the context of health is the negative association between a person and the group of people who share certain characteristics of a specific disease (Kwaghe., 2021). Many patients with chronic illness live with depression in fear of discrimination. As a result, stigma has led many people in severe emotional distress such as depression and may lead to suicide (Ruffell, 2017). Therefore, stigma is regarded as one of the major causes of emotion distress that leads to patients to yearn for counseling, reassurance and being compassionate.

## 2.6. STRATEGIES/MECHANISMS IN PLACE TO MEET EMOTIONAL NEEDS

Sickness and hospitalisation make the patients more vulnerable and dependent on others and providing care is a way of meeting their needs during the time of their vulnerability, providing them with comfort, support, and skillful care (Molazem & Ghadakpour, 2013). Therefore, meeting emotional needs is considered a central component of nursing care but it remains unclear as to exactly how this is implemented in practice (Hill et al., 2015). Policy, research and practical guidelines in place for health care professionals now routinely suggest that emotional needs are an essential component of holistic health care assessment (Nixon et al., 2013).

According to Government gazette of the Republic of Namibia (2014) registered nurses are required to meeting patients' emotional needs. Roles of nurses in meeting emotional needs of patients are identified worldwide as communicating sensitively by listening to and talking with clients; being with the patient by caring compassionately; supporting, showing empathy; facilitating participation in patients coping mechanisms, such reading books and promoting a sense of well-being, respecting, and encouraging (Fellow-Smith, 2012). Nurses also place high value on their relationships with their patients and they speak of treasuring the 'caring' nature of their work thus there is a quote 'nurses care, doctors cure' (Desouza institute, 2013). According to Government gazette of the Republic of Namibia (2014) registered nurses has a responsibility in Namibia to assess and diagnose the emotional health needs, prescribe, provide and execute a nursing regimen to meet the needs of a patient or a group of patients.

A guide by Guidance Interim: International Federation of Red Cross and Red Crescent Societies, (2020) gave guidance on how emotional needs of patients should be handled. Firstly, should the patient be worried, explore what the person is particularly worried about and what their specific concerns are. In cases of extreme stress, worry, fear or loss of control, reassure and normalize these reactions by explaining that such feelings are normal during this and any other crisis. Another option is to mention how having updated and correct information is helpful. One more option is to explain that naming feelings calms the mind and explore how to manage worries. Should a patient worry or ruminate excessively, it can be helpful to suggest setting time limits for the worrying. Finally, ask what the patient will choose to do and assist the patient to find out more about other things they can do and suggest they write a list for inspiration.

The American Holistic Medical Association has the following three of ten principles for working in holistic medicine which have an inclusivity to meeting emotional needs as discussed by a study on holistic care by (Ventegodt et al., 2016). Firstly, they clarified that optimal health is the primary goal of holistic medical practice. It is the conscious pursuit of the highest level of functioning and balance of the physical, environmental, mental, emotional, social and spiritual aspects of human experience, resulting in a dynamic state of being fully alive. This creates a condition of well-being regardless of the presence or absence of disease. Secondly, holistic care views the person as “whole”. Which is explained that holistic healthcare practitioners view people as the unity of body, mind, spirit and the systems in which they live. Another principle presented is called Innate healing power. All people have innate powers of healing in their bodies, minds and spirits.

Therefore, holistic healthcare practitioners should evoke and help patients utilize these powers to make an impact on the healing process.

The findings on the study done by Vuilleumier, and Saj (2013) on denial of illness suggests that the role of nurses on meeting emotional needs of patients involves recognising and satisfying an ill person's needs which include a need for physical comfort by alleviating or relieving pain through appropriate control of symptoms and professional care. Secondly, it involves a social need which yearns for intimacy and presence of another person. Finally, it involves a need for dignity and self-esteem satisfied by respect for and compliance with the patient's rights.

## 2.7. PERCEPTIONS ON THE ROLE OF REGISTERED NURSES IN MEETING NEEDS OF PATIENTS

Patients want both emotional and medical needs met in an environment that balances interpersonal and intergroup communication (Barker et al., 2020). Findings of the study done by Trivedi et al., (2021) suggest that many patients do not feel that their providers adequately manage, communicate, nor respond to their emotional needs. Patients appreciate a caring nurse, and they feel the essence of caring from nurses. When there is a caring environment in the unit, patients feel welcomed, respected and their compliance to treatment improves, thus reducing the number of readmissions (Kobe et al., 2020).

Nurses perceive their role to identify and ensure the emotional needs of patients are met (Currid, 2012). Therefore, nurses cannot claim to be holistically caring for their patients until they acknowledge and address those patients' emotional needs (Currid, 2012). Batey

(2012) illustrates that nursing's holistic health paradigm deals with holistic care of the human being, the body and mind. The role of the nurse involves supporting people when they are emotionally distressed (Sawbridge & Hewison, 2013). Therefore, another role of nurses is to assess and diagnose emotional needs on their interactions and communication with patients. Healthcare providers need to perform routine assessments on the emotional status of patients (Cai et al., 2021). Nurses need to play a major role on identifying patient's emotional needs when assessing psychosocial care and quality of life as these subjects can be the least explored by staff with their patients (Legg, 2011). Therefore, it is understood that nurses have perceive their role in executing emotional needs of patients such as listening to them, developing a relationship, kind, talking and reassuring patients (Curie, 2019).

A study conducted by Mesquita and De Carvalho, (2014) stressed that an appropriate use of communication skills is the basis of emotional care of the individual and family experiencing psychological and emotional stress. Nurses play a unique role in supporting patients; by building dialogue with patients, nurses can begin to understand how patients view themselves as individuals. Furthermore, they will understand what is important to patients, and how the patient's relationship with others may affect their decisions and their ability to live with those decisions during their treatment and beyond (Legg, 2011). An essential component of patient-centered care is the communication between patients and their health care providers, which can affect patients' health outcomes (Trivedi et al., 2021). Therefore, a trusting relationship, with an emphasis on empathy and understanding, can make patients more able to share involvement in their care (Parker et al., 2020). Furthermore, Molazem and Ghadakpour, (2013) explained that nurses are expected to

establish the relationship and improve the patient's mood, compassionate behavior, provision of information, improving physical environment, and attention to the companion's needs. Caring involves having a therapeutic relationship with the patient where nurses interact with patients when performing their nursing duty. As a result, studies shows that good patient-centered care improves interpersonal relationships between patients and healthcare providers, and increases patient satisfaction and overall perceived quality of life (Trivedi et al., 2021; Barker et al., 2020). Therefore, it is expected that nurses and other health professionals may improve their knowledge about different techniques of interpersonal communication, as the professional-patient interaction to transmit attention, compassion and comfort is considered important (Mesquita & De Carvalho, 2014).

Hence, sickness and hospitalisation makes a patients more vulnerable and emotionally distressed, the role of the nurses should be providing them with comfort, support, and skillful care (Molazem & Ghadakpour, 2013). Nurses gives comfort to their patients by allowing them personal choices such as listening to radio, television and significantly listening to musics. Humans have used music to help cope with awareness of life's transitoriness, realising meaning of life and feelings of transcendence (Schafer et al., 2013).

## 2.8. BARRIERS IN MEETING EMOTIONAL NEEDS OF PATIENTS

Epidemiological research has identified both structural and attitudinal barriers to care which lead to unmet mental health need (Rens et al., 2020). Studies emphasised different barriers nurses' encounters in fulfilling their role of meeting emotional needs of hospitals.

Systemic challenges limited providers' ability to deliver emotional support information (Ceballos, et al., 2020). Different barriers are discussed under the heading shortage of staff, lack of resources and stigma.

#### 2.8.1. Shortage of staff

Shortage of nurses in hospitals has affected the nurse–patient ratio, thus prompting nurses to be focused on completing nursing-related duties with less or no caring for the patient (Kobe et al., 2020). Occasionally, some nurses only talk to the patients and most of the time they are so busy that they cannot even ask about the patient's health (Molazem & Ghadakpour, 2013). Furthermore, Kobe et al (2020) explained shortage of nurses in South African hospitals has affected the nurse–patient ratio, thus prompting nurses to be focused on completing nursing-related duties with less or no caring for the patient (Kobe et al., 2020). The findings of the study done by Sullivan and Mansour suggested that staffing and the pressures of handling both clinical and emotional care were challenging for all professionals, although oncologists and surgeons believed that nursing staff generally had more time to address patients' psychological issues (Sullivan & Mansour, 2015).

#### 2.8.2. Lack of resources

Lack of structural resources was regularly mentioned as an important underlying factor for unmet emotional needs of patients (Rens et al., 2020). In addition to a lack of resources, professionals mentioned lack of time. Heavy workload was identified as a barrier for the nurses to providing more comprehensive care (McCarthy et al., 2016).

### 2.8.3. Fear of stigma

On the other hand, receiving mental health care is often a matter of demanding care, but many people don't actively seek help or prefer to deal with problems on their own. Professionals argued that many people with mental health issues do not perceive a need for mental health care (Rens et al., 2020). Clearly, stigma was identified that it hinders people from disclosing mental health problems and seeking help thus, they turn to internet for comfort (Rens et al., 2020; Brochu, et al., 2019). On the other hand, the social stigma, and the lack of social resources to establish new social networks are other aspects which negatively affect their quality of life (Molina & Forastero, 2015). Therefore, some patients are afraid of communicating their emotional needs to nurses because of fear of stigma (Sontag, 2017).

## 2.9. SUMMARY

This chapter dealt with the literature review of the study beginning with the introduction and background of emotional needs. Subsequently, the chapter presented different types of emotions and different types of emotional needs. Then, the factors that influence emotional needs of patients were discussed followed by the strategies/mechanisms in place to meet emotional needs of patients. Additionally, the chapter discussed the perceptions of registered nurses on their role in meeting emotional needs. Finally, barriers in meeting emotional needs were discussed. The next chapter presents the methodology used by the study.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1. INTRODUCTION

The previous chapter has focused on literature review, this chapter will emphasize on the research design and methodology. O’Leary (2010), explained methodology as overarching, macro-level frameworks that offer principles of reasoning associated with particular paradigmatic assumptions that legitimate various schools of research. The research methodology tells the reader what was actually done, how it was done, and why it was done the way it was done (Hennink et al., 2012). Methodologies provide both the strategies and grounding for the conduct of the study. Additionally, strategies for methods of sampling, data gathering, and analyses are not as tightly controlled as those of the quantitative paradigm (Burns & Grove, 2009).. This study will discuss the research design, sample and sampling methods, data analyses, ethical consideration and trustworthiness.

#### 3.2. RESEARCH DESIGN

Research design is explained as a plan of how the researcher systematically collect and analyse the data that is needed to answer the research question (Bertram & Christiansen, 2014). This study has used the qualitative, exploratory, descriptive research design to determine the perceptions of registered nurses on their role in meeting the emotional needs of patients at Engela Hospital.

### 3.2.1. Qualitative design

Qualitative design refers to a broad range of research designs and methods used to study phenomena of social actions and of which we do not have an understanding (Brink et al, 2012). Furthermore, Brink et al (2012) explained that qualitative design focus on the qualitative aspects of meanings, experience and understanding, used to study human experiences using participant's viewpoints in the context where action takes place. The qualitative research design was the most suitable design for this study because it helped reveal the perceptions of registered nurses on emotional needs and on their role in meeting emotional needs at Engela hospital.

### 3.2.2. Exploratory design

According to Stebbins (2001) exploratory design is the broad-ranging, purposive, systematic, prearranged undertaking designed to maximise the discovery of generalisation leading to description and understanding of an area of social or psychological life. This study used exploratory design to generate new knowledge on the perceptions of the registered nurses on their role in meeting emotional needs of patients. Therefore, in-depth face-to-face interviews were used to explore perceptions of registered nurses and probing questions were used to explore perceptions on what is not known.

### 3.2.3. Descriptive design

Burns & Grove (2009) defined descriptive design as a design that is used to develop theory, identify problems with current practice or determine what another similar situation is doing. This study have used the descriptive design to identify and describe the perceptions of registered nurses associated with practicing meeting emotional needs of patients. Therefore, the researcher conducted face-to-face interview with registered nurses

working at Engela hospital to explore their perceptions on emotional needs of patients and to describe their perceptions on their role in meeting emotional needs of patients in Engela hospital.

### 3.3. RESEARCH SETTING

Research setting refers to the place where the data are collected (Brink, Van der Walt, & Van Rensburg, 2012). In this study, data were collected at Engela district hospital, which is situated in a northern region of Namibia called Ohangwena region. Furthermore, Engela district hospital is comprised of five (5) wards which admit patients of different conditions. The researcher is a former employee of Engela district hospital, therefore, is immersed with cultures, environment and logistics of the study setting. In addition, the researcher visited the setting prior to the collection of data to re-familiarise himself with the nature of the environment and real-life situation. Observing a study setting before the start of data collection allowed the investigator to premeditate any practical challenges inherent in the organization, structure or layout of the study setting (Majid, 2018).

### 3.4. POPULATION

Population is the entire group of persons or objects that are of interest to the researcher, other words that meets the criteria which the researcher is interested in studying (Brink et al., 2012). Such a group should share a given set of characteristics about which the researcher wishes to draw conclusion (Brink et al., 2012). The population of this study was registered nurses working at Engela District Hospital only. The population of this

study was 84 registered (n = 84) nurses based on staff establishment (Nursing Service office, 2021).

### 3.5. SAMPLING METHOD AND SAMPLE

The study employed the simple purposive sampling procedure; which is sometimes called “Judgmental sampling” (Brink et al, 2012; Holloway & Stephanie, 2010). Purposive sampling is defined as a technique based on the judgment of the researcher regarding participants or objects that are typical or representative of the study phenomenon, or who are knowledgeable about the question at hand (Brink et al., 2012). In purposive sampling samples are chosen with a purpose to represent a location or type in relation to a key criterion (Ritchie & Lewis, 2003). Participants were selected based on the care they render to patients and their professional decision making on the care plan of the patients. Considering the nature of work and the number of registered nurses on duty per day, purposive sampling was employed to sample participants based on inclusive criteria, availability on duty and willingness to participate. The participants were selected until the data saturates.

Sample is a group of people, objects or items that are taken from a larger population for measurements (Bertram & Christiansen, 2014). The sample of this study was registered nurses working at Engela hospital wards. Registered nurses allocated to wards or in-patients are regarded to carry the special knowledge and experience of the topic. The sample size of this study was 20 registered nurses employed at Engela state hospital. Participants were selected prior meeting inclusion and exclusion criteria.

Inclusion criteria

- Only registered nurses were allowed to participate in this study.
- This study employed registered nurses employed at Engela hospital only. These are the registered nurses working in rotation between the wards, casualty, OPD, theater, TB and CDC clinic.
- Only registered nurses who have worked in the wards were employed by this study.

#### Exclusive criteria

- Registered nurses from other hospitals not Engela Hospital were not allowed to participate.
- Registered Nurses from Engela Clinic were excluded from the study.
- Registered nurses who were employed at Engela district hospital but never get allocated to work in the wards were not allowed to participate.

### 3.6. RESEARCH INSTRUMENT

This study used in-depth face-to-face individual interviews. The researcher used the audio recorders during data collection to ensure that all face-to-face interviews are captured. Audio-recording the interviews allowed the researcher to devote the full attention to listening to the interviewee and probing in-depth (Ritchie & Lewis, 2003). Furthermore, field notes were used to record expression of the participants for interpretation. Field notes provide an opportunity to record what the researchers see and hear outside the immediate context of the interview, their thoughts about the dynamic of the encounter, ideas for inclusion in later fieldwork and issues that may be relevant at the analytical stage (Ritchie

& Lewis, 2003). Purposive sampling method was used to select participants for one on one interview sessions.

The main question of the interview guide is derived from the aim of the study. The researcher was guided by the characteristics of the reliable instruments as explained by Brink, Van der Walt, and Van Rensburg, (2012) such as content stability, internal consistency, and equivalence reliability. The interview question was “Tell me your perceptions on emotional needs of patient’ and “Tell me your perceptions on your role in meeting emotional needs of patients.” This was followed by probing questions. Subsequently, interview guide was pre-tested in interview forms to five (5) registered nurses who met the inclusion criteria at Katutura Intermediate Hospital. Pre-testing (pilot study) was done to identify problems and barriers related to participant’s recruitment. The researcher became aware that registered nurses are few, busy at most times and work shifts. Therefore, considering the nature of work and the number of registered nurses on duty per day, purposive sampling was employed to sample participants based on their availability on duty and willingness to participate. Furthermore, pre-testing study allowed the researcher to engage in research before study and to assess the acceptability of the interview. Participants who participate in the pilot study were not legible to participate in the study.

### 3.7. PROCEDURE FOR DATA COLLECTION

The data collection was aimed at identifying the perceptions of registered nurses on their role in meeting emotional needs of patients. This study used face-to-face in-depth interviews. In-depth interviews provide more quality data for less money than focus group where the interviewer seeks information from a number of individuals (Burns & Grove,

2009). In-depth face-to-face interviews were conducted with registered nurses in order to obtain rich data about their perceptions in meeting patient's emotional needs.

The researcher employed self as the interviewer. The interviews were initially commenced with two pre-determined open-ended question such as "Can you tell me your perceptions on emotional needs" and "Can you tell me your perceptions on your role in meeting emotional needs of patients" followed by participant's open and free responses and probing questions. The researcher recorded the expressions of participants during the interview to assist on data analysis and interpretation. Twenty (20) face-to-face interviews were conducted. Participants were employed until data saturation. Saturation refers to the repetitions of discovered information and confirmation of previously collected data (Speziale & Carpenter, 2007)

The data was collected for seven (7) days between the 7<sup>th</sup> and 14<sup>th</sup> April 2021. The researcher physically visited the Engela Hospital to identify participants beforehand. The reason for conducting data collections at Engela hospital was to maintain the natural settings where phenomena occur (Speziale & Carpenter, 2007). The names and contact details of the nurses willing to participate in the study were noted by a researcher. Consequently, the researcher communicated with participants to discuss the appropriate time and date for the interviews. The researcher conducted interviews according to participant and researcher's scheduled appointments until the data saturate. Interviews were held in the separate rooms of every ward where participants work at Engela Hospital. A separate room is any silence room. The quiet place was chosen to satisfy the ideas of Brink et al., (2012) that regardless of the settings, the interviewer should attempt to seek as much privacy as possible for the interview.

The researcher organised the room with chairs, tables and the alcohol hand sanitiser to disinfect hands to protect themselves against the covid-19 infection. The participant and the researcher sat facing one another. Additionally, they sat 1.5 meter apart from one another with their face masks covering mouth and nose in adherence to covid-19 prevention protocols. The facilitator was the researcher and the language used was English, which is an official language in Namibia. The researcher welcomed the participant after sitting and explained the objectives of the study. Furthermore, the researcher obtained informed consent from participants those that have agreed to take part in the study and to be recorded. Rights of the participants were explained to the participants by the researcher before they started with the discussion as explained in the ethical consideration. Interviews were audio-recorded and conducted in the manner of the conversation, even though; the in-depth face-to-face individual interview main questions were planned beforehand. This explorative approach was used to allow participants to freely express themselves and disclose their perceptions on their role in meeting emotional needs of patients.

### 3.8. DATA ANALYSIS

The qualitative research data are non-numeric; therefore the data was recorded in the form of written words and audio-recorder. Henceforth, qualitative data analysis is a complex, non-linear process but also systematic, orderly and structured (Holloway & Stephanie, 2010). According to Brink et al, (2012), data analysis entails categorizing, ordering, manipulation, summarizing the data and discussing, explain and describing them in a meaningful way. Nevertheless, data analysis relies on the statement of the subject, including the question raised, the purpose, and the conceptual framework of the study

(Speziale & Carpenter, 2007). Speziale and Carpenter further indicated that the purpose of the study often directs the data analysis. Generally, data analysis is not a distinct step in the qualitative research studies process but is done concurrently with data collection (Brink et al., 2012). The researcher used qualitative techniques as discussed by (Botma et al, 2010). The researcher followed the stages as illustrated by Botma et al (2010) and their application is discussed as follow:

First stage is called organize and prepare – The researcher transcribed verbatim discussions and typed up field notes in the notebook. All the non-verbal communication, gestures and behavioral responses from the field notes were typed up before data analysis. Second is to develop a general sense- The researcher has read through all the data and obtained a general sense of information and reflect on its overall meaning. Start to write notes in the margins as well general thoughts about the data.

Stage three focused on data coding - The researcher in this stage began a detailed analysis with a coding process. Coding is the process of organizing the material into chunks or segments of text before bringing meaning of the information (Botma et al., 2010). The researcher took text data gathered during the discussion, segmenting (words, phrases), sentences and paragraphs into categories, and labeling those categories with a term based on the language of the participants.

After coding the data stage four dealt with describing and identify themes- The coding process was then used to generate a description of the setting or people as well as themes from the categories. Detailed information, about people, places, or events in a setting was given. The researcher generated four themes and several sub-themes. The themes refer to

the major findings. The themes were used and have created the headings in the report of findings. They have displayed multiple perspectives from individuals that are supported by diverse quotations and specific evidence.

Fifth stage was to represent findings- The most popular approach is to use a narrative passage to convey the findings of the analysis. The researcher has presented the discussions on the four themes completed with subthemes, specific illustration, multiple perspectives from individuals, and quotations and a discussion with interconnecting themes. Visuals, figures and tablets were used as aides to the discussion.

On the Sixth stage the researcher interpreted the data- On this stage an interpretation of the meaning of the data was made. The personal interpretation of the researcher was used in combination with literature and theories. This study summarised the stages of data analysis followed in the figure 3.1 below.



**Figure 1: Data Analysis Steps derived from (Botma et al., 2010)**

### 3.9. ETHICAL CONSIDERATION

The conduct of nursing research requires not only expertise and diligent but also honest and integrity (Burns & Grove, 2009). Burns and Groves further explained that ethical research is essential to generate sound knowledge for practice. Qualitative studies need to focus on maintaining ethical principles at different stages of research such as seeking permission and informed consents, voluntary participations, minimisation of harm, anonymity and confidentiality. (Hennink et al., 2012). Brink et al (2018) outlined three fundamental ethical principles based on human rights that need to be protected in research, respect of person, beneficence and justice. Three principles and other research ethic steps were considered to ensure adherence to research ethics and will be discussed individually as follow.

#### 3.9.1. Permission to conduct reserserch

Firstly, the approval letter to conduct the study was granted from the University of Namibia Research Committees. Secondly, the researcher acquired the permission from the Ministry of Health and Social Services. Thirdly, the permission from the Ohangwena Regional Director of health and Engela District Hospital Senior Medical Officer to conduct the study at Engela Hospital was granted. Finally, the permission through a written consent was obtained from the participants who participated in the study.

#### 3.9.2. Principle of respect for person

Principle of person is referred to the participants' right to self-determination (Brink et al., 2012). Moreover, participant's welfare should always take precedence over the interests of science or society. Else, participants should be treated with courtesy and respect, and

they should enter into research voluntarily and with adequate information (Hennink et al, 2012). In this study, leaflets with information about the study were made readily available to all the participants. The researcher was available for questions and clarifications where participants felt necessary. Furthermore, participants were given the right to decide whether or not to participate in the study without any risk, penalty or prejudicial treatment. Finally, participants' had the right to withdraw from the interviews any time, to refuse to give certain information and to ask for clarification during the interviews.

### 3.9.3. Principle of beneficence

Principle of beneficence refers to the rights to protect from discomfort and harm or balancing benefits against risks and costs (Holloway & Stephanie, 2010; Brink et al., 2012). Supporting the principle of beneficence Speziale and Carpenter (2007) in their book clearly indicated that participants must not be harmed. In this study, the researcher ensured the protection of participants from discomfort and harm by ensuring no medical experiment is done on the participants. Furthermore, the study interview questions were carefully drafted and pre-testing of the instruments was done to three nurses in a different hospital to ensure the questions poses no harm to participants.

### 3.9.4. Principle of Justice

Principle of justice refers to participants' rights to fair selection and treatment, right to privacy, anonymity and confidentiality (Brink et al., 2012). In this study, the researcher ensured the right to fair selection and treatment, right to privacy, anonymity and confidentiality and respect of human right and is described as follow:

#### 3.9.4.1. Fair selection and treatment

Brink et al (2012) stated that the researcher must select the population and participants with fairness. The researcher selected the population of registered nurses because they have knowledge on the problem statement and not merely because they were readily available. Furthermore, to ensure that participants were selected fairly, researcher used a purposive sampling whereby, the participants are selected based on their knowledge and care they render to patients.

#### 3.9.4.2. Right to privacy

Privacy is part of the principle of respect for autonomy. As stated by Holloway and Stephanie (2010) every precaution was taken to protect the privacy of participants. The researcher has respected the participants' privacy by ensuring that no information is obtained from the participants without their full consent or against their will. Participants individually determined the time, extend, and general circumstances under which their personal information was to be shared or withheld from the researcher (Burns & Grove, 2009). The participants' responses and behaviors were kept private.

#### 3.9.4.3. Anonymity and confidentiality

Anonymity means namelessness while confidentiality means not divulging participants' information without consent (Brink et al., 2012). In this study, participants were given numbers and only the researcher was able to match the real names and identities with the responses. Audio-recorders, field notes and transcriptions were kept secure and names were not located near the tapes (Holloway & Stephanie, 2010). The researcher demonstrated caution that has never used the names of the participants or mentioned them

during the interviews. On the other hand, there was no breach of confidentiality. The researcher has not given any unauthorised person to gain access to the study responses. Additionally, the researcher did not mention any participant name or identity in the study.

### 3.10. TRUSTWORTHINESS

Trustworthiness means methodological soundness and adequacy or a way of ensuring data quality (Holloway & Stephanie, 2010; Brink et al 2012). According to (Bertram & Christiansen, 2014) trustworthiness is defined as the degree of confidence that qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity. In this study, the researcher spent a prolonged period in the field to develop an in-depth understanding of the phenomenon under study to ensure credibility. While, to ensure transferability the researcher provided sufficient or thick descriptive data in the research report for readers to evaluate the applicability of the data to other contexts.

Furthermore, the researcher transcribed verbatim without personal biases, motivations, or perspectives in order to ensure confirmability. In addition, the study was reviewed and audited by the supervisor to make sure the university criteria are followed in order for the study to be dependable. Finally, the study concluded to be authentic as it carried the second hand lived perceptions of participants about the study. Lincoln and Cuba model as cited by Brink et al (2012) proposes four criteria for developing trustworthiness of a qualitative study such as credibility, dependability, confirmability, and transferability further Authenticity will be added and they will be discussed in detail as follow.

### 3.10.1. Credibility

Credibility alludes to confidence in the truth of the data and interpretation thereof (Brink et al., 2012). Credibility also corresponds to the notion of internal validity (Holloway & Stephanie, 2010). Credibility can be established through prolonged engagement with the subject matter or through member checking which means seeing whether participants recognise the findings (Holloway & Stephanie, 2010). Furthermore, member checking should be used to determine the accuracy. Therefore, this study maintained its credibility and ensured the accuracy of the findings as discussed below.

#### 3.10.1.1. Prolonged engagement

The researcher is a registered nurse, who at many times had contact with the registered nurses employed at Engela hospital where the study took place. The researcher was placed at Engela hospital for three years before was transferred to the different hospital. Whereby, the researcher gains an in-depth understanding of the phenomenon and the views, cultures, experience and religions. Furthermore, the researcher travelled and spends seven full days with the participants interviewing the participants until data saturation. Therefore, because of this background, there was trust between the researcher and participants, which helped in gathering rich information.

#### 3.10.1.2. Member checking

In order to ensure accuracy of the findings member checking was considered by this study. Throughout the interviews and observations, a check was done on the understanding of the data with the participants as elaborated to by (Holloway & Stephanie, 2010). The

researcher had been summarising, paraphrasing and repeating participants' word to establish whether the interpretation is a true and fair representation of their meanings. The researcher has communicated the themes to the randomly selected participants. These emerging of findings were taken back to the participants in order to discuss and confirm the adequacy of the findings thereof. Therefore, the participants have recognised the meanings that they themselves gave to the study and the truth of the findings in their own social context. The findings of this study are therefore confirmed to be compatible with the perceptions of the registered nurses at Engela Hospital.

### 3.10.2. Dependability

Dependability is the criterion met once the researcher have demonstrated the credibility of the findings which means the findings should be consistent and accurate (Speziale & Carpenter, 2007; Holloway & Stephanie, 2010). Brink et al (2012) refers dependability to the provisions of evidence such that if it were to be repeated with the similar participants in the similar context the findings would be similar. Furthermore, Holloway and Stephanie (2010) stated that upon dependability, the study context must be discribed in detail and there should be trail. This helps the readers to follow the path of the researcher and determine how the conclusion was achieved. Moreover, it also help other researchers wishing to carry out similar studies. Therefore, dependability audit and triangulation was discussed to confirm that dependability was ensured by this study.

#### 3.10.2.1. Dependability Audit

The study methodology, problem statement and interview questions guide were reviewed by the University School of Nursing Post graduate Committee and by the supervisor for

relevance before actual data collection. Furthermore, the supervisor was allocated to guide the researcher throughout the whole study to ensure compliance with the methodologies and university protocols. The literature review was conducted during the study and the findings were linked to the literatures. Finally, the qualitative experts were involved to give opinions whereby, the researcher had a chance to debate and be advised on the methods and findings.

#### 3.10.2.2. Triangulation

Triangulation of methods has the potential to contribute to the dependability of the findings (Speziale & Carpenter, 2007). Brink et al., (2012) defined triangulation as the use of multiple methods or perspectives to collect and interpret data about some phenomenon and therefore to converge on an accurate representation of reality.

Triangulation is vital because it raises the research above person biases by using different mutiple methods. Triangulation was achieved by this study through various techniques. As alluded above, this study has used various techiniques in achieving triangulation. Firstly, the study have used the reseacher triangulation. The study was allocated more than one polymath supervisors by the university in order to achieve intersubjetive agreement and they played a pivotal role in this study (Brink et al., 2012). Secondly, the study used data triangulation whereby the researcher used interviews, field notes and different sources. Finally, the research used qualitative, explorative, discriptive methods to achieve the dependability of the study. Therefore, it is considerable that the credibility of this study was reached.

### 3.10.3. Confirmability

The degree to which the findings of the research study could be confirmed by other researchers. Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but clearly derived from the data (Korstjens & Moser, 2017). The strategy used to ensure confirmability is called confirmability audit. The researcher attended seminar meetings at the University of Namibia and adhered to all decisions made during the research process, research team meetings, sampling and research materials adopted. Finally, an independent expert researcher from the different institution did the trail audit of the findings and confirmed the transparency of the research path.

### 3.10.4. Transferability

Korstjens and Moser (2017) defined transferability as the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. This means that the knowledge acquired in one context will be relevant in another and those that carry out the research in another context will be able to apply certain concepts originally developed (Holloway & Stephanie, 2010). To ensure transferability, the researcher provided a rich explanation of descriptive data, such as the context in which the research was carried out, its setting, sample, sample size, sampling method and clinical characteristics, inclusion and exclusion criteria, interview procedure and excerpts from the interview guide.

### 3.10.5. Authenticity

This term demonstrates that the findings of the study are representing the perspectives of the participants and the fairness of the study to help participants to understand their social world and improve it (Holloway & Stephanie, 2010; Brink et al., 2012).

**Table 2: Criteria for Developing Authenticity and their Applications**

<i>Authenticity</i>	<i>Application</i>
<i>Fairness</i>	The researcher maintained fairness in selecting the participants and gained their acceptance throughout the whole study. Researcher obtained the informed consent from the participant.
<i>Ontological authenticity</i>	This research made the participants and readers realize the emotional needs and their role in meeting emotional needs of patients through self-awareness of their own perceptions, perceptions of others and data gathered from different literatures.
<i>Educative authenticity</i>	Participants expressed the improvement in the way in which they understand the emotional needs of patients.
<i>Catalytic authenticity</i>	Participants decided to participate willingly and their rights was respected.
<i>Tactical authenticity</i>	The participants expressed that the study was a great learning opportunities and empowered them on their role in meeting emotional needs of patients.

### 3.11. SUMMARY

This chapter presented the methods employed by this study. It outlined the qualitative, exploratory, and descriptive designs used by the study. Furthermore, it identified the population of the study, the sample and sampling methods used, research instruments and the procedure followed during data collection. Additionally, the chapter dealt with how qualitative data was analysed. It further presented the explanation on how ethical considerations were followed. Finally, the chapter explained the trustworthiness of the findings. The next chapter will present the findings (themes and sub-themes) with applied literature control.

## CHAPTER FOUR

### DISCUSSION OF THE FINDINGS

#### 4.1. INTRODUCTION

The previous chapter has explained the methodology used by this study. This chapter will discuss the data analysis and further discuss the findings with quoted verbatim to support the findings. The data in qualitative study that was employed by this study is non-numeric and was in the form of written words transcribed from audio-recorders (Brink et al., 2012). The descriptions of qualitative findings are presented as verbatim quotes of participants. Face-to-face interviews were conducted with twenty (20) registered nurses at Engela hospital. Participants were selected using a purposive sampling method. Appointments were done according to the availability of the selected registered nurses. The participants were employed until the data saturates.

The main objectives of this study were to explore the perceptions of registered nurses on emotional needs of patients and to describe the roles of registered nurses in meeting emotional needs of patients at Engela hospital. Therefore, the two main question asked are (Tell me your perceptions on emotional needs of patients and Tell me your perceptions on your role in meeting emotional needs of patients). Probing questions were asked based on participant's responses.

Data analysis is not a distinct step in qualitative study; therefore it was done concurrently with data collection (Brink et al., 2012). The researcher started with managing and

organising data and interviews were transcribed. During the whole process the researcher's reflective remarks as meanings comes fore. Coding process commenced whereby patterns were found and produced meanings to categorise data in segments. Data was analysed manually through reviewing all recorded information that the researcher has obtained during data collection (Brink et al, 2012; Botma et al, 2010).

Theme is used as attribute, descriptor, element, and concept. As an implicit topic that organizes a group of repeating ideas, it enables researchers to answer the study question. It contains codes that have a common point of reference and has a high degree of generality that unifies. Each theme may have some subthemes as subdivisions to obtain a comprehensive view of data and uncovers a pattern in the participants' account (Vaismoradi et al., 2016). The findings are discussed and supported with existing literatures whether they agreed or disagreed.

#### 4.2. DISCRPTIONS OF RESEARCH FINDING

Themes are defined as the major findings of the study which are used to create headings (Botma et al., 2010). The researcher used a narrative passage to convey the findings of the analysis. Finally, themes and subthemes are discussed in details with interconnecting themes. Four themes were identified displaying different perspectives from individuals and are supported by diverse quotations and specific evidence. Table 4.1 below show the themes and sub themes on the perceptions of registered nurses on their role in meeting emotional needs of patients.

**Table 3: Presentations of themes and sub-themes of participant’s perceptions**

Themes	Sub-themes
<p><b>Theme 1: Participants perceived different negative emotions experienced by patients during hospitalisation.</b></p>	<ul style="list-style-type: none"> <li>• <b>Anger</b> emotions</li> <li>• <b>Hopelessness</b> emotions</li> <li>• <b>Depression and anxiety</b></li> <li>• <b>Fear</b> emotions</li> <li>• <b>Shame</b> emotions</li> <li>• <b>Shock</b> emotions</li> <li>• <b>Denial</b> emotions</li> </ul>
<p><b>Theme 2: Participants perceived psycho-social and physical factors that contributes to patients emotions</b></p>	<p>Physical factors [pain, diagnosis, medicine, financial challenges]</p> <p>Social factors [fear of stigma, isolation, relationships]</p> <p>Psychological factors [mental illness]</p> <p>Spiritual factor [Cultural and religious distress]</p>
<p><b>Theme 3: Participant perceived different roles in meeting emotional need</b></p>	<ul style="list-style-type: none"> <li>• Reassure</li> <li>• Counsel</li> <li>• Refer</li> <li>• Allow personal preferences</li> <li>• Render holistic care</li> </ul>

**Theme 4: Participants perceived barriers to fulfill their role in meeting emotional needs of patients**

- Nurse-related barriers[ Shortage of human resources, lack of knowledge and experience and neglecting emotional care]
- Administrative related barriers[ Lack of privacy]
- Patient-related barriers[ Lack of freedom]

#### 4.3. DISCUSSION OF THEMES

4.3.1. Theme 1: Participants perceived different emotions during patient's hospitalisation that needs to be met

The findings of this study describe how participant perceived different emotional needs within their patients that needs to be met. Participants described different negative emotions that patients experience under their care. According to Shamsavaran and Noohi (2014) emotions are subjective, biological, goal-directed, and are a social phenomenon. Therefore, patients with clinical depression have experiences of negative emotions such as anger, fear, loneliness, sadness, and hopelessness. Most of us feel anxious or depressed at times. A death in the family, losing a job or home, separation and divorce, financial instability, a severely ill child or self, the list is endless. Feelings of sadness, loneliness, fear, hopelessness, stress, and anxiety are normal, and they usually pass with time. However, if they interfere with daily activities, they can cause high level of distress, or

occupy your mind endlessly, you may have an anxiety disorder or depression or both. Several studies found that majority of the discharged patients reported experiencing problematic emotional reactions post-discharge (Asghari & Arabi, 2019; Stroke Association, 2012). Strengthening the above, one participant agrees to that as follow

*P14*“I do understand and believe that patients they do have emotional needs but in most cases we, we as nurses we fail to recognize or to pick up the emotional needs of the patient and then we help them if they might need help or maybe we refer them to the correct department for help to solve that emotional issues.”

According to (NICE, 2009) as cited by Currid (2012) the guideline on depression in adults with long-term conditions outlines the negative consequences that patients experience in their quality of life along with the associated costs to their families, health service and communities. Currid (2012) further argued that considering the evidence that exists in patient presentations with negative emotions, there can be no doubt about the importance of actively engaging in strategies that seek to address the psychological needs of the physically ill. Nevertheless, NHS (2012) agrees that people with long-term physical health conditions will often have psychological and emotional needs resulting from the burden of illness-related symptoms, the disability associated with the physical illness, and the impact of living with more than one physical condition at any time. This study also agrees that chronic conditions contribute negatively to the emotions of patients. One participant explained that

*P9* “it can be due to taking medication forever, like for the rest of their life. So not everyone likes taking medication, it’s just so stressful or they might just be emotional, so some of them may end up throwing the medication just because of that, so yeah”

The study done by Taylor et al (2016) further established that as a result of difficulties related to their illness, diagnosis and treatment, patients with end-stage renal disease experience significant emotional and psychological problems, which untreated can have considerable negative impact on their health and wellbeing.

#### 4.3.1.1 Sub-theme 1: Anger emotions

Anger is probably one of the mostly debated basic emotions, owing to difficulties in detecting its appearance during development, its functional and affective meaning especially in human beings (Williams, 2017). Anger could be considered as desirable, because it is a way for a human to show off her/his negative feelings. Nevertheless, Shahsavaran and Noohi (2014) indicated that high levels of anger cause many problems such as blood hypertension and other bodily changes resulting from anger, make thinking and decision-making procedures difficult and may harm physical and mental health. Anger is recognised as being associated with a risk of developing disease therefore prolonged moods of anger deserve more attention. This evidence is supported by a participant who agrees that chronic medication may be caused by emotions.

*P14* “let me say the patient came to me with high blood pressure but then I will not focus on the blood pressure itself but I fail to ask questions to see if the patient might have a social problem at home, might be financial

*problem, marriage problem, relationship problems or anything that might cause the high blood pressure which might, that failure might lead to poor prognosis of patient.”*

Anger is an emotion, however, scholars agrees that anger can lead to aggressive behaviour (Shahsavaran & Noohi, 2014). When patients feel abandoned or neglected may sometimes feel frustrated. This frustration can turn into anger toward oneself or other people. Another participant agrees to the danger of anger and indicted that patients becomes aggressive when angry.

**P9***“also anger, anger can also, is one of the emotional needs to the patient..... : it can be due to taking medication forever, like for the rest of their life. So not everyone likes taking medication, it’s just so stressful or they might just be emotional, so some of them may end up throwing the medication to you or away just because of that, so yeah”*

#### 4.3.1.2. Sub-theme 2: Hopelessness

Grassi et al (2010) defined hopelessness as a subjective and affective state characterized by a negative view of the future, a sense of loss of control, confidence, courage, and the energy to achieve one’s own goals. It is agreed that most patients with chronic disease become depressed and later become hopeless therefore the nurses should first look for problems such as suicidal ideation and hopelessness in these patients so that they can take the necessary steps to speed up patient adjustment and prevent complications of these disorders (Sarabi, 2020). Patients sometimes are reported loose hope and giving up on

their treatments. In this study, some of the participants agreed with the above statement saying:

*P20* “Let me say you find a person with mental problems who come to the hospital and tell you that is tired of that condition. I am taking my medication but I am taking this medication every day and I am tired.”

*P1* “Sometimes you find them crying and sometimes you find them feeling down just hopelessness, and sometimes angry which may cause problems like high blood pressure, even the heart cannot be pumping very well, it can affect vital.”

It is believed that, hopelessness is a major emotional problem in several patients not only to those diagnosed with chronic conditions. Majority of the participants expressed different complications from hopelessness in patients. These complications may affect the patients themselves or those that are close to them. Majority of the participants perceived different causes of hopelessness in patients.

To reinforce the above ideas, the participant said:

*P4* “A woman can come in, a pregnant woman, maybe the woman is pregnant and the father does not want that pregnancy. Maybe the father or boyfriend or whatsoever don’t support the woman. The woman might have emotional needs, not wanting the pregnancy or she doesn’t have something to satisfy her needs.”

#### 4.3.1.3. Sub-theme 3: Depression and anxiety

Majority of patients with depression are reported to have anxiety (Tiller, 2013). You may worry about feeling uncomfortable, appearing foolish or how successful you will be. In turn, these worries can affect your sleep, appetite and ability to concentrate. If everything goes well, the anxiety will go away. However, if the anxiety does not go away, and becomes a regular part of a person's life then it might said to be an anxiety disorder (Haddan et al., 2011). The researcher is of the belief that every negative emotion in the patient should not be taken lightly because it might hinder the healing process.

The preoperative is considered the stage in which the individual becomes more vulnerable for their needs, particularly the psychological needs, becoming more prone to an emotional imbalance, anguish, fear, often translating into anxiety and depression (Gomes et al., 2019). The hospitalisation for surgical reasons, even non-surgical ones has already great consequence in the levels of anxiety. Following is the participant's quote as a strengthening statement.

*P3 "We are talking about people who are coming and that person is going, the doctor order caesarean section and that person is having anxiety that might stay longer with that patient. That anxiety may cause a problem to the patient. For you as a nurse you should know how to remove that anxiety before person undergoes caesarean section."*

According to Apóstolo, Figueiredo et al (2011) the severity of depression is determined by severity of patient's individual affective-emotional state.

*P3 “Another case, we also use to meet patients who are coming and then the patients don’t take medication because is stressed or depressed. You want to give medication but the patient refuse. It is the right of the patient not just to force her to drink medication without her consent. Our patients are affected differently; some take their conditions too serious while some do not.”*

Therefore, it is believed by this study that depression may have been caused by diagnosis at many times or other social problems such as family issues, being neglected by friends and relatives (not being visited during hospitalisation).

To strengthen the above point, two different participants mentioned as below.

*P3 “And we also use to meet patients who are coming and they lost their babies while in our hands in the wards. You can also as a registered nurse, you need to know how to deal with that mother because is not easy for them to come to the hospital and just loose the baby like that, patient can be depressed or stressed, sometimes not eating, crying and just overthinking.”*

*P6 “But here in Engela we meet different patients with different emotional needs, for example you can meet patients coming here so stressed or frustrated either from home or either stressed by certain staffs member from at a certain department.”*

The negative impact of distressed mental states such as depression and anxiety on recovery and relapse is increasingly understood (Gilbert, Shame and the vulnerable self

in medical contexts: the compassionate solution., 2017). As argued by Gilbert, this study concur that depression and anxiety affects the prognosis of the patients. Thus, the participant related as below.

*P14* “To give example: let me say the patient came to me with high blood pressure but then I will not focus on the blood pressure itself but I fail to ask questions to see if the patient might have a social problem at home, might be financial problem, marriage problem, relationship problems or anything that might cause the high blood pressure which might, that failure might lead to poor prognosis of patient. Because we will not focus to the high blood pressure, you give the patient the medication, the blood pressure will get like better or drops at that moment but still patient will come one of the day with the same problem because the cause of the problem you did not target.”

#### 4.3.1.4. Sub-theme 4: Shame

According to Gilbert (2017) shame is one of our most powerful and important social emotions. It has a major impact on our experiences ourselves, others and our relationships, and physiological state including ones conducive to illness and vulnerability and recovery. Shame is immediately related to the other’s gaze. Typically, it arises in situations of disclosure or rejection. Shame pertains to a painful focus on the self (Gambina & Sharp, 2018). Behind the feeling of shame stands the fear of abandonment, the death by emotional starvation or medication rejection (Dolezal & Lyons, 2017). This study shares the same thought that shame arises from rejection of others, but it will cause

damage to self. Majority of the participants pointed out that out of shame many patients take decision that might interfere with their healing process. Below are the direct quotes from participants as narrated.

*P2 “As a registered nurse is just to rule out and act according to the needs. Some might be shameful on their diagnosis that may affect them from taking their medication and hinder healing process.”*

People with chronic illness mostly suffer rejection or avoidance which leads them into shame. The illness-related shame has a negative impact on psychological health and the quality of social relationships (Gilbert, 2017). Furthermore, resisting feelings of compassion and care from others and avoiding difficult internal experiences seem to underlie the impact of shame on psychological and social functioning in patients. Therefore, this study affirms that resisting feeling of compassion of patients in the community impact their life holistically. In support, another participant agreed perceiving shame in patients due to social rejections.

*P4 “Or maybe is a teenage. You know teenage doesn’t know what to do much when going into sex and when the pregnancy comes out now that pregnancy is unwanted so the person is feeling shame how will she go back to school to meet her classmate or the community now she may want to make abortion or kill the baby, she is afraid on how others will treat her, so you have to identify is the woman happy with the baby, is she treating the baby nicely feeling that is her baby.”*

#### 4.3.1.5. Sub-theme 5: Fear

Fear can cause patients to react in various ways to the proposed plan of medical evaluation, including resistance or noncompliance. According to Sepúlveda-Plata, García-Corzo and Gamboa-Delgado (2016) several factors, which can be classified as external or internal, may cause fear before surgery. External factors include the type of surgery, the quality of medical care, strange environments, lack of privacy in the rooms and surgical environments, undergoing anesthesia and lack of social support. On the other hand, internal factors include age, sex, socioeconomic status, occupation, physical condition, fear of hospital environment, personality type, internal locus of control, poor tolerance of ambiguity and emotion-focused coping. Some of the participants perceived patients who reacted differently to fear within the hospital. To strengthen the point, the participant noted below.

*P9 “One of the negative emotions of a patient can be fear, this fear can be due to pain, patient may be in pain and might be in fear that; maybe this pain might cause something more harmful than what the patient is having, like maybe the patient can have the fear of death or something like that.”*

Fear has a major negative impact to the healing process. Some patients are afraid of going to the hospital due to different reasons such as fear of injection, fear to be diagnosed with a chronic disease or even fear to be infected by other infections within the hospital facilities. In the study done by Sutcuoglu, Yazici, Ozet, and Ozdemir, (2020) on harmful consequences of covid-19 fear in patients with cancer, three patients who knew that delaying cancer treatment can be life-threatening, they were concerned about contacting

the hospital because they are afraid of becoming infected with COVID-19. Fear can also impact the surgery treatment. Fear experienced by patients before a surgical intervention is caused by the psychological stress to which they are exposed therefore they can complicate the surgical procedure (Sepúlveda-Plata, García-Corzo, & Gamboa-Delgado, 2016). Therefore, this study agrees that fear is a negative emotion that needs nursing intervention for patient's well-being.

#### 4.3.1.6. Sub-theme 6: Shock and denial

Shock and denial are two stages that affect the person when is diagnosed, especially with a severe or chronic illness. The patient at the shock stage does not believe that a severe illness has affected him while the denial stage created by the suspicion and unbelief of the patient by denying the disease trying to maintain its mental condition (Asghari & Arabi, 2019). Asghari and Arabi show that incurable dying patients' psychological suffering is due to the feeling of solitude and meaningless life. Even when thinking about it, many people are afraid of death; death has disturbed their daily lives and created a sense of insecurity and psychological distress in them. The researcher believes that patients might not take it easy with their severe diagnosis thus they may react to shock as unimaginable or denial as never experienced.

*P2 “Client or patient might react differently. Might be in denial, some of them might be in shock due to their diagnosis, you have to rule out how they react.”*

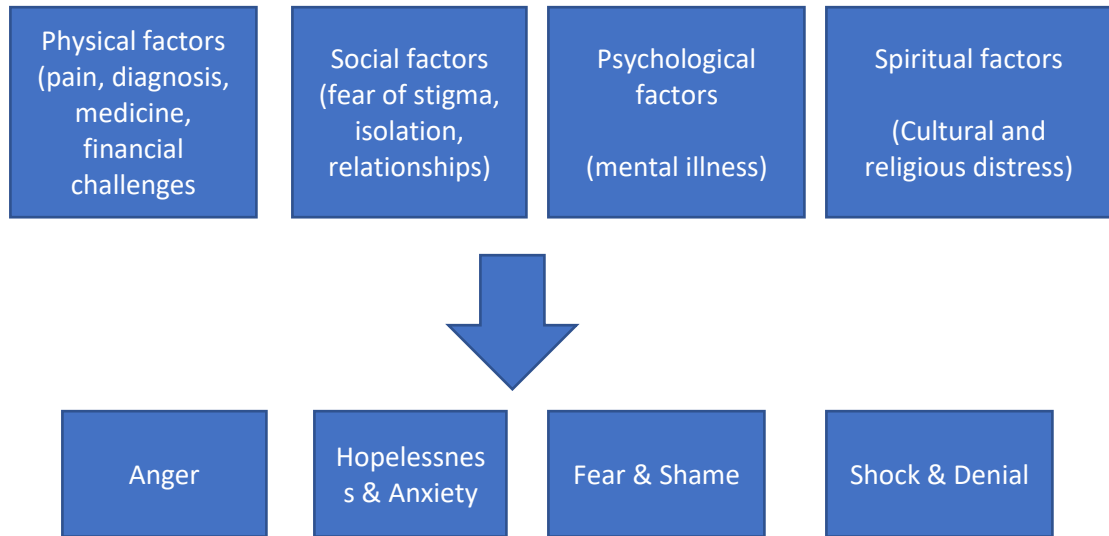
Shock and denial are regarded as a normal stage of grief (Tyrrell, Harberger, & Siddiqui, 2021). Notably, shock and denials forms part acceptance stage (Asghari & Arabi, 2019).

However, sometimes patients would often deny the reality of the new information after the initial shock of receiving a terminal diagnosis. Patients may directly deny the diagnosis, attribute it to faulty tests or unqualified health personnel, or simply avoid the topic in conversation (Asghari & Arabi, 2019). Therefore, the findings of this study reveal that, shock and denial can also be a negative impact to patients' well-being as it can hinder the treatment and healing process.

*P8 "Sometimes you find patients shocked about what you tell. Of courses if you tell the mother the child is dead while in the womb will be shocked and is even there denying it that noooo my child was moving, maybe is just your machine problem and so on until she get that proof after birth"*

*P2 "Client or patient might react differently. Might be in denial which can affect them not to take their medicine, some of them might be in shock due to their diagnosis, you have to rule out how they react."*

4.3.2. Theme 2: Participants perceived psychological, social and physical factors that contributes to patients’ negative emotions



**Figure 2 Emotions and their contributing factors**

4.3.2.1. Sub-theme 1: Physical factors

Dawn and Prothero (2012) defined physical as material things or relating to the body. This study explored physical factors that contributes to patients negative emotions such as pain and diagnosis, medicine and economical/financial challenges.

A. Pain and Diagnosis

Pain is a state of localized discomfort that ranges from mild distress to acute agony; usually caused by injury to the functioning part of the body or experienced during childbirth (Dawn & Prothero, 2012). Majority of the participants indicated that negative emotions arise in patients due to pain. As agreed by the participants, the negative

emotions, irritability, and feelings of anger that often affect patients with pain have a negative impact on the prognosis or contribute the severity of the disease (Duenas et al., 2016). Some of the participants strengthened the point of pain as quoted below.

*P9* “okay thank you, one of the emotional needs of a patient can be fear, this fear can be due to pain, patient may be in pain and my might be in fear that maybe this pain might cause something more harmful than what the patient is having, like maybe the patient can have the fear of death or something like that”

*P15* “Even pain sometimes the patient is more in pain or too much sick she/he may feel emotionally distressed. Sometimes you find them crying and sometimes you find them feeling down just hopelessness, and sometimes angry which may cause problems like high blood pressure, even the heart cannot be pumping very well, it can affect vital.”

## B. Medicine

Medicine is drug used to treat patients. Dawn & Prothero (2012) defines medicine as drug. Patients emotions is affected diferently when taking medicine they get from the hospital. In this study, participants indicated that they percieved patients with negative emotions due to the taste, amount, period or odor of the medicine. Therefore, the findings of this study demonstrate that some patients are in emotional distress because the of the type, number of tablets to take, smell and sixe of the medicine they received and that may have have affected their adherence and healing process.

To reinforce the above view, participant was quoted as below:

*P1* “Some people come with misunderstanding of medicine. Example a person is given medicine and come saying this medicine make (sic) this and that to me then start refusing medicine. While others get tired using or taking medicine saying they are not tasting good or smelling good.”

### C. Economical/Financial challenges

Witherspoon (2017) Financial challenges is commonplace in today's society. Unfortunately, the effects of this stress may go far beyond the stress itself. While many individuals are able to cope with financial stress and adapt, others cannot. As a consequence, potential long-term implications from an inability to cope with financial stressors may be problematic and lead to such things as poor physical health, diminished well-being, and reduced social functioning (Witherspoon, 2017). Majority of the participants agrees that some of the patient's negative emotions rise from economical or financial challenges. Therefore, the study attest that the consequences of lack of finance to cater the basic needs of patients may lead patients to a prolonged negative emotions or affect their well-being. To support the ideas the participants said:

*P4* “Maybe the father or boyfriend or whatsoever don't support the woman. The woman might have emotional needs, not wanting the pregnancy or she doesn't have something to satisfy her needs. We know the emotional needs

*how they affect the woman. The women doesn't work, doesn't have anything to support the baby now you have to identify those needs. What kind of needs the woman have. Maybe doesn't have the source of money to buy things for the expected baby. You can even read from the face of the woman, is the woman happy. Her expression facial can tell you. Sometimes the woman can cry without any reason."*

Another participant narrated as follow:

*P8 "So far I can only say that, most of the things happening here, like let me just say the patient came here for labour she delivers, she says she doesn't have money to pay, or maybe transport money or no one is visiting her and she needs some of the, those things we are using as women, the pads, the cosmetics in general."*

*P14 "Let me start with financial problems. Financial problems, let me say the patient might have kids who are studying for example at UNAM maybe one or two. Like now we are in this world of covid with problems of economy goes down because of the covid. The patient might be lost job because of covid, but the kids they are still at school and they are asked for money, they are maybe denied to write exam because of the account are not settled. The patient can develop high blood pressure because he or she will continue thinking on what to do to help the kids at school mmh."*

#### 4.3.2.2. Sub-theme 2: Social factors

The participants identified that there social factors leading to negative impact in patients such as discrimination, isolation and relationship problems.

##### A. Discriminations

Research suggests that perceived ethnic discrimination is associated with poor psychological and physiological health. Rumination, or perseverative thoughts about negative experiences, may constitute a maladaptive coping strategy that mediates the associations between perceived discrimination, emotional distress, and aggression (Borders & Liang, 2011). The findings of this study depict that if the patients are being discriminated unto, it doesn't matter of their diagnosis, that patient might be led into prolonged-negative emotions.

To motivate the above opinion, the participant stated:

*P15 “The emotional needs are a lot. For example, the patients may feel the families are not really taking care of them, mostly on their diagnosis, they sometimes say they are blaming them of their diagnosis and avoid associating with patients.”*

##### B. Isolation

Isolation may potentiate the adverse effect of negative emotions (Denollet et al., 2005). Some patients are in isolation due to their diagnosis as recommended by the health personnel while others are in isolation due to fear of discriminations. A person in a prolonged isolation may develop negative emotions that can affect well-being and healing negatively.

To empower the above statement, the participant mentioned:

*P13* “My perception on emotional needs of patients in this are; sometimes the patients has to come with some symptoms for example TB, whereby a patient has to be told by a doctor that, you have this type of sign concerning about the test results in case the ward is full, the person has to be told by a doctor just to be in a single room but, the moment you tell the patient that you need to be separated from others, they use to feel emotional and some may even start crying, stressing and remain thinking badly in that room.”

*P4* “Or maybe is a teenage. You know teenage doesn't know what to do much when going into sex and when the pregnancy comes out now that pregnancy is unwanted so the person is feeling shame how will she go back to school to meet her classmate or the community”

### C. Relationship problems

The study done by Liu et al (2009) on the relationship between psychosocial factors and onset of multiple sclerosis found significant differences between the two groups in the total number of negative life events, their family problems and the utilization of social support. Many kinds of negative emotions in the multiple sclerosis groups correlated positively with the total number of life events, negative life events and family problems. Many kinds of negative emotions in the multiple sclerosis groups correlated negatively with the utilization of social support. This could mean that social factors can cause negative emotions that may further cause serious problems or disease to patients.

Participants perceived or experienced patients with negative emotions arising from lack of social support as mentioned below.

*P7* “Some patients have problems with their families, boyfriends, husbands and they use to be stressed.”

*“Yeah, the person can come to the hospital high blood pressure just because they are having misunderstanding at home with the husband or with the wife but than if we could ask more and then the patient give us what is there at home, what is really the problem at home we might help them because sometimes it's just a simple problem that the patient just need counseling.”*

#### 4.3.2.3. Sub-theme 3: Psychological factors

As cited by Sumpi and Amukugo (2016) (Peterson, 2009) understands that psychological factors can affect the thoughts, feelings, attitudes, and other cognitive or affective characteristics of an individual that influence the way in which he or she behaves. Majority of the participants pointed out mental illness as a psychological major cause of negative emotions among patient.

*P20* “There are a lot of emotional problems in our society in our people. There are also mental problems. You find a mental problem. Let me say you find a person with mental problems who come to the hospital and tell you that is tired of that condition. I am taking my medication but I am taking this medication every day but I am tired.”

#### 4.3.2.4. Sub-theme 4: Spiritual factor

Spirituality is experienced, formed and expressed through a wide range of religious narratives, beliefs and practices, and is shaped by influences in the family, community, society, culture and nature. It is often expressed as a relationship with God, but it can be found in nature, art, music, family, community or whatever beliefs that give a person a sense of meaning and purpose in life (Chandramohan, 2013). It is demonstrated by the findings of this study that if the spiritual needs of hospitalized patients such as religious, cultural, social and all that made patient realize meaning of life are not cared for, can result in emotional distress. To support that idea, participants explained as follow:

*P19* “Because the question to rise is either we do not attend to patients according to their cultural believes that is going to cause emotional trauma. I can also view it in the perception of religion needs. Where religious have differences like eeeee... (Scratching face)... Some people are catholic and others. There are some perceptions to use like some religious say don't do ABC... one with different religious have different needs and if not considered will cause emotional distress to the patient as well as personal dignities as a human being and in the process may end up hurting patients”

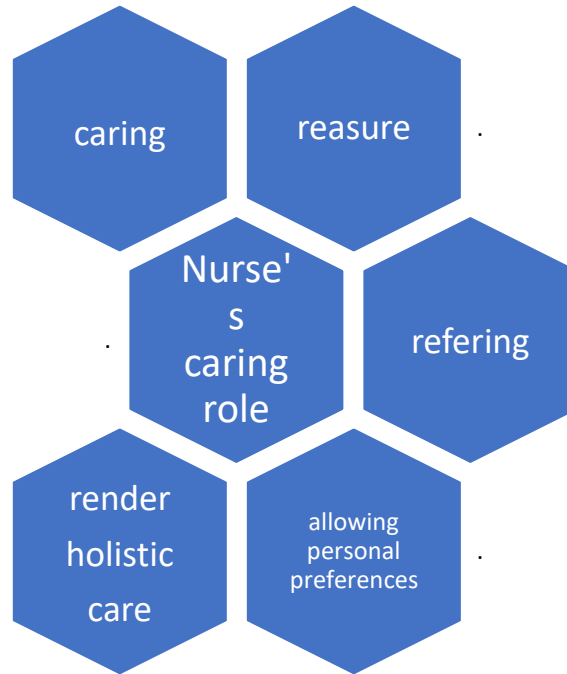
Caring for the spiritual needs of patients is a highly significant yet often neglected and misunderstood aspect of health care. Patient understandings of spirituality and their ability

to speak about it can have an impact both on their level of engagement in this area and the degree to which spirituality can be integrated into their care (Brémault-Phillips, et al., 2015). The findings of this study affirm that spirituality influences patients' emotion, however, if patients do acknowledge and engage their spirituality, the necessary help can be availed.

*P2 “My role is to take care of the patients, to allow personal choices  
..... So allow personal choices maybe he or she likes listening to  
the radio, watching TV you can find a room for that person just for  
support.”*

#### 4.3.3. Theme 3: Participant perceived their roles in meeting emotional need

After participants concurred to the emotional needs of patients, they further perceived their different roles in meeting emotional needs and will be discussed. The perceived roles of registered nurses on meeting emotional needs of patients are presented in the following figure and discussed thoroughly.



**Figure 3 Perceived roles of registered nurses in meeting emotional needs of patients**

#### 4.3.3.1.Sub-theme 1: Reassure

Participant pointed out their role of assurance to patients in with negative emotional. This concurs with (Asghari & Arabi, 2019) that reassurance is one of the most important therapies that primary care health givers give. Traege et al (2017) defined reassurance as the removal of fears and concerns about illness. Majority of the participant mentioned reassurance as their first role to care for their patients emotional needs. The findings of the study reveals that reassurance is most needed to patients to overcome negative emotion during nursing care. This statement is being empowered by the following words of the participants.

*P9 “Like when it comes to fear, you just need to reassure the patient. Sit with the patient, reassure the patient that everything will be fine, just give supportive....., reassure them, explain to them that whatever is happening to them, they must just be strong, they must just take their medication, explain more about their disease, some disease can be curable in the process, not really curable but they become better as they are taking their medication. Just explain to them everything to make them feel better. Make them feel safe also and what else just give support.”*

*P7 “My role as a registered nurse, mmhhh... Let’s say for example a patient comes in with labor pain, I have to inform and reassure the patient that labor is natural there is nothing that can be done and the pain should stop when the baby is delivered”*

#### 4.3.3.2.Sub-theme 2: Counseling

Some of the participants perceived their role of counseling a patient with negative emotions. Counseling is a process by means of which the helper expresses care and concern towards the person with a problem (Kamuzu College of Nursing , 2012). In the framework of nursing, nurses also play a counseling role. Initiation of counseling is important because the nurse often acts as the trigger for the counseling relation (Molina-Mula et al., 2020). A need for counseling is a clinical judgment made by the nurse and his/her response will be immediate situational counseling, continuing counseling sessions, or referral (Peplau, 2012). The role of the nurse with counseling abilities is to rehabilitate the patient physically, spiritually, and psychologically and to assist him to regain his previous personal and social roles in the best possible way. As a result, the findings of this study indicate that nurses have a major role of providing primary counseling to patients with negative emotions and keep on observing the patients for improvements or emotional recovery. This analysis is supported by the participant as follow.

*P5 “And the third one is to Counsel. So the patient can be more in stress that need more counseling and we are the first people to consult the patient so we don’t need to let them go with those problems so we need to tell and counsel them at first.”*

Nursing counseling of the patient can be as health education. The information and education offered to patients through nursing interventions can reduce preoperative fear, anxiety, hopelessness, shame and increase the degree of satisfaction and well-being in patients and, therefore, the quality of care provided to them (Sepúlveda-Plata, García-Corzo, & Gamboa-Delgado, 2016). It is evident that every nurse counsel patient (Hardy

& Winship, 2013). These can happen during their daily engagement with their patients as they provide comfort and reassurance.

*P9 “Reassure them, explain to them that whatever is happening to them, they must just be strong, they must just take their medication, explain more about their disease, some disease can be curable in the process, not really curable but they become better as they are taking their medication. Just explain to them everything to make them feel better. Make them feel safe also and what else just give support.”*

#### 4.3.3.3. Sub-theme 3: Refer

Almost, every participant perceived the role of referring patients with emotional needs to the next level or other disciplines. After counseling, participants argue that they assess their patients to assess whether their counseling was effective, if they realized it was not effective, they report the case to the doctor or refer to social worker, pastors and psychologists. However, some participants believe counseling is not their role but they are to refer to social workers. Effective treatment of patients is not the privilege of a health care professional, but it is a combined approach by all of them (Kamuzu College of Nursing , 2012).

Nurses, because of the nature of their work, can have a deeper understanding of the patient’s condition, through their increased contact with the patients. They also have the chance to achieve homogeneous care, by ensuring continuation of contact with the patient. However, for the treatment to be effective, patients, and health professionals should work

as a team. Evaluation of the patient's needs and of the appropriate intervention is based on the understanding of what is physiologically happening to the patient, on the possibility of positive response by the patient himself and by his caregivers, and on the resources that can assist the situation. Therefore, registered nurses as the custodian of patient care plan; they are to observe and diagnose patients physically and emotionally and report or refer those that they cannot help. To strengthen these points the participants explained as follow.

*P6 "As nurse you should be able to refer the patient to a next level"*

Furthermore, this participant explained that

*P6 "Talk to the patient, try to counsel the patient and if you are not able refer to a social worker or psychologists if you have one in hospital"*

Another patient explained that they refer those that are above their ability as follow.

*P14 "If I see the patient is having an emotional issue while with me and I try to talk to the patient individual and I see it's beyond my capacity, I have the responsibility to refer the patient to social worker for professional counseling."*

#### 4.3.3.4. Sub-theme 4: Allow personal preferences

In all health systems, responding to the needs and wishes of patients is a crucial priority (Jouyani, Barouni, Dehnavieh, & Bahrapour, 2013). Staff performance and their behavior help the patient feel more comfortable in the new situation. Furthermore, Jouyani et al (2013) argued that the staff behavior has a significant effect in reducing emotional

needs of patients. Patients know and understand their most-inner part better. Therefore, in emotional needs, their personal preference should be considered to soothe their emotions. Participants perceived patients who had personal preferences in meeting their own emotional needs or conquer their negative emotions. Below is the participant's narrative to support the above.

*P2 "My role is to take care of the patients, to allow personal choices ..... So, allow personal choices maybe he or she likes listening to the radio, watching TV you can find a room for that person just for support."*

#### 4.3.4. Theme 4: Participants perceived barriers to fulfill their role in meeting emotional needs of patients

Even though Hill, Evans, and Forbat (2015) illustrated that meeting emotional needs is considered a central component of nursing care. Participants' perceived barrier in meeting those needs. Majority of the participants agrees that they hardly meet the emotional needs of patients due to different barriers. This is strengthened by a participant quoted as below.

*P14 "I do understand and believe that patients they do have emotional needs but in most cases we, we as nurse we fail to recognize or to pick up the emotional needs of the patient and then we help them if they might need help or maybe we refer them to the correct department for help to solve that emotional issues"*

The barriers are discussed as follow

#### 4.3.4.1. Sub-theme 1: Nurse-related barrier

Nurse-related factors are those things that act as a barrier to meeting emotional needs of patients that are caused by nurses or nurses related issues. This study identified shortage of human resources as the main and major contributing factor to unmet emotional needs of patients. Nurse-related factors are discussed as shortage of human resources and time pressure below.

##### a) Shortage of human resources and time pressure

Majority of the participants mentioned shortage of staff as a barrier to execute their role of meeting emotional needs of patients. Furthermore, participants exemplified that shortage of staff keeps them busy and leave them tired unable to meet emotional needs of patients. In the same concurrence, Sagheria et al (2017) agreed in their study that hospital nurses are expected to maintain optimal work performance; yet, fatigue can threaten safe practice and result in unfavorable patient outcomes. In addition, the unbalanced nurse-patient ratio due to nurse shortage and large number of hospitalized patients, nurses are expected to do nonprofessional tasks such as coordinating, transporting patients and performing ancillary services which leading to increased workload. This excessive workload definitely affects the nurses' decision to allocate enough time to various tasks such as communicating with patients and their education (Karimi et al., 2016). Therefore, the researcher holds a judgment that staff shortage diminishes the role of registered nurses in meeting emotional needs of patients because of the work load when caring for the physical illness. To strengthen this point, the participants mentioned:

*P14* “We truly fail, maybe is because of time because many times we are busy with patients physical illness due to shortage of staff.”

When another participant was asked about the challenges in his or her role in meeting emotional needs of patients, participant illustrated:

*P15* “There are many challenges especially in this hospital..... sometimes we are few in the ward like shortage of staff. We can't really manage to care as required as how private hospitals do. We are few and always busy”

Nursing work is often characterized by a shortage of time to deliver patient care (Chan et al., 2013). Majority of the participants have also indicated that they have a challenge of time because of work load. Having more time can result in delivering quality nursing care to patients. Whenever there are less nurses being available for patients, the resulting time restriction dissuade the nurses from providing holistic care to patients (Karimi et al., 2016). The findings of this study establish that shortage of nurses can lead to insufficient time to care or meet emotional needs of patients. To reinforce the point, the participant mentioned:

*P15* “Shortage of staff can lead to lack of time. Whereby, the staff will not have enough time to help patients with their emotions.”

Another participant mentioned:

*P3* “I have met many challenges with the shortage of staff which make the work to be loaded to the staff whereby one nurse can be attending to 10 patients for instance like the nurses and patient ration is not correlating at all. Therefore, a nurse cannot get enough time to attend to that specific patient.”

b) Lack of knowledge and experience

Some of the participants indicated that they could not be able to meet the emotional needs of patients because they do not possess or acquired enough knowledge and experience on meeting or dealing with emotions. This concurred with Chandramohan, (2013) findings that some nurses received no training on emotional and spiritual care while other nurses received unsatisfactory or inadequate trainings leading to their lack of knowledge in clinical practice. When asked about their role in meeting emotional needs of patients, a participant answered:

*P18 “I truly feel we need to care for our patients holistically. I also feel is our duty to identify their problems. But I do not have enough knowledge on how to care for emotional needs of patients. I did not read much about emotional care or maybe is just because I do not have enough experience perhaps.”*

Another participant answered as follow when asked on why they do not meet patient’s emotional needs.

*P12 “Because sometimes we can be too busy and or not having enough knowledge on how to help. That is why I said we refer to pastors, social workers, and psychologists.”*

Congruently, experience is important for nurses, along with the need for continuous reflection. Junior nurses might not have good communication skills and also lack an understanding of the patients’ health conditions; thus, they might be unable to provide comprehensive care to patients (Chan, Tsang, Ching, Wong, & Lam, 2019) .

c) Neglecting emotional care

Majority of the participants perceived their role in meeting emotional needs of patients; however, some of the participants indicated that they neglected the emotional care. Respectively, Chan et al (2019) concurred that nurses tend to accord the highest priority to required tasks with immediate and visible effects, and the lowest to emotional care. In the nursing services there are psychological, emotional, or spiritual needs on one hand and physical needs on the other hand (Jouyani et al., 2013). When asked about his or her perception in meeting emotional needs of patients; the participant responded with the concern of negligence of emotional needs of patients among nurses with no valid reason as follow.

*P6 “My perception on emotional needs of the patient I do understand and believe that patients they do have emotional needs but in most cases we, we as nurses we fail to recognize or to pick up the emotional needs of the patient and then we help them if they might need help or maybe we refer them to the correct department for help to solve that emotional issues”.*

When asked about their role in meeting emotional needs of patients, another participant accepted there is negligence of patient’s emotional needs as a result of work load and time pressure.

*P15 “Sometimes can even promise to come help the patient and forget due to work load”*

Majority of the participants understands the implications of neglecting emotional needs of patients such as depression and prolonged hospitalisation. However, the happen to neglect their role with or without reasons.

*P14*“Not identifying the emotional needs can make a patient to be with us for a long time because is not going to heal anytime soon. But we fail to care for the, the mind or emotions maybe is because we are busy or is just a habit”

#### 4.3.4.2. Sub-theme 2: Administrative related barriers

Administrative related factors are the factors that can act as the barrier to meeting emotional needs. These barriers are mostly caused by administrative factors such as architectural and policy related. Therefore, administrative factors are discussed under the heading of lack of privacy as illustrated by participants.

##### 4.3.4.2.1. Lack of privacy

Some of the participants indicated that they do not have privacy to talk to their patients once they identified some emotions. According to participants the admission room accommodates more than four patients making it difficult for privacy and confidentiality. Furthermore, in such environment patients may not be free to speak out their emotions with their caregivers. A patient's right to privacy involves the confidentiality of information related to the patient and bodily privacy of the patient (Demirsoy, 2016). When asked based on his or her answer about barriers on their role in meeting emotional needs of patients, the participant answered as follow.

*P3*“Another challenge is that we don't have enough space in the hospital, like there is no private room to talk to patient in privacy. That remains a challenge also”

#### 4.3.4.3. Sub-theme 3: Patient-related barrier

Patients can also act as a barrier to meeting emotional needs. Therefore, emotional factors are those things that act as a barrier to meeting emotional needs caused by patients. Lack of freedom in patients to communicate their emotions or distress was identified as a hindrance to meeting emotional needs and is discussed as follows.

##### 4.3.4.3.1. Lack of freedom

Patients are at a time of crisis in their lives. Some of the participants indicated that patients sometimes are not free to communicate their emotions. There are numerous reasons that a patient might have initial mistrust. They might have had a bad experience with other doctors. They might have been given incorrect information about the health professional or about the cancer centre. Many patients don't trust established medicine in general. The participant is quoted explaining the lack of freedom in patients to communicate their emotions.

*P5*“*Jaah, there are many challenges especially in this hospital. Challenge number 1 is patient's freedom. Patients sometimes are not free to communicate their problems to us or their emotional needs.*”

There are three interrelated ways in which emotions play a part in the process of medical care. First, both caregiver and patients have emotions. They are influenced by emotions they have experienced in the past, emotions they experience in the present interaction with each other, and emotions they anticipate having in the future. As a result, patients may not trust in nurses if they were mistreated by any nurses before. Therefore, the nurse should

take into account that it might require time for the patient to trust and establish the relationship.

Privacy and confidentiality are the crucial rights of patients that need to be respected by nurses. However, since advancements in technology simplify the intervention in the private lives of individuals, some nurses divulge the rights of patients to privacy and confidentiality (Abuhammad, Alzoubi, Al-Azzam, & Karasneh, 2020). Privacy is vital since it offers a safe patient environment where patients get medical attention and offer complete and precise information, and which strengthens trust in healthcare and stresses the significance of respecting the patient's right. Even though, the findings of this study did not reveal reasons behind lack of patient freedom, the study affirms that nurses have the role to establish a nurse-patient trust relationship by protecting and advocating for patients right to privacy and confidentiality.

*P19* "Sometimes patients are not free to tell them their secrets or sometimes to share with them exactly what have brought them to the hospital. Therefore, that is also part of emotion because they need to trust the nurses, a nurse should behave well and accordingly to determine the cause of a problem so a person can trust him or her and cannot share my secret with anybody else."

#### 4.4. SUMMARY

This chapter has dealt with data analyses, presented the findings of the study and literature control. In depth, this chapter presented four themes that were identified from the data

collected. These four themes are identified as “Participants perceived different negative emotions during patient’s hospitalisation that needs to be met”, “Participants perceived psycho-social and physical factors that contributes to patients’ emotions”, “Participant perceived their roles in meeting emotional need” and “Participants perceived barriers to fulfill their role in meeting emotional needs of patients”. Furthermore, the subthemes were presented and discussed in depth. Literatures control was employed thoroughly. The next chapter will conclude this study with some limitations and recommendation.

## CHAPTER FIVE

### CONCLUSION, LIMITATION AND RECOMMENDATIONS

#### 5.1. INTRODUCTION

The previous chapter dealt with data analysis, presentation of the finding and literature control. Data of this data was analysed manually. As a result, four themes were identified from the perceptions of registered nurses on their role in meeting emotional needs of patients. Therefore, this chapter will deal with the conclusion, limitation and recommendations based on the study findings.

#### 5.2. SUMMARY OF THE FINDINGS

The study identified four themes namely “patients with different negative emotions” such as anger, hopelessness, depression and anxiety, fear, shame, shock and denial. The second theme was “Psychological and physical factors that contributes to patients’ emotions” such as pain, diagnosis, medicine, financial challenges, fear of stigma, isolation, relationships, mental illness and cultural and religious distress. Then, participants perceived their role in meeting emotional needs such as reassurance, counseling, refer, allow personal preferences and rendering holistic care. Finally, participants perceived barriers to fulfill their role in meeting emotional needs such as shortage of staff, lack of privacy and lack of freedom. The findings of this study are discussed based on the aims and objectives of the study as follow.

### 5.2.1. Methodology

The study employed the explorative, descriptive, qualitative research methods in order to meet the aim and objectives of the study. Furthermore, data was collected using the in-depth face-to-face individual interviews. In-depth face-to-face interview helps obtain rich information. Consequently, tape-recorders were used to capture the interviews and field notes to note the participant's expressions. The interviews were transcribed verbatim and analysed manually following the steps by (Botma et al., 2010). Finally, theme and sub-themes were identified from the data and presented.

### 5.2.2. Explore the perceptions of registered nurses on emotional needs of patients at Engela hospital

The description of the perceptions of registered nurses on emotional needs was done by analyzing data according to the steps provided by Botma et al (2010). The data was categorised in themes and sub themes. The data revealed patient's emotional needs as perceived by participants at Engela hospital.

Participants perceived different negative emotions in patients during their hospitalisation or visits at Engela hospital. Almost, every participant expressed experiencing patients with negative emotions that are perceived as emotional needs. This corresponds with several studies that indicated that majority of the patients suffer emotional distress during hospitalisation or visiting time to the hospitals that needs to be attended to within the hospital environment (Asghari & Arabi, 2019, Curie, 2019). Therefore, they expressed those emotional needs to be understood, and be diagnosed earlier. Different emotional

needs were outlined by the participants such as anger emotions, hopelessness, depression, anxiety, fear, shame, shock and denials. These finding corresponds with a study done by Fellow-Smith, (2012) which concur that patients experience different emotions such as shock, fear, anger, resentment, denial, helplessness, sadness, anxiety, denial, depression and frustration. Furthermore, participants expressed that these emotional needs hinder the prognosis of the patients. Moreover, participants expressed those unmet emotional needs that can lead to psychological disorders and overstay in hospitals.

Participants perceived psychosocial and physical factors that contribute to patients' emotions. These factors are labeled as physical factors, social factors, psychological factors and spiritual factors. The contributing factors can be hospital learnt such as pain, diagnosis, boredom, and lack of care or bad manners from the health personnel. On the other hand, some factors are community based such as economic challenges, discrimination and lack of support from family and communities. Therefore, these factors can contribute to the patient's emotional distress that may affect the physical and psychological wellbeing of the patients.

### 5.2.3. Describe the perceptions of registered nurses on their role in meeting emotional needs of patients at Engela hospital.

Majority of the participants perceived their roles in meeting emotional needs of patients. Participants expressed that it is their role to observe and diagnose patients with emotional needs and try to meet the emotional needs in any way possible. Consequently, participants mentioned few of the roles they take to meet the emotional needs of patients such as reassuring the patients, counseling, referring to social workers, psychologists or doctors,

allow personal preferences and render holistic care. Lastly, participants explained that those roles are catered within their scope of practice as the overseers of the patients care plan. The findings of this study, however, agreed with Monareng, 2012 and Chandramohan and Bhagwan, (2015) that there is minimum interest among nurses in the holistic view of health care in which emotional and spiritual needs are considered inseparable from physical needs. With the presence of the barriers to meet emotional needs of patients such as shortage of nurses, the findings revealed that the available personnel focus on meeting physical needs continuously and only meet emotional needs when time allows. Clearly, the findings confirm that participants separate emotions from physical by prioritising physical care over emotional care. Therefore, these findings illustrate that nursing care initiatives in general have paid insufficient attention to the relationship between physical and mental health. This aspect of revelation should be a major part of efforts to develop new models of nursing care. In conclusion, Naylor, Das, Ross, Honeyman, Thompson, and Gilburt (2016) substantiate that the case for seeking to support physical and mental health in a more integrated way is compelling, hence, as it stand has disadvantage holistic nursing care.

Even though participants perceived their role in meeting emotional needs of patients, they also perceived barriers to fulfill their role in meeting emotional needs of patients. Participants expressed that due to barriers, they fail at many times to meet the emotional needs of patients. The barriers expressed by participants are categorised as nurse-related barriers, patient-related barriers and administration-related barriers. Participants expressed that shortage of nurses and time management are the major barriers that push

the nurses to utilise the time they have on caring for the physical needs such as pain and hygiene. Furthermore, patients sometimes incline not to be free sharing their emotions with the nurses. Finally, participants expressed administrative issues such as lack of privacy in the hospital wards admission rooms. On the other hand, the social stigma and the lack of social resources to establish new social networks are other aspects which negatively affect their quality of life (Molina & Forastero, 2015). Therefore, some patients have fear of communicating their emotional needs to nurses because of fear of stigma (Sontag, 2017).

Many health professionals (nurses inclusive) are trained to deal with patient as a whole. However, meeting emotional needs of patients cannot be fulfilled by nurses alone. All physical health problems have a psychological dimension, particularly when they involve learning to live with a long-term condition, which may require intervention from all health stakeholders (Naylor, et al., 2016). Many barriers to emotional care seem to be above participant's control. Therefore, the findings concur that lack of support from patients, management and administrators in the fight against the barriers which hinders the emotional care of patient deters the nurses' role of meeting emotional needs.

### 5.3. CONCLUSIONS

The conclusion of this study was based on the aim and objectives of the study. The objectives of the study were to explore the perceptions of registered nurses on emotional needs of patients and describe the perceptions of registered on their role in meeting emotional needs of patients at Engela hospital. Face-to-face interviews were conducted on the registered nurses at Engela hospital in order to achieve the objectives of the study.

Two central questions were posed to the participants: “Tell me your perceptions on emotional needs of patients” and “Tell me your perceptions on your role in meeting emotional needs of patients”. The study concluded that patients have different emotions such as anger, hopelessness, depression and anxiety, fear, shame, shock and denial. These emotional needs are being influenced by pain, diagnosis, some medicine, financial challenges, fear of stigma, isolation and separation from relatives and families, relationship problems, mental illness and cultural and religious distress. Furthermore, participants perceived their role in meeting emotional needs of patients such as by assurance, counseling, referring, allowing personal preferences, and rendering holistic care. However, the participants experienced barriers to meet the emotional needs of patients that need to be addressed such as shortage of staff and lack of privacy.

#### 5.4. LIMITATIONS

Due to the study’s qualitative research design and the associated lesser sample size of 20 face-face interviews conducted, it is imperative to accept and caution that the findings are not statistically representative of the registered nurses as the study was only based in the district hospital in Ohangwena Region and, as such, it cannot be generalized and represent all nurses countrywide. Nonetheless, the inherent value of the qualitative approach is its ability to generate rich, in-depth responses and this is what the researcher strived for rather than focusing on quantity. The time to conduct the study was short for the researcher due to participant’s essential role.

## 5.5. RECOMMENDATIONS

Recommendations are outlined and discussed based on the findings. They are presented in different categories such management, education, future research and contribution to the body of knowledge.

### 5.5.1. Management

The findings of this study found out that there was shortage of staff, lack of knowledge and lack of privacy room for patients to express their emotions freely and confidentially, therefore the researcher recommended the following:

- Proactive care – This study suggests appropriate preparation for emotional care. The management should recruit enough nurses in the hospital to keep proper patient to nurse ration to avoid the poor patient holistic care to patients as more attention is being given to priority needs and neglect other needs because of shortage of staff.
- It is recommended that privacy should be considered by the management when planning the hospital infrastructures so that there are adequate rooms in every ward to minimize the capacity of patients per room. This will ensure suitable private environment to encourage patient's privacies and freedom to express their emotions to the nurses without fear and disturbance.
- There should be a continuous supervision by management to determine whether the nurses are meeting the holistic needs of patients in the departments, more importantly emotional needs.

- Ministry of Health and Nursing Council of Namibia to incorporate and explain the role of a registered nurses on holistic care and more specifically on meeting emotional needs of patients (emotional care). Moreover, it is important for the decision makers to put in their perspectives these data during policy making and consider the role of registered nurse on meeting emotional needs of patients.

#### 5.5.2. Education

This study found that some participants expressed lack of knowledge and experience on meeting emotional needs of patients. Therefore, on nurse's knowledge the researcher is recommending as follow:

- It is recommended by this study, that the management facilitates or conduct trainings on the implementations of holistic care and meeting emotional needs of patients, especially to the new registered nurses in the units. These will enhance knowledge of registered nurses on delivering emotional care to patients.
- Furthermore, there is a need to prioritize strengthening the diagnosis and care of emotional needs in the training curriculums of the registered nurses. Registered nurses need to assess patients and rule out emotional distress such as hopelessness, anger, denial and depressions. Nurses need knowledge on assessing the behaviour, word and general presentations of the patients.
- Clinical guidelines for emotional care in the clinical health care process may be needed to develop, guide and evaluate nursing practice.

- Moreover, it is recommended that nursing educators should be aware that the harvest of emotional care among nurses is valuable and should be emphasized during clinical and nursing education.

#### 5.5.3. Future Research

- Further methodologically sound research is needed to explore the role of registered nurses on meeting emotional needs of patients and what happens when emotional care and support are delivered in different care settings, obtaining the views of both parties involved.
- There is a need to develop a model to facilitate the diagnosis and care of emotional needs of patients. Such models and frameworks can be developed to match our patient's disease profile.

#### 5.5.4. Contribution to the body of knowledge

This study was a great learning opportunity and self-discovery both to the participating nurses on their perceptions, roles and how they can meet patients' emotional needs. This study contributes to the body of knowledge especially to the practicing registered nurses by understanding the emotional needs of patients, the consequences of unmet emotional needs and how best to meet those needs. The findings of the study create awareness of vital professional attributes of nursing – treating a patient as ‘whole’ and enhancing communication skills. Furthermore, patients might be encouraged to be the custodian and coordinators of their own emotional care – to advocate for their emotions by communicating their negative emotions to nurses. Additionally, it contributes to the knowledge of educators on the importance of emphasizing meeting emotional needs of

patients during nurse training. Finally, the findings of this study will result on improved emotional support to patients that may improve quality of life and good disease prognosis.

## 5.6. SUMMARY

This chapter discussed the findings of the study based on the aim and objectives. Furthermore, the study presented the conclusion of the study followed by the limitation. Finally, the chapter provided recommendations to management, education, future research and the contribution of the study to the body of knowledge. Therefore, this chapter serves as the conclusion of the entire study.

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## APPENDICES

### 1. ETHICAL CLEARANCE CERTIFICATE



**ETHICAL CLEARANCE CERTIFICATE**

**Ethical Clearance Reference Number: SON /596/2020      Date: 16 December, 2020**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

**Title of Project:** Perceptions Of Registered Nurses On Their Role In Meeting Emotional Needs Of Patients At Engela Hospital, Ohangwena Region, Namibia

**Researcher:** RAINHOLD V. NDAIKILE

**Student Number:** (201209555)

**Supervisor:** DR. H. J. Amukugo (Main) Ms. Lilian Masude (Co)

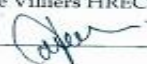

**Campus:** School of Nursing

Take note of the following:

- (a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the HREC. An application to make amendments may be necessary.
- (b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the HREC.
- (c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by HREC.
- (d) The HREC retains the right to:
  - (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
  - (ii) Request for an ethical compliance report at any point during the course of the research;
  - (iii) Cognizance and the observation of Namibia's Research Science and Technology Act, 2004 which makes it compulsory for Non-Namibian based researchers to obtain the compulsory Research Permit from the National Commission on Research Science and Technology (NCRST), FIRST, BEFORE the research can commence.

HREC wishes you the best in your research.

Dr. J.E. de Villiers HREC Chairperson      Ms. P. Claassen: HREC Secretary

## 2. RESEARCH PERMISSION LETTER FROM MINISTRY OF HEALTH



### REPUBLIC OF NAMIBIA

#### Ministry of Health and Social Services

Private Bag 13198  
Windhoek  
Namibia

Ministerial Building  
Harvey Street  
Windhoek

Tel: 061 – 203 2537  
Fax: 061 – 222558  
E-mail: [itashipu87@gmail.com](mailto:itashipu87@gmail.com)

#### OFFICE OF THE EXECUTIVE DIRECTOR

Ref: 17/3/RVN  
Enquiries: Mr. A. Shipanga

Date: 03 March 2021

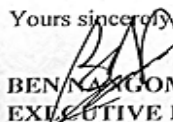
Mr. Rainhold V. Ndaikile  
PO Box 8708  
Bachbrecht  
Windhoek

Dear Mr. Ndaikile

**Re: Perceptions of Registered Nurses on their role in meeting emotional needs of patients at Engela Hospital, Ohangwena Region, Namibia.**

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
  - 3.1 The data to be collected must only be used for academic purpose;
  - 3.2 No other data should be collected other than the data stated in the proposal;
  - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
  - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
  - 3.5 Preliminary findings to be submitted upon completion of the study;
  - 3.6 Final report to be submitted upon completion of the study;
  - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and not of the MoHSS.

Yours sincerely,

  
BEN NANGOMBE  
EXECUTIVE DIRECTOR



*"Your Health Our Concern"*

### 3. RESEARCH PERMISSION LETTER FROM REGIONAL DIRECTORATE



REPUBLIC OF NAMIBIA

## MINISTRY OF HEALTH AND SOCIAL SERVICES

RMT1 - Erubana  
Private Bag 88006  
Erubana

OHANGWENA HEALTH DIRECTORATE  
OFFICE OF THE DIRECTOR

Tel No: 065 261260/239  
Fax No: 065 261063  
Email: opeubango009@gmail.com

Enq: John Hango

10 March 2021

To: Mr. Rainhold Ndaikile  
Student number 201209555

**RE: PERMISSION REQUIRED TO PURSUE A MASTER OF NURSING SCIENCE DEGREE UNDER THE SCHOOL OF NURSING – UNIVERSITY OF NAMIBIA**

1. Your request to pursue the above-mentioned degree is hereby acknowledged
2. Ohangwena Health Directorate has no objection for you to do your data collection at Engela hospital as proposed in your letter
3. You are however required to strictly follow the rules set out in the approval letter from the Executive Director of Ministry of Health and Social Services.
4. We are wishing you success in your endeavors

Faithfully yours

  
John Hango  
Chairperson



*All official correspondences must be addressed to the Regional Director*



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#### 4. INTERVIEW GUIDE

Interview #.....

Date ...../...../.....

##### **Interview guide for registered nurses**

Welcome and thank you for your participation today. My name is Rainhold Vatilifa Ndaikile and I am a masters of nursing science student at the University of Namibia currently conducting my study in fulfillment of the requirements for the degree of the Masters in nursing science. Thank you for accepting the invitation to participate in this study. This interview will take about 30 minutes of your time. Furthermore, this interview will include 2 questions regarding your perceptions on your role in meeting emotional needs of patients in Engela Hospital as registered nurse. I would like your permission to tape record this interview, so I may accurately document the information you convey. If at any time during the interview you wish to discontinue the use of the recorder or the interview itself, please feel free to let me know. All of your responses are confidential. Your responses will remain confidential and will be used to encourage meeting emotional needs of patients in Engela Hospital. The main aim of this study is to explore and describe the perceptions on the role of registered nurses in meeting emotional needs of patients in Engela Hospital.

At this time, I would like to remind you of your written consent to participate in this study. I am the responsible investigator, specifying your participation in the research project titled: The perceptions of the registered nurses on their role in meeting emotional needs of patients in Engela hospital, Ohangwena region, Namibia. You and I have both signed

and dated each copy, certifying that we agree to continue this interview. You will receive one copy and I will keep the other under lock and key, separate from your reported responses. Thank you.

Your participation in this interview is completely voluntary. If at any time you need to stop or take a break please let me know. You may also withdraw your participation at any time without consequence. Do you have any questions or concerns before we begin? Then with your permission we will begin the interview.

1. Tell me your perceptions on emotional needs of patients.
2. Tell me your perception on your role in meeting emotional needs of patients.
3. Then probing questions will follow.
  
4. Before we conclude this interview, is there anything else you would like to share?

5. TRANSCRIPTS OF AN INTERVIEW ON THE PERCEPTIONS OF REGISTERED NURSES ON THEIR ROLE IN MEETING EMOTIONAL NEEDS OF PATIENTS AT ENGELA HOSPITAL, OHANGWENA REGION, NAMIBIA

Interview no: 3

Date: 08 April 2021

Time: 09H00

Language used: English

Place: Engela District Hospital

Occupation: Registered nurse

My name is Rainhold Vatilifa Ndaikile a student at the University of Namibia currently studying towards masters of nursing science. I am currently conducting academic research titled: PERCEPTIONS OF REGISTERED NURSES ON THEIR ROLE IN MEETING EMOTIONAL NEEDS OF PATIENTS AT ENGELA HOSPITAL, OHANGWENA REGION, NAMIBIA.

The main aim of this study is to explore and describe perceptions on the role of registered nurses in meeting emotional needs of patients at Engela Hospital.

At this time, I would like to remind you of your written consent to participate in this study.

I am the responsible investigator, specifying your participation in the research project titled: Perceptions of registered nurses on their role in meeting emotional needs of patients at Engela hospital, Ohangwena region, Namibia. You and I have both signed and dated each copy, certifying that we agree to continue with this interview. You will receive one copy and I will keep the other under lock and key, separate from your reported responses.

Thank you.

Your participation in this interview is completely voluntary. If at any time you need to stop or take a break please let me know. You may also withdraw your participation at any time without consequence. Do you have any questions or concerns before we begin? Then with your permission we will begin the interview.

Researcher: please tell me your perceptions on meeting emotional needs of patients

Participant: Okay, in Engela, we use to meet different patients with different emotional needs. We are talking about people who are coming and that person is going, the doctor order caesarean section and that person is having anxiety that might stay longer with that patient. That anxiety may cause a problem to the patient. For you as a nurse you should know how to remove that anxiety before person undergoes caesarean section. And we also use to meet patients who are coming and they lost their babies while in our hands in the wards. You can also as a registered nurse, you need to know how to deal with that mother because is not easy for them to come to the hospital and just loose the baby like that, patient can be depressed or stressed,. Another case, we also use to meet patients who are coming and then the patients don't take medication because is stressed or depressed. You want to give medication but the patient refuse. It is the right of the patient not just to force her to drink medication without her consent. Our patients are affected differently; some take their conditions too serious while some do not. So, the role of the registered nurse, you need to explain to the patient the advantage and disadvantage of drinking that medication so that the patients understand why I am drinking this medication. We also use to meet these patients who are coming, they are qualified for admission in the wards but they refuse admission. As a nurse you cannot just leave the patient to go home while is sick. You need to sit with that patient, explain why admission is needed and give her time

to ask question, assess whether is in confusion state and then you come up with the decision so that the patient can be admitted in the ward. (Silenced then continued) there is also in some case, a woman is coming like those under 16 years old. They are coming brought by their parents and then that pregnant woman is refusing to be done vaginal examination. You cannot force someone to do vaginal examination. Is still your role to explain, to talk to that patient politely so that she understands. Not just to say hold that led (demonstrating) but you explain and make patient understand why you are doing that. mmmhh

Researcher: Thank you so much for this rich information. We can move to the next question, can you tell me your perceptions on your role in meeting emotional needs of patients?

Participant: My perception is to understand that everyone has right to be treated as she wants to be treated. You must learn to explain every procedure you are doing to that specific patient. And also, you must learn to allow to give them time to ask where they don't understand. If they don't understand you need to elaborate more so that, that patient will understand why you are doing that specific procedure to him or her. Mmmhh. (agreeing to self as she node her head)

Researcher: To those patients that present with anxiety due to diagnosis as you mentioned, how do you manage or what do you perceive is your role in that?

Participant: jaaah if I come in contact with the person who is having, who is anxious, I can ask the patient what do you think is the correct thing to be done? I explain what is to be done, I give advantage ad disadvantage and allow a patient to make decision according to what he or she think is right. Not just to force a patient to do what she does not want.

Researcher: Before we conclude the interview is there anything else you would like to share?

Participant: yeess (loudly) that if you meet someone who is anxious you need to sit with that patient in the separate room. If you are not agreeing to one another, you need to include someone else maybe a doctor or a senior someone in the ward because some patients may not understand you but may understand others. We need to include others when you are not reaching the right decision.

Researcher: did you ever encounter any challenges or barrier to meeting emotional needs of patients?

Participant: yes, I have met many challenges with the shortage of staff which make the work to be loaded to the staff whereby one nurse can be attending to 10 patients for instance like the nurses and patient ration is not correlating at all. Therefore, a nurse cannot get enough time to attend to that specific patient. Another challenge is that we don't have enough space in the hospital, like there is no private room to talk to patient in privacy. That remains a challenge also. And time, you can attend to one patient, you have identified an emotional need then while you are busy attending to that patient another emergency may come up so you have to go attend to that emergency and on that way you will leave that patient's need not attended.

Researcher: Any recommendation or suggestion in meeting patient's emotional need?

Participant: Yes, I am recommending pregnant mothers to start attending ante-natal care early so that if they have emotional needs can be identified early at the clinic and that will be addressed on time. We are also recommending the ministry of health to recruit as many

nurses as possible so that nurses will not be overloaded with a lot of work, and they need to recruit competent nurses.

Researcher: What do you mean by competent nurses?

Participant: A nurse who is qualified, either with a degree or diploma is qualified

Researcher: is there anything else you would like to share?

Participant: No

Researcher: Thank you very much for taking part in this study.

Participant: Thank you sir.