RESILIENCE AND COPING AMONG NURSES WORKING AT A PSYCHIATRIC HOSPITAL IN THE WESTERN CAPE

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ABSTRACT

Background: Resilience in nurses plays an important role in caring for mental health care users admitted to psychiatric hospitals, given that the working environment is stressful. Nurses are faced with various challenges on a daily basis; therefore, their ability to overcome a situation, and whether they are able to cope effectively, or develop lasting consequences, could be beneficial, or detrimental to themselves, or the mental health care users, to whom they provide care. Although resilience has been studied in various workplace settings, there is a paucity of literature on resilience among nurses working in psychiatric hospitals, as well as the coping strategies they employ, to enable them to cope with everyday stressors.

Aim and objectives: The aim of this current study was to investigate resilience and coping among nurses working at a psychiatric hospital in the Western Cape. The objectives of the study were to determine the nurses' ability to bounce back, or recover from stress, to describe coping strategies used by nurses in the psychiatric hospital, and to determine the association between resilience and coping strategies of nurses working at a psychiatric hospital in the Western Cape.

Method: A quantitative, descriptive survey design was used to investigate resilience and coping among nurses working at a psychiatric hospital in the Western Cape. Convenience sampling was used to secure a sample of 255 respondents from a total population of 382. The Brief Resilience Scale (BRS), which is a 6-item Likert scale, and the Brief COPE scale, which is a 28-item Likert scale, were used to collect data. The Statistical Package for Social Sciences (SPSS), version 25, was used to analyse the data.

Findings: The findings of this current study revealed that the overall mean score for the resilience of the respondents was 2.5 (±0.7), out of a possible of 4, which indicates that the level of resilience of the respondents was normal. The most frequently used coping strategies were religion and active coping, followed closely by positive reframing and planning. The coping strategy used least, was substance use. However, humour, denial and behavioural disengagement revealed significant difference between the groups. There was a significant correlation between resilience and active coping, denial and venting.

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Recommendations: Research studies on resilience and coping of psychiatric nurses in different contexts should be conducted. In addition, the use of the BRS and Brief COPE scales should be used as instruments, when conducting studies on psychiatric nurses.

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KEYWORDS

Coping

Coping Strategies

Mental health care users

Nurses

Psychiatric hospital

Resilience

Stressors

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ABBREVIATIONS

BRS	Brief Resilience Scale
CAP	Child and Adolescent Psychiatry
EN	Enrolled Nurse
ENA	Enrolled Nursing Assistant
GAP	General Adult Psychiatry
IDS	Intellectual Disability Service
MHCU	Mental Health Care User(s)
RN	Registered Nurse

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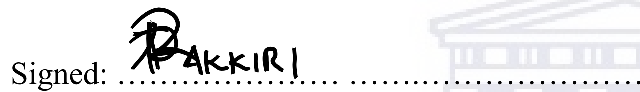
DECLARATION

I declare that the study, *Resilience and coping among nurses working at a psychiatric hospital in the Western Cape,* is my original work; that it has not been submitted for any degree, or examination at any other University, and that all the sources I have used, or quoted, have been indicated, and acknowledged by complete references.

Full name: Tramaine Chriselle Pakkiri

Date: November 2019

Signed:  ………………… ………………………

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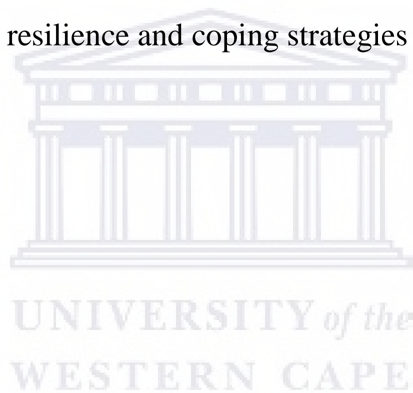
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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1. Introduction

The resilience of nurses, who work in psychiatric hospitals, is an important attribute, as it plays a role in dealing with the onset of, coping with, and recovery from health problems (Atkinson, Martin, & Rankin, 2009). Resilience allows nurses to adapt to adversity, positively (Foster, Roche, Delgado, Cuzzillo, Giandinoto, & Furness, 2018), which may be experienced while working in a stressful nursing environment. Stressors in the workplace may affect the ability of nurses to perform their duties optimally, and provide quality care to mental healthcare users (MHCUs), consequently, affecting patient outcomes (Hart, Brannan, & De Chesnay, 2014). Although, nurses would have experienced some adversity in their lives, and may have developed coping strategies that help them to cope with challenging situations. However, nursing is one of the most stressful professions (Foster et al., 2018; Gao, Ding, Chai, Zhang, Zhang, Kong, & Mei, 2017; Chana, Kennedy, & Chessell, 2015), which places nurses at a level of high health risk (Drach-Zahavy & Marzuq, 2013). In addition, psychiatric hospitals are stressful working environments, in which nurses face various stressors that range from caring for violent, aggressive MHCUs, recurrent relapses, and poor prognosis of mental disorders (Hasan, Elsayed, & Tumah, 2018). When the nurse can no longer cope, due to the intense stimuli in this stressful workplace, s/he may become overburdened, which may result in burnout (Van Vuren, 2012), compassion fatigue, stress, ill-health (psychological and physical), and vicarious trauma (Delgado, Upton, Ranse, Furness, & Foster, 2017). Therefore, it is important to determine the resilience in nurses, who work in these environments, to establish whether they would cope with workplace stressors, or develop lasting consequences.

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1.2. Background

Mental health nursing is one of the most stressful occupation in the helping profession, and nurses working in these settings face more stressors than general nurses do (Hasan, Elsayed, & Tumah, 2018; McTiernan & McDonald, 2015; Burnard, Edwards, Fothergill, Hannigan, & Coyle, 2000), as the structure and service is very unstable (Hasan, Elsayed, & Tumah, 2018). A frequent report of stressors include: caseload; too many administrative duties; management

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problems; and client-related issues, such as, increased admissions, aggressive and difficult clients, increased patient assessments, non-compliance of medication, self-harming behaviour, and crisis intervention (Burnard et al., 2000). Psychiatric hospital nurses, exposed to patients, who present with violence, agitation and suicide, may easily suffer from stress reactions (Hasan, Elsayed, & Tumah, 2018). It was also observed that episodes of violence, whether minor or major, trigger absenteeism (Burnard et al., 2000).

Nurses' stress is also connected to a decreased well-being, poor job performance, with workplace stressors affecting the quality of care (Chana et al., 2015). Stress affects, not only the one providing care, but also the one receiving care (Chana et al., 2015). As the healthcare environment contributes to workplace distress, compassion fatigue, burnout, and patient safety, it is essential to understand that these environmental factors affect the resilience of nurses (Cusack et al., 2016). The challenges in the workplace may also include heavy workloads, shortage of staff, continuous change and restructure within the organisation, which increases the vulnerability of nurses (Cusack et al., 2016), as well as conflict in the workplace, and high work demands (Lim, Bogossian, & Ahern, 2010).

Resilience is a term used to describe how an individual is able to *bounce back* and *adapt* to changes in their environment (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008; Middleton, Nicolson, & O'Neill, 2012). *Resilience* has been defined as a personal attribute that an individual develops when exposed to adversity (Delgado et al., 2017), or a skill mastered when adapting to a challenging event (Yilmaz, 2017). However, studies reveal that there are internal and external factors that promote *resilience* within an individual (Delgado et al., 2017). These internal factors include, being optimistic, having a sense of purpose or faith, a sense of self, insight, hope, self-efficacy, coping, control and adaptability (Delgado et al., 2017). The external factors include, support within, and outside, the workplace, as well as resources (Delgado et al., 2017). These factors could increase the resilience of nurses in the workplace (Delgado et al., 2017).

However, nurses, working in a psychiatric hospital, are exposed to increased episodes of violence and suicide (Delgado et al., 2017), a rise in patient admissions and discharges, implying an increased use of services by MHCUs, which presents with multiple conditions that complicate the treatment and recovery process, increasing pressure on these nurses (Yilmaz, 2017). In addition, these nurses face challenges, such as verbal and/or physical aggression, as

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well as emotional labour, and may be involved in forcible practices, such as seclusion, and physical restraint (Foster et al., 2018). Emotional labour is the consuming effort of supressing personal emotions to, effectively, care for others (Edward, Hercelinskyj, & Giandinoto, 2017). In addition, nurses working in psychiatric institutions are involved in emotionally intense situations, which require them to effectively engage in therapeutic interactions (Edward et al., 2017). These experiences could be disturbing, and cause them to experience feelings of guilt or fear (Foster et al., 2018). Additionally, stressors such as work overload, conflict between multidisciplinary team members, lack of time, poor self-care, struggling with the demands of the career, a feeling of powerlessness, and the lack of emotional preparation, could be negative, stressful and challenging for the nurses to provide quality care (Yilmaz, 2017), and may also cause psychological distress (Foster et al., 2018). Besides, occupational challenges such as shortage of staff, poor support, long hours, as well as high acuity, may lead to nurses making mistakes while on duty (Hart et al., 2014). The effects of these stressors may negatively impact nurses working in a psychiatric hospital/institution, leading to long-term stress, emotional discord, burnout and job dissatisfaction, which may affect workplace retention, thereby affecting the quality of care provided (Foster et al., 2018). These daily encounters affect the ability of the nurse to build and maintain their *resilience* (Hart et al., 2014).

Despite these challenges, *resilience* allows nurses to adapt and cope within the working environment, to maintain psychological functioning (Yilmaz, 2017). It is a necessary characteristic to survive in the workplace, as nursing is an emotionally challenging and stressful occupation (Aburn, Gott, & Hoare, 2015). It is observed that hope, coping, and self-efficacy promote the resilience in nurses (Foster et al., 2018). People who are resilient, use protective factors to bounce back and search for a positive meaning, to make light of their circumstances (Lanz & Bruk-Lee, 2017). Consequently, high-risk nurses require development and training in *resilience*, as they are exposed to extreme demands, on a daily basis (Lanz & Bruk-Lee, 2017). Resilience, therefore, is crucial for the reduction of stressors in the workplace (Delgado et al., 2017).

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Folkman and Lazarus (1985) developed a theory on stress and coping, which, subsequently was expanded by Carver, Scheier, and Weintraub (1989). This theory identifies the process of coping as a key mediator of stressful person-environment relations and the outcomes thereof (Baqutayan, 2015). The term, *stress*, was first introduced in 1926 as the “sum of nonspecific changes caused by function or damage”, or “the rate of wear and tear in the body” (Selye, 1956,

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cited in Baqutayan, 2015, p. 479). According to Baqutayan (2015), *stress* is a non-specific response of the body to a demand.

According to Monzani, Steca, Greco, D'Addario, Cappelletti, and Pancani (2015), coping is the process of responding to a stressor, dependent on an individual's psychological adjustment and well-being. In the 1980s, Folkman and Lazarus defined coping as a cognitive and behavioural efforts to either master, reduce, or tolerate demands (Baqutayan, 2015). Therefore, it is perceived as a way to soften the impact of demands (Baqutayan, 2015). Matheny, Aycock, Pugh, Curlette, & Silva Canella (1986) defined coping as a healthy or unhealthy, conscious or unconscious effort, which either reduces or endures the effects of stressors, in the least hurtful manner. Coping, however, is not always viewed as healthy and constructive, because, occasionally, individuals could adapt coping strategies, which could create further complications (Baqutayan, 2015). In addition, coping involves the behaviours and thoughts that an individual utilises to manage stressors (Baqutayan, 2015).

Additionally, coping refers to the way in which an individual responds to, and interacts with stressors (Baqutayan, 2015). According to Carver et al. (1989), individuals possess various differences that influence their coping strategies. These authors further explain that individuals already retain *set coping strategies*, from previous stressors they had encountered, and usually, do not develop new approaches, but use *fixed* strategies, to overcome new challenges (Carver et al., 1989). However, Folkman and Lazarus (1985) emphasise that coping should be perceived as a process that shifts from stage to stage during a stressful encounter. This implies that the use of a continual coping strategy is counterproductive, as it does not allow the individual the freedom to change, or adapt to challenges, but rather locks them into one mode (Carver et al., 1989).

Folkman and Lazarus (1980), as well as Carver et al. (1989) focused on two types of coping, namely, problem-focused and emotion-focused coping. Based on literature, individuals use different coping strategies at different times; therefore, coping is a process that changes over time. For example, an individual may use emotion-focused coping, and subsequently, shift to problem-focused coping, or vice versa (Baqutayan, 2015). Problem-focused coping involves efforts to change the source of the stressor, whereas emotion-focused coping involves efforts to change the individual's emotional response, rather than the stressor (Baqutayan, 2015). Research suggests that people tend to use both types of coping strategies to manage a stressor;

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therefore, determining the dominance of one coping strategy over another, is influenced by personal style and the stressful event (Lazarus & Folkman, 1980; Carver et al, 1989; Baqutayan, 2015).

Various methods could be used to measure coping, namely, the Psych nurse methods of coping which assess the degree to which coping strategies are utilized by psychiatric nurses and consist of 35 items (Hasan et al., 2018; Burnard et al., 2000). Then there is the Simple Coping Strategy, which is a 20-item scale that assess the frequency of different ways of coping, 12 positive and 8 negative (Cai, Li, & Zhang, 2008). Finally, the Ways of coping questionnaire is a 38-item scale used to explore coping strategies that people employ to deal with internal and external demands of stressors, encompassing thoughts and actions (Tsaras, Daglas, Mitsi, Papathanasiou, Tzavella, Zyga, & Fradelos, 2018).

1.3. Problem statement

Globally, literature alludes to nurses in psychiatric hospitals, functioning in highly stressful working environments that may cause burnout (exhaustion, negativity, feelings of helplessness, depression), and job dissatisfaction (Edward & Hercelinskyj, 2007). These conditions are triggered by stressors, such as, issues with management, shortage of staff, high work demands, conflict between nurses, lack of resources, as well as patients, who present with violent, aggressive, and other challenging behaviour (Edward & Hercelinskyj, 2007). In addition, nurses working in psychiatric settings in South Africa are exposed to traumatic, life-changing situations, such as, suicide and sexual assault (Edward, 2005). As the environment is stressful and demanding, this negative impact on job satisfaction, poses a risk to the caring and clinical role of nursing practitioners (Edward & Hercelinskyj, 2007).

However, despite the stress that they experience by working in psychiatric hospitals, the nurses appear to cope. They ensure quality service to the public, with limited resources (Hart et al., 2014), and remain enthusiastic and skilled in their caring, clinical approach; although, some become exhausted (Edward, 2005). They appear to retain the ability to overcome and move beyond the stressors, at any point in time (Edward, 2005). Not all people react to stressors in the same way; however, resilience has various approaches, which allow them to cope (Baynton, n.d).

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Ultimately, the challenging environment of working in a psychiatric hospital may affect the resilience of nurses. Therefore, as revealed in literature, because of the stressors that nurses encounter, while working in a psychiatric hospital, it becomes important to assess the resilience of these nurses, in order to identify the behaviour, which could assist them to cope with the demands of the career. Although resilience has been studied in various workplace settings, there is a paucity of literature on resilience among nurses working in psychiatric hospitals, as well as the coping strategies they employ, to enable them to cope with everyday stressors.

1.4. Aim of the study

The aim of this current study was to investigate the resilience and coping skills of nurses working at a psychiatric hospital in the Western Cape.

1.5. Objectives of the study

The objectives of the study were:

- To determine nurses' ability to bounce back, or recover from stress;
- To describe the coping strategies used by nurses in the psychiatric hospital; and
- To determine the association between the resilience and coping strategies of nurses working at a psychiatric hospital in the Western Cape.

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1.6. Significance of the study

The resilience of nurses in other specialties, including perioperative, intensive care, emergency, and palliative care, has been researched gradually; however, research on resilience in mental health nursing has been scant (Foster et al., 2018). The relationship between resilience and coping strategies of nurses remains vague (Gito, Ihara, & Ogata, 2013). As there is limited information regarding the resilience of nurses working in psychiatric hospitals (Itzhaki, Peles-Bortz, Kostistky, Barnoy, Filshtinsky, & Bluvstein, 2015), the stressors they face within the workplace, as well as how they cope with these events (Xianyu & Lambert, 2006), therefore, need to be investigated. There is an urgent need to address the influence of stress on nurses, given that they work in a stressful environment (Lanz & Bruk-Lee, 2017), as the stressful events that nurses are encounter in the workplace may determine their ability to cope effectively, or develop lasting consequences (Middleton et al., 2012). Ultimately, it is crucial

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to identify strategies that would reduce stressors, as well as their effect on nurses (Lanz & Bruk-Lee, 2017).

Two existing tools, the BRS and brief COPE were combined as one questionnaire, focusing on resilience and coping respectively as the researcher wanted to determine not only how resilient nurses working in a psychiatric hospital are, but also how they cope. This current study, therefore, could contribute to literature on the resilience and coping ability of nurses working at a psychiatric hospital. The awareness of resilience and coping at the selected psychiatric hospital could be elevated, while interventions to increase the resilience of nurses working in a psychiatric hospital, could be implemented, and effective coping strategies, identified. The findings of this current study could influence policy makers to draw up policies, which provide support for coping strategies that may be used to increase resilience. This would result in greater confidence among nurses working at a psychiatric hospital, to manage difficult, stressful encounters.

1.7. Research methodology

A quantitative approach, using a descriptive survey design, was used to achieve the aim of the study. Convenience sampling (whoever were on duty and available) was used to obtain a sample of 255 respondents, from a total population of 382. Data were collected using the Brief Resilience Scale (BRS) and the Brief COPE scale. Data was analysed using Statistical Package for Social Sciences (SPSS) version 25. Further details are discussed in Chapter 3.

1.8. Definitions of key terms

- **Coping**: Coping is defined as a process of executing a response to a threat (Carver et al., 1989). The researcher was interested in determining how nurses responded, when confronted with stressors. This was assessed by using the Brief COPE. In this current study, coping includes coping strategies.
- **Coping strategies**: A coping strategy is used, when faced with a stressful encounter. Behavioural and psychological efforts are employed to overcome these stressors, by either mastering, tolerating, or minimizing them (Yusoff, Low, & Yip, 2010). A coping strategy may be protective of, or harmful to, an individual's health and wellbeing (Su et al., 2015). These strategies are: Self-distraction, active coping, denial, substance

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abuse, emotional support, instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame (Carver, 1997). These strategies will be assessed, using the Brief COPE scale.

- **Mental health care user**: According to the Mental Health Care Act (Republic of South Africa [RSA], 2002, Act No. 17 of 2002), a MHCU refers to a person that receives care, treatment and rehabilitation services at a health facility, which aims to enhance the mental status of a user. In this study, a MHCU refers to a patient(s) that is/are hospitalised (involuntary, voluntary, or assisted) in the selected psychiatric hospital.
- **Nurses**: According to the Nursing Act (Republic of South Africa [RSA], 2005, Act No. 33 of 2005), a nurse is a person registered as either a professional nurse, midwife, staff nurse, auxiliary nurse, or auxiliary midwife, to practice nursing, or midwifery. In this current study, nurse(s) will be referred to as persons, who are trained to provide care to MHCUs in the various functional business units at the selected psychiatric hospital. The categories of nurses include: Registered Nurses (advance psychiatry and general); Enrolled Nurses and Enrolled Nursing Assistants, whose nursing functions range from providing highly skilled nursing care, to basic nursing care.
- **Nursing:** A caring profession practiced by a nurse, who provides support, cares for, and treats health care users to achieve, or maintain, health, and when this is not possible, provides care to a health care user, so that s/he may live in comfort and with dignity (RSA, 2005). In this current study, nursing will be referred to as a nurse, who provides care, treatment and rehabilitation to MHCUs in the selected psychiatric hospital.
- **Psychiatric hospital:** According to the Mental Health Care Act (RSA, 2002), a psychiatric hospital refers to a health establishment that provides care, treatment and rehabilitation services, exclusively, to persons with a mental illness. In this current study, a psychiatric hospital refers to the selected health care establishment.
- **Resilience**: Resilience is the ability of an individual to bounce back, or recover from stress (Smith et al., 2008). Specifically, surviving and recovering swiftly from bad/hard/difficult times, stressful events, and set-backs (Smith et al., 2008). This will be assessed by the Brief Resilience Scale (BRS).
- **Stressors**: A stressor is an event, or change in life that causes stress, and in some instances, distress, or a deterioration of an individual's mental health (Weller, 2009). These factors may either be physical, physiological, psychosocial (Weller, 2009),

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biological, or environmental (Freshwater & Maslin-Prothero, 2005). In this current study, a stressor will be referred to as an unpleasant, challenging event that a nurse encounters in the selected psychiatric hospital.

1.9. Chapter outline

In this chapter, Chapter 1, the researcher provides an orientation to the study, which included the introduction and background for this current research study, the problem statement, aim and objectives of the study, and the significance of the study. A brief description of the research methodology, as well as the definitions of key terms are also outlined. The following chapters of this mini-thesis are summarised as follows:

Chapter 2: Literature Review

The empirical literature on the construct of resilience, resilience in nurses working in psychiatric hospitals, coping strategies used by nurses in psychiatric hospitals, as well as the association between resilience and coping strategies are explored and discussed.

Chapter 3: Research Methodology

In this chapter, the research design and research methodology used in this study are thoroughly explained.

Chapter 4: Research Findings

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In this chapter, the results obtained from data collection and data analysis are explained and presented in graphs and tables.

Chapter 5: Discussion of Findings

In this chapter, the findings presented in Chapter 4 are interpreted and discussed to concur with findings of literature on resilience and coping.

Chapter 6: Conclusion, Limitations and Recommendations

In this chapter, the study is concluded, limitations are identified and recommendations are made for future studies.

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CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

During a literature review, the researcher seeks to determine the existent relevant knowledge of a problem under scrutiny, or whether there are any disparities in the research, which would assist him/her to interpret the findings of a given study (Polit & Beck, 2010). A literature review also allows readers to gain an understanding of the phenomenon under review, and highlights the relevance of the new study (Polit & Beck, 2010). The purpose of a literature review is to identify available evidence, which allows the researcher to determine the design and plan of the study, by determining which methods had been successful, and which not (Brophy, Snooks, & Griffiths, 2011). The aim of this review, therefore, is to provide an indication of what is known and unknown about the phenomenon, namely, resilience and coping among nurses working in a psychiatric hospital, to identify the most appropriate instrument, as well as determine whether the results concur, or differ (Brink, Van der Walt, & Van Rensburg, 2012).

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The databases used to access literature included the EBSCOhost, CINAHL, Wiley Online Library, psycARTICLES, PubMed, ScienceDirect and google scholar. The following key words were used to access relevant literature: *mental health*, *mental health nurse* or *nursing*, *psychiatric nurse* or *nursing*, *resilience*, *coping*, *coping strategies* and *stressors*. Most information extracted from the literature were published between the years 2008 and 2018; therefore, the researcher reviewed literature that was published in the last decade. However, as the researcher required additional information that was relevant to the study, some publications beyond the 10-year mark were also included. The review comprises the following topics: *Resilience - the construct*; *Resilience in nurses working in psychiatric hospitals*; *Coping strategies used by nurses working in psychiatric hospitals*; and *Association between resilience and coping strategies*.

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2.2. Resilience - the construct

Resilience has different definitions in various settings. *Resilience* originates from the Latin word *resilire*, which means *to leap back*; therefore, it is derived from two meanings, *to be able to recoil or spring back into shape* and *to recover easily and quickly* (Windle, 2011). In Developmental Psychology, it is known as a successful adaptation, despite challenges, or threats, and can either be a process of, capacity for, or an outcome (Windle, 2011). Recently, *resilience* has been defined as good outcomes, in spite of threats (Windle, 2011). In an environmental perspective, there are several factors that affect *resilience*, such as external stresses and disturbances, as a result of change (social, political, and environmental) (Windle, 2011). In Biology and Psychiatry, *resilience* is known as overcoming stress, and the identification thereof, requires the examination of psychological outcomes (Windle, 2011). As a personal characteristic, *resilience* is defined as personal qualities that equip the individual to thrive in the face of adversity (Windle, 2011). *Resilience* also refers to a process of adapting positively to adversity, to *bounce back* from difficult situations (Windle, 2011). According to Windle (2011), *resilience* is described as developing well, despite the risk for developmental problems, to function well under stressful conditions, and to recover to normal functioning after severe deprivation.

Controversy still exists around how *resilience* is formed in an individual; however, it is still an important trait to possess (Turner, 2014). *Resilience* as an overall concept, is known to have roots in two primary areas, "the physiological side of coping, and the adaptation and psychological management of stress and trauma" (Turner, 2014, p. 72). According to Smith, Epstein, Ortiz, Christopher, & Tooley (2013), the process of *bouncing back* involves three stages. First, an event that is perceived as stressful, should be confronted (Smith et al., 2013). Second, the individual concerned should be orientated towards an outcome that is positive of the event (Smith et al., 2013). Third, the individual concerned should actively engage in efforts to cope with the event (Smith et al., 2013).

According to Aburn et al. (2015), *resilience* is a contextual and dynamic process, which is ever changing in the environment that could either be a trait, process or outcome (Ramalisa, Du Plessis, & Koen, 2018), and, therefore, has various definitions. The context to which *resilience* is applied should be considered (Foster et al., 2018). *Psychological resilience* involves the use of a range of meta-cognitive and emotional processes to protect individuals from the negative

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effects of stress (Fletcher & Sarkar, 2013). According to Delgado et al. (2017), *resilience* is a personal attribute, which an individual develops when exposed to adversity and, according to Yilmaz (2017), is mastered when adapting to a challenging event.

In addition, *resilience* could be viewed as a process of adaptation to stress and adversity, where personal and environmental factors interact (Foster et al., 2018; Itzhaki et al., 2015), associated with post-traumatic growth (Itzhaki et al., 2015). Generally, *resilience* has been studied as an individual psychological construct. Studies have alluded to *resilience* as an ability or group of personal characteristics, as well as a process that occurs between people and their environment (Delgado et al., 2017).

Personal characteristics, such as hope, coping, and self-efficacy, have been observed to promote nurses' resilience (Hart et al., 2014). It is an individual ability, quality, or characteristic, as well as a process involving person-environment interactions (Foster et al., 2018). *Resilience* can be learned and developed through behaviour, thoughts and actions, as many people react with strong emotions and uncertainty to difficult circumstances (APA, 2011). It is a personal resource in an individual, developed through continuous exposure to challenging situations, in which adaptive behaviours are established (Foster et al., 2018). According to Lanz & Bruk-Lee (2017), *resilience* is considered to be an expressive level of strength that enables individuals to avoid the harmful effects of stress. Atkinson et al. (2009) assert that it is an ability to overcome stress, deprivation, threats, or trauma, and a response to challenges that implicate their behaviour. *Resilience* can also be defined as a process of positive adaptation, and an effective way of managing stressful events, being able to use it as a buffer to bounce back from adversity, and can be altered according to culture, age and gender (Gao et al., 2017). According to Smith et al. (2008) and Rodriquez-Rey et al. (2015), *resilience*, in its true and original form, is the ability to bounce back, or recover from stress.

Resilience, therefore, is a complex construct, which is interpreted in various ways, depending on the context.

2.3. Resilience in nurses working in psychiatric hospitals

In order to cope in the stressful working environment of the psychiatric hospital, caring for patients, nurses have to be resilient. Resilience in mental health settings has been studied by the following authors: Atkinson et al., 2009; Burnard at al., 2000; Cai et al., 2008; Edward,

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2005; Foster et al., 2018; Gito et al., 2013; Itzhaki et al., 2015; Ramalisa et al., 2018; and Zheng, Gangaram, Xie, Chua, Ong, and Koh, 2017.

According to Turner (2014), resilience is a vital quality for a nurse to possess, because of the stressful profession. Studies have revealed that nurses, who demonstrate a high level of resilience, remain in the profession as healthy nurses (Turner, 2014). Therefore, resilience plays an important role in nursing longevity (Turner, 2014). Resilient nurses exhibit characteristics such as, spirituality, hope, competence, coping, control, optimism, self-efficacy, as well as a sense of humour (Yilmaz, 2017). Resilient nurses display unique qualities, such as intelligence, self-confidence, resourcefulness, and flexibility (Ramalisa et al., 2018). Aburn et al. (2015) identify five key components of resilience, namely: rising above to overcome adversity; adapting and adjusting; magic; good mental health; and the ability to bounce back.

Gito et al. (2013) observed that the 313 nurses, working in a Japanese psychiatric hospital, were unable to conclude on the relationships of nurses' resilience and their coping strategies. They purported a possibility that nurses working in psychiatric hospitals would demonstrate an association between resilience, and *certain* coping responses; however, this was not tested. In addition, a study conducted by Itzhaki et al., (2015), with a sample of 118 nurses, working in a mental health care center in Israel, to explore the effects of exposure to violence, job stress, staff resilience, and post-traumatic growth, on the life satisfaction of nurses working in a psychiatric hospital, observed that they developed resilience, when exposed to violence in the workplace.

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Psychiatric mental health care is highly stressful; therefore, the nurses are considered the most vulnerable working group, who experience high levels of stress, as they are constantly exposed to emotionally challenging situations (Tsaras et al., 2018). Despite the key role that adversity plays in the development of resilience, the individual must be malleable, have conviction, and fortitude, to survive difficult times, be able to perceive the importance in life, and willing to accept support from others (Turner, 2014). According to Ramalisa et al. (2018), nurses should be allowed the opportunity to rejuvenate, or be restored by exercising spirituality, as well as encouraged and supported within the workplace, thereby allowing them to cope with challenges in the working environment, effectively, which in turn strengthens their resilience.

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2.4. Coping strategies used by nurses working in psychiatric hospitals

Coping is defined as ever-changing cognitive and behavioural efforts to cope with internal and external demands (Hasan et al., 2018). It involves the *changing* of cognitive and behavioural efforts, in order to cope with internal and external demands (McTiernan & McDonald, 2018). Coping strategies are techniques used to reduce, re-evaluate and/or solve demands, in order to minimise the stressors, which implies that stress levels could be resolved, if effective coping strategies are in place, to deal with the stressors (Hasan et al., 2018). Coping strategies are used to manage and respond to situations that are unavoidable (Baynton, n.d). The coping strategy used, could determine the outcome of a given situation, which influences the general health of the individual (Hasan et al., 2018).

According to literature, it was observed that more nurses were inclined to use problem-focus strategies, aimed at resolving issues that are work-related, rather than emotional-focus strategies, which deal with procuring social support to deal with workplace stress (Lim, Bogossian, & Ahern, 2010). Frequently, problem-focused coping was used in encounters that were deemed changeable, whereas emotion-focused coping, more often, was used in encounters that were deemed unchangeable (Folkman & Lazarus, 1985). However, the coping strategies employed to assist in a situation, may be either adaptive, or maladaptive (Carver et al., 1989).

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Recent findings have revealed that nurses, who use strategies to prepare themselves mentally for duty, before the start of their shift, experience a positive disposition towards dealing with stressors (Manomenidis, Panagopoulou, & Montgomery, 2019). The coping strategies identified were: relaxation and behavioural techniques, workshops on stress management, training in therapeutic skills, support from colleagues and friends, as well as leisure activities (Cai, Li, & Zhang, 2008). The strategies that were commonly reported by mental health nurses were peer/social support, relaxation, supervision, and self-belief (Burnard et al., 2000). Support (colleagues, managers, allied health professionals) was the most favoured coping strategy (Burnard et al., 2000). This contradicts with what was usually observed, as mentioned previously.

Positive coping strategies include, participating in hobbies and activities, revealing problems, and identifying what is important (Cai, Li, & Zhang, 2008), including positive reassessment,

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careful planning of problem-solving, and control of self, using support as a resource, relaxation techniques, and introspection (Xianyu & Lambert, 2006). Negative coping strategies include, suppressing feelings, self-consoling, taking a break or holiday to forget about encountered events, temporarily (Cai, Li, & Zhang, 2008). It was observed that, for nurses, the best time to recover from the stress they experienced at work, was over a weekend, having the opportunity to engage in pleasurable activities (Drach-Zahavy & Marzuq, 2013). During this period, recovery occurs, as job demands have no impact on the individual (Drach-Zahavy & Marzuq, 2013).

The use of effective coping mechanisms assists individuals to regain equilibrium and reduce the negative effects of stress (Hasan et al., 2018). In contrast, ineffective coping mechanisms increase the effects of stress (Hasan et al., 2018).

2.5. Association between resilience and coping strategies

The ability to bounce back, or recover, is identified as crucial in the development of resilience (Atkinson et al., 2009). According to Atkinson et al. (2009), resilience cannot be a personal trait, as people can only become resilient in the face of adversity, and resilience can vary in different settings. These authors assert that resilience is an acquired skill, which can be learned at any age, a process developed against hardship (Atkinson et al., 2009). Resilience provides room for psychological growth when faced with adversity, and is readily available when future stressors arise (Atkinson et al., 2009). A resilient individual is not immune to stressors, and will be able to re-establish equilibrium after experiencing adversity (Atkinson et al., 2009). Resilience demonstrates strength, and a resilient person persists in overcoming challenges, which is essential for professionals in the health field (Gao et al., 2017).

Recent evidence exists, which reveals that resilience acts as buffer against the negative effects, or workplace stressors, and is associated with positive patient outcomes and satisfaction, improved quality of care, and better attitudes towards patients (Manomenidis et al., 2019). Resilience maintains and re-establishes the coping strategies that are used (Baynton, n.d). Resilience needs to be used as a strategy to allow nurses to thrive, and strive, by tackling these situations, to reduce vulnerability, and allow positive changes within themselves, as well as the healthcare environment, from the experiences they encounter daily (Jackson, Firtko, & Edenborough, 2007).

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In addition, nurses should maintain flexibility, which is the ability to adapt to change (Earvolino-Ramirez, 2007), and develop a sense of humour that contributes to resilience, as it is important to make light of stressful situations, to improve coping mechanisms (Earvolino-Ramirez, 2007). Another crucial factor that contributes to the building of resilience is social support, which helps individuals to experience a sense of belonging (Baynton, n.d), and a support structure, when they are unable to cope. When strategies are not in place for anticipated circumstances in the workplace, the possibility for psychological injury is a reality (Baynton, n.d). Psychological injury occurs when a stressor overpowers the ability to cope, thereby affecting the ability to function, which includes, the way an individual thinks, how s/he responds or manages conflict and change, as well, as how s/he responds to social relations (Baynton, n.d). Resilience in the workplace enables individuals to adapt to and cope with different stressors, thereby allowing him/her to recover from challenges (Baynton, n.d).

About 70 literature papers were reviewed, to authenticate resilience as a strategy for coping in the workplace. This review revealed that nurses, exposed to specialised, emergency care, experience much higher stress levels than those in other areas of practice. It was observed that work overload was the main source of stress (Lim et al., 2010). These events may be a singular event, or may occur occasionally, which tests the nurse's ability to bounce back (Cusack et al., 2016). Zheng et al. (2017) suggest that resilient people tend to establish adaptive behaviour, as they are able to identify stressors, choose a realistic action plan, and solve problems effectively. Therefore, repeated mastery, equips individuals with a sense of competence, rather than fear, when confronting new challenges (Zheng et al., 2017).

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2.6. Summary

A supportive and strong workplace environment fulfils a significant role in the lives of these nurses (Lim et al., 2010). It is crucial to build resilience in nurses, to ensure that they remain skilled in the stressful environment, to deliver effective patient care (Cusack et al., 2016).

Nursing, as a profession in a psychiatric setting, is challenging, despite the area of psychiatry in which care is provided, whether General Adult Psychiatry, Forensics, Child and Adolescent Psychiatry, or Intellectual Disability. It places tremendous strain on the individual, due to the many challenges s/he faces on a daily basis, whether within the individual, the choices s/he has

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to make, and his/her reaction to events. Additionally, how s/he recovers from experiencing a traumatic event in the organisation; due to staff shortage, or the lack of resources, which prevents him/her from rendering appropriate care, and adds to the excess workload; or due to the mental health care user's challenging behaviour, also exacerbates the challenges. These factors affect the individual providing the care, as well the one receiving the care; thereby affecting the caring and clinical role which nurses exhibit. Nurses often leave the profession due to job dissatisfaction, as a result of emotion overload (Koen, Van Eeden, & Wissing, 2011). However, nurses who choose to remain, survive, cope and thrive within the workplace environment, despite adversities (Koen et al., 2011). Nurses are known to be the backbone of the health care structure, due to their caring, compassionate and professional dispositions (Koen et al., 2011).

In the following chapter, Chapter 3, the researcher explains the research methodology of this current study, in detail.

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CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

A research methodology comprises the techniques that the researcher uses to structure the study, and present information in a systematic manner (Polit & Beck, 2010). The following aspects will be covered in this chapter: research approach, research design, research setting, study population, sampling method, sample size, inclusion and exclusion criteria, data collection instrument, validity and reliability of the instrument, data collection process, data analysis and ethical considerations.

3.2. Research approach

A research approach is a strategy used to answer the research question, and best achieve the objectives (Brink et al., 2012). A quantitative approach was used to achieve the aim and objectives of this current study. This approach is suitable to explain the phenomena of resilience and coping, to present data numerically, consequently, providing facts on the collected data, which may reduce bias (Brink et al., 2012). As resilience and coping strategies can be measured, structured questionnaires, therefore, were used to collect the data, which were analysed, using the Statistical Package for Social Sciences (SPSS), version 25, to quantify the data.

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3.3. Research design

A research design is the overall plan of the researcher to answer the research question (Polit & Beck, 2010). It comprises the key features, and determines whether an intervention will be required, whether comparisons will be made, whether variables will be controlled, how long data will be collected, as well as where it will be collected (Polit & Beck, 2010). Using the given information, the researcher, subsequently, decides on the most appropriate design for the given study. The researcher used a non-experimental design; therefore, no manipulation was effected by the researcher, nor was the setting controlled, as the researcher was merely a bystander (Brink et al., 2012). The main aim of these designs is to describe the phenomena, and explain the relationships between variables (Brink et al., 2012).

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There are various non-experimental designs; however, for this current study, the researcher chose a descriptive survey design.

Descriptive designs are used when more information is required about a phenomenon. It describes the variables and ensures that the research question is answered, to determine what professionals have done in similar situations, as well as to gather information, where limited knowledge exists about the study population (Brink et al., 2012). It is dependent on observations, such as interviews, questionnaires, or visuals to collect data (Walliman, 2011). It aims to describe the nature of existing conditions, to determine the norm (Walliman, 2011). As it is a non-experimental design, there is no cause-effect relationship (Brink et al., 2012). A survey design is a procedure that the researcher uses to describe attitudes, opinions, behaviours, or characteristics of a population, by collecting quantitative data, in the form of questionnaires or interviews, and subsequently, statistically analysing this data to describe whether there are trends in the responses (Tanny, 2018). The researcher, therefore, used this design to gain more knowledge on the resilience of nurses working in a psychiatric hospital, and to determine the coping strategies these nurses use, in response to an unpleasant, challenging event, or difficult, stressful encounter. This was done through the distribution and collection of questionnaires, with the intention of summarising the quantitative data through statistical analysis, and generalising the results.

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3.4. Research setting

A research setting is the physical location where data collection of a given study takes place (Polit & Beck, 2010). This study was conducted in one of the four public psychiatric hospitals in the Western Cape metropole region. The hospital is based in Mitchells Plain, one of Cape Town's largest townships, an area with a population of, approximately 398 650 (Republic of South Africa [RSA], Department of Provincial and Local Government [DoLG], 2011). The area was established in the 1970s, when various communities were relocated, forcibly, by the Apartheid regime, to alleviate the shortage of housing in the Coloured community (RSA, DoLG, 2011). It is located about 20km from the city of Cape Town (RSA, DoLG, 2011). The area faces many challenges, namely, HIV/AIDS, overcrowded living conditions, crime, as well as the lack of access to public services (RSA, DoLG, 2011). Most of the population are poor, unemployed, and earn less than the household subsistence level of income (RSA, DoLG, 2011).

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The hospital is the largest of the four, with 722 inpatient beds, and also provides an outpatient service (UCT, 2017). The selected psychiatric hospital was built more than 20 years ago (Marinus, Parker, & Rippon, 2011). The grounds cover 104 hectares, occupied by 44 buildings, 33 wards, and support facilities (Marinus et al., 2011). The hospital functions as a secondary and tertiary referring institution, and is community-orientated, rendering a service to the population of the catchment area (Marinus et al., 2011). It consists of four functional business units, where services are rendered in the following areas: GAP (General Adult Psychiatry), CAP (Child and Adolescent Psychiatry), Forensics and IDS (Intellectual Disability Services) (UCT, 2017). The setting is a natural setting, as it will occur in the workplace of these nurses; therefore, no manipulation by the researcher could transpire (Brink et al., 2012). There is a total of 382 nurses currently employed by the hospital. The hospital caters for MHCUs with a wide range of mental illness, admitted as voluntary, involuntary or assisted clients, according to the Mental Health Care Act (RSA, 2002), specifically divided and cared for in the identified functional business units.

The researcher identified this hospital as the setting for this current study, because it is the largest of the four Psychiatric Hospitals in the Western Cape, where most nurses, who provide care to MHCUs would be employed/trained. This type of setting houses various MHCUs, according the Mental Health Care Act (RSA, 2002), and provides services in various functional business units, where the care provided, stressors and challenges experienced would differ from one to the next.

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3.5. Population and sample

The study population, sampling method, sample size, inclusion and exclusion criteria are discussed in this section.

3.5.1. Study population

A population is an entire group of people or objects that is of interest to the researcher (Brink et al., 2012). Once identified, the researcher selects a sample of the target population to make generalisations about the study population (Brink et al., 2012). The population for this current study was all nursing staff working at the selected psychiatric hospital, providing direct care across all four functional business units. The nurses were male and female and comprised Registered Nurses (RN) [advance psychiatry and

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general], Enrolled Nurses (EN), and Enrolled Nursing Assistants (ENA). The total population of the study was N=382 (RN [advance psychiatry]: N=67; RN [general]: N=56; EN: N=77; and ENA: N=182).

3.5.2. Sampling and sample size

Sampling is a process that the researcher uses to select a portion of the population to represent the entire population, from whom information regarding the phenomenon could be collected (Brink et al., 2012). Convenient sampling was used to select subjects to participate in this current study. The researcher contacted all the area managers, as well as all operational managers, via email, to introduce them to the nature of the research study, request permission to conduct the study on their premises, as well as access to the nursing staff in the wards. After permission was granted, the researcher went from ward to ward, to allow the inclusion of all staff, explained the aim and objectives of the study, and requested their voluntary participation. The researcher needed to ensure that the visits did not compromise patient care; therefore, the visits were scheduled for periods when the wards were less busy, for example, weekends, or during lunch times. Once on the premises, the researcher requested permission from the sister in charge of the ward, to be allowed access to the staff members. The researcher addressed the nursing staff in the tea rooms, or nurses' stations, as per their requests. Subsequently, the researcher introduced herself and the research study, providing a brief explanation of the data collection process, as well as what prospective respondents could expect, should they decide to participate in the study. Information sheets (Annexure E), consent forms (Annexure F) and the questionnaire (Annexure G) were handed to 268 nurses, who were on duty and available at the time of the researcher's visit. The response rate was 95.1%, as 255 nurses signed the consent forms and completed the questionnaire. Therefore, the sample for this current study was n=255.

3.5.2.1. Inclusion criteria

The inclusion criteria are the conditions under which the researcher wishes to include members of the population in a research sample (Brink et al., 2012). The inclusion criterion for this current study was all nurses, who provide direct patient care across all the functional business units, namely, RNs in advance psychiatry, RNs in general nursing, ENs and ENAs.

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3.5.2.2. Exclusion criteria

The exclusion criteria are the conditions under which the researcher wishes to exclude members of the population in a research sample (Brink et al., 2012). The exclusion criterion of this study was all nursing managers and nurses, who are not responsible for direct patient care, namely, the deputy manager, assistant managers, operational managers, the occupational health and safety RN, the NIMART RN, and the clinical coordinator. Agency nurses and community service nurses were also excluded from the study, as they spent limited time in the wards.

3.6. Data collection

Data collection is a process that adheres to guidelines, developed by researchers, to provide direction (Polit & Beck, 2010). The data collection instrument, validity and reliability of the instrument, as well as the process for data collection are discussed in this section.

3.6.1. Data collection instrument

A data collection instrument is a tool used by a researcher to collect data (Polit & Beck, 2010). The tool used to collect data in this current study was in the form of a questionnaire for a survey. A questionnaire is a research instrument portrayed as a list of questions in the form of a document to gather self-report data (Polit & Beck, 2010). Two existing structured self-report questionnaires, namely the Brief Resilience Scale (Smith et al., 2008), and the Brief COPE Scale (Carver, 1997), were adapted and used for data collection, to meet the objectives of this current study. Permission was obtained from the authors to utilise the scales for data collection in this current study (Annexure C and Annexure D). Both scales are Likert scales, used to test feelings and attitudes, by scoring each item with responses that rate from *strongly agree* to *strongly disagree* (Brink et al., 2012). The questionnaire consisted of 41 questions. For this current study, the researcher combined both scales as follows: The questionnaire (Annexure G) comprised three sections: Section A: Demographics; Section B: BRS; and Section C: Brief COPE. The questionnaire required about 10 to 20 minutes to complete.

- **Section A: Demographics**

  This section contained 7 questions that focused on age, race, gender, nursing category, years of experience, functional business unit and shift.

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- **Section B: Brief Resilience Scale (BRS)**

The BRS is a validated self-report 6-item Likert type scale, with a 5-point rating scale, developed by Smith et al. (2008), to measure a person's ability to bounce back, or recover from stress. The researcher, therefore, utilised the scale with nurses, who were experiencing challenges and stressors in the workplace, as well as how they recovered from these difficulties. The BRS has been used in other studies to test resilience in undergraduate students (Smith et al., 2008; Smith, Tooley, Christopher, & Kay, 2010), cardiac rehabilitation patients, women who either had fibromyalgia, or who were healthy (Smith et al., 2008), parents of children with intellectual disabilities or developmental disorders, oncology patients, HIV-positive patients, and the general population (Rodríguez-Rey et al., 2015). The BRS was modified according to items, now presenting as 8, 9, 10, 11, 12 and 13 (Smith et al., 2008). Usually, this scale contains three positively worded items and three negatively worded ones; therefore, items 8, 10 and 12 are positively phrased, while items 9, 11 and 13 are negatively phrased, which uses reverse coding to be scored (Smith et al., 2008). However, in this current study, the researcher adapted the scale, so that the negatively worded items were positively phrased, to prevent reversal of scoring; therefore, questions 9, 11 and 13 were changed, in consultation with a statistician. The ratings were as follows: 0 = *strongly disagree*, 1 = *disagree*, 2 = *neutral*, 3 = *agree*, 4 = *strongly agree* (Smith et al., 2008). This section contained 6 questions. The scoring key for resilience is illustrated Table 3.1.

Table 3.1: Resilience scoring

RESILIENCE SCORE (According to SMITH et al., 2013)	RESILIENCE SCORE (in this current study)	INTERPRETATION
1.00 - 2.99	0.00 - 1.99	Low resilience
3.00 - 4.30	2.00 - 3.30	Normal resilience
4.31 - 5.00	3.31 - 4.00	High resilience

(Smith, Epstein, Oritz, Christopher & Tooley, 2013, p.177)

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- **Section C: Brief COPE scale**

  The Brief COPE is a validated 28-item Likert type scale, with a 4-point rating scale, developed by Carver (1997), to assess various coping responses to stressful events, and comprises 14 dimensions with 28 questions (Carver, 1997). In this current study, the domains (Annexure H) were not provided to the respondents, to avoid confusion, and only assessed in the data analysis phase; therefore, only the items falling under the domains were stipulated in the questionnaire. This scale has been used in various empirical research that evaluated the role of coping, while facing various stressors, such as heart failure (Bean, Gibson, Flattery, Duncan, & Hess, 2009; Carels, Musher-Eizenman, Cacciapaglia, Pérez-Benítez, Christie, & O'Brien, 2004; Klein, Turvey, & Pies, 2007; Paukert, LeMaire, & Cully, 2009), HIV disease (Sanjuan, Molero, Fuster, & Nouvilas, 2013), terrorism (Stein, Schorr, Litz, King, King, Solomon, & Horesh, 2013), and caregiving for a family member with a mental illness (Wrosch, Amir, & Miller, 2011).

  The brief COPE scale (Carver, 1997) was modified according to items starting from 14 to 41 as both scales were combined. The ratings were as follows: 0 = *I haven't been doing this at all*, 1 = *I've been doing this a little bit*, 2 = *I've been doing this a medium amount*, 3 = *I've been doing this a lot*, scored from 0 to 3, respectively, which does not use reversals of coding (Carver, 1997; Monzani et al., 2015). The scale is aimed at determining how an individual copes with stressors, what coping style(s)/strategies s/he employs, to what extent the coping style/strategy is to be used, as well as how frequently (Carver, 1997). As individuals cope in different ways, there is no assumed dominant coping strategy (Carver, 1997); therefore, no overall score exists on this scale, as each item illustrates a particular way of coping (Carver, 1997).

3.6.2. Validity

According to Brink et al. (2012, p. 165) and Polit & Beck (2010, p. 377), the validity of the instrument is used to determine whether the identified instrument or tool that will be used to collect data, "measures what it is supposed to measure".

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The researcher used content validity and face validity to ensure that the instrument used in this current study was valid, which is the first step in establishing that the instrument is accurate (Brink et al., 2012). Content validity assesses how well an instrument represents all components of the variable (Brink et al., 2012). A pre-test was conducted with five respondents to ensure that the questionnaire was valid and reliable. The five respondents included in the pre-test were taken from the various units in the setting, which represented the sample. This also allowed the researcher to identify any fault on the questionnaire, or simplify it by any means where necessary, as well as identify the time needed for completion of the questionnaire. No changes were made to the questionnaire as the respondents easily identified what was required of them. The pre-test confirmed the clarity on items of the scale. Face validity ensures that the instrument measures what it is intended to measure (Brink et al., 2012). Table 3.2. Illustrates the validity of the instrument, where each objective is linked to items on the instrument.

Table 3.2: Validity of the BRS and Brief COPE scale

OBJECTIVES	ITEM
1. To determine nurses ability to bounce back and recover from stress.	BRS: Items 8 - 13
2. To describe coping strategies used by nurses in the psychiatric hospital.	Brief COPE: Items 14 - 41
3. To determine the association between resilience and coping strategies of nurses working at a psychiatric hospital in the Western Cape.	Demographics, BRS and Brief Cope: Items 1 - 41

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Table 3.2 stipulates that objective one was answered by the BRS from items 8 to 13, objective two was answered by the Brief COPE scale from items 14 to 41 and objective three was answered by all items from 1 to 41, which included the demographic section, BRS and the Brief COPE scale, as associations was made.

3.6.3. Reliability

The reliability of an instrument is used to assess its quality by being consistent with the outcome (Polit & Beck, 2010). Therefore, the measurements should be accurate and the errors, minimized (Polit & Beck, 2010). The three aspects of reliability are: “stability, internal consistency, and equivalence” (Polit & Beck, 2010, p. 373). The aspect of reliability that was used in this study is, internal consistency reliability, also known as ‘homogeneity’, which ensures that all items on the instrument are consistent and

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measures the same variable (Brink et al., 2012), usually assessed by using the Cronbach's Alpha Coefficient (Polit & Beck, 2010).

The reliability of the instrument was tested, using Cronbach's Alpha coefficient to ensure internal consistency. Cronbach's Alpha, also known as *coefficient alpha* is "a widely used reliability index that estimates the internal consistency of a measure composed of several subparts" (Polit & Beck, 2010, p. 551). The normal values for Cronbach's Alpha range from .00 and +1.00, thus the higher the Cronbach's Alpha, the higher the reliability, and the more accurate the measure (Polit & Beck, 2010).

In other studies, the internal consistency of the BRS study was good, which used Cronbach's Alpha, and ranged from .80 to .91 (Smith et al., 2008). The results found that the scale was reliable (Smith et al., 2008). The BRS was given twice, the test-retest reliability was found to be .69 in one month, and .62 in three months, using the interclass coefficient correlation (ICC) (Smith et al., 2008). The Brief COPE was given twice at two/three weeks, and again at ten weeks (Yusoff et al., 2010). The ICC ranged from 0.05 to 1.00 (Yusoff et al., 2010). The internal consistency of the Brief COPE showed fairly good reliability with internal consistencies, using Cronbach's Alpha ranging from 0.25 (self-blame) to 1.00 (substance abuse) (Yusoff et al., 2010). The Cronbach's Alpha of the BRS for this current study was .738, and the Cronbach's Alpha for the brief COPE scale in this current study was .912. The Cronbach's Alpha for both scales of the study was .891, which, according to Pallant (2011), a score above .7 is acceptable, but a score above .8 is preferable. This measure indicates that the tool was reliable.

3.6.4. Data collection process

During the data collection process, the researcher adhered to developed guidelines for direction to collect data (Polit & Beck, 2010). In this section, the researcher aimed to answer the *what*, *how*, *who*, *where* and *when* of the research process (Brink et al., 2012). Once ethics approval was obtained from the Biomedical Science Research Ethics Committee (BMREC) of the institution under scrutiny (Annexure A), as well as approval to conduct research from the institution's Research Committee (Annexure B), the data collection process commenced. However, before the main data collection survey, a pre-test was conducted with 5 respondents to ensure that the questionnaire was relevant, valid, and reliable, as stated previously.

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Upon agreement of dates and times for data collection, the researcher went from ward to ward, explaining the details of the study. The title of the study was revealed; what the aim was; what participation benefits and risks were involved; the duration of questionnaire completion; how data collection would take place; anonymity and confidentiality were stressed; as well as the willingness to participate, explained in terms of it being voluntary, and that they should not feel pressurized to participate in the study. The nursing staff were also informed about the institution that approved the study, and were given the opportunity to clarify any misunderstood information, or to request more information about the study.

An information sheet (Annexure E) stating the purpose of the research study and a consent form (Annexure F) was distributed to the available nurses, who were willing to participate in this current study, accompanied by a questionnaire (Annexure G) for the survey. These documents were left with the willing prospective respondents to complete. The researcher's contact details was included in the information sheets, in the event that the respondents would need any more clarity on the questionnaire, or intent of the study. The researcher, in agreement with the respondents, decided to either wait on them to sign the consent form (Annexure F) and complete the questionnaire (Annexure G), or return later that day, or the day after. The consent form (Annexure F) and questionnaire (Annexure G) was collected separately, each in its own envelope; therefore, no connection could be made between the respondent and the questionnaire, to ensure anonymity. Data collection took place from 17 May 2019 to 26 May 2019, for a period of 9 days.

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3.7. Data analysis

Data analysis is a methodical arrangement and synthesis of research data (Polit & Beck, 2010). A codebook (Annexure I) was created prior to data collection. A codebook is a guide for coding responses that serves as a document, which describes the layout of the data file to represent variables (Lavrakas, 2008), a summary of instructions used to convert collected data in a format SPSS understands, by defining variables and assigning numbers to responses (Pallant, 2011). Upon the completion of data collection, the questionnaires were checked to ensure that all were fully completed and valid for data analysis. Each questionnaire that was completed, was

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numbered in order to be identified. Subsequently, the codebook was used to code the raw data, extracted from the questionnaires, on to SPSS, using version 25. Coding is a process of transforming raw data in a systematic way, for data to be processed and analysed by numbering categories (Polit & Beck, 2010). After coding, the data captured was screened and cleaned to check for errors. The process of data analysis was done with the assistance of a statistician.

In this current study, descriptive and correlation analysis was used. Descriptive analysis aims to describe the characteristics of the sample, check variables for violations and address the research question (Pallant, 2011). This was used to answer objective 1 and 2, using the non-parametric statistics, specifically the chi-square test and analysis of variance (ANOVA). Correlation analysis describes the relationship between two variables (Pallant, 2011), which was used to answer objective 3, using Pearson product-moment correlation coefficient. The analysed data were presented in pie graphs and tables, as illustrated in Chapter 4.

3.8. Ethics

Before the commencement of the data collection process, ethics approval was obtained from the Biomedical Research Ethics Committee at the institution of study (Annexure A). In addition, permission was granted by the Western Cape Department of Health to conduct the study at the selected psychiatric hospital, and the Research Ethics Committee of the institution approved the study to collect data (Annexure B). Ethic principles (beneficence, respect for human dignity and justice) should be adhered to, when involving human subjects in a research study, to address any ethical issues that may be used against the evidence gathered (Polit & Beck, 2010). The researcher adhered to the following ethic principles during the research study:

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3.8.1. Principle of respect for persons

The respondents were given the right of autonomy, to freely choose whether or not they would like to participate in the study; therefore, their right of self-determination was protected (Brink et al., 2012). The respondents were given information sheets (Annexure E) explaining the purpose of the study, as well as consent forms (Annexure F) stating that they consent to participate in the study, should they voluntarily decide to do so. Subsequently, the respondents were assured that the information obtained would not be used against them in any way, but would remain confidential, and the respondents would remain anonymous, as the information would not be linked to any individual. The respondents were informed that they could withdraw from the study at any time, and

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were free to ask any questions, or raise concerns, when needed, or refuse to provide certain information, without exposure to penalty, or harm (Brink et al., 2012).

3.8.2. Principle of beneficence

As all research carries some sought of risk, the researcher ensured that the respondents' right to protection from harm were maintained by implementing the following: The researcher explained the purpose, objectives, and risk-to-benefit ratio to the respondents, to ensure they were aware of what was expected of them during the study, and to obtain their consent, as they were the main subjects in the study. The respondents were also informed that they were required to complete the questionnaire during their free time, such as during their lunch break, or at home, as they were not required to complete it while formally caring for patients, as this would compromise patient care. The safety of the respondents were maintained as the study was conducted in the hospital with a 24-hour security, or in their homes, which were considered safe environments. This research however, carried minimal risk; therefore, the researcher explained that respondents would be referred to a pre-arranged counsellor, should they experience any distress during participation in the study, such as fear of responses that may expose them, and may seek clarity on questions, or air complaints, if necessary. Fortunately, no respondents experienced, or reported distress during, or after the time of the study. The researcher maintained the anonymity of the hospital, by not identifying it in the study, to avoid harm to the reputation of the hospital (Brink et al., 2012).

3.8.3. Principle of justice

The researcher treated all respondents equally, and did not discriminate, based on age, race, gender, rank or years of experience. The information presented by the researcher was done in English, as it was expected of the respondents to complete the questionnaires in English, which is the language of communication used at the hospital. As the study was all-inclusive, each participant had an equal chance of participating in the study. The researcher ensured that no judgement was passed on those who were not willing to participate in the study, and demonstrated respect towards opinions and beliefs of respondents from various backgrounds. Agreements made were respected by the researcher, in terms of times of distribution and collection of questionnaires. The researcher ensured that information, received from the respondents were kept confidential, and anonymity was maintained; therefore, no information was shared with

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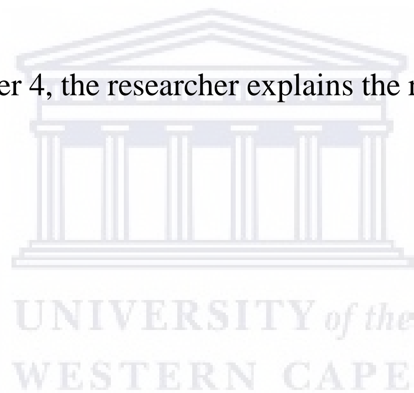
others, who were not directly involve with the study. In addition, the questionnaire did not require a name, as they were numbered during data analysis; therefore, no participant was exposed. The consent forms and the questionnaires were kept in separate envelopes, and all consent forms was collected first, ensuring that the respondents were not matched to the questionnaire; consequently, maintaining their privacy. After separately collecting consent forms and questionnaires, the researcher locked the documents away in a safe and secure place (Brink et al., 2012).

3.9. Summary

The following topics were addressed and thoroughly discussed in this chapter: research approach, research design, the setting, study population, sampling and sample size, inclusion and exclusion criteria, data collection instrument, validity and reliability of the instrument, data collection process, data analysis and ethics.

In the following chapter, Chapter 4, the researcher explains the research findings of this study.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CHAPTER FOUR

RESEARCH FINDINGS

4.1. Introduction

This chapter comprises the findings of the analysed data, as collected from the respondents. The purpose of this current study was to investigate the resilience and coping among nurses working at a psychiatric hospital in the Western Cape, South Africa, and to determine the association between resilience and coping strategies. The results of this study are presented in four sections based on the objectives, including the demographical data:

1. To determine nurses ability to bounce back and recover from stress in psychiatric hospital in the Western Cape.

2. To describe the coping strategies used by nurses in the psychiatric hospital in the Western Cape.

3. To determine the association between resilience and coping strategies of nurses working at a psychiatric hospital in the Western Cape

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Section A describes the sample realisation and a description of the respondents. **Section B** describes the main outcome of the study, namely resilience (Objective 1), **Section C**, the coping strategies (objective 2), and **Section D** presents the findings of the association between resilience and coping strategies (objective 3).

SECTION A

In this section, the researcher describes the sample and tests used, based on the demographics. The sample is described in the form of frequency tables and pie charts, using descriptive statistics. A description of the respondents is provided, with a total, and tabulated according to percentages, along with a brief explanation. The sole focus of this section is to unpack the demographics of the questionnaire.

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4.2. Sample Realisation

The population of the study were all the nurses working in a selected psychiatric hospital in the Western Cape, South Africa. At the time of the survey, there was a total of 382 nurses working at that facility, with 182 being enrolled nursing assistants, 77 enrolled nurses, 56 professional nurses (general), and 67 professional nurses (advance psychiatry). A total of 268 questionnaires were distributed to nurses in the psychiatric hospital; however, only 255 questionnaires were completed, a response rate of 95.1%. Thirteen (13) nurses were not available to follow-up. The remaining staff were also unavailable; some were on leave or off-sick at the time of data collection. Due to the different roles of the nurses in the various functional business units, the results are presented separately for these groups, and the differences tested with chi-square test and ANOVA, where relevant.

4.2.1. Demographic of respondents

In this section, the researcher provided a detailed outline of the demographics of the respondents. The following information was tabulated and presented in tables, figures and pie charts, according to the percentages of respondents, based on the demographics (age, race, gender, nursing category, years of experience, functional business unit and shift) followed by a brief discussion. Therefore, the numerical variables (age and years of experience) were presented in tables, and the categorical variables (race, gender, nursing category, functional business unit and shift) were presented in pie graphs.

Table 4.1: Age of the respondents

	N Statistic	Mean Statistic	Median Statistic	Std. Deviation	Minimum Statistic	Maximum Statistic
Age in years	255	44.26	44.0	9.323	27	64
Valid N	255					

The minimum age was 27 years, and the maximum age was 64 years. The average age was 44.26, and the median 44.0, with a standard deviation of 9.323 years.

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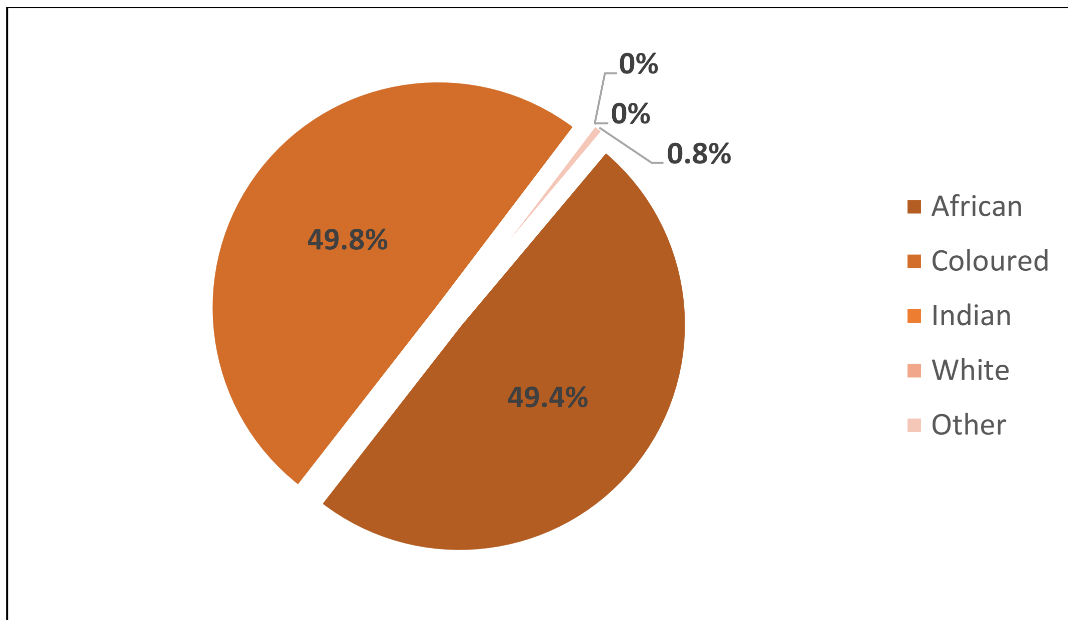

Figure 4.1: Race of respondents

In Figure 4.1, of the total of respondents, about half of the respondents, 49.4% (n=126) were African, and 49.8% (n=127) were Coloured, with only two, 0.8% (n=2) categorised as other.

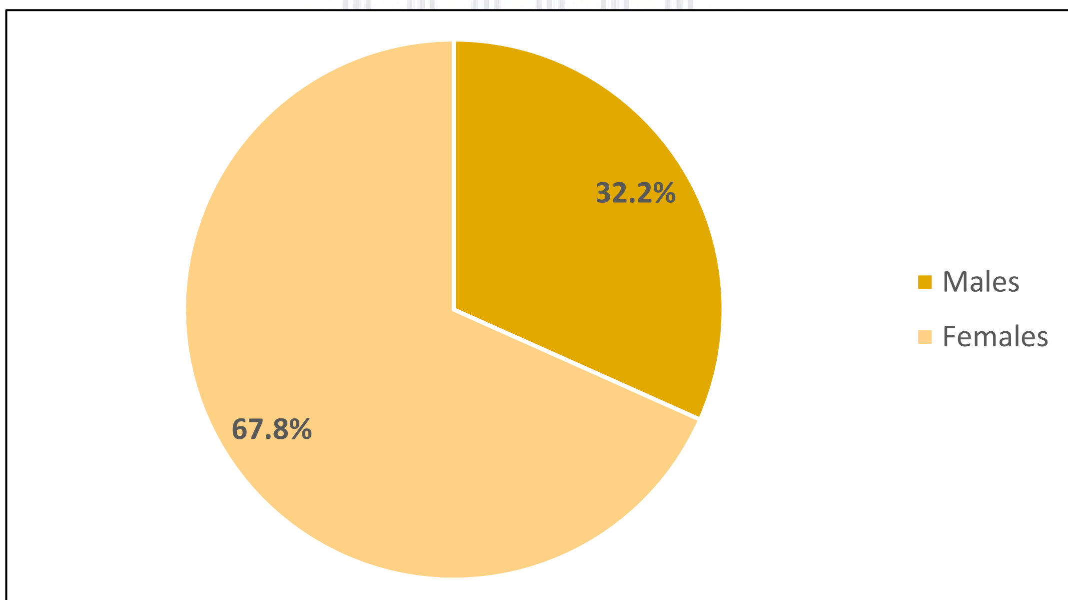

Figure 4.2: Gender of respondents

In Figure 4.2, of the total of respondents, most were female, 67.8% (n=173), while only 32.2 % (n=82) were male, which is about one-third of the population.

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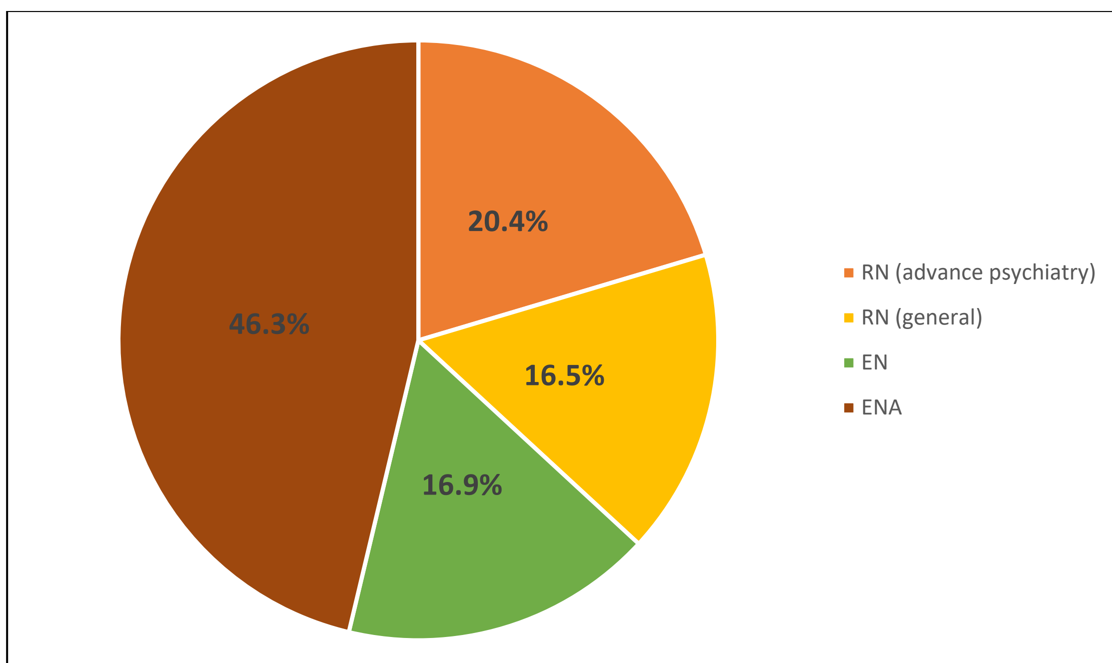

Figure 4.3: Nursing category of respondents

In Figure 4.3, the majority of the respondents were ENA 46.3% (n-118), with RN (advance psychiatry) 20.4% (n=52), followed closely by the EN 16.9% (n=43), and RN (general) 16.5% (n=42).

Table 4.2: Years of experience in institution of respondents

	N Statistic	Mean Statistic	Median Statistic	Std. Deviation	Minimum Statistic	Maximum Statistic
Years of experience	255	12.32	7.00	10.857	1	40
Valid N	255					

The minimum number of years of experience in the institution was 1 year, and the maximum amount of years of experience in the institution was 40 years. The mean was 12.32 years with a standard deviation of 10.857 years.

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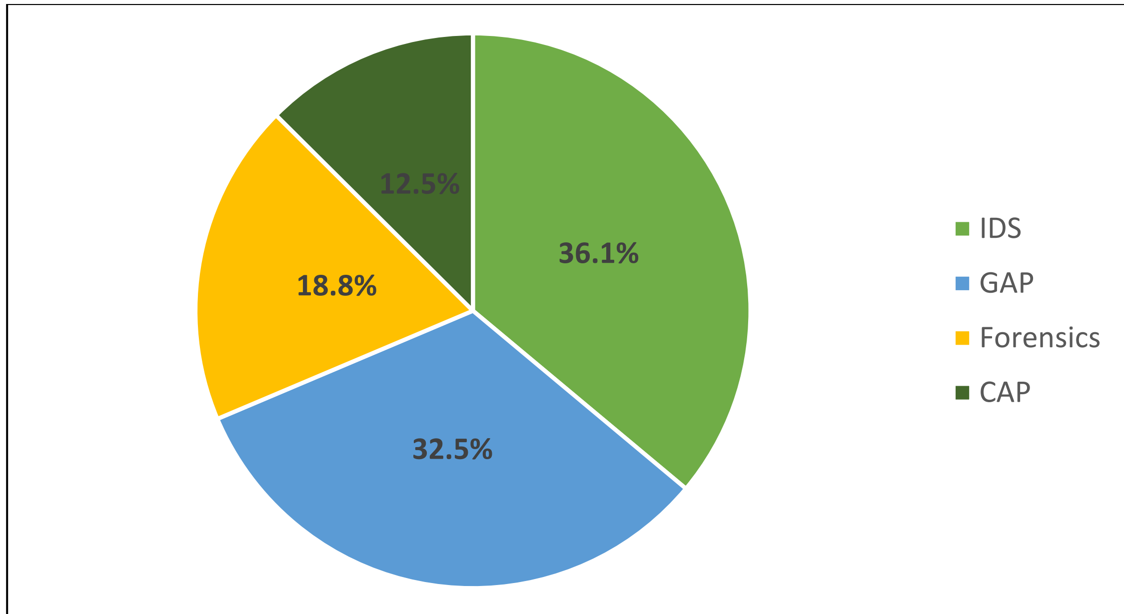

Figure 4.4: Functional Business Unit of respondents

In figure 4.4, most of the respondents 36.1% (n=92) were in the IDS functional business unit, followed closely by those in the GAP unit 32.5% (n=83), forensic 18.8% (n=48) and CAP 12.5% (n=32).

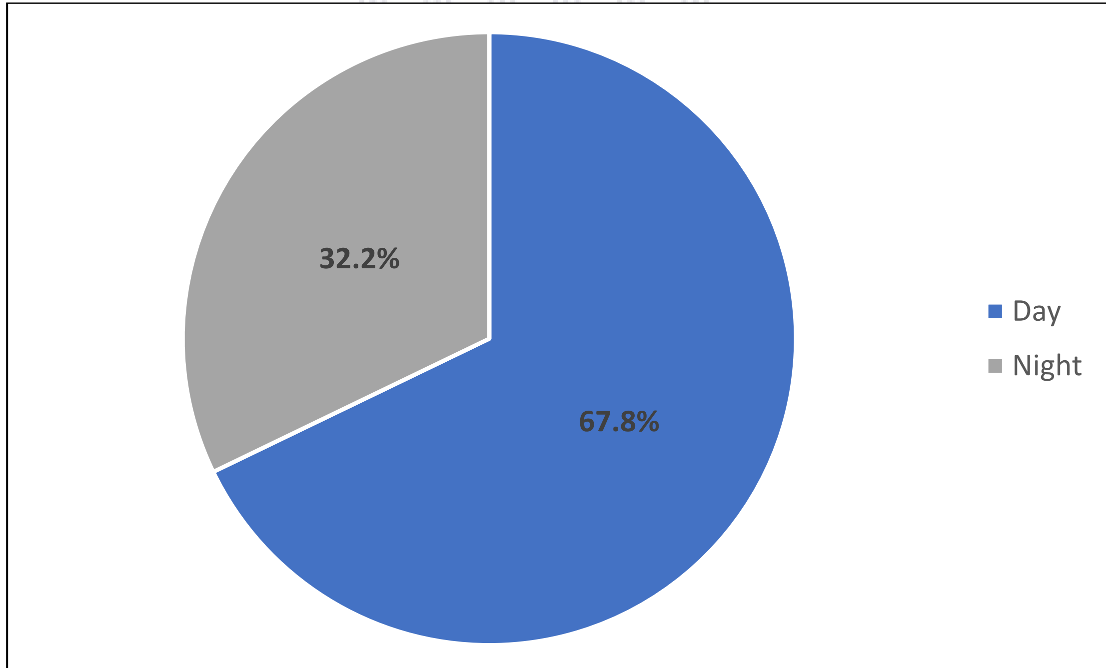

Figure 4.5: Shift of respondents

In figure 4.5, the majority of the respondents 67.8% (n=173) were working during the day shift, while 32.2% (n=82) were on the night shift.

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SECTION B

In this section, the researcher aimed to analyse the resilience of nurses, by determining their ability to bounce back and recover from stress, and tabulating the differences according to the various functional business units (GAP, Forensics, CAP and IDS), based on items of the BRS.

Table 4.3: Respondents ability to bounce back and recover from stress

Brief resilience items	Level of agreement							
	Total (N=255)	GAP (n=83)	Forensic (n=48)	CAP (n=32)	IDS (n=92)	Test	p-value	M(±sd)
10. It does not take me long to recover from a stressful event	183(71.8%)	60(72.3%)	36(75.0%)	21(65.6%)	66(71.7%)	X^2= 0.9	.836	2.8(0.9)
13. I do not tend to take a long time to get over set-backs in my life	176(69.0%)	50(60.2%)	35(72.9%)	25(78.1%)	66(71.7%)	X^2= 4.9	.180	2.7(1.0)
8. I tend to bounce back quickly after hard times	162(63.5%)	54(65.1%)	28(58.3%)	20(62.5%)	60(65.2%)	X^2= 0.7	.856	2.6(1.1)
12. I usually come through difficult times with little trouble	151(59.2%)	53(63.9%)	28(58.3%)	20(62.5%)	50(54.3%)	X^2= 1.8	.615	2.5(1.0)
11. It is not hard for me to snap back when something bad happens	142(55.7%)	51(61.4%)	28(58.3%)	14(43.8%)	49(53.3%)	X^2= 3.3	.345	2.4(1.0)
9. I do not have a hard time making it through stressful events	137(53.7%)	46(55.4%)	26(54.2%)	16(50.0%)	49(53.3%)	X^2= 0.2	.963	2.4(1.0)
Nurses ability to bounce back or recover from stress	**2.5(0.7) 95%CI 2.6-2.5 Range=0-4**	**2.6(0.6)**	**2.4(0.8)**	**2.5(0.6)**	**2.6(0.7)**	***F*=0.6**	**.609**	

*Chi-square Test (or Fisher Exact Tests where appropriate), Independence sample T-test. *Significant atp<.05*

4.3. Respondents ability to bounce back and recover from stress

The nurses' ability to bounce back/recover from stress was measured by asking the respondents to rate their level of agreement with a list of statements relating to resilience, using the brief resilience items, according to the brief resilience scale. Most of the respondents (183, 71.8%, 2.8 ±0.9 out of a possible of 4) agreed that, *It does not take them long to recover from a stressful event*, this was followed closely by, *I do not tend to take a long time to get over set-backs in my life* (176, 69.0%, 2.7 ±1.0). About two-thirds of the respondents (162, 63.5%, 2.6±1.1) tended to bounce back quickly after difficult times. More than half of the respondents (151, 59.2%, 2.5±1.0) agreed that they usually came through difficult times with little trouble, that,

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It is not hard for them to snap back when something bad happens (142, 55.7% 2.4±1.0) and that, *They do not have a hard time making it through stressful events* (137, 53.7% 2.4±1.0). There was no significant difference between the groups in these items. (Table 4.3). The mean resilience score was 2.5 (±0.7) out of a possible of 4 [95% CI 2.6 -2.5]. There was no significant difference found between the groups (F=0.6, p=.609), as illustrated in Table 4.3.

SECTION C

In this section, the researcher described coping strategies used by respondents, based on the Brief COPE scale. The information was tabulated in two separate tables (tables 4.5 4.6), focusing on the 14 domains and 28 items, according to percentages. Specific focus was on the difference between the functional business units.

Table 4.4: Coping strategies used by respondents

Domain	Item	Total	Doing a lot	Doing	Not doing at all
Religion	I've been trying to find comfort in my religion or spiritual beliefs	255(100%)	132(51.8%)	91(35.7%)	32(12.5%)
	I've been praying or meditating	255(100%)	132(51.8%)	92(36.1%)	31(12.2%)
Active Coping	I've been concentrating my efforts on doing something about the situation I'm in	255(100%)	103(40.4%)	134(52.5%)	18(7.1%)
	I've been taking action to try to make the situation better	255(100%)	115(45.1%)	111(43.5%)	29(11.4%)
Positive reframing	I've been trying to see it in a different light, to make it seem more positive	255(100%)	93(36.5%)	126(49.4%)	36(14.1%)
	I've been looking for something good in what is happening	255(100%)	115(45.1%)	110(43.1%)	30(11.8%)
Planning	I've been trying to come up with a strategy about what to do	255(100%)	116(45.5%)	113(44.3%)	26(10.2%)
	I've been thinking hard about what steps to take	255(100%)	103(40.4%)	117(45.9%)	35(13.7%)
Acceptance	I've been accepting the reality of the fact that it has happened	255(100%)	108(42.4%)	114(44.7%)	33(12.9%)
	I've been learning to live with it	255(100%)	87(34.1%)	127(49.8%)	41(16.1%)
Self-distraction	I've been turning to work or other activities to take my mind off things	255(100%)	76(29.8%)	129(50.6%)	50(19.6%)
	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming,	255(100%)	110(43.1%)	110(43.1%)	35(13.7%)
Use of instrumental support	I've been getting help and advice from other people	255(100%)	79(31.0%)	138(54.1%)	38(14.9%)
	I've been trying to get advice or help from other people about what to do	255(100%)	81(31.8%)	133(52.2%)	41(16.1%)
Use of emotional support	I've been getting emotional support from others	255(100%)	63(24.7%)	125(49.0%)	67(26.3%)
	I've been getting comfort and understanding from someone	255(100%)	77(30.2%)	136(53.3%)	42(16.5%)

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Venting	I've been saying things to let my unpleasant feelings escape	255(100%)	40(15.7%)	114(44.7%)	101(39.6%)
	I've been expressing my negative feelings	255(100%)	69(27.1%)	125(49.0%)	61(23.95)
Humour	I've been making jokes about it	255(100%)	72(28.2%)	104(40.8%)	79(31.0%)
	I've been making fun of the situation	255(100%)	47(18.4%)	102(40.0%)	106(41.6%)
Denial	I've been saying to myself "this isn't real"	255(100%)	42(16.5%)	129(50.6%)	84(32.9%)
	I've been refusing to believe that it has happened	255(100%)	34(14.1%)	119(46.7%)	100(39.2%)
Self-blame	I've been criticising myself	255(100%)	25(9.8%)	114(44.7%)	116(45.5%)
	I've been blaming myself for things that happened	255(100%)	29(11.4%)	103(40.4%)	123(48.2%)
Behavioural disengage-ment	I've been giving up trying to deal with it	255(100%)	28(11.0%)	99(38.8%)	128(50.2%)
	I've been giving up the attempt to cope	255(100%)	30(11.8%)	74(29.0%)	151(59.2%)
Substance abuse	I've been using alcohol or other drugs to make myself feel better	255(100%)	6(2.4%)	40(15.7%)	209(82.0%)
	I've been using alcohol or other drugs to help me get through it	255(100%)	11(4.3%)	33(12.9%)	211(82.7%)

Table 4.5: Domains of coping strategies used

Brief resilience items	Level of agreement						
	Total (N=255)	GAP (n=83)	Forensic (n=48)	CAP (n=32)	IDS (n=92)	Test	*p*-value
Religion	2.1(1.0)	2.1(0.9)	1.9(1.1)	2.0(1.1)	2.3(0.9)	F=2.1	.106
Active Coping	2.1(0.8)	2.2(0.8)	1.9(1.0)	1.8(0.9)	2.1(0.8)	F=2.0	.114
Positive reframing	2.0(0.9)	2.0(0.9)	1.9(1.0)	1.9(1.0)	1.9(1.0)	F=0.3	.809
Planning	2.0(0.9)	2.1(0.9)	1.8(1.0)	1.8(0.8)	2.1(0.9)	F=2.1	.105
Acceptance	1.9(0.9)	2.0(0.9)	1.8(1.0)	1.7(1.0)	1.9(0.9)	F=0.9	.457
Self-distraction	1.8(0.9)	1.8(0.9)	1.6(1.0)	1.7(0.9)	1.8(0.9)	F=1.8	.143
Use of instrumental support	1.8(0.9)	1.7(0.9)	1.7(1.0)	1.6(0.9)	1.9(0.9)	F=1.1	.348
Use of emotional support	1.6(1.0)	1.7(0.9)	1.3(1.0)	1.6(0.9)	1.7(0.9)	F=2.3	.078
Venting	1.3(0.9)	1.3(0.9)	1.2(0.8)	1.2(0.7)	1.5(0.9)	F=1.5	.222
Humour	1.3(1.1)	1.2(1.1)	1.3(1.1)	0.9(0.9)	1.5(1.1)	F=2.9	.037*
Denial	1.1(0.9)	0.9(0.9)	1.0(0.8)	1.1(0.9)	1.4(0.9)	F=4.0	.009*
Self-blame	0.9(0.9)	0.9(0.9)	0.9(0.9)	0.8(0.8)	0.9(0.9)	F=0.5	.746
Behavioural disengagement	0.8(0.9)	0.6(0.8)	0.7(0.8)	0.8(0.8)	1.1(1.0)	F=3.8	.012*
Substance Abuse	0.3(0.6)	0.3(0.6)	0.2(0.5)	0.2(0.5)	0.4(0.7)	F=0.8	.511

*Chi-square Test (or Fisher Exact Tests where appropriate), Independence sample T-test. *Significant at p<.05*

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4.4. Coping strategies used by respondents

In measuring the coping strategies items used by nurses in the psychiatric hospital, 28 items, grouped into 14 domains were used. The most frequently used coping strategy was the items of religion which was , *I've been trying to find comfort in my religion or spiritual beliefs* (132, 51.8%) and, *I've been praying or meditating* (132, 51.8%), which was followed closely by the items of Active coping, which were, *I've been taking action to try to make the situation better* (115, 45.1%) and, *I've been concentrating my efforts on doing something about the situation I'm in* (103, 40.4%). The least coping strategies used were the items of substance abuse, which were, *I've been using alcohol or other drugs to help me get through it* (11, 4.3%) and, *I've been using alcohol or other drugs to make myself feel better* (6, 2.4%) as illustrated in Table 4.4.

In measuring the domains of coping strategies used, religion and active coping were the most used coping strategies. Religion had an average use of 2.1(± 1.0), out of a possible of 3, with an average use of 2.1(± 0.9) among those in GAP, 1.9(± 1.1), among those in forensic, 2.0(± 1.1), in CAP and 2.3(± 0.9) among those in IDS. Active coping had an average use of 2.1(± 0.8), out of a possible of 3, with an average use of 2.2(± 0.8) among those in GAP, 1.9(± 1.0) among those in forensic, 1.8(± 0.9) among those in CAP, and 2.1(± 0.8) among those in IDS.

This was followed closely by Positive reframing and planning (Table 4.5). Positive reframing had an average use of 2.0(± 0.9), out of a possible of 3, with an average use of 2.0(± 0.9) among those in GAP, 1.9(± 1.0) among those in forensic, 1.9(± 1.0) among those in CAP, and 1.9(± 1.0) among those in IDS. Planning had an average use of 2.0(± 0.9), out of a possible of 3, with an average use of 2.0(± 0.9) among those in GAP, 1.8(± 1.0) among those in forensic, 1.8(± 1.0) among those in CAP, and 2.1(± 0.9) among those in IDS (Table 4.5).

Usage of the rest of the domains of coping strategies were lower (Table 4.4). However, humour, denial and behavioural disengagement showed a significant difference between the groups. The respondents in the IDS unit used humour more, 1.5(±1.0), as compared to those in GAP (1.2±1.1), Forensic (1.3±1.1), and CAP (0.9±0.9) (F=2.9, *p*=.037), as illustrated in Table 4.5. Similarly, the respondents in the IDS unit used denial more, (1.4±0.9) as compared to those in GAP (0.9±0.9), Forensic (1.0±0.8), and CAP (1.1±0.9) (F=4.0, *p*=.009). The respondents in IDS unit used behavioural disengagement more, (1.1±1.0), as compared to those in GAP (0.6±0.8), Forensic (0.7±0.8), and CAP (0.8±0.8) (F=2.9, *p*=.012), as illustrated in Table 4.5.

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SECTION D

In this section, the researcher determined the association between resilience and coping strategies, using the items of the BRS and various domains of the Brief COPE scale.

Table 4.6: Association between resilience and coping strategies of respondents

Coping strategies	Pearson Correlation (r)	*p*-value Sig. (2-tailed)
Self-distraction	.03	.61
Active coping	.14	.03*
Denial	-.13	.03*
Substance Abuse	-.06	.31
Use of emotional support	.07	.25
Use of instrumental support	.01	.86
Behavioural disengagement	-.03	.66
Venting	.12	.05*
Positive Reframing	-.03	.64
Planning	-.02	.74
Humour	.07	.25
Acceptance	.03	.60
Religion	-.06	.36
Self-Blame	-.12	.07*

The association between resilience (as measured by the BRS) and coping strategy (as measured by the Brief COPE scale) was investigated, using Pearson product-moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity.

Small	r = .10 to .29
Medium	r = .30 to .49
Large	r = .50 to 1.0

(Cohen, 1988, p. 79-81 as cited in Pallant, 2011)

There was a small correlation between resilience and the domains of Brief COPE (Table 4.5). It is important to note that there was a significant correlation between resilience and active coping, denial and venting. There was a positive correlation between resilience and active

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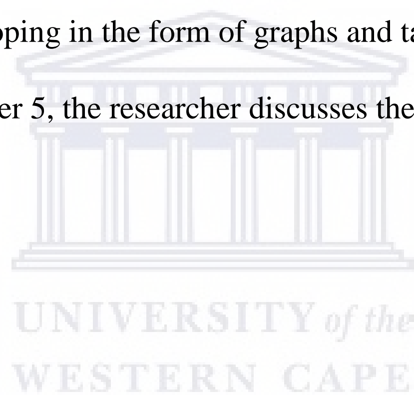
coping (r = .14, p = .03*, n = 255), which implied that, the more respondents actively coped with a situation, the more resilient they became. There was a negative significant correlation between resilience and denial (r = -.13, p = .03*, n = 255), which implied that, the more the respondents used denial in coping with a situation, the less resilient they became. There was also a positive correlation between resilience and venting (r =.12, p = .05*, n = 255), which implied that, the more the respondents used venting as a coping strategy, the more resilient they became. There was also a negative correlation between resilience and self-blame (r = -.12, p = .07*, n = 255), which implied that, the more the respondents used self-blame as a coping strategy, the less resilient they became.

4.5. Summary

In this chapter, the researcher illustrated the findings of resilience and coping strategies employed among nurses working at the selected psychiatric hospital, as well as correlations made between resilience and coping in the form of graphs and tables.

In the following chapter, Chapter 5, the researcher discusses the findings of this current study.



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CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1. Introduction

In this chapter, the researcher discusses the findings, based on empirical literature of resilience and coping among nurses, working in a psychiatric institution. The discussion is structured as follows: ability of nurses to bounce back, or recover from stress; coping strategies used by nurses in a psychiatric institution; and the association between resilience and coping strategies of nurses working at a psychiatric institution. In this current study, most respondents were female and Coloured, followed closely by Africans. Among the nursing category, more respondents were enrolled as nursing assistants, and more respondents worked during the day shift. Most of the respondents worked in the Intellectual Disability Service functional business unit.

Given the paucity of empirical literature regarding the use of the Brief Resilience Scale (BRS) developed by Smith et al., (2008), as well as the brief COPE scale developed by Carver (1997), with psychiatric nurses as respondents, the researcher drew on empirical literature, using other scales that measure similar concepts, for example, active coping, denial, humour in psychiatric nurses.

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5.2. Ability of nurses to bounce back or recover from stress

The results of this current study revealed that the majority of nurses, working in the selected psychiatric institution, rarely struggled to bounce back, or recover from stress. Their resilience level ranged between 2.00 and 3.30, indicating that these nurses had normal resilience, according to the BRS scoring key. In addition, there was no significant difference between the resilience of the respondents, working in the various functional business units (CAP, GAP, Forensics, and IDS).

Similar findings have been reported in a study conducted by Itzhaki et al. (2015); however, using the Connor-Davidson resilience scale, (CD-RISC), where more than one-third of the respondents (42.7%) experienced staff resilience often, or nearly incessantly. While all

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experienced it to some extent, no one reported that they did not experience it at all. This measure indicated for the entire sample, the total mean score of staff resilience was 2.88 (SD = 0.64, range: 1.5–4.00). In a qualitative study conducted by Ramalisa, Du Plessis, & Koen (2018), it was revealed that nurses, working in a psychiatric hospital, which is a complex, stressful environment, displayed resilience. In a study conducted by Rocha, Gaioli, Camelo, Mininel, & Vegro (2016) that identified the capacity of the resilience of nurses working in a psychiatric hospital, using the Resilience Scale, observed that 50% of these nurses had a high level of resilience, while 42.9% had a medium level of resilience.

However, different findings have been reported by Foster et al. (2018), indicating that mental health nurses' overall personal resilience is low-moderate, which concurs with a study conducted by Zheng et al. (2017). Using the Young and Wagnild scale, their findings indicated that the overall mean resilience score obtained was 127.99, which correlated with a moderately low level of resilience. Evidence suggests that a highly resilient nurse is likely to thrive, both inside, and outside the workplace (Turner, 2014).

5.3. Coping strategies used by nurses in a psychiatric institution

The findings of this current study revealed that the most frequently used coping strategy by nurses working in the selected psychiatric institution, according to the domains, was religion and active coping, followed closely by positive reframing and planning. The coping strategy used the least by these nurses was substance abuse. However, based on the various domains, nurses working in IDS appeared to use more coping strategies than the other functional business units (GAP, CAP and forensics), where humour, denial and behavioural disengagement showed significant difference between the groups.

The findings of a qualitative study, conducted by Ramalisa et al. (2018), revealed that nurses, working with MHCUs found it difficult and challenging to cope. In a study conducted by Hanohano (2017) in the United States, the findings revealed that the mean for active coping was not significant at 4.35 (2.02), which indicates that those nurses used active coping as a coping strategy less frequently that differs from the result of this current study. A study conducted by Hasan et al. (2018), using the PsychNurse methods of coping, observed that developing an individual plan was the least used coping strategy, with a mean of 2.29, and standard deviation of 1.10. This conclusion also differs with the findings of this current study. The simple coping strategy used by Cai, Li, and Zhang, (2008) determined that *positive* or

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problem-focused were the most commonly used by the nurses, which concurred with this current study, as the nurses observed the good aspects of the situation. According to Abdalrahim (2013), most nurses engaged in positive, problem-focused coping and considered it the most effective strategy.

Other findings by Burnard et al., (2000), using the PsychNurse coping questionnaire, revealed that coping strategies used were *personal approaches*, such as, *having a sense of humour* and *religious or spiritual conviction*, which concurred with this current study. Many respondents emphasised that spirituality was a preferred method to cope, as it provided a higher sense of protection (Ramalisa et al., 2018). Other authors concurred with this notion, reporting that nurses, who practice spirituality and faith, have higher coping abilities (Ramalisa et al., 2018). Edward (2005) agreed that having a sense of faith, helps an individual to cope. The findings of a qualitative study conducted in Canada by Prosser, Metzger, & Gulbransen (2017), with four psychiatric nurses, also revealed that having a belief system was an effective method of coping. However, in a study conducted by Tsaras et al. (2018), using the Ways of Coping questionnaire, the findings revealed that prayer was one of the lowest ranked coping skills.

Yilmaz (2017) agrees that interventions to build, or improve the resilience of nurses are, *spirituality/having spiritual beliefs* and *having a sense of humour*. People, who are resilient, use protective factors to bounce back, and search for a positive meaning, to make light of situations (Lanz & Bruk-Lee, 2017), indicating that people, who are resilient have a sense of humour. Another qualitative study conducted by Edward (2005) concurred that humour is used as a means to cope. The light-hearted conversations made an impact on someone, and regarded it as a good way to release anxiety. Resilience could be attributed to a supportive environment, which includes humour (Ramalisa et al., 2018).

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5.4. Association between resilience and coping strategies of nurses working at a psychiatric institution

The findings of this current study revealed that there was a small correlation between resilience and the domains of the Brief COPE. There was, however, a significant difference between resilience and the domains of active coping, denial, venting and self-blame. The sign of the Pearson correlation coefficient was positive for active coping and venting, indicating a positive correlation between these domains and resilience. The value of the Pearson correlation

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coefficient was between 0.14 and 0.12, respectively, indicating that, the more these domains of coping strategies are used, the more resilient these nurses became. The sign of the Pearson correlation coefficient for denial and self-blame was negative, indicating a negative correlation between these domains and resilience. The value ranged between 0.13 and 0.12, respectively. This was vice versa, as, the more these coping strategies were used, the less resilient the nurses became.

In a study conducted by Hanohano (2017), in the United States, the findings revealed the mean, significant for denial at 5.36 (3.21), which indicates that these nurses used denial as a coping strategy more frequently than active coping, which differs from the result of this current study. It is suggested that, if negative coping strategies are used, such as denial, it affects resilience, and may decrease the resilience level (Turner, 2014). This statement concurs with the results of this current study. Prosser et al. (2013) assert that the effectiveness of coping influences the outcome; therefore, the more effectively an individual copes, the more positive the outcome, and vice versa.

The findings of a study conducted by Hasan et al. (2018), using the PsychNurse methods, revealed that one of the least coping strategies used was venting, with a mean of 2.66 and (SD 1.18). Another study conducted by Hasan & Tumah (2019) revealed that venting was one of the coping strategies used the least, with a mean of 2.91, (SD 1.07), using the same questionnaire. These results differ from findings of this current study. However, a study conducted by Cai et al. (2008) supports the findings of this current study, which used the simple coping strategy, indicating that talking to others (venting) about problems, and examining one's thoughts, is considered important in life. Lateef, Ng, & Anantharaman (2001) concur that having social support in the workplace is an important coping strategy.

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5.5. Summary

In this chapter, the researcher discussed the overall resilience score of nurses working in the psychiatric hospital, the coping strategies used by the nurses in the selected psychiatric hospital, and the association between resilience and coping. The following chapter comprises the limitations, recommendations and conclusion.

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CHAPTER SIX

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1. Introduction

The objectives of this current study were:

- To determine nurses ability to bounce back or recover from stress;
- To describe coping strategies used by nurses in the psychiatric hospital; and
- To determine the association between resilience and coping strategies of nurses working at a psychiatric hospital in the Western Cape.

The findings of the study suggest that the BRS and brief COPE scale was effective to determine the resilience and coping strategies employed by nurses. In this chapter, the researcher provides a summary of how each objective was met. The limitations and recommendations for future studies, based on the findings of this current study, are also presented and discussed.

6.2. Summary

The objectives of the study are as follows:

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- **Objective 1: Nurses ability to bounce back or recover from stress**

  In this study, the scoring of resilience was as follows, according to the various functional business units: GAP (2.60), CAP (2.50), Forensics (2.40) and IDS (2.60). This indicated that nurses working at the institution showed a normal level of resilience, scoring between 2.00 and 3.30. In addition, it indicated that they did not have a hard time bouncing back or recovering from stress.

- **Objective 2: Coping strategies used by nurses in the psychiatric hospital**

  The findings of the study revealed that the more dominant coping strategies used by these nurses was religion and active coping. The strategy used the least was the use of substances. There was a significance between humour, denial and behavioural disengagement among the various functional business units; however, IDS appeared to use the most coping strategies.

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- **Objective 3: Association between resilience and coping strategies of nurses working at a psychiatric hospital in the Western Cape**

  Firstly, the findings suggested that there was a positive correlation between resilience and the domains of coping strategies, active coping and venting, indicating that, when these coping strategies were used more often, the resilience of these nurses increased. Lastly, the findings suggested that there was a negative correlation between resilience and the domains of coping strategies, denial and self-blame, indicating that, when these coping strategies were used more often, the resilience of these nurses decreased. As the use of denial would be avoiding the situation and not coming to terms with what has taken place and self-blame refers to accusing oneself of the outcome of the situation for actions taken and blaming oneself for what has taken place. Thus, both these coping strategies does not allow an individual to overcome a situation therefore no improvement or bouncing back from the situation would occur. Hence, the resilience level decreases.

6.3. Limitations

The study was conducted in one of the four psychiatric hospitals in the Western Cape. As data were collected in only one setting, generalisations to other settings could not be made. There is a paucity on literature, regarding the use of the BRS and the Brief COPE scale to assess resilience and coping among nurses working in a psychiatric institution; therefore, the researcher used other scales of resilience and coping to concur, or differ with the findings.

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6.4. Recommendations

6.4.1. Clinical practice

Resilience in the workplace can be increased by the following:

- Increase support systems, such as improving relationships with managers;
- Employ adequate nursing staff to prevent work overload, thereby decreasing the absenteeism rate, and providing effective, as well as efficient quality patient care;
- Boost staff morale on ward level;
- Identify workplace stressors and implement effective coping strategies to deal with the stressors and challenges, thereby overcoming setbacks easily;

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- DIY activities to be available at work (during or after hours) such as sport, running, boxing, meditation, yoga, breathing exercises, cooking, gardening, reading etc. to alleviate workplace stress; and
- Managers should understand that resilience applies to staff, thereby, improving and enhancing this concept in others.

6.4.2. Education

Evidence-based educational programmes to teach resilience, as well as continuous training and development, such as in-service training, including ward level training, to enable nurses to become resilient, thereby using the knowledge and skills gained to implement in the workplace, when facing a challenge.

6.4.3. Research

More research studies on resilience and coping in psychiatric nurses should be conducted. In addition, the use of the BRS and Brief COPE scales should be used as instruments, when conducting studies with psychiatric nurses. Studies could be conducted at other psychiatric institutions in the Western Cape to obtain an overview of how resilient nurses working in psychiatric hospitals or institutions are, as well as which effective coping strategies they employ, to assist them with the demands of the career.

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6.5. Conclusion

The purpose of this current study was to investigate the resilience and coping among nurses working in a psychiatric hospital in the Western Cape. According to findings of this current study, nurses working at the selected psychiatric hospital in the Western Cape have an overall normal resilience. The most effective coping strategies these nurses implement to cope was religion and active coping. There was a significant difference between the groups and domains of coping, such as, denial, humour and behavioural disengagement. A positive correlation existed between resilience and active coping, as well as venting, while a negative correlation was observed between resilience and denial, and self-blame.

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ANNEXURES

ANNEXURE A – Ethics clearance letter

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

07 August 2018

Mr TC Pakkiri
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: BM18/5/1

Project Title: Resilience and coping among nurses working at a psychiatric hospital in the Western Cape.

Approval Period: 22 June 2018 – 22 June 2019

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the extension of the research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The permission from the Provincial DoH must be submitted for recordkeeping purposes.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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ANNEXURE B – Approval letter from Ethics Committee of institution

Western Cape Government

Health

DIRECTORATE: GENERAL SPECIALISED AND EMERGENCY SERVICES

REFERENCE: Research Committee

ENQUIRIES: Ms Nadine Jacobs

28 March 2019

To: Tramaine Chriselle Pakkiri

Thank you for your submission to the Research and Ethics Committee at [redacted]. We note that your proposed study was approved by the University of Western Cape.

This serves to confirm that your research project titled "**Resilience and coping among nurses working at a psychiatric hospital in the Western Cape**" has been granted approval by the hospital Research Ethics Committee for the period March 2019 to March 2020.

You would be required to submit progress and final report to the hospital for our record of research conducted at the facility.

Dr L. Phahladira
Chair-Research Ethics Committee

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ANNEXURE C – Email from Bruce Smith granting permission to use BRS

Bruce Smith

to me

2018/04/02 View details

Hi TC,

Thanks for your interest in the Brief Resilience Scale. You are welcome to use it free of charge and for as much as you like. I have attached the original validation article, a copy of the scale as it usually appears in questionnaires, a chapter with suggested cut-offs for high and low resilience which also has data on predictors of resilience, an article with a validated Spanish version of the scale, and an article on the relationship between the BRS and various outcomes. Please let me know what you find when you can. I wish you the best in your research.

Kind Regards,

Bruce

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ANNEXURE D – Email from Charles Carver granting permission to use Brief COPE scale

Carver, Charles S.

to me

2018/04/01 View details

I apologize for this automated reply. All measures I have developed are available for research and teaching applications without charge and without need to request permission; we ask only that you cite their source in any report that results. If you wish to use a measure for a purpose other than that, you must also contact the copyright holder, the publisher of the journal in which the measure was published.

Information concerning the measure you are asking about can be found at the website below. I think most of your questions will be answered there. If questions remain, however, do not hesitate to contact me. Good luck in your work.

http://www.psy.miami.edu/faculty/ccarver/CCscales.html

Charles S. Carver
Department of Psychology
University of Miami
Coral Gables FL 33124-0751

305-284-2817
ccarver@miami.edu
http://www.psy.miami.edu/faculty/ccarver/

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ANNEXURE E – Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 9345 Fax: 27 21-959 2679

E-mail: 3250957@myuwc.ac.za

INFORMATION SHEET

Project Title: Resilience and coping among nurses working at a psychiatric hospital in the Western Cape.

What is this study about?

This is a research project being conducted by Tramaine Chriselle Pakkiri at the University of the Western Cape. We are inviting you to participate in this research project because you meet the criteria for the study. The purpose of this research project is to investigate resilience and coping amongst nurses working at a psychiatric hospital in the Western Cape. The researcher is interested in studying resilience and coping at the identified psychiatric hospital as it comprises of four units providing care to various mental health care users and according to literature, nurses providing care to mental health care users is one of the most demanding careers across the globe.

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What will I be asked to do if I agree to participate?

You will be asked to complete a questionnaire that consists of 41 questions. The researcher will introduce herself, explain what the study entails (resilience and coping), explain voluntary consent and participation, explain how the questionnaire should be completed and refer respondents to a pre-arranged counsellor if distress is experienced during the study. The researcher will provide you with a questionnaire, an information sheet stipulating various concerns about the study as well as providing you with a consent form requiring your voluntary consent. Once completed, the questionnaires and consent forms will be collected separately by the researcher. The questionnaire consists of questions regarding demographics, resilience and coping.

Would my participation in this study be kept confidential?

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The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, data will not be linked to respondents in any way. There will be no names on the questionnaires as it will be coded. Consent forms and questionnaires will be collected separately, thus no link can be made to the participant. To ensure your confidentiality, the questionnaires will be stored in a locked filing cabinet using identification codes only on data forms.

If we write a report or article about this research project, your identity will be protected.

What are the risks of this research?

There may be some risks from participating in this research study. This might involve questions that make you uncomfortable. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimize such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the researcher learn more about resilience and coping amongst nurses working at a psychiatric hospital. We hope that, in the future, other people might benefit from this study through improved understanding of resilience and coping amongst nurses working at a psychiatric hospital. The study may also contribute to policy and add to the knowledge base of resilience and coping.

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Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Tramaine Chriselle Pakkiri at the University of the Western Cape. If you have any questions about the research study itself, please contact Tramaine Chriselle Pakkiri at: contact number: 083 423 3366, email address: 3250957@myuwc.ac.za

http://etd.uwc.ac.za/

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Jennifer Chipps

Head of School of Nursing

University of the Western Cape

Private Bag X17

Bellville 7535

jchipps@uwc.ac.za

Prof Anthea Rhoda

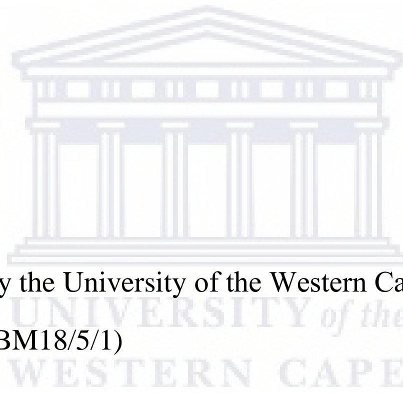
Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

chs-deansoffice@uwc.ac.za



This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee. (Reference Number: BM18/5/1)

Biomedical Research Ethics Committee Office

University of the Western Cape

Private Bag x17 Bellville 7535

Tel: +27 21 959 2988

Email: research-ethics@uwc.ac.za

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ANNEXURE F – Consent Form

UNIVERSITY OF THE WESTERN CAPE

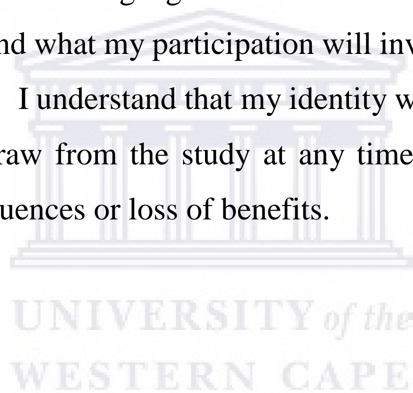
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 9345 Fax: 27 21-959 2679

E-mail: 3250957@myuwc.ac.za

CONSENT FORM

Title of Research Project: Resilience and coping among nurses working a psychiatric hospital in the Western Cape.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.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Participant's name: ……………………….
Participant's signature: …………………….
Date: ………………………………………

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ANNEXURE G – Data collection tool

QUESTIONNAIRE: INVESTIGATING RESILIENCE AND COPING AMONG NURSES WORKING AT A PSYCHIATRIC HOSPITAL IN THE WESTERN CAPE

Section A: Demographical Data

Please tick or write the appropriate answer

1. Age: _______
2. Race: African ☐ Coloured ☐ White ☐ Indian ☐ Other: _________
3. Gender: Male ☐ Female ☐
4. Nursing Category: PNB ☐ PNA ☐ EN ☐ ENA ☐
5. Years of experience in institution: _______
6. Functional Business Unit: GAP ☐ Forensics ☐ CAP ☐ IDS ☐
7. Shift: Day ☐ Night ☐

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Section B: Brief Resilience Scale (BRS)

Please indicate the extent to which you agree with each of the following statements

Items	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
8.I tend to bounce back quickly after hard times	0	1	2	3	4
9.I do not have a hard time making it through stressful events	0	1	2	3	4
10.It does not take me long to recover from a stressful event	0	1	2	3	4
11.It is not hard for me to snap back when something bad happens	0	1	2	3	4
12.I usually come through difficult times with little trouble	0	1	2	3	4
13.I do not tend to take a long time to get over set-backs in my life	0	1	2	3	4

(Smith et al., 2008)

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Section C: Brief COPE scale

Please respond to each item by choosing one option per row (Choose the most accurate answer for YOU)

Items	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I have been doing this a lot
14.I've been turning to work or other activities to take my mind off things	0	1	2	3
15.I've been concentrating my efforts on doing something about the situation I'm in	0	1	2	3
16.I've been saying to myself "this isn't real"	0	1	2	3
17.I've been using alcohol or other drugs to make myself feel better	0	1	2	3
18.I've been getting emotional support from others	0	1	2	3
19.I've been giving up trying to deal with it	0	1	2	3
20.I've been taking action to try to make the situation better	0	1	2	3
21.I've been refusing to believe that it has happened	0	1	2	3
22.I've been saying things to let my unpleasant feelings escape	0	1	2	3
23.I've been getting help and advice from other people	0	1	2	3
24.I've been using alcohol or other drugs to help me get through it	0	1	2	3
25.I've been trying to see it in a different light, to make it seem more positive	0	1	2	3
26.I've been criticizing myself	0	1	2	3
27.I've been trying to come up with a strategy about what to do	0	1	2	3
28.I've been getting comfort and understanding from someone	0	1	2	3
29.I've been giving up the attempt to cope	0	1	2	3
30.I've been looking for something good in what is happening	0	1	2	3
31.I've been making jokes about it	0	1	2	3
32.I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping	0	1	2	3
33.I've been accepting the reality of the fact that it has happened	0	1	2	3
34.I've been expressing my negative feelings	0	1	2	3
35.I've been trying to find comfort in my religion or spiritual beliefs	0	1	2	3
36.I've been trying to get advice or help from other people about what to do	0	1	2	3

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37.I've been learning to live with it	0	1	2	3
38.I've been thinking hard about what steps to take	0	1	2	3
39.I’ve been blaming myself for things that happened	0	1	2	3
40.I've been praying or meditating	0	1	2	3
41.I've been making fun of the situation	0	1	2	3

(Carver, 1997)

Thank you for your participation ☺

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ANNEXURE H - Factors for Brief COPE

Coping Response	**Item**
Self-distraction	1. I've been turning to work or other activities to take my mind off things. 19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
Active Coping	2. I've been concentrating my efforts on doing something about the situation I'm in. 7. I've been taking action to try to make the situation better.
Denial	3. I've been saying to myself "this isn't real". 8. I've been refusing to believe that it has happened.
Substance Abuse	4. I've been using alcohol or other drugs to make myself feel better. 11. I've been using alcohol or other drugs to help me get through it.
Use of emotional support	5. I've been getting emotional support from others. 15. I've been getting comfort and understanding from someone.
Use of instrumental support	10. I’ve been getting help and advice from other people. 23. I’ve been trying to get advice or help from other people about what to do.
Behavioural disengagement	6. I've been giving up trying to deal with it. 16. I've been giving up the attempt to cope.
Venting	9. I've been saying things to let my unpleasant feelings escape. 21. I've been expressing my negative feelings.
Positive reframing	12. I've been trying to see it in a different light, to make it seem more positive. 17. I've been looking for something good in what is happening.
Planning	14. I've been trying to come up with a strategy about what to do. 25. I've been thinking hard about what steps to take.

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Humour	18. I've been making jokes about it. 28. I've been making fun of the situation.
Acceptance	20. I've been accepting the reality of the fact that it has happened. 24. I've been learning to live with it.
Religion	22. I've been trying to find comfort in my religion or spiritual beliefs. 27. I've been praying or meditating.
Self-blame	13. I’ve been criticizing myself. 26. I’ve been blaming myself for things that happened.

(Monzani, Steca, Greco et al, 2015)

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ANNEXURE I – Codebook

Codebook

Variable	SPSS variable name	Coding instruction
Identification number	Id	Subject identification number
1. Age	Age	Age in years
2. Race	Race	1 = African 2 = Coloured 3 = White 4 = Indian 5 = Other
3. Gender	Sex	1 = Male 2 = Female
4. Nursing category	Rank	1 = RN (advance psychiatry) 2 = RN (general) 3 = EN 4 = ENA
5. Years of experience in institution	Experience	Experience in years
6. Functional Business Unit	Functional Business Unit	1 = GAP 2 = Forensics 3 = CAP 4 = IDS
7. Shift	Shift	1 = Day 2 = Night
8. I tend to bounce back quickly after hard times	Question 8 - 13	1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree
9. I do not have a hard time making it through stressful events		

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10. It does not take me long to recover from a stressful event		5 = Strongly agree
11. It is not hard for me to snap back when something bad happens		
12. I usually come through difficult times with little trouble		
13. I do not tend to take a long time to get over set-backs in my life		
14. I've been turning to work or other activities to take my mind off things	Questions 14 -41	1 = I haven't been doing this at all 2 = I've doing this a little bit 3 = I've been doing this a medium amount 4 = I have been doing this alot
15. I've been concentrating my efforts on doing something about the situation I'm in		
16. I've been saying to myself "this isn't real"		
17. I've been using alcohol or other drugs to make myself feel better		
18. I've been getting emotional support from others		
19. I've been giving up trying to deal with it		
20. I've been taking action to try to make the situation better		
21. I've been refusing to believe that it has happened		
22. I've been saying things to let my unpleasant feelings escape		
23. I've been getting help and advice from other people		
24. I've been using alcohol or other drugs to help me get through it		

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25. I've been trying to see it in a different light, to make it seem more positive		
26. I’ve been criticizing myself		
27. I've been trying to come up with a strategy about what to do		
28. I've been getting comfort and understanding from someone		
29. I've been giving up the attempt to cope		
30. I've been looking for something good in what is happening		
31. I've been making jokes about it		
32. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping		
33. I've been accepting the reality of the fact that it has happened		
34. I've been expressing my negative feelings		
35. I've been trying to find comfort in my religion or spiritual beliefs		
36. I’ve been trying to get advice or help from other people about what to do		
37. I've been learning to live with it		
38. I've been thinking hard about what steps to take		
39. I’ve been blaming myself for things that happened		
40. I've been praying or meditating		
41. I've been making fun of the situation		

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ANNEXURE J – Editorial Certificate

14 November 2019

To whom it may concern

Dear Sir/Madam

RE: Editorial certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

RESILIENCE AND COPING AMONG NURSES WORKING AT A PSYCHIATRIC HOSPITAL IN THE WESTERN CAPE

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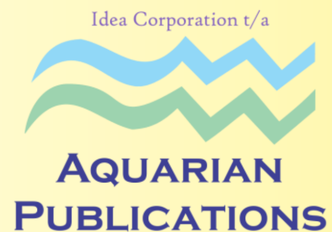

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