

Exploring the resilience of nurses providing mental health care to involuntary mental health care users

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Declaration

I, Rudo Juliet Ramalisa, student number 20716176, hereby declare that **Exploring the resilience of nurses providing mental health care to involuntary mental health care users** is my own work and complies with the research ethical standards of the North West University.

RJ Ramalisa

Acknowledgement

I wish to acknowledge and give thanks to God, Who guided and guarded me throughout this research. Jer. 29:11

Undertaking this Master's degree would have been a solitary journey if it were not for the following persons:

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“Oritondaho, Unarine misi yothe”

Summary

Providing mental health care to involuntary mental health care users (MHCUs) is challenging and an ethical adversity nurses often have to deal with. The literature, in general, indicates that nurses might possess coping and resiliency in the work environment where they are often faced with adversities. However there is a paucity of information regarding the resilience of nurses providing mental health care (MHC) to involuntary MHCUs. Therefore the research objectives explored the resilience of nurses using the Connor-Davidson scale (CD-RISC), to explore and describe how nurses cope and strengthen their resilience in providing MHC to involuntary MHCUs and to formulate guidelines to strengthen the resilience of these nurses to provide quality nursing care in the work environment where MHCUs are often involuntarily admitted.

To achieve these objectives, the research followed both a qualitative and quantitative approach and an exploratory and descriptive design which was contextual in nature. A convenience sampling method was used to achieve a sample size of 28 participants, who were handed questionnaires to complete, containing demographical information, the CD-RISC and a narrative. A response rate of 85.7% was reached. Quantitative data was analysed by using the SPSS programme while data from narratives, for the qualitative data, were grouped and themed.

The results in the first phase indicated that resiliency was high amongst participants, as the mean score of the CD-RISC was 79.9 out of a total score of 100; whilst only one participant scored below 50. The mean for the highest scores was on item 25 (*pride in your achievements*) (3.8) and item 10 (*best effort no matter what*) (3.6) and two critical aspects which scored low were item 18 (*make unpopular or difficult decisions*) and item 19 (*can handle unpopular feelings*) (2.3) amongst participants. Interestingly, the majority of participants (66.7%) do not have training in psychiatric nursing.

In the second phase, two themes were identified from the questions. The first theme "*Coping mechanisms*" identified four methods to cope with involuntary MHCUs. These subthemes are "*support system*", "*knowledge, skills and experience*", "*nurse-patient relationship*" and "*spirituality and selfcare*". The second theme "*Resilience*

strategies” brought forth five subthemes as follows: “*support*”, “*trained staff*”, “*security measures and safety*”, “*teamwork*” and “*in-service training and education*”.

Conclusions suggest that nurses are resilient to provide MHC for involuntary MHCUs. Furthermore, they take pride in their achievements and have passion for their work. On the contrary, they find it difficult to make unpopular decisions which affect others and to handle unpleasant feelings. This is indicative of internal conflict and difficulty in being assertive. Nurses take pride in their achievements and want to give nursing care that’s in the best interest of the MHCUs whilst they feel that they might not always be able to do so due to the involuntary nature of the MHCUs admission and treatment.

Recommendations for nursing practice, namely guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs could be developed from the research findings. Facilitating assertiveness and a supportive environment might strengthen resilience and should be addressed by management and supervisors. Recommendations for nursing education and further research were also formulated.

Key words: resilient/ resilience, professional/ registered nurses, mental health care, involuntary mental health care users.

OPSOMMING

Die verskaffing van geestesgesondheidsorg aan nie-vrywillige geestesgesondheid verbruikers is 'n uitdaging en 'n etiese teenspoed, waarmee verpleegsters dikwels te doen het mee. Die literatuur, in die algemeen, dui daarop aan dat verpleegkundiges oorwelf, en veerkragtigheid besit, in die werksomgewing waar hulle dikwels met teenspoed gekonfronteer word. Nietemin, daar is 'n gebrek aan inligting oor die veerkragtigheid van verpleegkundiges wat geestesgesondheidsorg aan nie-vrywillige geestesgesondheid verbruikers verskaf. Daarom het die navorsings doelwitte, die veerkragtigheid van verpleegsters verken met behulp van die Connor-Davidson skaal (CD-RISC); om te verken en te beskryf hoe verpleegsters oorwelf en hulle veerkragtigheid versterk in die verskaffing van geestes gesondheidsorg aan nie-vrywillige geestesgesondheid verbruikers en om riglyne te formuleer wat die veerkragtigheid van hierdie verpleegsters versterk om kwaliteit verpleegsorg in 'n werksomgewing waar nie-vrywillige geestesgesondheid verbruikers opgeneem is.

Om hierdie doelwitte te bereik het die navorsing beide 'n kwalitatiewe en kwantitatiewe benadering gevolg, en 'n ondersoekende en beskrywende ontwerp wat kontekstueel van aard is. 'n Gerieflikheidssteekproef is gebruik en het 'n steekproef grootte van 28 deelnemers bereik, wat met vraelyste voorsien is wat demografiese inligting, die CD-RISC en 'n beskrywende verhaal bevat. 'n Responstelling van 85.7% is bereik. Kwantitatiewe data was ontleed deur gebruik te maak van die SPSS program, terwyl die data van die verhale gegroepeer is in temas vir die kwalitatiewe data.

Die resultate in die eerste fase het aangedui dat veerkragtigheid hoog was onder deelnemers want die gemiddelde telling van die CD-RISC was 79.9 uit 'n totaal van 100, terwyl slegs een deelnemer onder 50 behaal het. Die gemiddeld vir die hoogste telling was op item 25 (trots op jou prestasies) (3.8) en item 10 (beste poging maak nie saak wat) (3.6); en twee kritiese aspekte wat lae tellings behaal het, was item 18 (maak ongewilde of moeilike besluite) en item 19 (ongewilde gevoelens kan hanteer) (2.3) onder die deelnemers. Interessant genoeg, die meerderheid van deelnemers (66.7%) het nie opleiding in psigiatriese verpleegkunde nie.

In die tweede fase is twee temas geïdentifiseer vanaf die vrae. Die eerste tema 'Coping meganismes' het metodes geïdentifiseer om te cope met nie-vrywillige geestesgesondheid verbruikers. Hierdie subtemas is 'ondersteuning stelsel', 'kennis, vaardighede en ervaring', 'verpleegster-pasiënt verhouding' en 'spiritualiteit en self sorg'. Die tweede tema 'veerkragtigheid strategieë' het ook vyf subtemas soos volg 'ondersteuning', 'opgeleide personeel', 'sekuriteitsmaatreëls en veiligheid', 'spanwerk' en 'in diens opleiding en opvoeding'.

Gevolgtrekkings impliseer dat verpleegsters veerkragtig is om geestesgesondheidsorg aan nie-vrywillige geestesgesondheid verbruikers te voorsien. Verder, is hulle trots op hul prestasies en het 'n passie vir hulle werk. Inteendeel, hulle vind dit moeilik om ongewilde besluite te neem wat ander beïnvloed en om onaangename gevoelens te hanteer. Dit is 'n aanduiding van interne konflik en probleme in selfgeldendheid. Verpleegsters is trots op hulle prestasies en hulle wil verpleging wat in die beste belang van die geestesgesondheid verbruikers lewer; terselfdertyd voel hulle dat hulle nie altyd dalk in staat is om dit te doen as gevolg van die nie-vrywillige aard van die geestesgesondheid verbruikers.

Aanbevelings vir die verpleegpraktyk, naamlik riglyne om die veerkragtigheid te versterk van verpleegkundiges, wat geestesgesondheidsorg aan nie-vrywillige geestesgesondheid verbruikers lewer, kan ontwikkel word uit die navorsingsresultate. Fasilitering van selfgeldig en 'n ondersteunende omgewing kan veerkragtigheid versterk en moet aangespreek word deur die bestuur. Aanbevelings vir verpleegonderrig en verdere navorsing is ook geformuleer.

Sleutelwoorde: *veerkragtig/ veerkragtigheid, professionele/ geregistreerde verpleegkundiges, geestesgesondheidsorg, nie-vrywillige geestesgesondheidsorg verbruikers.*

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CD-RISC	Connor-Davidson Resilience Scale
EMS	Emergency Medical Services
HHE	Head of Health Establishment
HIV	Human Immune deficiency Virus
MHCA	Mental Health Care Act
MHCN	Mental Health Care Nurse
MHCP	Mental Health Care Provider
MHCU	Mental Health Care User
MHRB	Mental Health Review Board
N	Population
n	Sample size
NHS	National Health Service
NWU	North West University
OR	Operating room
PPC	Perspectives in Psychiatric Care
PTSD	Post-Traumatic Stress Disorder
SA	South African
SANC	South African Nursing Council
SAPS	South African Police Services
SD	Standard deviations
SPSS	Statistical Package for the Social Science
UK	United Kingdom
USA	United States of America
WHM	World Mental Health
WHO	World Health Organisation

SECTION 1

Overview of the research

1. OVERVIEW OF THE RESEARCH

In the face of adversities within the health care service, South African nurses remain in the profession and provide quality health care. This research explores and describes the resilience of mental health nurses and how they remain resilient in their workplace where adversities, such as providing care to involuntary mental health care users, are inevitable. The layout of this research is as follows:

- Section 1: Overview of the research.
- Section 2: The manuscript titled *Resilience in nurses providing mental health care to involuntary mental health care users*.
- Section 3: The conclusions, limitations and recommendations.

This overview comprises discussions on the problem statement and substantiation, paradigmatic perspective, method of investigation as well as the literature review.

1.1. Problem statement and substantiation

South Africa has a significantly higher prevalence rate of common mental disorders than any other World Mental Health (WMH) country (Williams, Herman, Stein, Heeringa, Jackson, Moomal & Kessler, 2008:6). This is making a significant contribution to the burden of disease in the country, as a number of societal-level socio-economic risk factors are direct and indirect causes of mental illnesses; such as poverty, harsh economic circumstances, unemployment, crime and violence, the HIV/AIDS pandemic and drug abuse (Burns, 2011:101, Williams *et al.*, 2008:2-8), all of which are prevalent in South Africa.

Fourteen percent (14%) of the global mental health burden is attributed to mental and neurological disorders (Burns, 2011:100). Furthermore, in 2007, 16.5% of the South African population suffered from common mental disorders, which is a crucial public health and development issue in the country (Lund, Kleintjes, Campbell-Hall, Mjadu, Petersen, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Funk, Green, Omar & Flisher, 2008:8). The greater majority of this population is cared for and treated at public health care facilities, as opposed to 17% who make use of medical aids and have access to private facilities. This places severe strain on the public health care facilities, as health care providers struggle to meet the increasing demands (Cullinan, 2006:5), more especially nurses because the South African health care system is largely nurse-based (Harrison, 2009:27).

Generally, the situation of the South African health care services is compromised by many factors, such as the poor distribution of doctors and nurses; which falls below requirements of the Millennium Goal Development as regarded by the World Health Organisation (WHO) (Harrison, 2009:27). In 2002 there were fewer nurses employed in the public sector, than the number of nurses registered with the South African Nursing Council (SANC) (Nthuli & Day, 2004:5), leaving a burden within the mental health care services where only 10 nurses per 100 000 population are available (Burns, 2011:105). Simultaneously, however, there has been an increase in hospital admissions, due to the HIV/AIDS pandemic (Cullinan, 2006:11, Nthuli & Day, 2004:10). This resulted in health care providers becoming overwhelmed with a sense of hopelessness to render the care that meet the needs of patients (Nthuli & Day, 2004:6). Koen and Du Plessis (2011:3) mentioned that these nurses may develop job dissatisfaction and despondency due to poor working conditions which places their own well-being at risk.

Nurses deal with severe risk factors, such as unappreciative workplace and poor remuneration, insecure environment and acknowledgement deficit, in the working environment (Koen, Van Eeden, Wissing & Du Plessis, 2011:111-114). These factors, may leave them de-motivated, angry and dissatisfied whereas some nurses resolve in leaving the country in search of greener pastures; resulting in the remaining nurses suffering low morale (Buchan, 2006:22). According to Segall (cited by Harrison, 2009:32) low morale amongst health care workers, more especially nurses, is caused by factors such as overwork, a sense of neglect and lack of support. Together with other adversities, low staff morale compromises the quality of health care provided (Nthuli & Day, 2004:5, Koen & Du Plessis, 2011:3, Buchan, 2006:22).

In mental health care specifically, certain factors further contribute to mental health care providers (MHCPs) experiencing job dissatisfaction. Matos, Neushotz, Quinn, Griffin and Fitzpatrick (2010:309) identified factors affecting work satisfaction amongst psychiatric nurses, namely salaries, work schedule and environment, co-workers, staffing, supervisors and doctors. An increase in admissions, specifically involuntary admissions could as well lead to adversities and MHCPs feeling overwhelmed. It is reported that in Gauteng Province, there was an increase in the

annual rate of involuntary admissions between 2007 and 2008, from 6,6 per 100 000 to 12,8 per 100 000 population respectively (Moosa & Jeenah, 2010:128). This is opposed to desired mental health reforms, which have an objective to decrease the rates of involuntary admission and treatment of mental health care users (MHCUs) in most countries (Moosa & Jeenah, 2010:128). Furthermore, the increased admission rate places work overload on health care providers. Van Rooyen, Hiemstra and Habib, (2007:14) stated that involuntary admissions in a mental health institution should be avoided as it has financial, legal and ethical implications.

The Mental Health Legislation and Human rights policy and service guidance package published by the WHO, addresses the issue of involuntary admission within mental health institutions (WHO, 2003). This guidance package serves to guide legislation makers when drafting mental health legislation and ultimately assist MHCPs with information on rendering quality care as well as improving access to care for MHCUs (WHO, 2003:9). According to this service guidance, MHCUs have to provide consent for admission and treatment. Nevertheless, this is not always possible because sometimes MHCUs are unwilling or unable to consent due to mental illness (Van Rooyen *et al.*, 2007:14a). For example, Jarrett, Bowers and Simpson (2008:546) stated that there is a link between psychotic symptomatology and retrospective noncompliance, which indicates that in psychiatry lack of agreement is often due to a lack of insight. To deal with this situation, the South African Mental Health Care Act (17 of 2002) (MHCA) has made provision for involuntary admission and treatment in the care of these patients (SA, 2002).

The MHCA sets clear regulations regarding the involvement, collaboration and co-operation between various stakeholders such as the South African Police Services (SAPS), MHCPs, the judiciary, and emergency medical services (EMS) at a local and national level, on the involuntary admission of MHCUs (Jonsson, Moosa & Jeenah, 2009:37). Furthermore, it serves as an advocacy guideline (Moosa & Jeenah, 2008:110) and plays a role in protecting the health and human rights of MHCUs. Section 32 of the MHCA (2002) states that MHCUs must be provided with care, treatment and rehabilitation services without his or her consent at a health establishment on an outpatient or inpatient basis under conditions that the user poses a harm to himself or others (SA, 2002). Care, treatment and rehabilitation are

involuntary, if the user is at the time of admission incapable to make an informed decision. This section of the MHCA is discussed in detail in the literature review.

Although the legislation is clear in its regulations, the dilemma remains within its implementation in the clinical field, where MHCPs (in this regard, nurses) are obligated to provide quality health care while, at the same time, they have to address and maintain the human rights of the MHCUs. Hummelvoll and Severinsson (2002:422) state that most nurses wish that caring co-operation, respect for the patient's dignity, integrity and autonomy formed the basis of their work, and they do not want to interrupt the patient's autonomy with paternalism. In the light of involuntary admission and treatment, this may thus pose a problem to nurses who may experience these aspects, of involuntary patients' autonomy and paternalism, as conflicting. This is confirmed by a Finland study conducted by Lind, Kaltiala-Heino, Suominen, Leino-Kilpi and Valimaki (2004:382) who stated that 18% of one hundred and seventy psychiatric nursing staff agrees that forced treatment is the most ethically-problematic aspect of their work. Usually, the patient receives the appropriate care, but in certain instances, they do not. This problem is aggravated by the fact that health care professionals tend to have limited knowledge on mental health legislation (Aveyard, 2003:704).

According to Aveyard (2003:699), nurses might feel uneasy when providing care without the voluntary consent of the patients. The uncertainty or uneasiness in the manner by which nurses approach the management of these patients indicates a lack of conviction in their care. Ultimately, this result in a distressing situation for nurses and the administering of care is thus fragile and shattered. In another study by Hummelvoll and Severinsson (2002:422) to illuminate nursing staff's perceptions of persons suffering with Bipolar mood disorders and how this influences the provision of nursing care; it was concluded that nurses find it challenging to understand and meet the individual needs of each patient. These patients are often admitted and treated involuntarily, and the principle of informing patients about planned treatment, nursing interventions and their consequences are often not followed, which creates tension in the balance of paternalism and autonomy in providing care (Hummelvoll & Severinsson, 2002:422). Another study indicated that nurses reflect that a paternalistic approach made them worried because there was no assurance that they were acting in the best interest of the patients who cannot

make his or her own decisions (Aveyard, 2003:702). Hummelvoll and Severinsson (2002:422) emphasize the issue that nurses find it difficult to determine when and how they should intervene when a patient cannot consent for treatment. However, in the case that they have to provide coercive care and treatment, such as restricting and limiting the movement of a MHCU, the nurses view this as 'caring' (Hummelvoll & Severinsson, 2002:422). The distressing situation in this regard is an ethical adversity, which puts the wellbeing of the nurses at risk. Such adversities may ultimately lead to lowered quality of health care (Koen & Du Plessis, 2011:3).

However, Koen and Du Plessis identified in their RISE study, (Strengthening the resilience of health caregivers and risk groups), that despite these adversities and challenges, many nurses survive and even thrive while providing high quality care (Koen & Du Plessis, 2011:4). These nurses who achieve better-than-expected outcomes are labelled survivors, resilient, stress-resistant and even invulnerable (Yates & Masten, 2004:521).

According to Masten and Reed (2002:75), resilience is characterised in individuals reflecting patterns of positive adaptation in the context of significant adversity or risk. The resilience perspective stresses the importance of promoting competence through positive models of interventions and change (Yates & Masten, 2004:522) and it can be understood by identifying these related concepts; assets, risks, protective factors and vulnerabilities (Yates & Masten, 2004:524). These individuals are generally doing better under threatening circumstances. Koen *et al.* (2011:105) stated that intra- and interpersonal strengths and abilities are resources, which enable individuals by promoting stress resistance to risk and resilience for positive adaptation and benign outcomes in adverse working circumstances. Indeed, the nurses who choose to remain in the profession, although experiencing adversities, in this case providing care for involuntary admitted MHCUs, not only adapt positively but are also resilient while providing high quality care (Koen & Du Plessis, 2011:4). There is, however, scarce information that addresses concepts surrounding strengths, assets, competencies or resilience itself, that enable health care providers to remain committed to their profession and deal with adversities (Koen & Du Plessis, 2011:4, Siu, Hui, Phillips, Lin, Wong & Shi, 2009:770).

From the above discussion, it is clear that nurses experience adversities in the workplace, which may de-motivate them; but some thrive and continue to provide the required care. In mental health care, dealing with involuntary admitted and treated MHCUs is a challenge as this care might be experienced as an ethical adversity and both the well-being of the nurse and care provided can be compromised. In spite of these adversities, nurses demonstrate resilience and opt to continue providing mental health care to involuntary MHCUs. With these considerations in mind, the proposed studies thus seek to address the following question: What is the resilience of mental health nurses and how do they cope and strengthen their resilience to provide care in the work environment where MHCUs are often involuntarily admitted?

1.2. Research aims and objectives

This research is overarched by the RISE study. The RISE study aims to explore and describe a multifaceted approach to strengthen the resilience of health care providers and risk-groups (Koen & Du Plessis, 2011:5). The aim of this specific research is to explore and describe how to strengthen the resilience of nurses providing mental health care; in order for them to provide quality nursing care in the work environment where MHCUs are often involuntarily admitted. The objectives, which will assist the researcher to achieve this aim, are as follow:

- To explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).
- To explore and describe how nurses cope in providing mental health care to involuntary mental health care users.
- To explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened.
- To formulate guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs.

1.3. Paradigmatic perspective

Research is guided by a philosophical belief concerning the world, in other words, a worldview or paradigm (LoBiondo-Wood & Haber, 2002:127). The term paradigm is the assumptions developed and revealed by the researcher, which are rooted in the philosophical basis, framework or study design (Burns & Grove, 2005:39).

The paradigmatic perspectives within which the researcher conducted this research are laid out in the meta-theoretical, theoretical and methodological assumptions.

1.3.1. Meta-theoretical assumptions

Meta-theoretical assumptions reflect the researcher's assumption and views of the environment, man, health and nursing. These assumptions are non-epistemic and are not to be tested (Mouton & Marais, 1994:192). The researcher's assumptions are based on her belief system, which is a Christian perspective. God created man or each person in His image and commanded man to rule over and populate the earth. He gave each person talents, attributes and roles which differentiate him or her from the next. By utilising these talents wisely, man honours God in return. Furthermore, man should love one another and above all love and honour God with all his or her heart and soul. Within this framework the researcher will define the views of man, mental health and environment in the following paragraphs.

1.3.1.1. View of the man

Man is an individual being consisting of physical, psychological, spiritual and cultural attributes. These attributes define him or her and play an important role in his or her socialization with the environment and decision making ability. The researcher believes that man coexists in a family or community, which provides him or her with support and a foundation on which he or she socializes and functions with the environment and others around him or her. Man has talents, attributes and roles which God gave him or her, and he or she must utilize these to honour God in return. In this research, man refers to both the nurse and the MHCU. The nurse has the role to provide care for the frail, vulnerable and ill, therefore utilizing this attribute; she or he acts as an instrument of God and honour God by using the attribute He gave her or him. The MHCU, as man created also in the image of God, should receive optimal (mental) health care.

1.3.1.2. View of mental health

The WHO defines mental health as *"a state of wellbeing in which an individual realises his or her potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to the community"* (WHO, 2013). In this research mental health refers to an overall state of mental wellbeing of involuntary MHCUs and the provision of mental health care, for MHCUs

in a particular environment. The involuntary MHCU has a right to receive mental health care without consent due to him or her having the potential to inflict harm to himself (herself) or others. Mental health services, just as any other health care services are a basic human right.

1.3.1.3. View of environment

The environment provides man with resources which he or she can utilise to function optimally. Furthermore the environment contains the community and family in which the individual socialises and interact. Man adapts to norms and values in that environment which shapes his or her socialisation. In this research the environment comprises of the psychiatric ward, the workplace, where care is provided to involuntary MHCUs. This environment provides support which could enable man to strive in the face of adversity. The researcher believes that the environment acts as the support system by equipping or providing man with adaptive skills and behaviours in order to thrive.

1.3.2. Theoretical statements

Klopper (2008:67) states that the theoretical statements are the researcher's view of valid knowledge in existing theoretical or conceptual frameworks. They guide the research. For this research, the applicable theoretical statements include the theoretical framework, central theoretical argument and conceptual definitions.

1.3.2.1. Theoretical framework

The framework which guided the research was the Resilience framework of Kumpfer, (1999) who identified various variables that are related to resilience. The constructs of the framework have four domains of influence, namely the acute stressor or challenge, the environmental context, the individual characteristics, and the outcome; and two transactional points which are the confluence between the environment and the individual and choice of outcomes. Furthermore all six of these variables are needed to organise predictors of resilient outcomes because these different constructs are predictive of resilience in an individual (Kumpfer, 1999:184).

1.3.2.2. Central theoretical argument

The central theoretical argument for this research is that, exploring and describing the nurses' resilience and how they cope in providing care for involuntary admitted and treated MHCUs and further exploring and describing how these nurses'

resilience can be strengthened, will enable the formulation of guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs.

1.3.2.3. Concepts

The conceptual definitions presenting the layout of concepts that are applicable in this research are as follows: professional or registered nurse, mental health care, involuntary admission and treatment, mental health care user and resilience.

- **Professional nurse or registered nurse**

According to the Nursing Act (33 of 2005), a professional nurse is a person who is registered and accredited, who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (SA, 2005). The professional nurse in this regard is a person who meets the aforementioned criteria and is working in a psychiatric ward for a minimum of three months.

- **Mental health care**

According to the Bailliere's nurses' dictionary (2009:254), mental health is a state of wellbeing characterised by the absence of mental or behaviour disorder, whereby the person has made a satisfactory adjustment as an individual, and to the community in relation to emotional, personal, social and spiritual aspects of their life. Mental health care is providing welfare and protection (Bailliere, 2009:69), to promote well-being, prevent mental disorders, and the treatment and rehabilitation of people affected by mental disorders (WHO: 2012) and to meet the state of wellbeing. In this research mental health care refers the provision of health care, whether voluntarily or involuntarily, to promote and achieve mental wellbeing.

- **Involuntary mental health care user**

A mental health care user is described by the MHCA (SA, 2002:10), as a person receiving care treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner. An involuntary MHCU is, therefore, described as a person who receives involuntary care, treatment and rehabilitation and is admitted and treated under Section 33 of the MHCA. According to Moosa and Jeenah (2010:110), involuntary admitted MHCUs refuse treatment, have higher incidences to

act dangerously towards others and cause bodily harm on themselves. For the purpose of this research, an involuntary MHCU is any person who received or is receiving involuntary care at a psychiatric ward.

- **Resilience**

Resilience embodies personal qualities that enables one to thrive in the face of adversity (Connor & Davidson, 2003:76). According to Yates and Masten (2004:522), the study of resilience began from the observation that some individuals who are exposed to incontrovertible adversity achieve positive developmental outcome. Resilience is to adapt positively in the context of adversity or risk whereby the individuals are doing well or better than well under extenuating circumstances that pose a threat to adjustment (Masten & Reed, 2002:75). Resilience in this research refers to the ability of professional nurses to cope, thrive and indicate strength in the face of adversity, and in this case involuntary MHCUs are a constant adversity.

1.3.3. Methodological assumptions

The methodological assumptions guide the researcher on the scientific methods of investigation (Mouton & Marais, 1996:16). The researcher believes that nursing research should be conducted in a manner, that the method of investigation and the results should be valid and trustworthy. She does not commit to a single approach for data collection and analysis. Although she is employing multiple approaches in a single research, the findings should none the less improve health outcomes and nursing care.

The researcher positions a pragmatic claim as the methodological assumptions for this research. This entails focusing on the research is problem solution focused instead of the methods and employs multiple approaches to gain knowledge about the phenomena (Creswell, 2009:10). This claim or worldview is applicable to this research as the researcher draws from both qualitative and quantitative assumptions.

1.4. Method of investigation

1.4.1. Research design

An exploratory and descriptive research design which is contextual in nature was used to address the research question and phenomena in detail. The use of a multi-

method approach, both quantitative and qualitative, presented the opportunity to uncover the resilience of nurses, and how they cope, to provide mental health care to involuntary MHCUs, a phenomenon of which there is little research information. The purpose of this exploratory design was to gain new knowledge regarding the nurses' resilience and its descriptive nature provides for claiming how the actual state of the matter is (Mouton, 1999:103); that is to explore the level of resiliency and to describe how these nurses cope in their work environment. Furthermore, Mouton (1999:133) stated that the contextual nature of the research allows the research to be studied in an intrinsic and immediate contextual significance and produces extensive description of the phenomena.

The context of this research was a psychiatric ward providing treatment, care and rehabilitation for voluntary, involuntary and assisted admitted and treated MHCUs. The total admission ratio for the year 2011 to 2012 was estimated at 88, voluntary, involuntary and assisted MHCUs per month of which the majority were involuntary MHCUs. The professional or registered nurses providing care and treatment to these MHCUs in the ward, for a period longer than three months were 32 (Hospital statistics 2011/2012).

The following Figure 1.1 provides an overview of the research design and method.

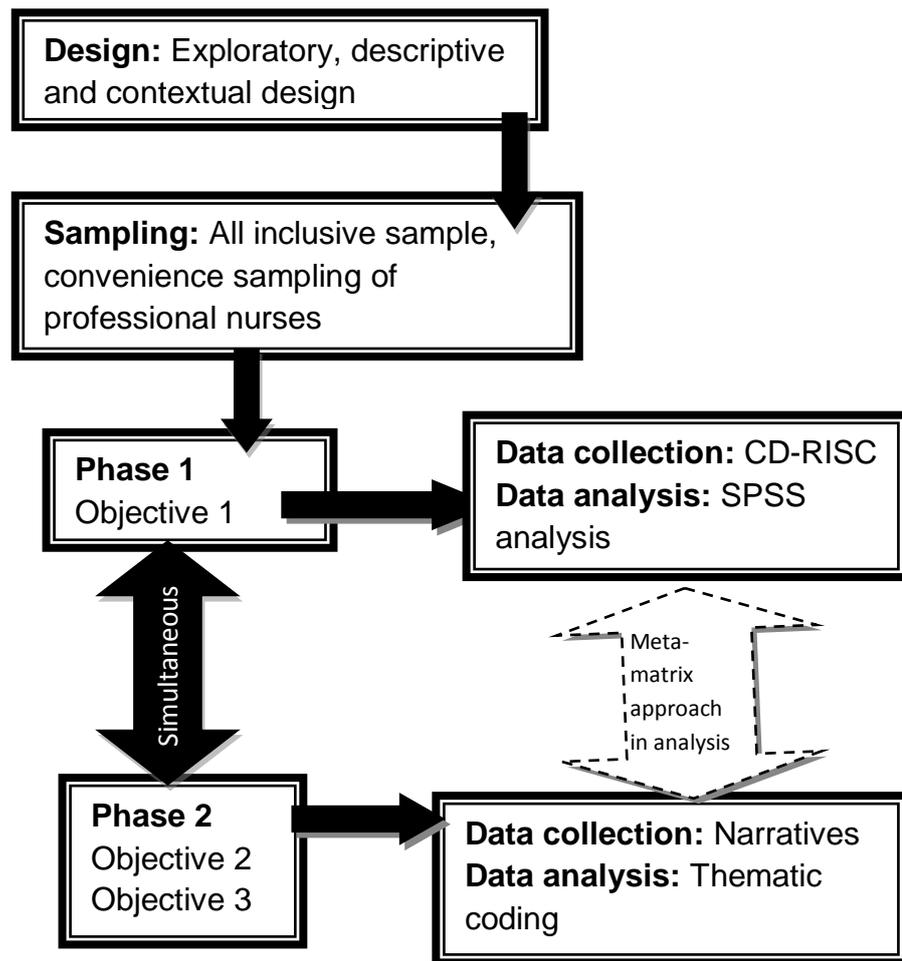


Figure 1.1: Overview of the research and method

1.4.2. Research method

Research method refers to the population, sampling and sampling size, data collection and data analysis (Klopper, 2008:69). In order to reach the objectives in this research, the research method occurred in two phases (Phase 1 and Phase 2). Table 1.1 provides an overview of these phases within the research, which are discussed thoroughly in the following sections.

1.4.2.1. Phase one

1.4.2.1.1. Population, sampling and sample size

The research population was professional nurses (N=32) working in a psychiatric ward, for a period of longer than three months. The ward comprises of ±120 male, female and children beds; and is situated in a public academic (psychiatric) hospital, which caters largely for over 600 patients with intellectual disabilities and genetic

disorders. This population was selected in order to obtain information provided by knowledgeable and experienced participants. Selection criteria for the inclusion to participate were the following:

- Professional nurse registered with the SANC.
- Working in the psychiatric ward for longer than three months.

In this first phase the sample was an all-inclusion of professional nurses, registered with SANC, who work in the selected psychiatric ward and met the selection criteria. The sample size in this phase (quantitative data) had to be proportionate with the total number of the population of nurses in the ward in order for it to be representative (Mouton, 1999:139). After consultation with a statistician, a response rate of 75%, of the total population (N=32) was envisioned. However, as much as 28 (n) participants were accessible to partake in this research and the overall response rate was above target at 85.7% (n=24).

Participants who made up the sample in this phase were recruited at the ward by word of mouth, with the nurse manager and operational manager as the go-between person. Furthermore, an information session with the participants, explaining the research and what was expected of them, was conducted prior to data collection.

1.4.2.1.2. Data collection

Data collection took place in the clinical setting, with the gathered data obtained from professional nurses. The two phases occurred simultaneously during data collection and participants could complete the forms at their own pace and submit later. In this first phase, the data was collected by questions on the participants' demographical information and the CD-RISC (See Appendix 7 and Appendix 8). Table 1.1 provide an overview of the research phases.

Table 1.1 Overview of the research phases

Phase 1 (Quantitative data)			
Objective 1: To explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).			
Data collection	Population and sample	Data analysis	Reliability and validity
CD-RISC questionnaire and demographical information	All inclusive of professional nurses in the ward (convenience sampling)	Frequency of ordered rank, presented as descriptive statistics	Face validity of instrument, scale validated, consult expert in resilience
Phase 2 (Qualitative data)			
Objective 2: To explore and describe how nurses cope in providing mental health care to involuntary mental health care users.			
Objective 3: To explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened.			
Data collection	Population and sample	Data analysis:	Trustworthiness
Narrative in response to two open-ended questions	Determined by data saturation	Content analysis: thematic coding	Triangulating quantitative with qualitative data Credibility, transferability, dependability and confirmability (see Table 1.2)

- **Demographical information and the CD-RISC**

In this first phase, questions on the demographical information of the participants were handed to participants together with the CD-RISC. Each participant was required to complete their demographical information which included age, gender, years of service and educational level (see Appendix 7). The demographical information was to evaluate whether these variables had an impact on the resilience outcomes.

The CD-RISC, on the other hand, is a self-rating scale, developed in 2003 by Kathryn Connor and Jonathan Davidson to measure the resilience of individuals, more especially those with post-traumatic stress disorder (PTSD). According to these authors and creators of the scale, Connor and Davidson (2003), the goals of the scale are to develop a valid and reliable measure to quantify resilience, to have reference values in the population and clinical samples for resilience and to assess whether resilience is modifiable in response to pharmacologic treatment in a clinical setting. The scale has 25, 10 and 2 item versions. Furthermore, this scale has been used widely in a variety of populations, and is not only applicable to persons with PTSD; but with large community samples, survivors of various traumas and members of different ethnic groups and cultures (Connor & Davidson, 2012:3). The scale can be applied to research which investigate adaptive and maladaptive strategies for coping with stress and as a tool to assist in screening individuals for high-risk, high-stress activities or occupations (Connor & Davidson, 2003:81). The validity and reliability of the CD-RISC is discussed in section 1.6.1.

For this research the 25 item version was used, to ensure comprehensive data. The participants answered the questions by self-rating on an ordinal scale, from 0 (not true at all) to 4 (true nearly all the time). Permission was obtained from the developers of the scale to use for the purpose of this research (see Appendix 11).

1.4.2.1.3. Data analysis

As mentioned previously, this research employed both qualitative and quantitative approaches. Therefore, in this regard, the qualitative data is used to support the quantitative data, in the sense that the quantifiable resilience indicated by the CD-RISC, is addressed by the same nurses as to how they strengthen it. A meta-matrix approach of data analysis was thus used. This refers to triangulating qualitative and

quantitative data in a single research study or interpreting the statistical and narrative data in overall patterns (Polit & Beck, 2008:529).

In the first phase of data analysis, the questions on demographical information were analysed quantitatively to determine and evaluate whether these variables (age, gender, years of service and educational level) had an impact on the resilience outcomes. Furthermore, it was used for statistical purposes to describe the sample, namely the number of females and males, their age variation and the educational training of the participants as a group.

The CD-RISC was analysed according to the frequency of each ordered rank in the scale. Data gathered by means of the CD-RISC was computed and analysed by a Statistical Consultant at the North-West University, Potchefstroom Campus, using the Statistical Package for the Social Science (SPSS 16.0) Institute Inc. software package (SPSS Inc., 2009). The data was analysed by computing frequencies, descriptive and inferential statistics, which include the mean, frequency, range, variances, percentages, standard deviations, Cronbach's alpha (α) coefficient, correlations and Spearman's rank order correlation. These data was then used to describe relationships of and between the variables, the reliability of the scale items as well as the correlation between the items in the scale. Although the data obtained was quantitative, it was described and summarised to be meaningful for the readers and therefore the statistics are descriptive (Brink, 2006:172).

1.4.2.2. Phase two

1.4.2.2.1. Population, sampling and sample size

The second phase of the research was qualitative in nature and involved the same sample. Data from the narratives were analysed until data saturation was obtained (Brink, 2006:134, Elliott, 2005:40). Polit and Beck (2008:70) state that in qualitative research sampling, data collection, analysis and interpretation of data are concurrent and on-going. Therefore the sample size in the second phase was determined by the saturation of the data, where no new themes emerged from the narrations (Polit & Beck, 2008:70). Data saturation was reached after analysing all the narratives for sub-themes.

1.4.2.2.2. Data collection

As mentioned earlier the data collection took place in the clinical setting, at the psychiatric hospital. The data collected for the second phase occurred simultaneously with the first phase. In this phase, the data was collected by open-ended questions which were to be answered in the form of narratives (See Appendix 9).

- **Open-ended questions (Narratives)**

The second phase of data collection consisted of two open ended questions which were handed to participants together with those used in Phase 1 (CD-RISC and demographical information). These questions were to be answered in the form of narratives. Brink (2006:149) stated that the participants may answer in any way they see fit to a structured form of open-ended questions. This approach ensures a description of the essence of the experience (Creswell & Maietta, 2002:147). Elliott (2005:15) stated that narratives are told in a specific context for a particular purpose. Therefore, narratives are relevant for this research because of its contextual nature and the essence of professional nurses' view on their resilience and coping when caring for an involuntary MHCU needed to be explored.

The open-ended questions were as follow:

Please share your story by writing about the following:

- How do you cope to provide mental health care to an involuntary admitted MHCU?
- How can your resilience be strengthened to provide mental health care to involuntary admitted and treated MHCU?

1.4.2.2.3. Data analysis

In the second phase all narratives were analysed qualitatively; the quality of the data did thus not depend on statistical calculations (Brink, 2006:163) and quantifiable measures, but on the meanings and experiences of the participants. The main themes were identified from the two questions and the narratives or participants' responses were scrutinised to extract sub-themes until data saturation was achieved. Extracting these sub-themes involved searching for commonalities and natural variations (Polit & Beck, 2008:515). Each narrative was analysed and responses were divided into units of meaning. These units, of common recurring

data, were grouped to form the sub-theme. To ensure credibility, the truth of the data and its interpretations were reflected by involving an independent co-coder (Polit & Beck, 2008:539) (see appendix 10).

1.4.3. Pilot study

A pilot study was conducted with the first five participants who completed the documents (demographical information, CD-RISC and narratives). This was done in order to identify any unforeseen problems and errors, which may arise with the data collection instrument (Brink, 2006:166) and it provided a platform for the researcher to do a trial run of the planned methodology and the instrument (Uys & Basson, 1991:103). One problem identified was the understanding of the term “*resilience*” which needed to be clarified with the participants. Individual participants had different explanations for the term; however this was identified in the pilot study, and was able to be addressed promptly. The term was explained to the participants with reference to an example for clarity.

1.4.4. Meta-matrix analysis

Meta-matrix analysis in this research was employed by triangulating the qualitative and quantitative data by interpreting the statistical and narrative data in overall patterns (Polit & Beck, 2008:529). The construction of the meta-matrix analysis in this research was used as a second level analysis (Wendler, 2001:522) and to assist the researcher to uncover contradicting or unexpected relationships between the quantitative and the qualitative data.

The quantitative (phase 1) and qualitative (phase 2) data were analysed and evaluated separately in the traditional manner. However, on its own, the quantitative data, namely the resilience outcomes measured by the CD-RISC provide minimal information regarding how these participants cope and how their resilience can be strengthened (Wendler, 2001:523). Therefore, the qualitative data obtained from the narratives were compared with the quantitative data to identify patterns, commonalities and/or contrasts to support and strengthen the quantitative data.

To further enrich the meta-matrix analysis, an overview included all sources of data, findings from the quantitative and qualitative phases, existing literature and the researcher’s reflective responses were discussed with the study supervisors as the experts in the field of resilience.

Results from the quantitative and qualitative phases and the meta-matrix analysis are portrayed in Section 2.

1.5. Literature review

A literature review was conducted to give an account of previous research on related topics and existing literature on this issue (Klopper, 2008:64). The literature review covered international and national legislation on the care of involuntary admitted MHCUs; the perception of nurses to care for involuntary admitted MHCUs as well as the resilience of nurses. A literature search in ScienceDirect, SAE Publications, Elsevier, Wiley online library, Academic Search Premier, Cinahl, Health Source and Medline found no South African published study conducted on the resilience of nurses working in a mental health field; except on the resilience of general nurses. The search terms that were used were mental health nurs*, psychiatric nurs* and resilien*. The literature review is presented in the following paragraphs.

1.5.1. International legislation and the South African MHCA on the care of involuntary admitted users

The WHO (2003:9) stated in a Mental Health Legislation and Human Rights policy and service guidance package that 25% of countries worldwide do not have national mental health legislation. However, those countries that do have such legislation, or are in the process of drafting this legislation, such as South Africa, should still take the WHO package into consideration. With regard to involuntary admitted MHCUs a number of criteria should be met before and after involuntary admission and treatment takes place (WHO, 2003):

- Qualified MHCPs with legal authorization should determine that the individual has a mental disorder. Ideally, two psychiatrists are required to do this; however, developing countries with a shortage of psychiatrists can use medical doctors, social workers, psychologists or nurses.
- The MHCPs should be convinced that the mental disorder represents a high probability of immediate or imminent harm to this individual or other persons, or, that failure to admit the individual could result in serious deterioration in the person's condition.

- Encourage voluntary admissions and permit involuntary admission, however, in the case that involuntary admission is necessary, both the following criteria have to be met:
 - there is evidence of a mental disorder of specified severity as defined by internationally accepted standards; and,
 - there is a likelihood of self-harm or harm to others and/or of a deterioration in the patient's condition if treatment is not given.
- The legislation should contemplate emergency procedures by allowing a mental health specialist to evaluate individuals with mental disorders or 48 to 72 hours admission for assessment. The user is admitted and the mental health multi professional assesses both physical and mental health status for a period of 72 hours in the manner prescribed.
- This legislation should reflect the rights of individuals who are deprived of their liberty and those admitted involuntarily should have an opportunity to appeal against their involuntary hospitalisation to the Mental Health Review Board (MHRB) and Head of Health Establishment (HHE).

The South African MHCA (17 of 2002) does address the crucial information and issues as outlined by the WHO Mental Health Legislation and Human rights policy and service guidance package. Moosa and Jeena (2010:125) state that the Act serves to raise issues and profiles of mental health and support MHCUs. With regard to involuntary admissions of individuals, sections 32 and 33 of this Act should be considered. The latter Section states the terms for admission application such as a person applying for involuntary treatment and the availability of two mental health practitioners during admission. While involuntarily admitted and treated MHCUs are admitted under Section 33, Section 32 states the conditions under which an individual should be admitted as follows:

“Involuntary admission should occur, if at the time of making the application, there is reasonable belief that the MHCU has a mental illness of such a nature that:

- i. the user is likely to inflict serious harm to himself/herself or others; or*
- ii. care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user and*

iii. *that at the time of admission the user is incapable of making an informed decision on his needs and unwilling to receive care treatment and rehabilitation” (SA, 2002).*

According to Moosa and Jeena (2010:125), the current MHCA which replaced the MHCA of 1973 in December 2004 includes the following important issues stipulated in the WHO’s Mental Health Legislation and Human rights policy and service guidance package (WHO, 2003)

- The admission of MHCUs without consent has moved from the judiciary services and the clinical decisions are placed as the responsibility of MHCP based on clinicians report and family representation.
- All involuntary MHCUs prior admission for further care treatment and rehabilitation undergo a 48-72-hour assessment. In this assessment period improvement is often anticipated in the user’s capacity to consent for further care, treatment and rehabilitation or discharged.
- In accordance to international requirements, MHRBs have been established to oversee that MHCUs human rights are protected and promoted.
- The Act removes the distinction between health care professionals in that medical practitioners, psychiatric trained nurses, occupational therapists, psychologists and social workers, defined as MHCPs are allowed to provide mental health care, treatment and rehabilitation services.

In conclusion legislation set internationally on the care, treatment and rehabilitation of MHCUs serves as guidelines and frameworks for countries to formulate similar legislations. Although in South Africa the National Department of Health addresses the burden of mental health, priority to mental health should be increased, and furthermore it is evident in that the South African legislature does not currently have a policy guideline and strategic plans with sound local information (Lund *et al.*, 2008:9). Lastly, as far as the South African MHCA is concerned, it covers all aspects of the human rights of MHCUs and persons with intellectual disability, therefore meeting the international standards.

1.5.2. Nurses’ perception on caring for MHCUs

Many nurses are not ardent to care for mentally ill patients. A number of studies have been conducted to illustrate the perceptions nurses and other health care providers have towards mentally ill patients (Mavundla, 2000; Breeze & Repper,

1998) or aggressive or so perceived difficult patients (Whittington, 2005, Nolan, Murray, Dallender, 1998 & Nijman, Bowers, Oud & Jansen, 2005).

Within Sub Saharan Africa, very few studies regarding the perception of nurses and allied health care professionals to care for MHCUs could be identified. However, two studies which are applicable were identified from Zambia (Kapungwe, Cooper, Mayeya, Mwanza, Mwape, Sikwese & Lund, 2011) and South Africa (Mavundla, 2000).

In the South African based study (conducted in Durban general hospitals) by Mavundla (2000:1573), nurses' self-perception to care for mentally ill patients were both negative and positive. They reported that they lack knowledge to care for these patients in their units and are therefore inadequately equipped. Furthermore the nurses believe that with the right training and skills, they will be empowered to care for mentally ill patients (Mavundla, 2000:1574). Similarly, Kapungwe *et al.* (2011:293) found that 30.8% of 26 Zambian registered nurses were extremely uncomfortable when dealing with people with mental disorders. In Zambia a registered nurse is someone with three years of training. Other health care professionals, including enrolled psychiatric nurses, enrolled nurses, clinical officers in psychiatry and clinical officers generally ranged between being extremely uncomfortable and being uncomfortable when working with people who have a mental illness. Recommendations for empowering these health care professionals with more effective awareness-raising, training and education programmes were suggested.

Furthermore, in the absence of more recent literature, Breeze and Repper (1998:1309) stated that nurses need trust, knowledge, concern, communication skills, caring, respect and courtesy in order to empower patients. Without these skills they are unable to empower patients whereas this result in the nurses distancing themselves from the patients. The lack of these skills, however, illuminate that they are incompetent to care for what is defined as difficult patients. Knowledge needed by mental health care nurses (MHCNs) is on a personal and professional level. According to Rydon (2005:83) personal knowledge allows the MHCN to know himself or herself whereas they are said to be in need of resilience in high levels in terms of their emotional stability. On a professional level, on the other hand, the

knowledge required is acquired through interactions and liaising with other MHCNs. It allows the nurses to better inform MHCUs and empower them to meet their goals. A positive perception of the MHCUs is in turn demonstrated by these nurses.

In Britain, 74% of 104 participants (primary health care practice nurses) who participated in a study by Nolan *et al.* (1998) stated that they are not confident to care for and treat MHCUs. Another 13% of these nurses stated that they are anxious to care for MHCUs with psychosis. Many nurses however feel that with improvement in the appropriate mental health training as well as detailed protocols to follow they would have been equipped to provide excellent mental health care. In the same study, other nurses were much concerned about the issue of violence in the care of these MHCUs. The National Health Service (NHS) in the United Kingdom (UK) has adopted a “zero tolerance” attitude towards violent patients (Whittington, 2002:819). An attitude of such nature can however not be applicable to MHCUs, due to protection by MHCAs. None the less, a study by Whittington (2002:824) indicated that MHCNs with work experience of over 15 years are more tolerant of violent MHCUs than their colleagues with 15 years or less experience.

It is thus clear from the above discussion that some health care workers, nurses included, are ardent to care for MHCUs. Despite the challenges they face in the care of MHCUs, the nurses further identified interventions as to how the challenge can be managed, such as skills development.

1.5.3. The resilience of nurses

Research over the past three to four decades has demonstrated that resilience is a multidimensional characteristic which changes with context, time, age, gender, and cultural origin, as well as within an individual subjected to different life circumstances (Connor & Davidson, 2003). For the past few years, a number of studies have focused on resilience (Edward, 2005:143). Resilience has rekindled researchers' interest in positive psychology, where its perspective emphasizes promoting competence (Yates & Masten, 2004:522). According to Edward (2005:143), resilient behaviours have been explored through quantitative and fewer qualitative perspectives. It is coextensive with the outcome of having survived in the face of adversities and is related to a desirable outcome, manifesting competence despite risks and dangers (Kaplan, 1999:19, Yates & Masten, 2004:528). The latter authors

(2004:522) as well as Tusaie and Dyer (2004:3) stated that the study of resilience began from the observation that some individuals, who are exposed to incontrovertible adversities, achieve positive developmental outcomes.

One Australian-based study was identified exploring the phenomenon of resilience in Australian crisis care mental health clinicians working in demanding complex, specialised and stressful environments (Edward, 2005:142). In her qualitative phenomenological study, Edward focused on the meaning of resilience as described by crisis care clinicians in mental health fields. Her study involved nurses (n=4), an allied health practitioner (n=1) and a doctor (n=1). The themes identified which gave insight to whether the experiences of the participants were indeed resilient behaviour were, *sense of self, faith and hope, having insight and looking after oneself*.

Similarly a study was conducted by Gillespie, Chaboyer, Wallis and Grimbeek (2007) to examine the relation between resilience with competence, collaboration, control, self-efficacy, hope, coping, age, experience, education in operating room (OR) nurses. The study findings suggested that collaboration, age, education, experience and years of employment are not significant in the explanation of resilience in OR nurses. However, hope, self-efficacy, coping, control and competence indicate the association with resilience. Hope and resilience ($r=0.67$, $P<0.001$, $b=0.344$), scored higher amongst the variables and is an intrinsic factor of resilience. This has also been observed by Edward's (2005) study findings. In this case the resilience of the OR nurses is explained by the supportive environment that reduces potential stressors and ultimately enhances hope (Gillespie *et al.*, 2007:434).

McLennan (2005:316) also stated that dissatisfaction and burnout in the workplace are the factors significantly related to nurses' stress levels. Furthermore, the author stated that research on nursing work environments showed that personal-, job-, and organisational factors influence nurses' work satisfaction, stress, and commitment (2005:311). She identified that using a proactive approach to measure enabling factors have successful outcomes. However, certain practices by unit management, such as personnel precedence, can erode individual and unit performance and ultimately decreased coping enabling factors of these nurses. The nurses in the study demonstrated that valuing democratic ideals of free and open dialogue together with views of fairness and equal participation in a humanistic social

environment where purposes are shared and relationships are supportive. Lastly the enabling factors facilitates workplace change, create resilience in nurses. Therefore, enabling factors should be taken into consideration as efforts to improve nursing work environments (McLennan, 2005:317).

Kumpfer (1999) identified factors which contribute to what makes some people more resilient than others. These factors, internal self-resiliency factors, are incorporated in the resilience framework and play a role in resiliency. According to Kumpfer (1999:201), intellectual competence and academic job skills are protective or enabling factors that resilient people possess. Other factors, identified by Kumpfer (1999:208) and Warelow and Edward (2007:135), which can assist people to turn negative experiences into positive outcomes, are emotional intelligence or competence. In their study on caring of the MHCNs, Warelow and Edward (2007:135) stated that caring in the mental health care setting should be extended to encompass the additional expertise of emotional intelligence and resilience. In order to assist MHCNs transform negative experiences into positive, self-enhancing ones; resilient practices and education related to enhancing emotional intelligence must be offered.

In a study by Koen *et al.* (2011), to determine the prevalence of resilience and its difference with psycho-social well-being in private and public health care professional nurses in South Africa; it was indicated that 43% to 45% of these nurses are resilient. This was supported by the finding that 54% of professional nurses are seemingly not flourishing and wish to leave the profession. The researchers further indicated that people in the nursing profession are more resilient than people in the general population and concluded that there is a need to facilitate the well-being of those less resilient nurses (Koen *et al.*, 2011:10).

A study to examine the relationship between resilience and job satisfaction among psychiatric nurses working in inpatient units, conducted by Matos *et al.* (2010:307), found that over 10% of the nurses' job satisfaction was explained by their resilience scores. Specifically, these researchers used the Index of Work Satisfaction subscale, which showed a salient positive correlation with resilience; indicating 20% of the nurses' satisfaction with professional status. The professional status in this regard

comprises questions addressing nurses' attitudes regarding recognition, importance, significance, pride, and skill in the nursing profession (Matos *et al.*, 2010:311).

In summary, research on resilience among nurses, conducted in many countries such as the USA, South Africa and Australia indicate that nurses in various specialities or work environments are resilient (Matos *et al.*, 2010, Koen *et al.*, 2011b, Gillespie *et al.*, 2007). However, none could be found on strengthening the resilience of nurses who provide mental health care to involuntary admitted and treated MHCUs, in order for them to provide quality nursing care in the work environment, confirming the need for this research.

1.6. Rigour in this research

Rigour implies to strive for excellence in research and it describes the strategies the researchers used to ensure the validity of their findings (Burns & Grove, 2005:34). Qualitative and quantitative research approaches aim to comply with epistemological standards; however the decision taken in each phase of the research process determines the validity of the generated knowledge. Furthermore, each approach has to contend with various threats to validity as well as comply with its various techniques to ensure validity (Klopper & Knobloch, 2010:318). The epistemological standards which guided the research approaches are the truth value of the research findings, applicability of the research findings to the population, consistency within the findings when the research is repeated in the same context and neutrality, by ensuring that the research findings are the view of the participants.

The rigour for this research has been ensured by implementing epistemological standards of truth value, applicability, consistency and neutrality (Lincoln & Guba, 1985:290-300, Klopper & Knobloch, 2010:318) as mentioned in the previous paragraph. The following paragraphs describe rigour as it will be applied in phase one and phase two of this research.

1.6.1. Phase 1: Reliability and validity of the CD-RISC

Rigour in quantitative research involves validity (internal and external validity) and reliability. According to Burns and Grove, 2005: 215, validity is the measure of truth or accuracy of a claim. The truthfulness and reality is referred to as the internal validity and external validity is reflected in the ability to generalise and contextualise the study findings (Burns & Grove, 2005:215-219).

Validation of the CD-RISC occurred with general population (n=577), primary care patients, psychiatric outpatients (n=139), psychiatric outpatients in private practice (n=43); generalized anxiety (n=25) and two PTSD clinical trial subjects (n=22; n=22) (Connor & Davidson, 2003:78). The authors state that the scale displays validity relative to other measures of stress and hardiness, and reflects different levels of resilience in populations that are thought to be differentiated by their degree of resilience. Reliability and validity by Cronbach's α for the full scale was 0.89 for the general population group (n=577) and item-total correlations ranged from 0.30 to 0.70. Variables which were identified to likely cause an effect on the resilience outcomes in other studies using the CD-RISC included demographical features such as age, ethnicity and level of education (Connor & Davidson, 2012); which were also included in this research.

The CD-RISC has been validated in different countries, South Africa included, which identified two studies measuring the resilience of high school students and school adolescents (Bruwer, Emsley, Kidd, Lochner & Seedat, 2008 & Jorgensen & Seedat, 2006). This scale has been used more widely in a variety of populations and it is applicable to PTSD, large community samples, survivors of various traumas, members of different ethnic groups and cultures, nurses and university students amongst others, which makes the use thereof applicable for this research and within a South African context.

1.6.2. Phase 2: Trustworthiness in qualitative research

In qualitative research designs the terms of validity and reliability are substituted by the term trustworthiness (Klopper, 2008:69, Lincoln & Guba, 1985:290). Krefting (1991:215) stated that the aforementioned terms are used in quantitative designs, and are not necessarily appropriate for qualitative research designs. Furthermore, Lincoln and Guba (1985:219) as well as Krefting (1991) described credibility (truth value), transferability (applicability), dependability (consistency) and confirmability (neutrality) as strategies that are appropriate for and to maintain trustworthiness. They are important to design ways of increasing the rigour and assessing the value of the findings. Application of rigour in the qualitative phase of this research is illustrated in Table 1.2.

Table 1.2 Criteria and strategies used, to enhance rigour in the qualitative phase of this research

Strategy and standard	Description	Criteria used in this research	Application
Credibility (Truth value)	-Credibility is the assumption of a tangible reality that research will unearth relationships with that reality and it is referred to as internal validity (Krefting, 1991:215, Lincoln & Guba, 1985:296). The researcher's confidence with the truth of the research finding is established by the truth value based on the research design, informants and context (Krefting, 1991:215). According to Lincoln and Guba (as cited by Polit & Beck, 2008:539), credibility involves two aspects which are to enhance believability of the findings and taking steps to demonstrate it to the readers. A research study is credible when it presents accurate descriptions or interpretation of human experience that other people sharing the similar experiences as the participants, would recognize the descriptions (Krefting, 1991:216). Within this research, to ensure credibility, the researcher used triangulation and peer debriefing.	-Triangulation	-Implies to the use of multiple references and perspectives to draw conclusions about what entails truth (Polit & Beck, 2008:543), to ensure that all aspects of a phenomenon have been investigated. -Data was collected over an array of participants to ensure multiple perspectives. -Meta-matrix analysis of the quantitative and qualitative data (triangulation).
		-Peer examination and debriefing	-Peer debriefing as a quality enhancement strategy was obtained through sessions with peers to explore aspects of the research. -Consultation with an expert on the field of resilience was conducted, in this case the study leaders
Transferability (Applicability)	-Klopper (2008:69) and Krefting (1991:216) stated that the strategy of transferability is used to generalise or transferred to other settings or groups. This is insured by the representativeness of the sample to population. Although the qualitative researcher does not take up the responsibility to transfer the findings, she must however give sufficient descriptive data to allow readers to compare or evaluate with other research studies in other contexts (Krefting, 1991:216, Polit & Beck, 2008:539). The criteria for transferability used in this research are thick description and selection of sources.	-Thick description-	-Providing a rich and thorough description of information concerning the participants, context and settings. -A detailed description of the research methodology was provided to ensure applicability of the finding to other contexts and ultimately provide another researcher with sufficient information to evaluate similarity in contexts,
		-Data saturation	-Identification of prominent themes and categories in the data that are repetitive (Polit & Beck, 2008:71). -Data saturation was reached with the content analysis for the most prominent repetitive information or themes in the narratives.
Dependability (Consistency)	-Dependability has to do with consistency of a research findings, that is, should the research study be replicated, by other researchers, on the same participants in a similar context, the findings should be the same (Krefting, 1991:216).	-Dense description of research methods	-The precise methods of data gathering, analysis, and interpretation in qualitative research are described. -The precision in the research method will ensure a stepwise replication of the research, when conducted by other researchers in a similar context (Krefting, 1991:221).

Confirmability (Neutrality)	-The strategy of confirmability is used to ensure neutrality in a study. This strategy is concerned with that the information provided by the participants is free from the biases, motivations and perspectives of the researcher in the research procedures and results (Polit & Beck, 2008:539, Klopper, 2008:70, Krefting, 1991:216). According to Krefting (1991:217) confirmability is achieved when truth value and applicability are established.	-Confirmability audit	-An audit involves an external auditor following the progress of the research methods and draw conclusions about the trustworthiness (Polit & Beck, 2008:748; Krefting, 1991:221). -Raw data that was used to gather the data as well as all other notes made or taken are kept for auditing purposes. -The research will undergo examination to determine its trustworthiness.
		-Triangulation	-Triangulation was obtained by combining multiple research methods from qualitative and quantitative approaches as well the perspectives from the literature.

1.7. Ethical considerations

When conducting research there are fundamental ethical principles which the researcher has to consider. As mentioned previously the current research merges as a sub-study under the RISE study which aims to explore and describe a multifaceted approach to strengthen the resilience of health care providers and risk-groups (Koen & Du Plessis, 2011:5). This research proposal was submitted to the Research Committee School of Nursing Science, of North-West University, Potchefstroom Campus, for approval. As this research is overarched by the RISE study, it received ethical clearance within Ref no. (NWU-00036-11-S1) (see Appendix 1a and 1b).

Permission from the Department of Health as well as the Psychiatric hospital where data was collected from was obtained prior commencement of the research (see Appendices 2-5).

In addition the researcher ensured that the participants' rights were protected. These rights include the right to self-determination and informed consent, the right to privacy, anonymity and confidentiality and benefit of the research to the participants (Burns & Grove, 2005:195, Jooste, 2010:278). Table 1.3 illustrates how these rights and principles were applied to this research.

The intended research investigated the phenomena, using humans as participants; hence, informed consent was obtained prior commencement. Full information was explained by the researcher to participants including the risks and benefit ratio, that participation is voluntary and that they may withdraw from participation at any time (see appendix 6). The researcher ensured that the participants have a comprehension regarding this information prior participation.

Table 1.3 Application of the rights and principles in the research

Rights	Application
Self-determination and informed consent	Self-determination has to do with the participants' decision to voluntarily partake in the research or terminate participation without coercion from the researcher when they chose to participate (Burns & Grove, 2005:181). This right was adhered to, as participants were informed in the consent form, they were fully aware of their decision to participate and withdraw as they wish (see appendix 6).

<p>Privacy, anonymity and confidentiality</p>	<p>The participants' information was handled with confidentiality. Any information regarding the participants was not shared with anyone and the privacy of the participant was maintained as the information they shared remained with the researcher. Furthermore although permission was granted by the hospital management to conduct the research, the results will be given to them, however any confidential information shared by the participants will remain concealed. The results were described in a way that prevented the association of the participants with the information provided.</p>
<p>Beneficence</p>	<p>Prior conducting the research, the researcher had to consider the risk benefit ratio and whether the research is feasible without causing harm to the participants. Another aspect which had to be taken into consideration is what the participants will gain from the research, and not only for the benefit of the researcher. The recommendations of this research provide benefits which could be applied in practice in the care of involuntary MHCUs as well as other nursing practice fields (Jooste, 2010:280).</p>

1.8. Conclusion

This section provided an overview of the research. This included the research methodology, literature review as well as the ethical considerations. The overview guided the reader on how the research will be performed and the planning conducted by the researcher. The following section contains the manuscript, including the research findings and the conclusions.

SECTION 2

Manuscript: Resilience in nurses providing mental health care to involuntary mental health care users

To be submitted to “Perspectives in Psychiatric Care”

Section 2 comprises a manuscript, written according to the author guidelines of **Perspectives in Psychiatric Care**. These guidelines are provided, followed by the manuscript.

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Reference with more than 7 authors: Bramley, D., Riddell, T., Whittaker, R., Corbett, T., Lin, R-B., Wills, M., . . . Rodgers, A. (2005). Smoking cessation using mobile phone text messaging is as effective in Maori as non-Maori. *New Zealand Medical Journal*, 118(1216), 1491.

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Manuscript

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This research forms part of the RISE project.

Abstract

Purpose: To explore the resilience of nurses, using the Connor-Davidson Resilience Scale (CD-RISC) (2003), with regard to how they cope in providing mental health care to involuntary admitted and treated mental health care users (MHCUs), how their resilience can be strengthened and to formulate guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs.

Design and Method: Qualitative and quantitative approaches in an exploratory and descriptive design which were contextual in nature were used. Participants (n=28) were handed questionnaires containing demographical information, the CD-RISC (Phase 1) and open-ended questions to be answered in the form of narratives (Phase 2). Quantitative data was analysed by means of the SPSS programme while the narratives, for the qualitative data, were grouped and themed.

Findings: Phase 1: Resiliency mean score for the CD-RISC is 79.9 out of a total score of 100. The mean (SD) for the two highest scores was item10 (3.6(0.6)) and item 25 (3.8(0.4)) and the two lowest item 4 (2.8(0.8)) and item 18 (2.3(1.4)). Only one participant scored below 50. Interestingly, 66.7% of participants do not have training in psychiatric nursing.

Phase 2: In the second phase, two themes were identified from the questions. The first theme "*Coping mechanisms*" identified four methods to cope with involuntary MHCUs. These subthemes are "*support system*", "*knowledge, skills and experience*", "*nurse-patient relationship*" and "*spirituality and selfcare*". The second theme "*Resilience strategies*" brought forth five subthemes as follows: "*support*", "*trained staff*", "*security measures and safety*", "*teamwork*" and "*in-service training and education*".

Practice Implications: Nurses take pride in their achievements and have passion for their work; however they find it difficult to make unpopular decisions which affect others and to handle unpleasant feelings, indicative of internal conflict and difficulty in being assertive. This shows concordance with the nurse-patient relationship sub-theme as nurses want to give nursing care that is in the best interest of the MHCUs because they take pride in achievements.

Keywords: *resilient, mental health, involuntary mental health care users, professional nurse*

2.1. Introduction

South Africa has a significantly higher prevalence rate of common mental disorders than any other World Mental Health (WMH) country. This is making a significant contribution to the burden of disease in the country (Williams, Herman, Stein, Heeringa, Jackson, Moomal & Kessler, 2008). Burns (2011) stated that mental and neurological disorders attributed to 14% of the global mental health burden; whereas in 2007 it was reported that 16.5% of the South African population suffered from common mental disorders, which was a crucial public health and development issue in the country (Lund, Kleintjes, Campbell-Hall, Mjadu, Petersen, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Funk, Green, Omar & Flisher, 2008). This is due to the fact that the greater majority of the population are cared for and treated at public health care facilities, compared to 17% who make use of medical aids and have access to private facilities (Cullinan, 2006). Furthermore the public health care services are compromised by factors such as the poor distribution of doctors and nurses which falls below the threshold to meet the Millennium Goal Development as regarded by the World Health Organisation (WHO) (Harrison, 2009). This places severe strain on the public health care facilities as health care providers struggle to meet the increasing demands, more especially nurses, as the South African health care system is largely nurse-based (Harrison, 2009).

In 2002 there were less nurses employed in the public sector than the actual number registered with the South African Nursing Council (SANC) (Nthuli & Day, 2004), with implications felt within health care services where, for example, 10 nurses per 100 000 population were available to provide mental health care services (Burns, 2011). Hospital admissions increased simultaneously due to the HIV/AIDS pandemic (Cullinan, 2006; Nthuli & Day, 2004). This resulted in health care providers becoming

overwhelmed with a sense of hopelessness to render the care so as to meet the needs of patients (Nthuli & Day, 2004). Koen and Du Plessis (2011) stated that they develop job dissatisfaction, despondency and work in poor working conditions whereby their own well-being is at risk.

Koen, Van Eeden, Wissing and Du Plessis (2011) stated that nurses have to deal with severe risk factors, such as unappreciative workplace and poor remuneration, insecure environment and acknowledgement deficit, in their working environment. These factors leave them de-motivated, angry and dissatisfied and some nurses resolved in leaving the country in search for greener pastures, whereas the remaining nurses suffered from low morale (Buchan, 2006) which, according to Segall (cited by Harrison, 2009 pp 32), is caused by overwork, a sense of neglect and lack of support. The low staff morale as well as other adversities compromised the quality of health care provided (Nthuli & Day, 2004, Koen & Du Plessis, 2011, Buchan, 2006). Matos, Neushotz, Quinn, Griffin and Fitzpatrick (2010) identified factors namely, salaries, schedule, environment, co-workers, staffing, supervisors and doctors as predicting factors affecting work satisfaction among psychiatric nurses. Dissatisfaction and feeling of being overwhelmed were experienced by mental health care providers (MHCPs) with increased hospital admissions, specifically involuntary, which led to adversities. It was reported that in Gauteng Province, between 2007 and 2008, involuntary admissions increased from 6,6 per 100 000 to 12,8 per 100 000 population respectively (Moosa & Jeenah, 2010). This further also placed work overload on MHCPs.

The South African Mental Health Care Act, 17 of 2002, (MHCA) addresses the issue of involuntary admission within mental health institutions and makes provision for involuntary admission and treatment in the mental health care for mental health care

users (MHCUs). Involuntary MHCUs are admitted with reference to section 32 of the MHCA which states that a MHCU must be provided with care, treatment and rehabilitation services without his or her consent at a health establishment on an outpatient or inpatient basis under certain conditions. *This should occur, if at the time of making the application, there is reasonable belief that the MHCU has a mental illness of such a nature that:*

- i. the user is likely to inflict serious harm to himself/herself or others; or*
- ii. care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user and*
- iii. that at the time of admission the user is incapable of making an informed decision on his needs and unwilling to receive care treatment and rehabilitation (SA, 2002 p. 32).*

Although the legislation is clear in its regulations, the dilemma remains within its implementation in the clinical field, where MHCPs (in this regard nurses) are obligated to provide quality health care while, at the same time, they have to address and maintain the human rights of the MHCU. Hummelvoll and Severinsson (2002) stated that most nurses wish that caring co-operation, respect for the patient's dignity, integrity and autonomy formed the basis of their work, and they do not want to interrupt the patient's autonomy with paternalism. In the light of involuntary admission and treatment, this may thus pose a problem to nurses who may experience these aspects, of involuntary patients' autonomy and paternalism, as conflicting. According to Aveyard (2003), nurses felt uneasy when providing care without voluntary consent. The uncertainty or uneasiness in the manner by which nurses approach the management of these patients indicates a lack of conviction in their care. Ultimately, this resulted in a distressing situation for nurses and the

administering of care is thus fragile and shattered. They find it challenging to understand and meet the individual needs of each patient (Hummelvoll and Severinsson, 2002). Manic patients, for example, are often admitted and treated involuntarily, and the principle of informing patients about planned treatment and nursing interventions and their consequences are often not followed, which creates tension in the balance of paternalism and autonomy in providing care. Paternalistic approaches made nurses worried because there was no assurance that they were acting in the best interest of the patients who cannot make his or her own decisions (Aveyard, 2003). However, in the case that they had to provide coercive care and treatment, such as restricting and limiting the movement of a MHCU, the nurses viewed it as *'caring'*. The distressing situation was an ethical adversity, which puts the wellbeing of the nurses at risk. Such adversities ultimately might lead to lowered quality of health care (Koen & Du Plessis, 2011).

However, despite these adversities and challenges, many nurses survive and even thrive while providing high quality care (Koen & Du Plessis, 2011). The nurses who achieved better-than-expected outcomes are labelled as survivors, resilient, stress-resistant and even invulnerable (Yates & Masten, 2004). Koen *et al.* (2011) stated that intra- and interpersonal strengths and abilities were the resources, enabling individuals by promoting stress resistance to risk and resilience for positive adaptation and benign outcomes in adverse working circumstances. Indeed, the nurses who chose to remain in the profession, although experiencing adversities, and providing care for involuntary admitted MHCUs, not only adapt positively but also are resilient while providing high quality care (Koen & Du Plessis, 2011). However, there is scarce information that addresses concepts surrounding strengths, assets, competencies or resilience itself that enable health care providers to remain

committed to their profession and deal with adversities more specifically with regard to mental health (Koen & Du Plessis, 2011, Siu, Hui, Phillips, Lin, Wong & Shi, 2009).

From the above discussion, it is clear that nurses experience adversities in the workplace, which may de-motivates them but some thrive and continue to provide the required care. In mental health care, dealing with involuntary admitted and treated MHCUs is a challenge as this care might be experienced as an ethical adversity and both the well-being of the nurse and care provided can be compromised together with other workplace related challenges. In spite of these adversities, nurses demonstrate resilience and opt to continue providing mental health care to involuntary MHCUs. With these considerations in mind, this research thus seeks to address the following question: How can the resilience of mental health nurses be strengthened to cope in the work environment where MHCUs are often involuntarily admitted and treated?

2.1. Research aims and objectives

This research is overarched by the RISE study. The RISE study aims to explore and describe a multifaceted approach to strengthen the resilience of health care providers and risk-groups (Koen & Du Plessis, 2011). The aim of this specific research is to explore and describe how to strengthen the resilience of nurses providing mental health care; in order for them to provide quality nursing care in the work environment where MHCUs are often involuntarily admitted. The objectives, which will assist the researcher to achieve this aim, are as follow:

- To explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).

- To explore and describe how nurses cope in providing mental health care to involuntary mental health care users.
- To explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened.
- To formulate guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs.

2.2. Research methodology

2.2.1. Research design

An exploratory and descriptive research design which is contextual in nature was used to address the research question and phenomena in detail. The use of a multi-method approach, both quantitative and qualitative, presented the opportunity to uncover the resilience of nurses, and how they cope, to provide mental health care to involuntary MHCUs, a phenomenon of which there is little research information. The purpose of this exploratory design was to gain new knowledge regarding the nurses' resilience and its descriptive nature provides for claiming how the actual state of the matter is (Mouton, 1999:103); that is to explore the level of resiliency and to describe how these nurses cope in their work environment. Furthermore, Mouton (1999:133) stated that the contextual nature of the research allows the research to be studied in an intrinsic and immediate contextual significance and produces extensive description of the phenomena.

The context of this research was a psychiatric ward providing treatment, care and rehabilitation for voluntary, involuntary and assisted admitted and treated MHCUs. The total admission ratio for the year 2011 to 2012 was estimated at 88, voluntary, involuntary and assisted MHCUs per month of which the majority were involuntary MHCUs. The professional or registered nurses providing care and treatment to these

MHCUs in the ward, for a period longer than three months were 32 (Hospital statistics 2011/2012).

2.2.2. Research method

Research method refers to the population, sampling and sampling size, data collection and data analysis (Klopper, 2008). In order to reach the objectives in this research, the research method occurred in two phases (Phase 1 and Phase 2).

2.2.2.1. Phase one

2.2.2.1.1. Population, sampling and sample size

The research population was professional nurses (N=32) working in a psychiatric ward, for a period of longer than three months. The ward comprises of ±120 male, female and children beds; and is situated in a public academic (psychiatric) hospital, which caters largely for over 600 patients with intellectual disabilities and genetic disorders. This population was selected in order to obtain information provided by knowledgeable and experienced participants. Selection criteria for the inclusion to participate were the following:

- Professional nurse registered with the SANC.
- Working in the psychiatric ward for longer than three months.

In this first phase the sample was an all-inclusion of professional nurses, registered with SANC, who work in the selected psychiatric ward and met the selection criteria. The sample size in this phase (quantitative data) had to be proportionate with the total number of the population of nurses in the ward in order for it to be representative (Mouton, 1999). After consultation with a statistician, a response rate of 75%, of the total population (N=32) was envisioned. However, as much as 28 (n)

participants were accessible to partake in this research and the overall response rate was above target at 85.7% (n=24).

Participants who made up the sample in this phase were recruited at the ward by word of mouth, with the nurse manager and operational manager as the go-between person. Furthermore, an information session with the participants, explaining the research and what was expected of them, was conducted prior to data collection.

2.2.2.1.2. Data collection

Data collection took place in the clinical setting, at the psychiatric hospital, with the gathered data obtained from professional nurses. The ward is situated in a public hospital.

The two phases occurred simultaneously during data collection and participants could complete the forms at their own pace and submit later. In this first phase, the data was collected by questions on the participants' demographical information and the CD-RISC (See Appendix 7 and Appendix 8).

- **Demographical information and the CD-RISC**

In this first phase, questions on the demographical information of the participants were handed to participants together with the CD-RISC. Each participant was required to complete their demographical information which included age, gender, years of service and educational level (see Appendix 7). The demographical information was to evaluate whether these variables had an impact on the resilience outcomes.

The CD-RISC, on the other hand, is a self-rating scale, developed in 2003 by Kathryn Connor and Jonathan Davidson to measure the resilience of individuals, more especially those with post-traumatic stress disorder (PTSD). According to

these authors and creators of the scale, Connor and Davidson (2003), the goals of the scale are to develop a valid and reliable measure to quantify resilience, to have reference values in the population and clinical samples for resilience and to assess whether resilience is modifiable in response to pharmacologic treatment in a clinical setting. The scale has 25, 10 and 2 item versions. Furthermore, this scale has been used widely in a variety of populations, and is not only applicable to persons with PTSD; but with large community samples, survivors of various traumas and members of different ethnic groups and cultures (Connor & Davidson, 2012). The scale can be applied to research which investigate adaptive and maladaptive strategies for coping with stress and as a tool to assist in screening individuals for high-risk, high-stress activities or occupations (Connor & Davidson, 2003). The validity and reliability of the CD-RISC is discussed in section 2.6.1.

For this research the 25 item version was used, to ensure comprehensive data. The participants answered the questions by self-rating on an ordinal scale, from 0 (not true at all) to 4 (true nearly all the time). Permission was obtained from the developers of the scale to use for the purpose of this research (see Appendix 11).

2.2.2.1.3. Data analysis

As mentioned previously, this research employed both qualitative and quantitative approaches. Therefore, in this regard, the qualitative data is used to support the quantitative data, in the sense that the quantifiable resilience indicated by the CD-RISC, is addressed by the same nurses as to how they strengthen it. A meta-matrix approach of data analysis was thus used. This refers to triangulating qualitative and quantitative data in a single research study or interpreting the statistical and narrative data in overall patterns (Polit & Beck, 2008).

In the first phase of data analysis, the questions on demographical information were analysed quantitatively to determine and evaluate whether these variables (age, gender, years of service and educational level) had an impact on the resilience outcomes. Furthermore, it was used for statistical purposes to describe the sample, namely the number of females and males, their age variation and the educational training of the participants as a group.

The CD-RISC was analysed according to the frequency of each ordered rank in the scale. Data gathered by means of the CD-RISC was computed and analysed by a Statistical Consultant at the North-West University, Potchefstroom Campus, using the Statistical Package for the Social Science (SPSS 16.0) Institute Inc. software package (SPSS Inc., 2009). The data was analysed by computing frequencies, descriptive and inferential statistics, which include the mean, frequency, range, variances, percentages, standard deviations, Cronbach's alpha (α) coefficient, correlations and Spearman's rank order correlation. These data was then used to describe relationships of and between the variables, the reliability of the scale items as well as the correlation between the items in the scale. Although the data obtained was quantitative, it was described and summarised to be meaningful for the readers and therefore the statistics are descriptive (Brink, 2006).

2.2.2.2. Phase two

2.2.2.2.1. Population, sampling and sample size

The second phase of the research was qualitative in nature and involved the same sample. Data from the narratives were analysed until data saturation was obtained (Brink, 2006, Elliott, 2005). Polit and Beck (2008) stated that in qualitative research sampling, data collection, analysis and interpretation of data are concurrent and on-going. Therefore the sample size in the second phase was determined by the

saturation of the data, where no new themes emerged from the narrations (Polit & Beck, 2008). Data saturation was reached after analysing all the narratives for sub-themes.

2.2.2.2.2. Data collection

As mentioned earlier that data collection took place in the clinical setting at the psychiatric hospital. The data collected for the second phase occurred simultaneously with the first phase. In this phase, the data was collected by open-ended questions which were to be answered in the form of narratives (see Appendix 9).

- **Open-ended questions (Narratives)**

The second phase of data collection consisted of two open ended questions which were handed to participants together with those used in Phase 1 (CD-RISC and demographical information). These questions were to be answered in the form of narratives. Brink (2006) stated that the participants may answer in any way they see fit to a structured form of open-ended questions. This approach ensures a description of the essence of the experience (Creswell & Maietta, 2002). Elliott (2005) stated that narratives are told in a specific context for a particular purpose. Therefore, narratives are relevant for this research because of its contextual nature and the essence of professional nurses' view on their resilience and coping when caring for an involuntary MHCU needed to be explored.

The open-ended questions were as follow:

Please share your story by writing about the following:

- How do you cope to provide mental health care to an involuntary admitted MHCU?

- How can your resilience be strengthened to provide mental health care to involuntary admitted and treated MHCU?

2.2.2.2.3. Data analysis

In the second phase all narratives were analysed qualitatively; the quality of the data did thus not depend on statistical calculations (Brink, 2006) and quantifiable measures, but on the meanings and experiences of the participants. The main themes were identified from the two questions and the narratives or participants' responses were scrutinised to extract sub-themes until data saturation was achieved. Extracting these sub-themes involved searching for commonalities and natural variations (Polit & Beck, 2008). Each narrative was analysed and responses were divided into units of meaning. These units, of common recurring data, were grouped to form the sub-theme. To ensure credibility, the truth of the data and its interpretations were reflected by involving an independent co-coder (Polit & Beck, 2008) (see appendix 10).

2.3.3 Pilot study

A pilot study with the first five participants who completed the documents (demographical information, CD-RISC and narratives) was conducted. This was done in order to identify any unforeseen problems and errors, which may arise with the data collection instrument (Brink, 2006) and it provided a platform for the researcher to do a trial run of the planned methodology and the instrument (Uys & Basson, 1991).

One problem identified was the understanding of the term "*resilience*" which needed to be clarified with the participants. Individual participants had different explanations for the term; however this was identified in the pilot study, and was able to be

addressed promptly. The term was explained to the participants with reference to an example for clarity.

Conducting this pilot study assisted the researcher in the planning of the actual research and circumventing unforeseen circumstances. The data collected during the pilot study did not significantly differ from the data collected from the sample, and could be included in the overall data.

2.5.5. Data analysis and meta-matrix analysis

Both qualitative and quantitative data analysis were used in this research. In this regard the quantitative data supports the qualitative data, in the sense that the quantifiable resilience scores indicated by the CD-RISC are addressed by the same nurses as to how they strengthened it. A meta-matrix approach of data analysis was thus applied (Polit & Beck, 2008) in order to triangulate qualitative and quantitative data by interpreting the statistical and narrative data in an overall pattern.

In the first phase the CD-RISC questionnaires were evaluated and analysed quantitatively, according to the frequency of each ordered rank in the scale. This was done with the assistance of a Statistical Consultant by computing frequencies, descriptive and inferential statistics, which include the mean, frequency, range, variances, percentages, standard deviations, Cronbach's alpha (α) coefficient, correlations and Spearman's rank order correlation. The obtained data was described and summarised to be meaningful descriptive statistics (Brink, 2006). However on its own, the quantitative data, namely the resilience outcomes measured by the CD-RISC provided minimal information regarding how these participants cope and how their resilience can be strengthened (Wendler, 2001).

Therefore, the narratives were also analysed quantitatively in the second phase by scrutinising them and searching for common ideas (units) to ultimately create

themes. Extracting these themes involved searching for commonalities and natural variations (Polit & Beck, 2008). The credibility or the truth of the data and its interpretations was reflected by using a co-coder (Polit & Beck, 2008) in this phase

2.6. Rigour in this research

2.6.1. Phase 1: Reliability and validity of the CD-RISC

Rigour in quantitative research involves validity (internal and external validity) and reliability. According to Burns and Grove, (2005) validity is the measure of truth or accuracy of a claim. The truthfulness and reality is referred to as the internal validity and external validity is reflected in the ability to generalise and contextualise the study findings (Burns & Grove, 2005).

Validation of the scale occurred with general population (n=577), primary care patients, psychiatric outpatients (n=139), psychiatric outpatients in private practice (n=43); generalized anxiety (n=25) and two PTSD clinical trial subjects (n=22; n=22) (Connor & Davidson, 2003:78). The authors stated that, the scale displays validity relative to other measures of stress and hardiness, and reflects different levels of resilience in populations that are thought to be differentiated by their degree of resilience. Reliability and validity by Cronbach's α for the full scale was 0.89 for the general population group (n=577) and item-total correlations ranged from 0.30 to 0.70.

Variables which were identified to likely cause an effect on the resilience scale outcomes in other studies using the CD-RISC included demographical features such as age, ethnicity and level of education (Connor & Davidson, 2012). These variables were also included in this research.

The CD-RISC has been validated in different countries, South Africa included, where two studies measuring the resilience of high school students and school adolescents

(Bruwer, Emsley, Kidd, Lochner & Seedat, 2008, Jorgensen & Seedat, 2006). This scale has been used more widely in a variety of populations and it is applicable to PTSD, large community samples, survivors of various traumas, members of different ethnic groups and cultures, nurses and university students amongst others, which makes the use thereof applicable for this research and within a South African context.

2.6.2. Phase 2: Trustworthiness in qualitative research

In qualitative research designs the terms of validity and reliability are substituted by the term trustworthiness (Klopper, 2008, Lincoln & Guba, 1985). Krefting (1991) stated that the aforementioned terms are used in quantitative designs, and are not necessarily appropriate for qualitative research designs. Furthermore, Lincoln and Guba (1985) as well as Krefting (1991) described credibility (truth value), transferability (applicability), dependability (consistency) and confirmability (neutrality) as strategies that are appropriate for and maintain trustworthiness. They are important to design ways of increasing the rigour and assessing the value of the findings.

- **Credibility**

Credibility is the assumption of a tangible reality that research will unearth relationships with that reality and it is referred to as internal validity (Krefting, 1991, Lincoln & Guba, 1985). Data was collected over an array of participants to ensure multiple perspectives and a meta-matrix analysis of the quantitative and qualitative data (triangulation) was done.

- **Transferability**

This is insured by the representativeness of the sample to population and was applied by providing a rich and thorough description of information concerning the

participants, context and settings. A detailed description of the research methodology was also provided to ensure applicability of the finding to other contexts and ultimately provide another researcher with sufficient information to evaluate similarity in contexts.

- **Dependability**

Dependability has to do with consistency of a research findings, that is, should the research study be replicated, by other researchers, on the same participants in a similar context, the findings should be the same (Krefting, 1991). The precise methods of data gathering, analysis, and interpretation in qualitative research are described to ensure replication when the research is conducted by other researchers.

- **Confirmability**

This is used to ensure neutrality in a study. This strategy is concerned with that the information provided by the participants is free from the biases, motivations and perspectives of the researcher in the research procedures and results (Polit & Beck, 2008, Klopper, 2008, Krefting, 1991). Raw data that was used to gather the information as well as all other notes made or taken is kept for auditing purposes. The research study will undergo examination to determine its trustworthiness.

2.7. Ethical considerations

The current research merges as a sub-study under the RISE research study which aims to explore and describe a multifaceted approach to strengthen the resilience of health care providers and risk-groups (Koen & Du Plessis, 2011). This research proposal was submitted to the Research Committee School of Nursing Science of North-West University for approval. As this research merges under the RISE study, it received ethical clearance within Ref no. (NWU-00036-11-S1).

Permission from the Provincial Department of Health as well as the Psychiatric hospital where data was collected from was obtained before commencement of the research.

The researcher had to oversee that the participants' rights were protected. These rights include the right to self-determination and informed consent, the right to privacy, anonymity and confidentiality and benefit of the research to the participants (Burns & Grove, 2005, Jooste, 2010). Informed consent from the participants was obtained and the data did not include any information by which any of the participants could be identified.

2.8. Results

2.8.1. Phase 1 results

One of the research objectives was to explore the resilience of nurses, by using the CD-RISC, a scale used to measure the resilience of people. Twenty eight participants were approached to complete the questionnaires. This following section provides the results of the scale.

Data gathered by means of the CD-RISC was computed and analysed by a Statistical Consultant at the North-West University, Potchefstroom Campus, using the Statistical Package for the Social Science (SPSS 16.0) Institute Inc. software package (SPSS Inc., 2009). The data was analysed by computing frequencies, descriptive and inferential statistics, which include the mean, frequency, range, variances, percentages, standard deviations, Cronbach's alpha (α) coefficient, correlations and Spearman's rank order correlation. These data was then used to describe relationships of and between the variables, the reliability of the scale items as well as the correlation between the items in the scale. The subsequent sections are a layout of the findings from the CD-RISC, followed by the discussion thereof.

2.8.1.1. Descriptive statistic: Sample characteristics (demographical data)

A total of 28 (accessible population) registered nurses were handed the CD-RISC and 2 open-ended questions. The ward has a total of 32 (population) registered nurses working both day and night shifts. The response rate was (n=24) 85.7%, out of 28 nurses who were handed the questionnaires, which met the desirable expectation. Nurses in the ward are divided into 4 shifts which render continuous nursing care throughout a week. Thus, 2 shifts work opposite one another for both day and night care. Nurses in all the shifts were handed the questionnaires to complete.

Table 2.1: Questionnaires distribution

Shift	Accessible population	Response	%
Shift 1 day	10	9	90%
Shift 2 night	5	5	100%
Shift 3 day	9	8	88.9%
Shift 4 night	4	2	50%
Total	28	24	85.7%

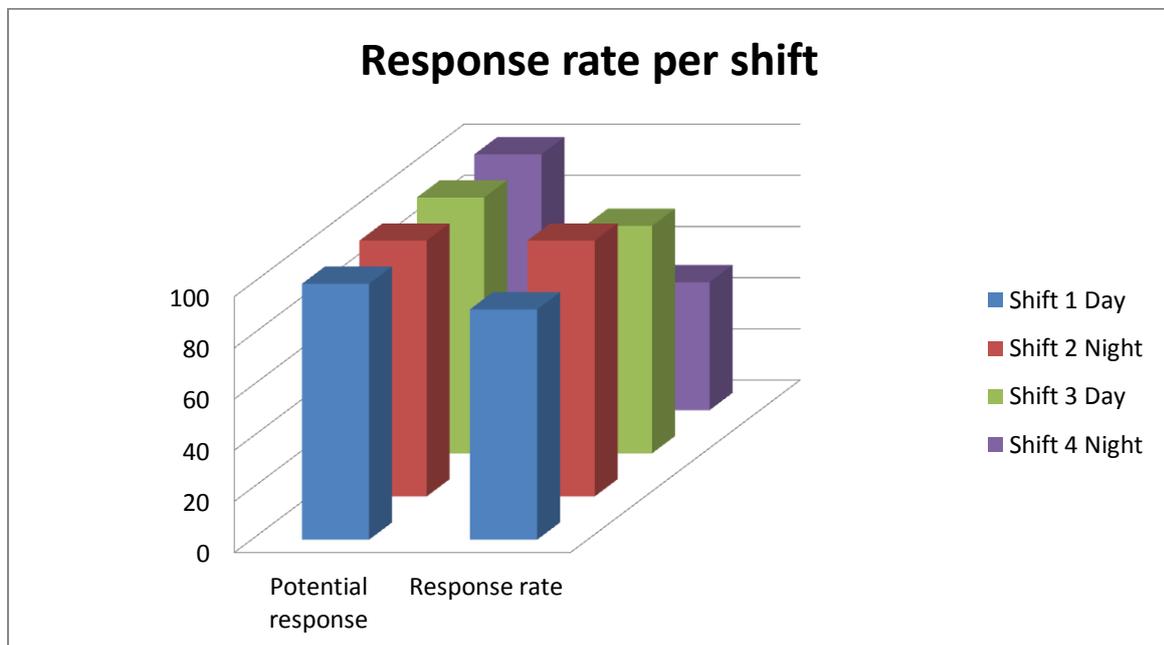


Figure 2.1: Response rate per shift

The sample consisted of 4 males (16.7%) and 18 females (75%); 2 participants (8.3%) did not indicate their sex on the demographical information. The age ranges from 27 with the oldest being 53 years of age. Again, only 2 participants' age data were missing. Tables 2.2 and 2.3 present the ages of the participants according to sex. The mean score of the number of years in service amongst the participants who responded is 2.7 years. Participants with 1 year working experience in the psychiatric ward, comprise 33.3% of the sample (n=24) compared to 8.3% participants who have 7 years experience. Figure 2.2 indicates the percentages of the participants' experience.

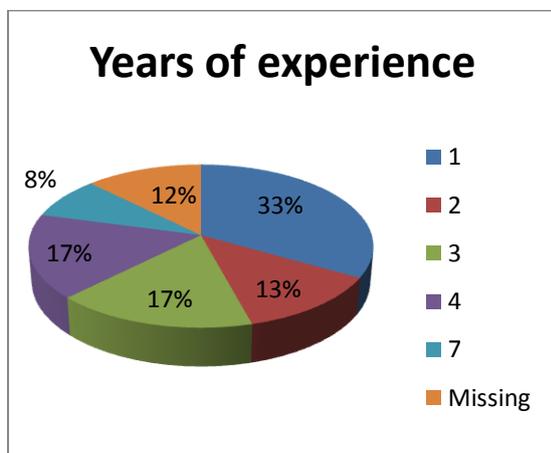


Table 2.2: Age ranges according to sex

Age	n	%	Male	Female
21-30	5	21	1	4
31-40	10	42	1	9
41-50	5	21	2	3
51-60	2	8	-	2
Mean	-	-	37.5	35.8
Total	24	100	4	18
*Missing	2	8	-	-

Figure 2.2: Years of participants' experience

Table 2.3: Summary of the participants' age by category (sex)

Sex	Median	Mean	Min	Max
Males	37	37.75	30	47
Females	35.5	37.5	27	53

The response rate was high. Initially, the researcher had set a desirable rate of at least 75% in order for the sample to be representative of the population within the given context. Table 2.1 and Figure 2.1 give an indication of the response rate per shift. Also noted in the sample (n=24) is that most (75%, n=18) of the participants are

females with a mean age of 35.8 which is slightly lower than that of the male (n=4) participants at 37.5.

With regard to employment, all the participants were employed on a full time basis. The level of education amongst the participants varied astoundingly, and the majority (66.7%) (n=16) of participants (n=24), indicated that they have a diploma in general nursing psychiatric training. With regard to any form of training in mental health care, only 18.8% (n=3) indicated that they only have a diploma in psychiatric nursing, which consists of an additional one year nursing training and education (SANC, 2013).

Only n=4 participants (16.7%) hold a bachelor degree in nursing science which includes education in mental health care. The remainder n=4 (16.7%) of the participants' data regarding the level of education was missing. With regard to post graduate training in mental health nursing only n=1 (4.2%) participant indicated that she/he is currently studying towards a postgraduate degree (Masters) in advanced psychiatric nursing.

Table 2.4: Analysis of educational level

Education	N	%
*Diploma in general nursing without psychiatric training	16 (n=24)	66.7
Diploma with psychiatric training	3 (n=16)	18.8
*Bachelor degree	4 (n=24)	16.7
Postgraduate (degree)	1 (n=4) (in progress)	25
*Missing	4 (n=24)	16.7
Total *	24	100

*Total calculation included: diploma in general nursing, bachelor degree and missing information for a total of 100% (n=24). Diploma with psychiatric training and postgraduate (degree) are additional qualifications to diploma in general nursing and bachelor degree respectively.

It is evident from the information that the majority of participants only have diplomas in general nursing, which is in line with the percentage of Registered nurses whom registered with SANC as having diplomas in general nursing (SANC, 2013). This is represented by Table 2.4 and Figure 2.3

2.8.1.2. Reliability and validity of the CD-RISC as applied in this research

This section reports the reliability and validity of the scale used in this research, the Connor-Davidson scale (CD-RISC).

The following results are discussed with reference to the CD-RISC scale, reliability and validity of the scale, the individual resiliency score of each participant and findings from the open-ended questions.

2.8.1.2.1. Connor-Davidson scale

The scale contains 25 items which carry 5 points range responses on a Likert scale, where 0 reflects *“not true at all”* and 4 is *“true nearly all the time”*. Table 3 comprises the individual items reflected on the scale. The total score varies from 0 to 100, where the highest score reflects greater resilience (Connor & Davidson, 2003) in an individual.

Table 2.5: Items in the Connor-Davidson resilience scale

Item number	Item
1	Able to adapt to change
2	Close and secure relationships
3	Sometimes fate or God can help
4	Can deal with whatever comes
5	Past success gives confidence for new challenge
6	See the humorous side of things
7	Coping with stress strengthens
8	Tend to bounce back after illness or hardship
9	Things happen for a reason
10	Best effort no matter what

11	You can achieve your goals
12	When things look hopeless, I don't give up
13	Know where to turn for help
14	Under pressure, focus and think clearly
15	Prefer to take the lead in problem solving
16	Not easily discouraged by failure
17	Think of self as strong person
18	Make unpopular or difficult decisions
19	Can handle unpleasant feelings
20	Have to act on a hunch
21	Strong sense of purpose
22	In control of your life
23	I like challenges
24	You work to attain your goals
25	Pride in your achievements

According to the developers of the scale the content of the scale was drawn from a number of sources (Connor & Davidson, 2003). The scale includes the works of Kobasa (1979) with the construct of hardiness, items reflecting control, commitment, and change, viewed as challenge, were included. From the works of Rutter (1985), the features included in the scale are, developing strategy with a clear goal or aim, action orientation, strong self-esteem, adaptability when coping with change, social problem solving skills, humour in the face of stress, strengthening effect of stress, taking on responsibilities for dealing with stress, stable affection bonds, and previous experiences of success and achievement. They included the items assessing patience and the ability to endure stress or pain adapted from the works of Lyons (1991), whereas Shackleton identified that the spiritual component is an important aspect for resilience. Factor analysis in previous studies yielded 5 factors in data from the general population sample (Connor & Davidson, 2003). See Table 2.6.

Table 2.6: Factors analysis

Factor	Construct	Eigenvalues
1	Personal competence	7.47
2	Trust in own instincts	1.56
3	Accept changes	1.38
4	Control	1.13
5	Spiritual influence	1.07

*adapted from Connor and Davidson (2003)

Variables which are identified to likely cause an effect on the resilience scale outcomes that were identified in other studies using the CD-RISC include demographical features such as age, ethnicity and level of education (Connor & Davidson, 2012). These variables were also included in this research.

The scale CD-RISC has been validated in different countries, South Africa included, where two studies measuring the resilience of high school students and school adolescents (Bruwer, Emsley, Kidd, Lochner & Seedat, 2008 & Jorgensen & Seedat, 2006). This scale has been used more widely in a variety of populations and it is applicable to PTSD, large community samples, survivors of various traumas, members of different ethnic groups and cultures, nurses and university students amongst others, which makes the use thereof applicable for this research and within a South African context.

The reliability of the scale was assessed using Cronbach's alpha (α) index. This index estimates the internal consistency of a scale's sub items namely that it measures attributes which it is supposed to measure. According to Polit and Beck (2008) and Burns and Grove (2005) the acceptable Cronbach's α parameters are ≥ 0.70 . Therefore, internal consistency for this scale is at acceptable parameters which corresponds with what was found by Connor and Davidson, the developers of

the scale, which is 0.89 ($n=577$) as well as measurable against another study such as that of Gillespie (2007) (0.90 and 0.91 with $n=735$ and $n=119$ respectively). Table 2.7 indicates the reliability of the scale with regard to this research.

Table 2.7: Internal consistency of the measuring instrument for the total group (n=24)

Scale	Scale items	Min	Max	Mean	Variance	Cronbach alpha
CD-RISC	25	-0.17	0.87	0.36	0.045	0.93

As stated above, a desirable internal consistency parameter should be ≥ 0.70 for the scale to be reliable. With a Cronbach α of 0.93; the internal consistency reflected by research indicated by the scale developers is reflected of what was found in this research. This indicates that the scale is appropriate for use in the context of this research.

Each item on the scale is evaluated empirically to assess the degree of the inter-item correlation. For items to be congruent on the same subscale, Polit and Beck (2008) state that the inter-item correlations must be between .30 and .70, to not be considered as “*little congruent*” and “*over redundant*” respectively. In this research, the mean inter-item correlation fell within the parameters namely at .36 with ranges from 0.28 to 0.80. Only 1 item (question 19) scored below 0.30 and 7 items (questions 6, 9, 11, 15, 16, 17, 22) scored above the desired range. Table 2.8 indicates the inter-total statistics for each item on the scale:

Table 2.8: Internal item correlation

Item	Inter item correlation	Cronbach α
1. Able to adapt to change	0.47	0.92
2. Close and secure relationships	0.38	0.92
3. Sometimes fate or God can help	0.57	0.92

4. Can deal with whatever comes	0.42	0.92
5. Past success gives confidence for new challenge	0.59	0.92
6. See the humorous side of things	0.80	0.91
7. Coping with stress strengthens	0.56	0.92
8. Tend to bounce back after illness or hardship	0.30	0.92
9. Things happen for a reason	0.80	0.91
10. Best effort no matter what	0.56	0.92
11. You can achieve your goals	0.79	0.91
12. When things look hopeless, I don't give up	0.60	0.92
13. Know where to turn for help	0.48	0.92
14. Under pressure, focus and think clearly	0.58	0.92
15. Prefer to take the lead in problem solving	0.78	0.91
16. Not easily discouraged by failure	0.80	0.91
17. Think of self as strong person	0.81	0.91
18. Make unpopular or difficult decisions	0.52	0.92
19. Can handle unpleasant feelings	0.28	0.92
20. Have to act on a hunch	0.334	0.92
21. Strong sense of purpose	0.45	0.92
22. In control of your life	0.76	0.91
23. I like challenges	0.62	0.92
24. You work to attain your goals	0.68	0.91
25. Pride in your achievements	0.35	0.92

*Inter item correlation mean= 0.35

These findings indicate the existence of correlations between the items in the scale.

2.8.1.3. CD-RISC results

With a sample size of 24 participants, the mean score for the resilience was 79.9, out of a scale total of 100, with the standard deviation at 12.2. The individual resilience score for each participant is indicated in Figure 2.4. Actual per item scores on the scale ranged from 1.72 to 3.9 on the Likert-type scale. Out of a range of 0 to 4 on the Likert-type scale, 62.5% scored 3 and above in relation to mean item score. Participant 19 scored the lowest (43) on the resilience scale in comparison to participant 16 who scored 97 out of the scale total of 100.

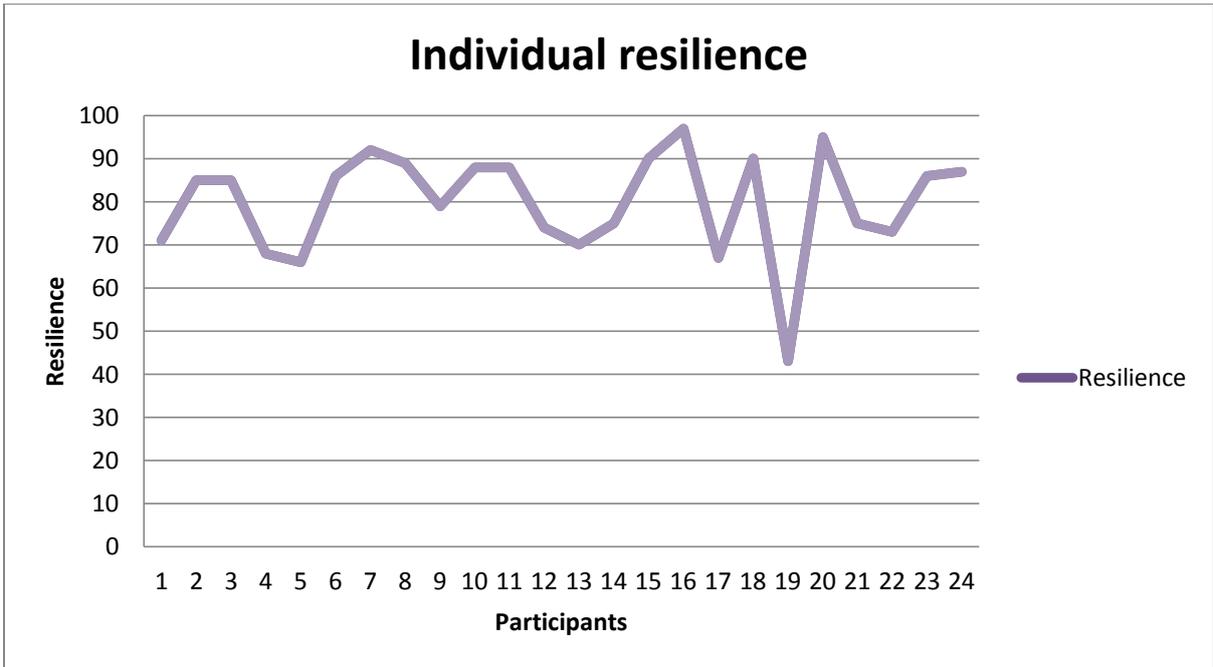


Figure 2.3: Individual resilience scores

The above Figure 2.4 illustrates the individual resilience score of the participants. The median for the resilience scale is 85 whereas the mean is 79.9. These indicate that the resilience score among the participants was high. Only one participant scored below 50 on the scale which suggests that his or her resilience level is low, whereas the remainder scored well above 50 on the scale.

Participants scored the lowest on question 18 “*make unpopular or difficult decisions*” and the highest on question 25 “*pride in achievements*” with mean (SD) scores of 2.3(1.4) and 3.8(0.4). Table 2.9 suggests the highest and lowest scores allocated per question (n=24) as well as the number of participants who completed the specific question.

Table 2.9: Participants response per question

Question (q) and item	N	Minimum score	Maximum score	Mean	SD
q1 Able to adapt to change	24	2.0	4.0	3.2	0.8

q2 Close and secure relationships	24	1.0	4.0	2.9	0.9
q3 Sometimes fate or God can help	24	0.0	4.0	3.5	1.1
q4 Can deal with whatever comes	24	2.0	4.0	2.8	0.8
q5 Past success gives confidence for new challenge	24	1.0	4.0	3.1	0.8
q6 See the humorous side of things	24	0.0	4.0	2.5	0.9
q7 Coping with stress strengthens	24	2.0	4.0	3.3	0.8
q8 Tend to bounce back after illness or hardship	23	2.0	4.0	3.1	0.8
q9 Things happen for a reason	24	1.0	4.0	3.5	0.7
q10 Best effort no matter what	24	2.0	4.0	3.6	0.6
q11 You can achieve your goals	24	1.0	4.0	3.4	0.8
q12 When things look hopeless, I don't give up	24	2.0	4.0	3.3	0.6
q13 Know where to turn for help	24	1.0	4.0	3.0	0.9
q14 Under pressure, focus and think clearly	24	2.0	4.0	3.0	0.8
q15 Prefer to take the lead in problem solving	24	1.0	4.0	3.2	0.9
q16 Not easily discouraged by failure	23	1.0	4.0	3.3	0.8
q17 Think of self as strong person	24	2.0	4.0	3.5	0.7
q18 Make unpopular or difficult decisions	24	0.0	4.0	2.3	1.4
q19 Can handle unpleasant feelings	23	0.0	4.0	2.9	1.3
q20 Have to act on a hunch	24	1.0	4.0	2.9	0.9
q21 Strong sense of purpose	23	2.0	4.0	3.5	0.7
q22 In control of your life	24	1.0	4.0	3.5	0.8
q23 I like challenges	24	2.0	4.0	3.3	0.7
q24 You work to attain your goals	24	2.0	4.0	3.4	0.7
q25 Pride in your achievements	24	3.0	4.0	3.8	0.4

2.8.1.4. Correlations between demographical information and resilience scores

One of the research objectives was to explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003). Gillespie (2007) identified variables which have an effect on the individual resilience outcome of an individual. In her research she refers to the operating room nurse. These variables include age, ethnicity and level of education among others (Connor & Davidson, 2012). The variables which have been identified as significant to this research, includes age, sex, level of education and the number of years of experience. The following Table

(2.10) illustrates the simple bi-variate statistics used to examine the correlation between the independent variables, age and years of experience, with regard to the dependant variable, resilience, of all the participants.

Table 2.10: Correlation analysis of measurable variable with resilience

Variable	<i>r</i> -value	<i>p</i> -value sig. (2-tailed)	n
Age	-0.18	0.40	22
Years of experience	-0.017	0.94	21

The nature of the relationship between two variables is assessed by using correlation coefficients (Kerr, Hall & Kozub, 2003). Correlation measures the degree to which variable(s) have an effect on the dependant variable(s). According to Kerr *et al.* (2003), values for correlation coefficients will be between -1 and +1, therefore a positive sign indicates a positive relationship between the variables whereas on the other hand a negative sign indicates opposite relationships.

Correlations between participants' measurable demographical information and resilience were determined using the Spearman rho test. The above Table 2.10 illustrated the correlation between age and years of experience with resilience. The results indicate that there is a significantly weak negative relationship between the ages of the participants with their resilience scores. A weak negative relationship was also identified between the participants' years of experience and resilience.

The level of education with resilience outcomes of the participants did not show a significant correlation. However it was noticed that 75% (n=4) of the participants with a bachelor degree have scored below 80 on the resilience scale. Participants who scored lowest and highest on the scale, 43 (n=100) and 97 (n=100) respectively, were in this group category. Of the participants in possession of a diploma, 37.5%

(n=16) scored below 80. None of them indicated whether they had further training in psychiatric nursing.

With regards to the relationship between sex and resilience, which is tabulated in Table 2.11, the results suggest that female participants are more resilient than their counterpart in the sense that they scored a higher mean value.

Table 2.11: Resilience by group category

Variable	Sex	N	Mean	SD
Resilience	Male	4	2.8	.78
	Female	18	3.2	.39
Resilience1	Male	4	70.3	19.7
	Female	18	80.9	9.8

In this research the demographical information (age, level of education and years of experience) of the participants indicates that there is no significant (if not weak) correlation with resilience. The first objective of the research was to explore the resilience of nurses by using the Connor-Davidson Resilience Scale (CD-RISC) (2003). This objective was reached successfully.

This phase in the research sought to explore the resilience of nurses, by making use of the CD-RISC. According to the illustration in Figure 2.4, most of the research participants are resilient which points out that they have greater resilience regardless of their sex, age and level of education. This is in line with other research indicating that nurses are resilient and possess strategies to cope with adversities (Warelow & Edward ,2007; Gillespie, 2007).

2.8.2. Phase 2 results

The objectives in this second phase of data analysis were to explore and describe how nurses cope in providing mental health care and how the resilience of these

nurses can be strengthened. This was obtained by analysing the narratives. In this phase of data analysis, the narratives were scrutinised to extract similar ideas and thoughts, until data saturation was achieved, to create sub-themes. Extracting these themes involved searching commonalities and natural variations (Polit & Beck, 2008). Credibility was ensured by assistance of a co-coder in the identification of the themes (Polit & Beck, 2008).

2.8.2.1. Sample characteristics

Along with the CD-RISC, the participants (n=24) were required to write a narrative guided by two open-ended questions which they had to answer according to their own lived experiences. The response rate for question one and two were (n=21) 87.5% and (n=16) 66.7% respectively out of 24 participants who participated.

Qualitative data analysis of participants' narrative responses was done by searching commonalities and extracting themes. The following two main themes were identified from the narratives namely "*coping mechanisms*" and "*resilience strengthening*". A discussion of these themes and their sub-themes are presented in the following paragraphs. The theme is discussed, followed by extracts from the narratives as well as relevant literature.

Table 2.12: Themes and sub-themes

Themes	Coping mechanism	Resilience strengthening
Sub-themes	<ul style="list-style-type: none"> • Knowledge, skills and experience • Nurse-patient relationship • Support system • Spirituality (religion) and self-care 	<ul style="list-style-type: none"> • Support • Trained staff • Security measures and safety • Teamwork and in-service training • Education

2.8.2.2. Coping mechanisms

This identified theme, *coping mechanisms*, emerged from the participants' response to: "How do you cope to provide mental health care to an involuntary admitted MHCU?" The participants indicated various methods to cope with the adversity of caring for involuntary MHCU's, which included knowledge, skills and experience, nurse-patient relationship, support system and spirituality (religion) and self-care. See Table 2.12. These similar and common coping methods which were shared among the participants were identified as the themes in the subsequent section.

2.8.2.2.1. Sub-theme 1: Knowledge, skills and experience

From their responses, it was evident that knowledge, skills and experience play a role in the participants' ability to cope to provide mental health care to an involuntary admitted MHCU. They indicated that skills gained through their experience enabled them to cope. They shared this theme as follows:

"As a health care provider understanding, patience and assertiveness need to be encouraged..." (participant (prt). 11)

"Skills and experience that I have acquired make me cope easily..." (prt. 2)

"Using skills to control them." (prt. 23)

"Coping mechanism differ day by day depending on the nature and atmosphere..." (prt. 12)

"Due to the training and skill obtained in my training and practical, I believe for me to cope..." (prt. 11)

"Also with help from your supervisor with in-service training..." (prt. 20)

Knowledge obtained by training and in-service training also assisted in the participants' ability to cope in the workplace, such indicated by the aforementioned participants. Knowledge, skills and experience have been shown in previous

conducted research as aspects that facilitated nurses to cope with adversities in the workplace. Cameron and Brownie (2010) stated that the resilience among a group of registered nurses is associated with clinical knowledge, skills and experience, which led to competent, skilful and holistic care of the patients. Gillespie, Chaboyer, Wallis and Grimbeek (2007) concurred with preceding literature by stating that nurses with the specialised knowledge and skills are more likely to perceive themselves to be competent.

2.8.2.2.2. Sub-theme 2: Nurse-patient relationship

Participants focused on their relationships and interactions with MHCUs. They loved providing care to MHCUs and would go beyond their duty to alleviate suffering of users. Communication with the MHCUs, which facilitates the nurse-patient relationship, was viewed as strategies to get the work done and participants indicated that they often had to *“bribe and lie”*. On the other hand, opposing strategies used by other participants included *“health education”* and explanation which promote building relationships with users. Both strategies were viewed as a coping mechanism to provide care which is in the best interest of the MHCUs and to building a relationship between the nurse and the user.

“Through-out the admission period, health education should be emphasised...” (prt. 11)

“Most of the times you find yourself lying/bribing these users in order to get your work done...” (prt. 24)

“...to be able to explain to the patient the reason for them to drink medication...” (prt. 1)

Building nurse-patients relationships involves the use of self. By not having a relationship which facilitates health and alleviate suffering, coping in the workplace

would be non-existing. Therefore, nurses have to create clear boundaries with users while creating an alliance to build the relationship (Warelow & Edward, 2007). In communicating with the users the boundaries assist the nurses, in relationship building with the users, so that they would not compromise or deny the care given to them. Hummelvoll and Severinsson (2002) emphasised that communication and understanding, formed the foundation in building relationships with patients.

2.8.2.2.3. Sub-theme 3: Support system

Participants also focused on having support from various people in their lives which facilitate their ability to cope with involuntary MHCUs. These people included their own support system, fellow colleagues, management and family. Workplace support, provided by colleagues and management is the key in the direct delivery of care as lack thereof and teamwork would compromise patient care. As these following participants stipulated in the narratives:

“Involuntary patients are dangerous but because of the teamwork I can cope.”
(prt. 7)

“...lack of support from management in MHCU such as managing aggressive in-service training.” (prt. 8)

“Teamwork is the only thing that can make me cope...” (prt. 9)

This form of support (peer support) provided by their colleagues is valuable as they provide knowledge and guidance to the participants, and because they share in similar situations and experiences with involuntary MHCUs.

However, having support from outside the workplace could also play a crucial role in the participants' ability to cope as these participants exemplified:

“Have your own support system, to give daily encouragement...” (prt. 4)

“...and support from your colleagues and family.” (prt. 20)

Jackson, Firtko, and Edenborough, (2007) emphasised professional relationships for nurses that become a professional support system. The support provided by nurses to one another facilitates teamwork in the workplace. Nurses who experienced resilience were as a result of the caring environment of the team in which they worked (Warelow & Edward, 2007). Koen *et al.* (2011) and Gillespie *et al.* (2007) identified the role of the support system to enable coping in the nurse workplace, and facilitate resilience. The latter went on to state that strengthening peer or colleague support required collaboration. In their research, resilience was characterised by providing support, social inclusion and valuing other nurses' contributions (Gillespie *et al.*, 2007).

2.8.2.2.4. Sub-theme 4: Spirituality (religion) and self-care

Several participants emphasised spirituality and self-care (exercise) in their ability to cope. Having a sense of higher protection and rejuvenation by exercises enable these participants to cope. One participant stated that the latter enables him or her to see things positively. In this way participants cope because they take care of themselves. The following were extracted from the narratives:

“Religion: God’s grace is new every morning..., take regular breaks.” (prt. 4)

“...and by praying to God that He should protect me...” “I also exercise so that I can be healthy mentally and see thing in a positive way.” (prt. 16)

Koen *et al.* (2011) made reference to these two aspects of spirituality and having a healthy lifestyle as coping strategies. Other literature addressed the importance of occupying other healthy activities outside the professional life to retain a life balance (Jackson *et al.*, 2007). These activities and tasks reduce anxiety and bolster resilience in the workplace (Edward, 2005). Kumpfer’s Resiliency model confirms

this and states that spirituality predicts resilience and life adaptation (Kumpfer, 1999).

2.8.2.3. Resilience strengthening

From the theme of resilience strengthening, five sub-themes emerged: support, enough trained staff, security measures and safety, teamwork and in-service training and education (see Table 2.12). These themes emerged from the participants' response to the second question: How can your resilience be strengthened to provide mental health care to involuntary admitted and treated MHCU? The participants in this research shared similar notions on the factors which strengthen their resilience, which will be discussed in the following paragraphs.

2.8.2.3.1. Sub-theme 1: Support

The aspects of psychological and physical support were addressed by many participants who indicated that their resilience can be strengthened through these aspects. The support referred to include support from the management and supervisors, support groups and peer support. Providing support for each other could alleviate workplace adversities and giving precedence to these aspects and factors, the resilience of the participants' workplace could be strengthened. As with the question on coping with involuntary MHCU's, the participants mentioned support as a way to strengthen their resilience. The following were the identified examples from the narratives:

"Prompt psychological support to personnel who are working with..." (prt. 1)

"I believe institutions should provide some sort of counseling for their employees..." (prt. 4)

"Management support" (prt. 8)

“Continuous support from management, immediate supervisor, colleagues and subordinates.” (prt. 15)

“...support those who are injured emotionally, to have management that is understanding and supportive.” (prt. 16)

“It does help a lot when one has a support group or someone...” (prt. 24)

Edward (2005) indicated that resilience in nurses was promoted by non-work related support and through support at work. If peer cohesion is facilitated and promoted and educative support offered, then nurses in that environment will manifest higher levels of hope (Gillespie *et al.*, 2007). The notion of professional support was also emphasised in Koen *et al.* (2011). The resilience of mental health nurses can be strengthened by support provided to them. Physical or psychological support including opportunities to self-reflect, debrief or validate as well as provide relief through humour and team camaraderie foster resilience (Cameron & Brownie, 2010).

2.8.2.3.2. Sub-theme 2: Trained staff

The participants indicated that the workload overwhelmed them and that with sufficient personnel, the workload could be minimized. Another participant suggested that the staff should be trained on mental health. If there are sufficient personnel to provide care to MHCUs the participants' resilience could be strengthened.

“Increase in personnel working in the unit to minimized workloads...” (prt. 1)

“Enough trained staff on mental health.” (prt. 15)

Professional development was identified by Edward (2005) as a factor to strengthen and foster resilience of nurses.

One participant indicated that recuperating by taking leave of absence from work on a frequent base would enhance their resilience such as the comment by the following participant:

“Take leave after every six months, exhaustion creates a low interest in trying to motivate others.” (prt. 4)

The participants’ resilience can also be strengthened by compassion towards MHCUs.

“Passion that I have towards those patients strengthened me.” (prt. 13)

“...you as a nurse have empathy towards these users and understand their life stories.” (prt. 24)

2.8.2.3.3. Sub-theme 3: Security measures and safety

Two participants indicated the importance of safety and security in the workplace. They indicated that improving security infrastructures could provide the participants with the reassurance that they are safe and ultimately able to thrive in the workplace. The mental health environment could often not be conducive as the users were likely to inflict bodily harm upon themselves or others including professionals. The participants mentioned the following:

“Increase in security measure, i.e. the unit must be well secured with burglars...”
(prt. 1)

“Security and safety measures be attended to.” (prt. 15)

The aspect of safety and security in the workplace contributing to resilience outcome of nurses was addressed by Koen *et al.* (2011), nurses become victims to patient violence.

2.8.2.3.4. Sub-theme 4: Teamwork

Teamwork amongst the multi-professional members, colleagues and supervisors enhances resilience of participants. Many participants focused on this aspect as they share similar experiences with the involuntary MHCUs. The participants have the courage to share incidents with managers and have moral to provide care because

they work as a team. Therefore teamwork has to be emphasised with regard to strengthening resilience.

“Good or prompt communication with senior superiors especially when incidents occur...” (prt. 1)

“...can also help working together also with all the multi-professional team...” (prt. 9)

“Even the team spirit can help us have moral in providing a total care...” (prt. 10)

“...and lastly teamwork.” (prt. 12)

“Team work is important to me...” (prt. 18)

Edward (2005) stated that the team is a protective veneer to nurses work stress. Hummelvoll and Severinsson (2002) insinuated on the notion of a united stance exhibited by nurses. They stated that communication and achieving consensus are essential to maintain this united stance.

2.8.2.3.5. Sub-theme 5: In-service training and education

The participants indicated that with ongoing or continuous in-service training and education, their resilience would be strengthened. The in-service trainings should keep them updated with the latest developments and learning opportunities should be created. As it was expressed in the following participants' narratives:

“By continuous in-service training and learning opportunities...” (prt. 2)

“In-service training” (prt. 6 and 8)

“Education or in-service on mental health act and latest development...” (prt. 15)

“...the necessary facilities to teach those who don't understand how to care for such a patient...” (prt. 16)

Jackson *et al.* (2007) stated that nurses needed to be assisted in developing skills which will aid them to be resilient and cope better with workplace adversities.

Without the assistance in developing these skills, they compromise their ability to provide care which resulted in staff retention and future recruitment (Gillespie *et al.* 2007). By identifying those factors which could be implemented to strengthen resilience these negative impacts could alternatively be curbed.

Other participants indicated that the care they render, to MHCUs, is specialised, so forth should the training and education. The education would enable more effective care delivery to MHCUs, to improve and to diminish their fear of aggressive behaviour (Nolan *et al.*, 1999). They expressed that if they could be equipped with in-service training on how to handle involuntary MHCUs, their resilience would be strengthened. This is evident in the responses by the participants:

“Specialty programme training for mental patients” (prt. 8)

“It can be strengthened by having knowledge on how to handle an involuntary mental care user...” (prt. 10)

“adherence to mental health care act and proper health education...” (prt. 12)

Koen *et al.* (2011) also concurred in their study that there are not enough opportunities for in-service training, attendance of workshops, seminars or staff development in the workplace to equip them to provide the necessary care.

2.9. Conclusions

Phase one of this research was conducted to achieve the first objective: *to explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).*

The summated nurses' resilience outcomes, as measured by the CD-RISC, were suggestive that regardless of demographical differences the registered nurses have manifested resiliency in the workplace.

The results indicated that these nurses have a *passion (best effort no matter what)* for their work and *take pride in their achievements* (items 10 and 25). Although the nurses take pride in their achievements and the fact that they give their best effort, regardless of the outcomes, it is suggestive of their passion and dedication to their work. In the same context, findings from the CD-RISC indicated that these nurses have *difficulty in making unpopular or difficult decisions which affect others* and they tend to find it *difficult to handle unpleasant feelings* (items 18 and 19). This might lead to internal conflict arising between their “pride in achievements and passion for the profession” and “making unpopular decisions and handling unpleasant emotions”. Considering that the nurses feel proud of their achievements, the setback is when they are unable or find it difficult to make an unpopular decision, which might be indicative of their level of assertiveness. On a daily base, these nurses are faced with making decisions which affects their colleague, subordinates as well as the MHCUs. For example having to decide which treatment intervention might be in the best interest of the involuntary MHCU, or rather using the paternalistic approach, as the nurse decides which intervention to follow. In the work environment where decision making is critical, inability to make unpopular decisions could results in a lack of confidence when caring for involuntary MHCUs. Furthermore these nurses want to do what is best for the involuntary MHCU because they have a passion for what they do, however they also find it difficult to handle unpleasant feelings with regard to involuntary MHCUs admission in treatment. They could develop a low self-confidence and inner conflict as a result, seeing that decision making and handling unpleasant feelings are challenges for them.

The second phase of this research was to achieve the second and third objectives: to explore and describe how nurses cope in providing mental health care to involuntary admitted and treated mental health care users and to explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened.

In order to thrive and cope, knowledge, skills and experience, a nurse-patient relationship, a support system from all aspects of the nurses' life and having a sense of spirituality or religion is the coping mechanism influencing the resilience outcome. Their professional relationship enables them to promote the best interest of the MHCUs and ultimately strengthening the nurse-patient relationship. In consideration of the latter, it is linked to the findings that the nurses are proud of their achievements, in this case competence to care and advocate for involuntary MHCUs. Another aspect which fosters their coping to care for involuntary MHCUs involves their support towards one another and from their families as well as teamwork. Supporting one another in challenging situations enhances teamwork. Whereas the support provided by their families, spirituality and religious practice as well as self care through exercises are factors not directly linked to their professional aspects but enables them to cope with caring for involuntary MHCUs. No matter how challenging or difficult the work environment is nurses seem to cope with caring for involuntary MHCUs by employing various mechanisms from all walks of life.

Considering the aspects which have been described by the nurses to facilitate coping in the difficult work environment, the nurses also identified that strengthening some of these and other factors lead to resilience.

Education and skills development have been mentioned as a factor which facilitates coping, as well as resilience strengthening. Equip nurses with skills and educational

development in mental health care; in this case 18% of the nurses have psychiatric nursing training, which is a key skill in the care and treatment of these involuntary and other MHCUs. Education strengthens the nurses to be confident in their work.

Providing support for the nurses by the management and supervisors will strengthen resilience. Support further encourages the nurses to cope in the difficult work environment. Enhancing security measures in the work environment satisfy the nurses' need to be physical secured at work, increase their wellbeing, which strengthens resilience.

Adequate personnel in the ward results in a productivity and teamwork, furthermore, with sufficiently trained personnel in the ward, workload is divided equally and reduces burnout amongst the nurses. MHCUs receive the utmost care and treatment and risks such as suicide and physical aggression are annulled.

Although the nurses reported that they are coping and suggested ways in which their resilience can be strengthened, they do find caring for involuntary MHCUs as difficult and challenging. They reported the factors which need to be observed and fostered in order to strengthen resilience, such as support, trained staff, security measures and safety, teamwork, education and in-service training. However even in identifying the factors which strengthen resilience, they scored low on the questions relating to being able to make difficult decisions and dealing with unpleasant feelings. The factor of education on resilience strengthening for example, they indicated that with the difficulty in caring for involuntary MHCUs, linked with their inability to make difficult decisions and handle unpleasant feeling, could result in hindering their resilience. Even with relevant education and training, without the ability to make unpopular decisions indicate a lack in being assertive in their profession. They might thus need further support in these aspects.

2.9.1. Meta-matrix analysis: general conclusions

The nurses in this research have high resilience as indicated by the CD-RISC. They take pride in whatever they achieve and are driven by passion for what they do. To achieve these high resilience outcomes, the nurses in this research use strategies and mechanisms from various walks of life, including personal and professional, to cope and remain resilient in the difficult work environment and allow them not to succumb after each negative incident. These coping mechanisms and resilient strategies mentioned by the nurses concurred with the competencies needed in resiliency as described by Kumpfer (1999). The competencies fulfil each aspect of the human being, holistically. Therefore nurses do not only become resilient because of one aspect, such as the support, but other aspects such as spirituality and religion play a role. Nurses are able to cope because they apply these competencies in the day to day challenges and strengthen their resilience.

- Skills and training promote a feeling of competence in these nurses, because these mechanisms enhance the nurses' cognitive competency. Furthermore nurses take pride in what they achieve, such as a higher educational training which increases their resilience.
- Nurse strive to act in the best interest of the MHCUs and avoid a paternalistic approach to care, this strengthen the nurse-patient relationship. This also strengthen resilience as it result in the nurses taking pride in their achievements when caring for involuntary MHCUs.
- Nurses should value each other's contributions and sharing experiences which in turn increases quality of care and built a support system in the work place which fosters and strengthen resilience. A supportive work environment

also enables the nurses to cope with challenges in caring for involuntary MHCUs.

- Spirituality or having a sense of belief and exercising, result in nurses able to cope in the workplace and strengthen their resiliency. These aspects, often not taken into consideration, allow the nurses to rejuvenate and gain strength to cope and to be resilient.

These coping mechanism and resilience strengthening strategy sub-themes that emerged from the narratives as well as the CD-RISC questionnaire are illustrated together with the competencies in resiliency as described by Kumpfer (1999) in the figure (3.2) below. The coping mechanisms and resilient strategies in this research concur with the literature that aspects that contribute to resiliency are within these competencies by Kumpfer (1999).

2.10. Recommendations for nursing practice, education and research

- **Practice:** Strengthen and encourage support from families as well as colleagues and supervisors. Promote a work environment that empowers nurses with opportunities for educational training with skills relevant to providing care for involuntary MHCUs. This will in turn instil a feeling of competence and pride in their achievements as they have conviction in their work. Empowerment should also include nurses contributing to policy development which are relevant to nursing care of MHCUs. Promote teamwork and provide sufficient human resource in order to weigh down burnout, by distributing workload and responsibilities equally. The notion that each individual (nurse) is an asset, who is acting in the best interest of the MHCUs, and his or her contributions are taken into consideration, should be emphasised. This enhances and encourages the nurse-patient relationship

and ultimate strengthens resilience in caring for involuntary MHCUs. Training on being assertive could also be provided to the nurses as it promotes self care in the nurses and result to their resilience. When nurses are self confident, in turn they tend to be able to handle unpleasant feelings because of the conviction in their work.

- **Education:** The field of mental health nursing should attract many students as a career of choice. Proper facilitation and guidance, equip students to enter the workplace with confidence. Nursing students should be equipped with skills required for psychiatric nursing, as this will enable them to act with conviction in their work in the future. For example they could be taught on the caring for involuntary MHCUs and the management of aggressive patients which includes the ethical and legal aspects involved in admitting and treating these patients. Continuous education, skills development and specialisation in the field should also be encouraged. Therefore the workplace should make means that their employees obtain further educational training in the field of mental health, as this result in them being assertive. All these strategies can instil and strengthen resilience.
- **Research:** Future research on the topic could include different sampling methods with regards to the sample size and population framework as this research was contextual. Researchers pursuing in resilience research could identifying how strengthening coping mechanism for example knowledge, skills and experience have an outcome on or result to the nurses' resilience. The current research identified factors used as coping mechanisms and how resilience could be strengthened but knowledge on how these mechanisms facilitate resilient outcomes have to be incorporated in future research.

Longitudinal research focusing on nursing students' perception of mental health care and future resilient outcome is recommended. This research was a cross-sectional design and more knowledge on forecasting resilience strategies could be appreciated.

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SECTION 3

Limitations, conclusions and recommendations

3.1. Introduction

In this section the researcher presents the conclusions, limitations and recommendations. These conclusions were drawn from the research and literature findings in the previous section; in order to answer the research question and to achieve the aim and objective namely, to formulate recommendations for nursing science, nursing practice and nursing research.

The research was conducted in two phases as mentioned. Conclusions were drawn from the findings obtained from the nurses' responses to the CD-RISC (phase 1) and their narratives (phase 2). The research question was stated as follows: What is the resilience of mental health nurses and how do they cope and strengthen their resilience to provide care in the work environment where MHCUs are often involuntarily admitted? In order to address this question the aim of this research was to explore and describe how to strengthen the resilience of nurses providing mental health care; in order for them to provide quality nursing care in the work environment where MHCUs are often involuntary admitted.

3.2. Conclusions

The subsequent section highlights the conclusions for both phases one and two as well as the meta-matrix analysis of the results of phase 1 and 2. Ultimately, these conclusions formulated recommendations for nursing practice, education and research. This section also achieved the fourth objective namely: to formulate guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs.

3.2.1. Conclusions on Phase one

Phase one of this research was conducted to achieve the first objective: *to explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).*

The summated nurses' resilience outcomes as measured by the CD-RISC were suggestive that regardless of demographical differences the registered nurses have manifested resiliency in the workplace. Although caring for involuntary MHCUs is challenging for nurses, the nurses in this research demonstrated to have high resilience outcome despite the challenges they face with caring for them. Research has shown that when people have previously faced adversities, they tend to come

out stronger (Waller, 2000), as in this case. Furthermore Koen *et al.* (2011:114) support this notion by concluding that registered nurses show enabling strengths which facilitate resiliency in difficult workplace circumstances, as seen with the nurses in this research. These strengths are acquired from their day to day experiences and incorporated in their professional lives. However, these experiences may not always be positive; and transcending from a negative experience into a positive strength is an attribute of resiliency in these nurses, which increases their resiliency.

Some feel that it is difficult and challenging to care for these MHCUs. However, they cultivated this negative experience into resilience by incorporating previous experiences. Indeed, factors such as experience and knowledge contribute to these higher resilient outcomes amongst the nurses and are accompanied by certain mechanisms or behaviours which the nurses possess and implement in their professional lives. The certain behaviours and mechanisms acquired by an individual's personal life, plays a role in their resilient behaviour, and in this case the nurses (Gillespie, 2007:177). With that said a previous encounter with a negative experience, regardless of the environment or setting, enabled the nurses to relate and strive towards the objective. This is identified in the resiliency process by Kumpfer (1999:183) that individuals consciously or unconsciously modify or selectively perceive their environment. They thrive because they possess competencies needed in resiliency, which are spiritual, cognitive, behavioural, physical and affective (Kumpfer, 1999:195). The nurses in this research possess attributes of these strengths to facilitate their resilience outcomes.

Furthermore, the results indicated that these nurses have a *passion (best effort no matter what)* for their work and *take pride in their achievements* (items 10 and 25). Although the nurses take pride in their achievements and the fact that they give their best effort regardless of the outcomes, it is suggestive of passion and dedication to their work. In the same context, findings from the scale indicated that these nurses have *difficulty in making unpopular or difficult decisions which affect others* and they tend to find it *difficult to handle unpleasant feelings* (items 18 and 19). This might lead to internal conflict arising between their “pride in achievements and passion for the profession” with “making unpopular decisions and handling unpleasant emotions”. Considering that the nurses feel proud of their achievements, the setback

is when they are unable or find it difficult to make an unpopular decision, which might be indicative of their level of assertiveness. On a daily base, these nurses are faced with making decisions which affects their colleagues, subordinates as well as the MHCUs. For example having to decide which treatment intervention might be in the best interest of the involuntary MHCU, or rather using the paternalistic approach, as the nurse decides which intervention to follow. In the work environment where decision making is critical, inability to make unpopular decisions could result in a lack of confidence when caring for involuntary MHCUs. Furthermore, these nurses want to do what is best for the involuntary MHCU because they have a passion for what they do. However, they also find it difficult to handle unpleasant feelings with regard to involuntary MHCUs admission in treatment. They could develop a low self-confidence and inner conflict as a result, seeing that decision making and handling unpleasant feelings are challenges for them.

3.2.2. Conclusions on Phase two

From the second phase of this research the second and third objectives were addressed. These objectives were to explore and described how nurses cope in providing mental health care to involuntary admitted and treated MHCUs and to explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened. The qualitative data analysis identified two themes namely coping mechanisms and resilience strengthening each with five sub-themes. Conclusions for the two themes will be discussed separately and will provide clarification on the research question and support the high resilience outcomes discussed in the previous section (Section 2).

3.2.2.1. Coping mechanisms

Coping mechanisms in this environment are linked to the qualitative descriptions by the nurses. To foster the coping mechanisms result not only in higher resiliency but also enable nurses to render quality care. Therefore, they have to foster these mechanisms and simultaneously nurture their individual coping mechanisms. When they are able to articulate their coping ability and not succumb after each adversity they identify characteristics within themselves which are resourceful for future challenges. In general the attainment to successfully prosper and thrive in difficult circumstances results in a sense of self-confidence amongst nurses. Their passion and dedication for the profession result in the nurses striving for excellence in their

work environment regardless of the challenges they face, whereas ultimately they take pride in their achievements.

In order to thrive and cope, knowledge, skills and experience, a nurse-patient relationship, a support system from all aspects of the nurses' life and having a sense of spirituality or religion are the coping mechanisms influencing the outcome. Clearly, in spite of their various demographical information nurses drew these similar notions regarding coping skills in their work environment. They cope with caring for involuntary MHCUs by relying on their competence obtained through training. Their professional relationship enables them to promote the best interest of the MHCUs and ultimately strengthening the nurse-patient relationship. In consideration of the latter, it is linked to the findings that the nurses are proud of their achievements, in this case competence to care and advocate for involuntary MHCUs. Over a period in time, experience and knowledge in their work environment contribute to their coping skills.

Furthermore, the nurses indicated that they are able to cope with caring for involuntary MHCUs through their support towards one another as well as teamwork. The contributions, knowledge and experiences of their professional peers bring value to the quality of care. Supporting one another in challenging situations enhances teamwork amongst them and that strengthens individual coping. On a personal level, the support provided by their families, spirituality and religious practice as well as exercise enables them to cope with caring for involuntary MHCUs. None the less, no matter how challenging or difficult the work environment is nurses seem to cope with caring for involuntary MHCUs.

Based on these conclusions, the following figure illustrates how the identified coping mechanisms foster resilience in the work place:

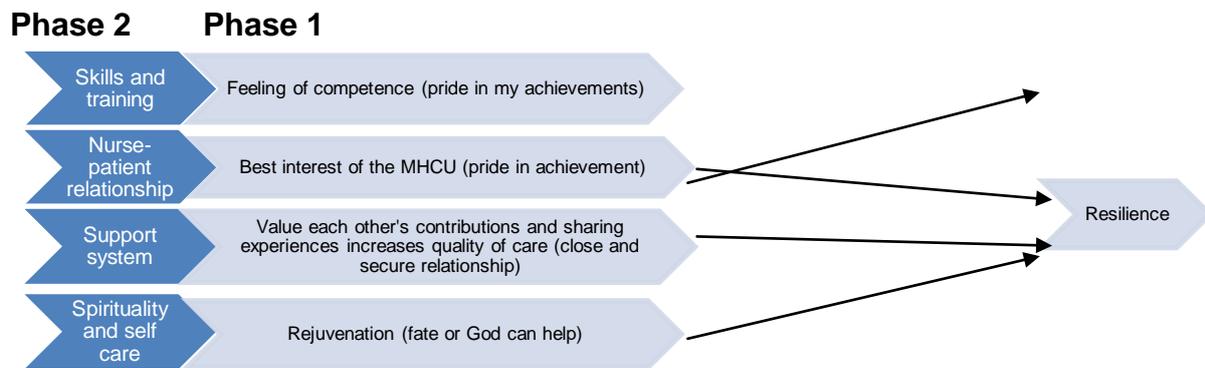


Figure: 3.1. Meta-matrix analysis: How nurses' coping mechanisms foster resilience

3.2.2.2. Resilience strengthening

Considering the aspects which have been described by the nurses to facilitate coping in the difficult work environment, the nurses also identified that strengthening some of these and other factors lead to resilience.

Education and skills development have been mentioned as a factor which facilitates coping, as well as resilience strengthening. Equip nurses with skills and education development in mental health care; in this case 18% of the nurses have psychiatric nursing training, which is a key skill in the care and treatment of these involuntary MHCUs. Education strengthens the nurses to be confident in their work.

Providing support for the nurses by the management and supervisors will strengthen resilience. Support further encourages the nurses to cope in the difficult work environment. Enhancing security measures in the work environment satisfy the nurses' need to be physically secured at work, which strengthens resilience. Management should get involved in enhancing the wards' safety measures.

Adequate personnel in the ward result in higher productivity and teamwork. Furthermore, with sufficiently trained personnel in the ward, workload is divided equally and reduces burnout amongst the nurses. MHCUs receive the greatest care and treatment and risks such as suicide and physical aggression are annulled.

Resilience of nurses can be strengthened by looking into the above aspects, as the consequences thereof can be permanently irreversible. Nurses could resolve in leaving the environment in search for greener pastures; they could develop burnout and dissatisfaction in their work. However, through managements' support,

facilitation of training and skills development and proper security systems in place, these nurses' resilience to provide care to involuntary MHCUs can be strengthened.

Although the nurses reported that they are coping and suggested ways in which their resilience can be strengthened, they do find caring for involuntary MHCUs as difficult and challenging. They reported the factors which need to be observed and fostered in order to strengthen resilience, such as management's support, trained staff, security measures and safety, teamwork, education and in-service training. However even in identifying the factors which strengthen resilience, they scored low on the questions relating to being able to make difficult decisions and dealing with unpleasant feelings. For example, with regard to education on resilience strengthening, they indicated that the difficulty in caring for involuntary MHCUs, linked with their inability to make difficult decisions and handle unpleasant feelings, which could result in hindering their resilience. Even with relevant education and training, without the ability to make unpopular decisions indicate a lack in being assertive in their profession. They might thus need further support in these aspects.

3.2.3. Meta-matrix analysis: general conclusions

The nurses in this research have high resilience as indicated by the CD-RISC. They take pride in whatever they achieve and are driven by passion for what they do. To achieve these high resilience outcomes, the nurses in this research use strategies and mechanisms from various walks of life, including personal and professional, to cope and remain resilient in the difficult work environment and allow them not to succumb after each negative incident. These coping mechanisms and resilient strategies mentioned by the nurses concurred with the competencies needed in resiliency as described by Kumpfer (1999). The competencies fulfil each aspect of the human being, holistically. Therefore nurses do not only become resilient because of one aspect, such as support, but other aspects such as spirituality and religion also play a role. Nurses are able to cope because they apply these competencies in the day to day challenges and strengthen their resilience through the following:

- Skills and training promote a feeling of competence in these nurses, because these mechanisms enhance the nurses' cognitive competency. Furthermore nurses take pride in what they achieve, such as a higher educational training which increases their resilience.

- Nurses strive to act in the best interest of the MHCUs and avoid a paternalistic approach to care. This strengthens the nurse-patient relationship as well as the resilience, because it results in the nurses taking pride in their achievements when caring for involuntary MHCUs.
- Nurses should value each other's contributions and sharing experiences which in turn increases quality of care and build a support system in the work place which fosters and strengthen resilience. A supportive work environment also enables the nurses to cope with challenges in caring for involuntary MHCUs.
- Spirituality or having a sense of belief and exercising (self care), result in nurses able to cope in the workplace and strengthen their resiliency. These aspects, often not taken into consideration, allow the nurses to rejuvenate and gain strength to cope and be resilient.

These coping mechanisms and resilience strengthening strategy themes that emerged from the narratives as well as the CD-RISC questionnaire are illustrated together with the competencies in resiliency as described by Kumpfer (1999) in the Figure (3.2) below. The coping mechanisms and resilient strategies in this research concur with the literature that aspects, which contribute to resiliency, are imbedded within these competencies by Kumpfer (1999).

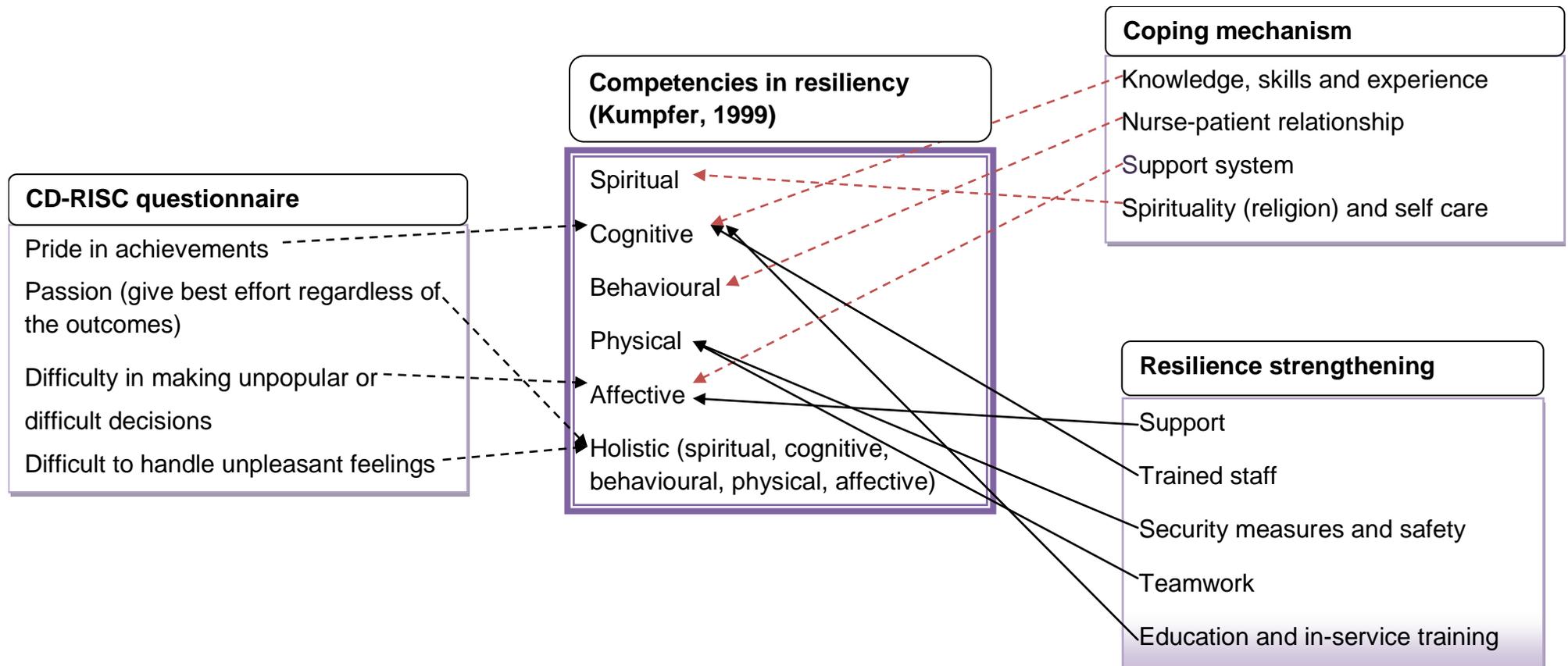


Figure 3.2: Coping mechanisms, competencies in resiliency (Kumpfer, 1999:185) and resilience strengthening

3.3. Limitations of the research

Specific limitations were encountered with certain aspects regarding this research. This section will focus on the limitations in the research design, sampling and the data collection.

3.3.1. Design

The research was contextual in nature, therefore it should be agreed that generalisation of the findings to other settings and context should be applied so with prudence. Research that is contextual in nature can be studied in an intrinsic and immediate contextual significance and produce extensive description of the phenomena (Mouton, 1999). However, generalisation and context application can be done when consideration is given to professional characteristic for example considering the nurses years of experience.

3.3.2. Sampling

Sampling occurred in two phases whereas in the first phase the sample was all inclusive, convenience sampling and the second phase was selective. Response rate in phase 1 was higher than that in phase 2. Although initially the sample size of 24 nurses was relatively lower than anticipated. This led to risk of bias as the sample was not representative of the population in the overall context. However the lower response rate in the second phase could none the less provide informative data as the nurses who responded shared similar views and data saturation was reached.

The sample size in both phases limits transferability of the research to other South African contexts. Should the sample have included other nurse from other hospitals in both public and private facilities, transferability and generalisation would be more possible.

3.3.3. Data collection

Data collection in the second phase was by means of narratives. Limitations in the amount of information which the nurses provided occurred as a result. Should data collection in this phase, takes place by means of focus groups or individual interviews for example more information and clarification could have been obtained. These methods might have enriched the data and the research findings. Additionally the pilot study conducted with the first five participants assisted the researcher to

identify barriers which could have hindered the outcome of the research. This gave the researcher the platform to explain and clarify comprehensively in the case of uncertainty.

3.4. Recommendations

Although the research was contextual of nature, the findings contributed to the formulation of recommendations in nursing practice, nursing education and nursing research which will be discussed in the subsequent section.

3.4.1. Recommendations for nursing practice

Recommendations for nursing practice are formulated as guidelines to strengthen the resilience of nurses caring for involuntary MHCUs. The qualitative research findings indicated that resiliency can be strengthened with support, either from colleagues, supervisors and family. In practice, supervisors as well as managers could provide opportunities for educational training which aims on empowering nurses with skills relevant to providing care for involuntary MHCUs, for example, “refresher” in-service training on policies regarding the handling of aggressive patients on a quarterly basis. This will in turn facilitate a feeling of competence and pride in their achievements as they have conviction in what they do. Furthermore, this empowerment in practice should include nurses contributing to policy development which is relevant to nursing care of these MHCUs. This aspect of continuous education and empowerment will not only increase resiliency, but it will also comprise a form of support provided by the supervisors. Building these skills and knowledge capacity produces resilient nurses in the workplace where adversities are inevitable. Furthermore, encouraging nurses to pursue in education produces effective care for the MHCUs. Cameron and Brownie (2010) stated that resilience amongst a group of registered nurses is associated with clinical knowledge, skills and experience, which leads to competent, skilful holistic care.

Focusing on and fostering factors which facilitate resilient behaviour in nurses, lead to better care for involuntary MHCUs. Nursing managers and supervisors should focus on promoting support and teamwork as it allows continuous, uninterrupted care for MHCUs. Furthermore, the high workload and responsibilities of the ward should be distributed equally amongst the nurses to reduce burnout and dissatisfaction. Good communication with supervisors, colleagues and the multi

disciplinary team is effective as it facilitates teamwork in the work environment. Each team member is viewed as an asset, and his or her contributions are valued as it increases quality of care. Ultimately, this results in uncompromised nursing care that is uninterrupted and in the best interest of the MHCUs. The nurse-patient relationship is enhanced as it is the vehicle to advocate for involuntary MHCUs. Managers and supervisors should put effort to build on the strengths factors (teamwork, pride, passion and safety and security) to promote resilience in caring for involuntary MHCUs.

Lastly, training on being assertive promotes self care in the nurses as it ultimately contributes to their resilience. When nurses are self confident, in turn they tend to be able to handle unpleasant feelings because of the conviction in their work. Supervisors should also focus on this aspect of assertiveness as it could reduce burnout and dissatisfaction in the workplace.

3.4.2. Recommendations for nursing education

Nursing educators should attract students and guide them into the field of mental health. Choosing a field of occupation involves developing and selecting a field, the concept of opportunity structure, whereby education make-up the students and interaction between class and family experiences to choose an occupational field (Lane, 1972 (as cited by Wells, Ryan & McElwee, 2000:81)). Their role as educators thus includes facilitating nursing students to choose mental health nursing as a career of choice. With the correct facilitation and guidance, the students would feel equipped to enter the workplace with confidence. The Nursing undergraduate curricula in South Africa focus mainly on general nursing. Most students are introduced to mental health nursing in their third and final year of study. Teaching the fundamentals and basics of psychiatric nursing at an earlier level will ensure that student nurses have a variety of specialities to choose from such as midwifery, psychiatry or critical care nursing, from an early stage of their professional development. This should prepare the undergraduate nursing students for the practice and consideration of specialisation and advancement in psychiatric nursing.

The educators should implant nursing students with resilient strategies in preparation for the workplace. According to Wells *et al.* (2000:85), psychiatric nursing students use general nursing skills as a reference in terms of role and status and perceived

that they were inferior in terms of skills. Nursing education's aims to facilitate and equip students with general nursing skills. With sufficient skills in mental health, it is evident that the students will have conviction in their work in the future. For example they could be taught on the caring for involuntary MHCUs and the management of aggressive patients which includes the ethical and legal aspects involved in admitting and treating these patients. Furthermore, continuous education, skills development and specialisation in the field should also be encouraged. Therefore, the workplace should make means that their employees obtain further training in the field of mental health, as this result in them being assertive. All these strategies can instil and strengthen resilience.

3.4.3. Recommendations for nursing research

Further research on the topic could include different sampling techniques with regards to the sample size and population framework. In this contextual research the researcher used a convenience sample which was smaller and made the findings more contextual. Future researchers can include mental health nurses from other facilities as a comparative sample or control group and make the findings representative of all nurses providing mental health care to involuntary MHCUs.

Furthermore researchers pursuing in resilience research could identify how strengthening coping mechanisms, for example, knowledge, skills and experience have an outcome on nurses' resilience. The current research identified factors used as coping mechanisms and how resilience could be strengthened but knowledge on how these mechanisms facilitate resilient outcomes have to be incorporated in future research. This could as well be applicable to other professions.

Longitudinal research focusing on nursing students' perception of mental health care and future resilient outcome is recommended. This research was a cross-sectional design and more knowledge on forecasting resilience strategies could be appreciated. Conducting such a research design could assist into understanding rate changes into resilient and whether resilient is a state or trait (Gillespie, 2007:206).

3.5. Concluding remarks

The objectives if this mini-dissertation has been reached and recommendations were formulated; which could assist nurses to be more resilient, in the workplace where adversities are inevitable. These strategies might lead to improvement in retention of

staff as well as better nursing care outcomes. It is important to note that nurses possess various coping mechanisms and resilient strategies which they acquired from their personal and professional behaviours and engagements. Therefore, nursing managers, educators and researchers should focus on strengthening these ordinary everyday strategies for better resilient behaviours. These strategies could also be applicable to other specialities of nursing as well as other health care professions. The results in this research seem to concur with other literature that indeed nurses are resilient, and with factors which facilitate their resilient behaviours in the workplace.

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Appendix 1a: Ethical clearance

Private Bag X6001, Potchefstroom
South-Africa, 2520

Tel: (018) 299-1111/2222
Web: <http://www.nwu.ac.za>

Faculty of Health Sciences

Tel: (018) 299 4237
Fax: (018) 299 2464
E-mail: Este.Vorster@nwu.ac.za

Mrs. Marietjie Halgryn

13 May 2011

Dear Marietjie

ETHICS APPLICATION: NWU-00036-11-S1 (M.P. KOEN & E. DU PLESSIS)

The applicants responded in a satisfactory way to the comments made by the panel members.

Ethical approval is recommended.

Yours sincerely

Este (H.H.) Vorster

Prof. H.H. Vorster

Appendix 1b: Ethical clearance



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

To whom it may concern

School of Nursing Science
Tel: 018 2991884
Fax: 018 2991827
Email: emmerentia.duplessis@nwu.ac.za

Dear

Confirmation of ethical clearance

Regarding the project: Exploring the resilience of nurses providing mental health care to involuntary mental health care users

This research will focus on:

- To explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).
- To explore and describe how nurses cope in providing mental health care to involuntary admitted and treated mental health care users.
- To explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened.
- To formulate guidelines to strengthen the resilience of nurses providing mental health care to involuntary MHCUs.

This research is a sub-study in an overarching research project, entitled: *Strengthening the research of health caregivers and risk group*, with ethical clearance from the Ethics Committee of the North-West University (Ref no NWU-00038-11-S1). The co-investigators are Prof MP Koen and Dr E du Plessis.

Background information: Strengthening the resilience of health caregivers and risk groups

The co-investigators identified the problem that the resilience of health caregivers as well as risk groups should be strengthened by means of a comprehensive, multi-faceted approach and that research should be conducted on how resilience of health caregivers and risk groups can be strengthened by means of such an approach. The purpose of the research is thus to develop a comprehensive, multi-faceted approach to strengthen the resilience of health caregivers as well as risk groups. We intend to reach this purpose through the following objectives:

- To explore and describe the resilience of health caregivers and risk groups
- To implement and validate strategies developed by Koen, Van Eeden and Wissing (2010c) to strengthen resilience of professional nurses and other health caregivers and risk groups

- To explore and describe faith community nursing as intervention to strengthen the resilience of health caregivers and risk groups
- To explore and describe sensory stimulation as intervention to strengthen the resilience of health caregivers and risk groups

To achieve these objectives, it is necessary to explore and describe various health caregivers and risk groups. Within this overarching research project, RJ Ramalisa intend to focus on exploring and describing how to strengthen the resilience of nurses providing mental health care; in order for them to provide quality nursing care in the work environment where MHCUs are often involuntarily admitted. This study's objectives are in line with those of the overarching project and because there is a need to address resilience of vulnerable populations or risk groups, in this case nurses providing care to involuntary mental health care users. The results of this sub-study will contribute to reaching the objectives of the overarching project and further provide information, as there is a paucity of knowledge regarding this risk group's resilience. We therefore confirm that the sub-study of RJ Ramalisa is covered by the above-mentioned ethical clearance.

Yours sincerely

Prof MP Koen
Co-investigator

Dr E du Plessis
Co-investigator

Appendix 2: Request letter for the provincial department of health

The Department of Health

North West Province

South Africa

Dear Sir/ Madam

REQUEST TO THE DEPARTMENT OF HEALTH FOR PERMISSION TO CONDUCT RESEARCH

I am currently studying for the M,Cur (Psychiatric Nursing Science) degree at the North-West University, Potchefstroom Campus. I am working on a research project: **Exploring the resilience of nurses providing mental health care to involuntary mental health care users**. This study forms part of the RISE project (Strengthening the resilience of health caregivers and risk groups, Koen and Du Plessis, 2011).

I would like to obtain your consent to invite professional nurses rendering mental health care services to mental health care users (MHCU) in a psychiatric ward in a psychiatric hospital in the North West Province, to participate in my research project. The School of Nursing Science and the ethics committee of the North-West University, Potchefstroom Campus (see attachment) have approved the research.

The objectives of my research project are the following:

- To explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC, 2003).
- To explore and describe how nurses cope in providing mental health care to involuntary admitted and treated mental health care users.
- To explore and describe how the resilience of nurses providing mental health care to involuntary MHCU's can be strengthened.

To achieve the abovementioned objectives, the professional nurses will each be requested to complete a form which consists of two parts, the CD RISC and open ended questions with their demographical background.

Before commencement and completion of the form, an information session will be held in the ward with the professional nurses to give them a background and insight on the research. Consent to partake in the research will be obtained when the professional nurses complete the form. Furthermore, all information will be handled with strict confidentiality and the professional nurses and the name of the institution will not be mentioned in the research.

The professional nurses who will be selected to participate in this research must:

- be registered as professional nurses with the South African Nursing Council,
- working in the psychiatric ward and
- willing to participate in the research and provide consent by completing the form.

Kindly find attached a copy of the research proposal which includes the questionnaire and open-ended questions.

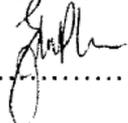
Your consideration of the above matter and a response at your earliest convenience will be appreciated.

Yours sincerely,

Rudo Ramalisa (M. Cur Student)

.....

Supervisor: Dr E. du Plessis


.....

Appendix 3: Granted permission from the provincial department of health to conduct research



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2nd Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO 2735

Tel: (018) 387 5757
kshogwa@nwcd.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Ms R. Ramalisa

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval – Exploring the resilience of nurses providing mental health care to involuntary mental health care users.

Purpose

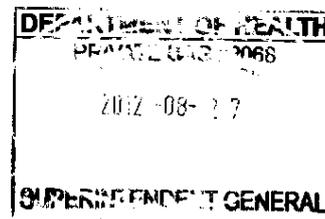
To inform Ms R. Ramalisa that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

3.14/2012
Date



Healthy Living for All

Appendix 4: Request letter for the psychiatric hospital



Dear Matron [REDACTED]

I am inviting Professional nurses, working in the psychiatric unit, to participate in the research titled: **Exploring the resilience of nurses providing mental health care to involuntary mental health care users.**

The aim is to explore and describe how to strengthen the resilience of nurses providing mental health care in order for them to provide quality nursing care in the work environment where mental health care users are often involuntarily admitted and treated.

Details of data collection

Data will be collected from Professional nurses in the psychiatric ward. In order to obtain valid data, preferably all Professional nurses in the ward are advised participate. Participation is voluntary though. These nurses will be given questionnaires to complete (see Attachment). Questionnaires will be collected and analysed thereafter by the researcher and a statistical consultant.

I will brief the participants in the ward on what the research entails. Seeing that data will be collected from Professional nurses I was hoping to do it at the time that will not inconvenience ward activities of the participants as well as other multi-disciplinary team members. I will do this over a period of October (2012) month, on the weekends if possible (Saturdays and/ or Sundays), for both day and night staff from opposite shifts.

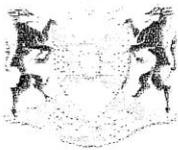
Yours sincerely,

Rudo Ramalisa

IFC/OHS

076 727 3461

Appendix 5: Granted permission from the psychiatric hospital to conduct research



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

POTCHEFSTROOM
2520



OFFICE OF THE SENIOR MANAGER MEDICAL SERVICES:

19/09/2012

ATTENTION: RUDO RAMALISA

Me R Ramalisa
IFC/OHS Department

Tel: 076 727 3461

RESEARCH REQUEST: EXPLORING THE RESILIENCE OF NURSES PROVIDING MENTAL HEALTH CARE TO INVOLUNTARY MENTAL HEALTH CARE USERS

1. The above-mentioned research request refers
2. As you already obtained approval from the North West Department of Health in Mahikeng you are hereby informed that your request has been approved.
3. As it involves the Department of Nursing mainly address all further arrangements with Mrs A de Bruin at the Nursing department
4. The local PSG will be informed of the approval already granted by the Department at its next sitting

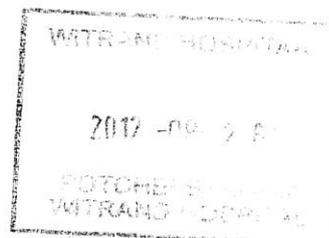
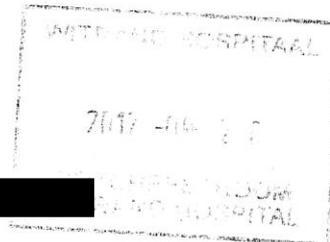
Kind regards

DR T G K OOSTHUIZEN
SENIOR MANAGER: MEDICAL SERVICES:
CHAIRPERSON PSG

MRS N L MOCWALEDI-SENYANE
CEO

Cc Mrs A de Bruin

DR. T.G.K. OOSTHUIZEN
MEDICAL MANAGER



Appendix 6: Information leaflet and consent form for participants



Dear colleague

You are invited to participate in the research study titled: **Exploring the resilience of nurses providing mental health care to involuntary mental health care users**. The aim is to explore and describe how to strengthen the resilience of nurses providing mental health care in order for them to provide quality nursing care in the work environment where mental health care users are often involuntarily admitted and treated. The following general principles which are applicable for the study and are important for you to read thoroughly and understand:

1. Participation to the study is completely voluntary, without any pressure from anyone.
2. By signing the consent form below, completing the questionnaire (CD-RISC) and two (2) open ended questions, you give consent to take part in the study. This takes less than twenty (20) minutes. You are kindly invited to participate, in order for a reliable reflection of the statistical results.
3. No personal contact details are required from you on the questionnaire, to insure that none of the information you provide are directly associated to you. Further take note that the information you provide will be handled with confidentiality and used strictly for the purpose of this study only.
4. You are encouraged to address any questions regarding the study, prior, during or after giving consent to participate to the researcher on the following contact details:

076 727 3461

20716176@nwu.ac.za/ rudoramalisa@yahoo.com

Your signature below indicates that you have fully understood the preceding and verbal information provided regarding the study. You hereby give voluntary consent to participate in the study.

Signature of the participant

Date

Signature of the researcher

Date

Yours sincerely,

Rudo Ramalisa

Appendix 7: Demographical information



Exploring the resilience of nurses providing mental health care to involuntary mental health care users.

Demographical information

Age:

Sex:

Number of years in the ward:

Level of education: _____

Appendix 8: The CD-RISC (removed)

Appendix 10a: Co-coder's instructions

(7 unread) - rudoramalisa - Yahoo Mail

Page 1 of

Home Mail News Sports Finance Weather Games Groups Answers Screen Flickr Mobile More

SCROOBY Search Mail Search Web rudo

Facebook - Facebook® Account Sign Up. Join For Free Today! - Sponsored

Search results | Delete | Move | More | Collapse All

Co-coder (8)

Me Morning Miss B I am a Masters in nursing science student and I need someone to assist me as a co-coder for the study. | Jan 23

Belinda Scrooby that will be fine, please send your research objectives, and the questions as well as the data with the methc | Jan 23

Me To Belinda Scrooby | Jan 23

Hey

The research aims and objectives
-This research forms part of the RISE study. The RISE study aims to explore and describe a multifaceted approach to strengthen the resilience of health care providers and risk-groups. The aim of this specific research is to explore and describe how to strengthen the resilience of nurses providing mental health care; in order for them to provide quality nursing care in the work environment where MHCUs are often involuntary admitted and treated, leading to ethical adversities. The objectives are as follows:
*To explore the resilience of nurses, by using the Connor-Davidson Resilience Scale (CD-RISC) (2003).
*To explore and describe how nurses cope in providing mental health care to involuntary admitted and treated mental health care users.
*To explore and describe how the resilience of nurses providing mental health care to involuntary MHCUs can be strengthened.

The qualitative data will be analysed by extracting common themes from all the participants. See attachments Sent via my BlackBerry from Vodacom - let your email find you!

-----Original Message-----
From: "Belinda Scrooby" <Belinda.Scrooby@nwu.ac.za>
Date: Wed, 23 Jan 2013 08:24:45
To: <rudoramalisa@yahoo.com>
Subject: Re: Co-coder

that will be fine, please send your research objectives, and the questions as well as the data with the method you are using for analyzing it, then i can do it and then we can make an appointment for the discussion of results.

many thanks
belinda

Dr Belinda Scrooby (Ph.D; M.Cur; RN; NE; NM)
Senior Lecturer & Subject Head: Anatomy
School of Nursing Science
Potchefstroom Campus
Tel: +27 (0) 18 299 1833
Fax: +27 (0) 18 299 1827
Email: Belinda.Scrooby@nwu.ac.za
Website: www.nwu.ac.za Dr Belinda Scrooby (Ph.D; M.Cur; GV; VO; VB)
Senior Lektor & Vakgroepvoorsitter: Anatomie
Skool vir Verpleegkunde
Potchefstroomkampus
Tel: +27 (0) 18 299 1833
Faks: +27 (0) 18 299 1827
Epos: Belinda.Scrooby@nwu.ac.za
Webwerf: www.nwu.ac.za

Vrywaringsklousule / Disclaimer: <http://www.nwu.ac.za/it/gov-man/disclaimer.html>
>>> <rudoramalisa@yahoo.com> 2013/01/23 03:12 AM >>>
Morning Miss B

I am a Masters in nursing science student and I need someone to assist me as a co-coder for the study. My research study consist of both qualitative and quantitative designs. The number of participants is 24, whereby each participant had to complete 2 questions, including a scale which already has been analysed quantitatively. Kindly let me know whether you will be able to assist me.

Thank you in advance
Rudo
Sent via my BlackBerry from Vodacom - let your email find you!

8 Attachments | Download all

- Participant 1.pdf Download
- Participant 2.pdf Download
- Participant 3.pdf Download
- Participant 4.pdf Download
- Participant 5.pdf Download
- Participant 6.pdf Download
- Participant 7.pdf Download
- Participant 8.pdf Download

<http://us-mg6.mail.yahoo.com/neo/launch?.rand=7a3tk33vcalse>

2013/11/2

Appendix 10b: Co-coder findings

Themes identified from narratives

THEME 1: COPING				
Sub-theme 1.1: Difficult and challenging	Sub-theme 1.2: Knowledge, skills and experience	Sub-theme 1.3: Nurse-patient relationship	Sub-theme 1.4: Support system	Sub-theme 1.5: Religion and exercise
<ul style="list-style-type: none"> • very stressfull • difficult • experience challenges • control my emotions <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “at times it its difficult... (prt. 1) 	<ul style="list-style-type: none"> • Knowledge received via training • Experience • Use skills = patience, assertiveness, understanding • Keep updated with acts, policies and development • In-service training <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Skills and 	<ul style="list-style-type: none"> • Enjoy work • Health education to patients • Understanding the patients • Level of the patients • Lie/bribe patients <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “...to be able to explain to the patient the reason for them to drink 	<ul style="list-style-type: none"> • At home • Colleagues • Team work <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Have your own support system, to give daily encouragement...” 	<ul style="list-style-type: none"> • pray to God • enough breaks • exercise = healthy mentally <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Religion: God’s grace is new every morning..., take regular breaks.”(prt.

<ul style="list-style-type: none"> • "...sometimes I'm experiencing challenges from them..." (prt. 6) • "to shortage of staff I am always stressed up cause at times you will be working alone." (prt. 9) • "It is difficult because sometimes they refuse treatment..." (prt. 10) • "At times its challenging..." (prt. 12) • "It is very stressfull but I have to stay calm and positive..." (prt. 20) • "It is not easy, 	<ul style="list-style-type: none"> • experience that I have acquired, make me cope easily..." (prt. 2) • "Due to the training and skill obtained in my training and practical, I believe for met to cope..." (prt. 11) • "As a health care provider understanding, patience and assertiveness need to be encouraged..." (prt. 11) • "Coping mechanism differ day by day depending on the nature and 	<ul style="list-style-type: none"> • medication..." (prt. 1) • "Because I enjoy my work so much ..." (prt. 3) • "Through-out the admission period, health education should be emphasised..." (prt. 11) • "Most of the times you find yourself lying/bribing these users in order to get your work done..." (prt. 24) 	<ul style="list-style-type: none"> • (prt. 4) • "Involuntary patient are dangerous but because of the teamwork i can cope." (prt. 7) • "...lack of support from management in MHCU such as managing aggressive in service training." (prt. 8) • "Teamwork is the only thing that can make me cope..." (prt. 9) • "...and support from your colleagues and family." (prt. 20). 	<ul style="list-style-type: none"> • 4) • "... and by praying to God that He should protect me..." "I also exercise so that I can be healthy mentally and see thing in a positive way." (prt. 16)
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<p>because the mental health care user can sure be difficult.” (prt. 24)</p>	<ul style="list-style-type: none"> • atmosphere...” (prt. 12) • Also with help from your supervisor with in-service training...” (prt. 20) • “Using skills to control them.” (prt. 23) 			
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THEME 2: RESILIENCE				
Sub-theme 2.1:	Sub-theme 2.2:	Sub-theme 2.3: Team	Sub-theme 2.4: In-	Sub-theme 2.5:
<p>Enough trained staff</p> <ul style="list-style-type: none"> • trained personnel • increase in personnel leave after six months 	<p>Security measures and safety</p> <ul style="list-style-type: none"> • adequate facilities security measures (burglars, security doors) 	<p>work</p> <ul style="list-style-type: none"> • multi-professional team • share knowledge and support <p>team spirit = moral</p>	<p>service training and education</p> <ul style="list-style-type: none"> • keep up to date • speciality programme training <p>teach those who don't know how to</p>	<p>Support</p> <ul style="list-style-type: none"> • psychological management = co-operation, understanding, victimisation

<ul style="list-style-type: none"> • well staffed • passion and empathy <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Increase in personnel working in the unit to minimized workloads...” (prt. 1) • “Take leave after every six months, exhaustion creates an low interest in trying to motivate others.” (prt. 4) • “Passion that I have towards those patients strengthened me 	<p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Increase in security measure, ie the unit must be well secured with burglars...” (prt. 1) • “Security and safety measures be attended to.” (prt. 15) • “...the necessary facilities to teach those who don’t understand how to care for such a patient...” (prt. 16) 	<ul style="list-style-type: none"> • co-operation • communication with superiors <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Good/prompt communication with senior superiors especially when incidents occurs...” (prt. 1) • “... can also help working together also with all the multi-professional team...” (prt. 9) • “Even the team spirit can help us have moral in providing a total care...” (prt. 10) • “...and lastly 	<ul style="list-style-type: none"> • care for these patients • health education <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “By continuous in-service training and learning opportunities...” (prt. 2) • “In-service training” (prt. 6 and 8) • “Speciality programme training for mental patients” (prt. 8) <p>“It can be strengthened by having knowledge on how to handle an involuntary mental</p>	<ul style="list-style-type: none"> • colleagues • counselling <p>EXAMPLES:</p> <ul style="list-style-type: none"> • “Prompt psychological support to personnel who are working with...” (prt. 1) • “I believe institutions should provide some sort of counselling for their employees...” (prt. 4) • “Management support” (prt. 8) • “Continuous support from management, immediate supervisor, colleagues and
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<ul style="list-style-type: none"> • (prt. 13) • “Enough trained staff on mental health.” (prt. 15) • “... you as a nurse have empathy towards this users and understand their life stories.” (prt. 24) 		<p>teamwork.” (prt. 12)</p> <ul style="list-style-type: none"> • “Team work is important to me...” (prt. 18) 	<p>care user...” (prt. 10)</p> <ul style="list-style-type: none"> • “adherence to mental health care act and proper health education...” (prt. 12) • “Education or in-service on mental health act and latest development...” (prt. 15) 	<ul style="list-style-type: none"> • subordinates.” (prt. 15) • “...support those who are infused emotionally, to have management that is understanding and supportive.” (prt. 16) • “It does help alot when one has a support group or someone...” (prt. 24)
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Appendix 11: Permission to use the CD-RISC

Dear Rudo:

Thank you for your interest in the Connor-Davidson Resilience Scale (CD-RISC). We are pleased to grant permission for use of the CD-RISC in the project you have described under the following terms of agreement:

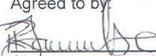
1. You agree not to use the CD-RISC for any commercial purpose, or in research or other work performed for a third party, or provide the scale to a third party. If other off-site collaborators are involved with your project, their use of the scale is restricted to the project, and the signatory of this agreement is responsible for ensuring that all collaborators adhere to the terms of this agreement.
2. You may use the CD-RISC in written form, by telephone, or in secure electronic format whereby the scale is protected from unauthorized distribution or the possibility of modification.
3. Further information on the CD-RISC can be found at the www.cd-risc.com website. The scale's content may not be modified, although in some circumstances the formatting may be adapted with permission of either Dr. Connor or Dr. Davidson. If you wish to create a non-English language translation or culturally modified version of the CD-RISC, please let us know and we will provide details of the standard procedures.
4. Three forms of the scale exist: the original 25 item version and two shorter versions of 10 and 2 items respectively. When using the CD-RISC 25, CD-RISC 10 or CD-RISC 2, whether in English or other language, please include the full copyright statement and use restrictions as it appears on the scale.
5. A fee of \$ 30 US is payable to Jonathan Davidson at 3068 Baywood Drive, Seabrook Island, SC 29455, USA, either by PayPal, cheque, bank draft, international money order or Western Union. (Please note: An additional \$16 fee is charged for bank wire transfers).
6. Complete and return this form via email to mail@cd-risc.com, along with the attached project description form.
7. In any publication or report resulting from use of the CD-RISC, you do not publish or partially reproduce the CD-RISC without first securing permission from the authors.

If you agree to the terms of this agreement, please email a signed copy to the above email address, along with the completed project description form. Upon receipt of the signed agreement and of payment, we will email a copy of the scale.

For questions regarding use of the CD-RISC, please contact Jonathan Davidson at mail@cd-risc.com. We wish you well in pursuing your goals.

Sincerely yours,

Jonathan R. T. Davidson, M.D.
Kathryn M. Connor, M.D.

Agreed to by:

Signature (printed) RJ Rando Date 16/04/2012

Miss
Title

North West University (Pretoria Campus) South Africa
Organization

Appendix 12: Example of narrative

Please share your story by writing about the following:

- How do you cope with providing mental health care to an involuntarily admitted MHCU?

I cope sometimes, only challenge
relating cope of aggressive patients,
substance problems, those who
substance dependant patients, lack of
support from management in MHCU
such as managing aggressive in service
training

- How can your resilience be strengthened to provide mental health care to involuntarily admitted and treated MHCUs?

1 In service training
2 Management support
3 Speciality programme training for
Mental health professionals