Coping experiences of partners of professional nurses venting traumatic information

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PREFACE

This study is a first in nursing science, in view of the fact that the researcher entered the unexplored field of professional nurses' venting to their partners and the impact thereof on their partners. This study is aimed at determining coping experiences of partners of professional nurses venting traumatic information to them.

Firstly, the researcher anticipates that this study will provide clear insight into the impact of professional nurses' venting of traumatic information on their partners. Secondly, the researcher trusts that the results of this study will make the importance of support to not only the partners, but also to the professional nurses, evident, and that this would ultimately better the quality of care provided.

In the interest of reporting this study's results in the best way possible, the dissertation was written in an article format. Chapter 1 includes a comprehensive overview of literature on coping and resilience, as well as a detailed description of the methodology of this study. Chapter 2 is an article in the correct format, as required by the author's guidelines for Health SA Gesondheid. Chapter 3 comprises the study's conclusion, and limitations, as well as the researcher's recommendations. In chapter 3 the researcher paid specific attention to formulating recommendations that focus on strengthening the partners' coping skills in order to enhance their resilience.

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ABSTRACT

Professional nurses who are employed in trauma units face many stressors in their work place. Yet they all cope with the stress in different ways. One of the methods that professional nurses use is to vent traumatic information to their partners. By venting to their partners, they rely on their partners for support. However, the researcher could find no current studies on how these partners cope with the traumatic information being vented to them. The aim of this study is to explore and describe the coping experiences of partners of professional nurses venting traumatic information to them, with the goal of making recommendations on how to strengthen the partners' resilience.

A qualitative design with an interpretive descriptive approach was used to explore, interpret and describe the coping experiences of the partners. Purposive sampling was used to select partners (N=14; n=10) to partake in the study. The researcher collected data by means of semi-structured interviews. Tesch's eight steps of open coding were used to code each transcription and to analyse the data. An independent and experienced co-coder analysed the data using a protocol that the researcher provided; consensus was reached with regard to the themes and sub-themes.

The following four main themes emerged from the data: 1) How partners experience the traumatic information they hear from the professional nurses; 2) The partners' personal coping skills and strategies; 3) Reciprocal communication and relationship support between the partners and the professional nurses; and 4) Partners need resilience in dealing with the professional nurses' occupation.

The researcher found that partners cope in many different ways with traumatic information. In addition, partners feel a great need to develop their resilience due to the supportive role they need to fulfil in their relationships with the professional nurses. The partners categorically agreed that the nursing profession is filled with hardship and trauma. The professional nurses' lack of support in the workplace was the main reason for the partners wanting to become more resilient. This state of affairs leaves the partners as the professional nurses' primary support structure.

The researcher formulated recommendations to strengthen the coping skills of other partners so that, in the long-term, partners' resilience could also be strengthened. Some of these recommendations are listed below.

- Hospitals could conduct workshops for family members every four months to discuss different topics such as effective coping, communication skills and setting boundaries, among others.

- Discuss the findings of this study in a workshop to assists others in building resilience and in coping better.

For the nursing practice:

- Develop a guideline or protocol to be followed after a professional nurse has been exposed to a traumatic event.

- Organise monthly "emotional check-in sessions" with the sister who is in charge to discuss any ongoing problems and, if necessary, to refer a nurse to a psychologist or counsellor to facilitate emotional problems.

The researcher hopes that implementing these recommendations, as well as conducting further research on the topic, will not only assist the partners and families of professional nurses, but also result in improved support for professional nurses.

Keywords: Partner, professional nurse, venting, coping, resilience.

OPSOMMING

Professionele verpleegkundiges wat in trauma-eenhede werk, word aan baie verskillende stressors in hul werkplek blootgestel. Tog hanteer professionele verpleegkundiges hierdie stressors op verskillende maniere. Een van die metodes wat professionele verpleegkundiges gebruik is om teenoor hul lewensmaats te “vent” of stoom af te blaas oor die dag; sodoende deel hulle die traumatiese inligting van die dag met hul lewensmaats. Deur teenoor hul lewensmaats stoom af te blaas, steun die professionele verpleegkundiges op hul lewensmaats. Die navorser kon egter geen hedendaagse studies vind oor die lewensmaats van professionele verpleegkundiges se hantering van die traumatiese inligting wat hulle aanhoor nie. Die doel van die studie is om die lewensmaats van professionele verpleegkundiges se hantering van die uitwoed (“venting”) van traumatiese inligting te verken en te beskryf en om aanbevelings te maak oor hoe om die veerkragtigheid (“resilience”) van die lewensmaats te versterk.

'n Kwalitatiewe metode met 'n interpretatiewe beskrywende ondersoek-benadering is gebruik om te verken, te interpreteer en te beskryf hoe lewensmaats die traumatiese inligting hanteer. Doelbewuste steekproefneming is gebruik om lewensmaats te kies (N = 14; n = 10) om aan die studie deel te neem. Die navorser het die semi-gestruktureerde onderhoude met die lewensmaats gevoer. Tesch se agt stappe van oopkodering is gebruik om elke transkripsie te kodeer en die data te analiseer. ‘n Onafhanklike, ervare mede-kodeerder het die data met die hulp van 'n protokol wat die navorser verskaf het, ontleed; konsensus is oor die temas en sub-temas wat uit die data na vore gekom het, bereik.

Die volgende vier hooftemas is uit die data geïdentifiseer: 1) Hoe lewensmaats die traumatiese inligting wat hulle by die professionele verpleegkundiges hoor, ervaar; 2) Die lewensmaats se persoonlike hanteringsvaardighede en -strategieë; 3) Wedersydse kommunikasie en verhoudingsondersteuning tussen die lewensmaats en die professionele verpleegkundiges; en 4) Lewensmaats het veerkragtigheid nodig om die professionele verpleegkundiges se beroepe te kan hanteer.

Die navorser het gevind dat lewensmaats die traumatiese inligting op baie verskillende maniere hanteer. Verder het die lewensmaats 'n groot behoefte om hul veerkragtigheid te ontwikkel as gevolg van die ondersteunende rol wat hulle in hul verhoudings met die professionele verpleegkundiges vervul. Die lewensmaats was dit almal eens dat die

verpleegkunde se beroep gevul is met ontbering en trauma. Die professionele verpleegkundiges se gebrek aan ondersteuning by die werk was die hoofrede waarom die lewensmaats meer veerkragtig wil wees. Hierdie toedrag van sake laat die lewensmaat as die professionele verpleegkundige se enigste ondersteuningstruktuur.

Die navorser het aanbevelings geformuleer om die hanteringsvaardighede van ander lewensmaats te versterk sodat, oor die lang termyn, hulle veerkragtigheid ook versterk kan word. Van die aanbevelings word nou genoem.

- Hospitale moet elke vier maande ’n werkwinkel vir familielede aanbied wat verskillende onderwerpe soos onder meer effektiewe hanterings- en kommunikasievaardighede en begrensing, bespreek.
- Bespreek die bevindinge van hierdie studie in 'n werkwinkel om ander lewensmaats te help om beter hanteringsvaardighede en veerkragtigheid te bou.

Vir die verpleegspraktyk:

- Ontwikkel 'n riglyn of protokol wat gevolg moet word nadat 'n professionele verpleegkundige aan 'n traumatiese gebeurtenis blootgestel is.
- Hou maandelikse "emosionele inloer-sessies" met die suster in bevel om voortdurende probleme te bespreek en, indien nodig, ’n professionele verpleegkundige na 'n sielkundige of berader te verwys om met emosionele probleme te help.

Die navorser hoop dat die implementering van hierdie aanbevelings, sowel verdere navorsing oor die onderwerp, nie net die lewensmaats en families van professionele verpleegkundiges sal help nie, maar ook die professionele verpleegkundiges se ondersteuning sal verbeter.

Sleutelwoorde: Lewensmaat, professionele, verpleegkundige, uitwoed, hanteringsvaardighede, veerkragtigheid,

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LIST OF ABBREVIATIONS

A

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral

C

CPD	Continuing professional development

H

HREC	Health Research Ethics Committee

I

ICN	International Council of Nurses

N

NWU	North-West University

P

PTSD	Post Traumatic Stress Disorder
RISE	Strengthening the resilience of health caregivers and risk groups

S

SANC	South African Nursing Council
STS	Secondary Traumatic Stress

W

WHO	World Health Organisation

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SECTION 1
OVERVIEW OF STUDY

SECTION 1

1.1 OVERVIEW OF THE STUDY

The background and rationale of the study are discussed first, followed by the problem statement, paradigmatic perspective and research methodology. The study is presented in an article format, with the manuscript prepared according to the instructions of the journal of choice. The last section comprises an evaluation, as well as the limitations and recommendations of the study.

1.2 INTRODUCTION

A variety of research studies have been conducted on the experiences that professional nurse encounter in their workplace. Most of these studies focussed on the areas of the nurses' emotional needs and emotional fatigue (Aycock & Boyle, 2008:183; Komachi *et al.,* 2012:155). However, no studies were found on the experience of being the partner of a professional nurse and how such a partner copes after listening to accounts of traumatic events that the professional nurse experienced in the workplace. Therefore, the aim of this study was to explore and describe the experience of how partners are coping with professional nurses venting traumatic information to them. The findings of this study assisted the researcher in making recommendations regarding how to strengthen resilience in partners.

1.3 BACKGROUND

Several professional nurses choose nursing as a career with the intention to serve the wider community by providing quality care to meet the patients' physical, emotional, mental and spiritual needs (Lombardo & Eyre, 2011:3). Driven by the inspiration to impact on the lives of patients and their families, professional nurses maintain competency in their work while challenged with high levels of workplace stress (Komachi *et al.,* 2012:156). Professional nurses are affected by a multitude of stressors in their workplace such as conflict with physicians, problems with peers and supervisors, discrimination, heavy work load, long working hours, having insufficient resources to work productively, shortage of equipment and supplies, dealing with difficult clients, coping with death, dying patients and all the emotions of the families (Suresh *et al.,* 2013:772; Johnston *et al.,* 2013:349; Jinbo *et al.,* 2012:350;

French *et al.,* 2000:165; Koen & Du Plessis, 2011:3). Often these stressors create scenarios that professional nurses experience as traumatic events, leaving them with feelings and thoughts of helplessness (Komachi *et al.,* 2012:156) anger, disappointment and sadness. When professional nurses are constantly bombarded with and exposed to these types of stressors, it may cause many different emotional or physical disorders among them, such as compassion fatigue, post-traumatic stress disorder (PTSD), secondary traumatic stress (STS) and burnout (Özden *et al.,* 2013:443; Klopper *et al.,* 2012:686; Lombardo & Eyre, 2011:3). In addition, Komachi *et al.* (2012:162) found that 60% to 90% of professional nurses are at a high risk of experiencing a stress disorder. It was found that professional nurses experienced their relationships as less satisfactory when these stress disorders were present. What is more, a higher number of partners complained of suffering from a stress disorder themselves, which made the relationship even more troublesome. This vicious circle results in more negative emotions and lower intimacy (Campbell & Renshaw, 2012:19). This state of affairs also places the partners of these professional nurses in a high-risk group of contracting a stress disorder like secondary trauma, burnout or even compassion fatigue (Campbell & Renshaw, 2012:19).

As mentioned previously, research has been conducted on how professional nurses cope with stress. It was found that most nurses find safety in and relief by sharing their traumatic experiences with those people with whom they have a close emotional bond, such as family members or, more specifically, their partners (Laal & Aliramaie, 2010:180). This technique of sharing is also known as venting or “social sharing of emotion” (Lohr, 2007; Nils & Rimé, 2012:672). Venting is defined as the release or expression of strong emotions and energy (Online Oxford Dictionary, 2013). By venting, the professional nurses generally relive their experiences in that they share the information of the traumatic event (Lohr, 2007). Venting to their partners thus enables the professional nurses to find relieve and feel safe (Brans *et al.,* 2013:1037; Nils & Rimé, 2012:673).

Various studies have been done to determine the effect on the “person” (professional nurse in this study) sharing the traumatic information. Some research found that sharing their emotions helped them to find emotional relief, to experience positive feelings with regard to the situation or to just find partial emotional stability for the time being (Brans *et al.,* 2013:1037; Nils & Rimé, 2012:673). However, not much is known about how the partners of these professional nurses experience having to listen to these emotions and venting. According to Figley, C.R. and Figley K.R (2009:173), often the listener (partner in this study) will become empathetically involved, reliving the story with the professional nurse. This

exchange of information may indirectly traumatise the partner. The trauma that a partner experiences as a result of the professional nurse sharing the information is known as secondary trauma. Secondary trauma can be described as behaviour and emotions resulting from knowledge about a traumatising event experienced by a significant other, or by identifying with the experiences and feelings of a direct victim (Holdsworth, 2009:4; Goff *et al.,* 2006:451; Carll, 2000:178; Figley, 1999:10; Figley, 1988:80). This may possibly have a profound effect on the partners in terms of their own emotional and physical well-being, although it has not yet been proven to be true.

No research was found on how this venting may affect their relationship and how the partner may cope or be resilient to this. Resilience is the human capacity to adapt, thrive and "maintain relatively stable, healthy levels of psychological functioning" in response to potentially traumatic events (Bonanno, 2004:20). Coping with traumatic information can be stressful at times. Studies have shown that couples who suffer from high levels of stress experience their relationships as less satisfactory (Neff & Karney 2007:595). However, even though many relationships crumbled under stress, others were unharmed and even grew more resilient in terms of facing future stressors. It was suggested that stressful events could afford both individuals, as well as the relationship, the opportunity to grow (Neff & Broady, 2011:1-50). Relationships are in most cases very complex and have many facets to them. Gonzaga and Haselton (2008:40) mention that a relationship typically has an innate "romantic love" that is seen as a very strong bond designed to lead men and women to investing long periods of time in one another. But even romantic love cannot guarantee that a relationship will work. Unfortunately love is not the only building block necessary to build a strong relationship. Every relationship is challenged by the realities of both the partners (Fletcher & Kerr, 2010:629). In the setting of this study, the "reality" of both partners is their work places and how they cope when sharing information with each other at home. This reality of their relationship ultimately plays a role in how the couple experiences resilience. Various research has proven the importance hereof, since it was found that relationships are a very important source of life satisfaction, happiness and general well-being for both parties (Towler & Stuhlmacher, 2013:280; Koen & du Plessis 2011:3; Powers *et al.,* 2006:614; Tolpin *et al.,* 2006:5670). This could ultimately assist both in using their coping skills to increase their confidence and strengthen their resilience as well as that of their relationship (Tolpin *et al.,* 2006:5670). Coping has been defined as a response aimed at diminishing the physical, emotional and psychological burden that is associated with stressful life events (Chesney *et al*., 2006:423). By developing coping skills, one directly also develop resilience (Jackson *et al*., 2007:6-7). Good coping mechanisms enable one to better bounce back from

stress. According to Jackson *et al*. (2007:6-7), the following factors help to strengthen one's resilience: maintaining positivity, developing emotional insight, that is, emotional intelligence, achieving life balance, spirituality and social support. All these factors in the end relate to different coping mechanisms. However, social support has been identified as one of the most significant components of building resilience. Social support helps one to feel connected, to achieve life balance and lastly to become more reflective (Jackson *et al*., 2007:7). It is thus important to explore how partners cope in order to make recommendations regarding how they can better their resilience, which then also aligns with the objectives of the RISE study.

This is a sub-study of the RISE study (strengthening the resilience of health caregivers and risk groups). The RISE study noted a shortage of research on the concept of resilience and the strengths and coping abilities of members in health caregivers and risk groups (Koen & Du Plessis, 2011:4). In this study, the partners of professional nurses belong to the category of risk groups, according to the RISE study. Koen and Du Plessis (2011:4) recommend further investigation into the resilience of health caregivers and risk groups. This study addresses their recommendation by focusing on how the partners of professional nurses cope with traumatic information vented to them. The knowledge gained by conducting the study can assist in strengthening the resilience of the partner who belongs to the "risk group". In addition, this may inspire further investigation into the RISE study to determine whether and how nurses' relationships enhance their resilience in the workplace.

The researcher investigated how partners are coping with professional nurses venting traumatic information to them. This assisted the researcher in making recommendations to strengthen partners' resilience.

1.4 PROBLEM STATEMENT

Working in the nursing profession is often demanding and stressful (Suresh *et al.,* 2013:772; Johnston *et al.,* 2013:349; Jinbo *et al.,* 2012:350; Laal & Aliramaie, 2010:168). Professional nurses can experience trauma daily in their working environment (in this study, a casualty unit); most of these experiences are moreover inevitable. Laal and Aliramaie (2010:169 & 180) state that nurses can cope with stress in many ways, of which one is nurses finding safety and relief through venting their traumatic experiences to their families or partners.

The partners of professional nurses find themselves in a difficult situation, seeing that they are often the professional nurses' first line of contact, having to listen to their stories about work stressors or traumatic events that might have occurred in the workplace. Exchanging details and empathising with one another, as well as the barrage of traumatic information, may affect the equilibrium of the relationship between the partner and the professional nurse. It may also lead to the partner feeling emotionally overwhelmed (Holdsworth, 2009:4).

The researcher noted that there was a lack of research on understanding the coping experiences of partners of professional nurses venting traumatic information to them. This study assisted the researcher in exploring partners' coping experiences and in applying the results of her investigation to make recommendations on how to strengthen the partners' resilience.

1.5 RESEARCH QUESTION

The background and problem statement led to the following research question being posed to help guide the study:

- How do the partners of professional nurses cope with the nurses venting traumatic information to them?

1.6 AIM AND OBJECTIVES OF THE STUDY

1.6.1 Aim

This study aims to explore and describe the coping experiences of partners of professional nurses venting traumatic information to them in order to make recommendations on how to strengthen the partners' resilience.

1.6.2 Objective

The following objective was formulated to bridge the gap between the problem and the aim (Brink *et al.,* 2006:79):

- Explore and describe how partners of professional nurses cope with the professional nurses venting traumatic information to them.

1.7 RESEARCH ASSUMPTIONS

The discussions of meta-theoretical, theoretical and methodological assumptions in the paragraphs that follow define the structure in which the researcher conducted this study.

1.7.1 Meta-theoretical Assumptions

Since the researcher is a Christian and thus believes in the values and beliefs of the Bible, these values and beliefs will form the basis of the meta-theoretical assumptions of this study.

1.7.1.1 Man

The researcher believes that mankind was made to love and to be loved. The Lord God created human beings, all having a body, mind and spirit/soul. God made each human to lead a holistic life, implying a healthy body, a sound mind and a fulfilled soul. Living a full life points toward taking care of the temple of God. The researcher believes that every human being has the innate desire to love and support one another. All these areas of a man's inner and external environments are interlinked; if one is out of balance, it affects all the others. In this study, the term man refers to two people, namely partner and professional nurse.

The **partner** of a professional nurse is a male or female who is in a relationship with the professional nurse.

The **professional nurse** is a nurse registered at the South African Nursing Council (SANC) who is currently practising in the casualty unit in one of two private hospitals in Gauteng.

1.7.1.2 Health

Health, as seen by the researcher, refers to the holistic image of a human being; not only being physically healthy but also mentally and spiritually healthy. Dennill *et al.* (1999:122-123) and Hattingh *et al.* (2010:4) explain that health is not only the absence of disease but also a state of physical, mental and social well-being. According to the World Health Organisation (WHO) (WHO, 1948), health is defined as a "state of complete physical, mental and social well-being, not merely the absence of disease or infirmity". Thus, a human being's health is influenced by his or her external and internal environments.

The researcher believes that one of the greatest external influences on the health of a human being is the relationships he or she enters during his or her lifetime. If a man is

physically healthy but emotionally not stable, it will manifest in all areas of his life. The researcher believes that relationships have a big role to play in achieving emotional stability within one self and also in helping others to manage and control their emotions. In this study, the researcher explores and describes the coping skills of the partners of the professional nurses who may have been exposed to the professional nurses venting traumatic information to them.

1.7.1.3 Environment

The environment of this study comprises two parts, namely the professional nurses' workplace where they may be exposed to trauma or work stressors, and the couple's home environment where the partner could possibly be exposed to the traumatic information vented by the professional nurse.

1.7.1.4 Nursing

Nursing is a selfless giving to and serving of others to help individuals, families and ultimately the community, to attain better health. The International Council of Nurses (ICN) (ICN, 2010) defines nursing as a profession that encompasses the autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing also includes the promotion of health, the prevention of illness and the care of ill, disabled and dying people. Nursing is thus not a profession of merely addressing people's physical health, but a profession of touching lives every day and assisting with spiritual health.

However, nursing has two sides to it. It has the positive side of giving, helping and experiencing joyful endings and the negative, unrewarding side that could potentially cause trauma to the professional nurse. In this study, nursing is considered to be a profession where the professional nurses not only have an influence on their clients in the casualty unit, but also on their partners at home when venting traumatic information.

1.7.2 Theoretical Assumptions

The theoretical assumptions include the central theoretical statement and conceptual definitions of this research study.

1.7.3 Central Theoretical Statement and Conceptual Definitions

1.7.3.1 Central theoretical statement

The exploration and description of the coping experiences of partners of professional nurses venting traumatic information to them will assist the researcher in formulating recommendations on how to strengthen the partners' coping skills and resilience.

1.7.3.2 Conceptual definitions

Partner

The Merriam-Webster dictionary (2013) defines a partner as a person with whom one shares a committed relationship. The Online Oxford dictionary (2013) describes a partner as either a member of a married couple or of an established unmarried couple. For the purposes of this study, a partner refers to a person in a relationship with a professional nurse in which they see themselves as a couple, married or unmarried.

Professional nurse

The SANC refers to a professional nurse as "a person who is registered as a nurse or midwife in terms of the Act" (SANC scope of practice, R. 2598). ICN (ICN, 2010) defines a professional nurse as a person who gives holistic, self-directed and combined care to individuals of all ages, families, groups and communities, sick or well and in all settings. The professional nurse promotes a safe environment, and participates in research and in shaping health policy. The professional nurse also plays the role of a manager and an educator (ICN, 2010). For the purposes of this study, a professional nurse is registered at SANC and is currently working in the casualty unit in one of the two private hospitals in Gauteng.

Venting

Venting is defined as the release or expression of strong emotions and energy (Online Oxford Dictionary, 2013). Rimé *et al.* (2010:1030) observe that when individuals experience a strong emotion or event, they manifest an urge to talk about the episode and their feelings, and to share this experience with people around them. This expression is labelled "social sharing" of emotion or, as is more commonly known, emotional venting. In the study venting

is seen as the action when the professional nurse shares their daily experiences with their partner.

Coping

Chesney *et al*. (2006:423) define coping as behavioural or cognitive efforts to manage situations that are appraised as stressful, where the external and/or internal demands of the situation exceed the person's resources. In other words, coping is defined as a response aimed at diminishing the physical, emotional and psychological burden that is associated with stressful life events (Tuncay *et al*., 2008:6). Consequently coping is the interaction between a person and a situation and depends on a person's perceived ability to manage the stressor (Meehan *et al*., 2007). In this study the coping experiences of the partners will be investigated.

Resilience

Resilience is the human capacity to adapt, thrive and "maintain relatively stable, healthy levels of psychological functioning" in response to potentially traumatic events (Bonanno, 2004:20).

1.7.3.3 Literature review of key concepts

Introduction

The following section contains the results of the researcher's in-depth literature review during which she expanded the concepts of the following key definitions: the stressors that nurses experience in the workplace, venting, different types of coping mechanisms and resilience.

Nursing practice

Nursing is a profession of many facets. It has also been documented that nursing is a profession with a highly stressful environment; it is also an emotional demanding job (Carson *et al.,* 1991:9; Coffey & Coleman 2001:399; Dolan, 1987:10; Fagin *et al.,* 1995:349; Snelgrove 1998:102; Sullivan, 1993:593; Van der Colff & Rothmann, 2014:630). Nursing is known to have many different stressors in the workplace (French *et al.,* 2000:165; Jinbo *et al.,* 2012:350; Johnston *et al.,* 2013:349; Koen & Du Plessis, 2011:3; Suresh *et al.,* 2013:772). Stressors include long work hours, high volumes of work (Kowalski *et al*.,

2010:1656), insufficient resources to work with and a shortage of important supplies and equipment that are required to do the work correctly. Other stressors include dealing with physicians, conflict with colleagues and/or supervisors (Guidroz *et al.*, 2012:75), having to work with difficult clients or difficult family members, working with clients who are dying (Davhana-Maselesele & Igumbor, 2008:48), death and consoling grieving families (French *et al.,* 2000:165; Jinbo *et al.,* 2012:350; Johnston *et al.,* 2013:349; Koen & Du Plessis, 2011:3; Suresh *et al.,* 2013:772). An emergency care unit is considered one of the units with the highest levels of stressors. Emergency care nurses must be able to think on their feet and to take control of a situation. Emergency nurses are the first line of contact when a patient arrives at a hospital; they witness the brutal trauma caused to a patient's body as well as the trauma that the family experiences. They deal with stressful resuscitations and attempt to keep critical patients alive; or watch a patient die and have to tell the patient's family that they could not "save" them (Oliveira, *et al*., 2014:151). These are but some of the known stressors that have an emotional and physical effect on professional nurses.

Working in South Africa as a professional nurse also has its own unique challenges and stressors specific to the South African health-care milieu. Since South Africa is still a developing country, some of the major stressors that a professional nurse may face is heavy workloads, staff shortages (Oosthuizen, 2012:60), average to poor salaries and poor work environments as a result of inadequate public and private health infrastructure (Gibson, 2004:2022; Hall, 2004:34; Görgens-Ekermans & Brand, 2012:2276). Workplace stress also includes working with HIV and AIDS patients and their families, testing for and treating HIV and AIDS and ARV shortages (Buchan, 2006:24; Kagee *et al.,* 2012:542; Rafferty *et al.,* 2007:180; De Wet & Du Plooy, 2012:39). Having to perform at work without the required medical equipment, medication, beds and uniforms also causes stress (Bester & Engelbrecht, 2009:115; Smit, 2005:28). In addition, a number of studies have shown that the lack of management support in the work environment is a great stressor (De Wet & Du Plooy, 2012:39; Delobelle *et al.,* 2009:1072; Van Dyk, 2007:64). In addition to all this, professional nurses have to deal with the trauma of violence in all its forms; be it violence towards a patient in their care or verbal and physical violence towards them, the professional nurses (Crabbe *et al.,* 2004:570). All the stressors mentioned above have an impact on the professional nurse. Koen *et al*. (2010 & 2011:6) found that professional nurses may experience fatigue, stress, low morale and demotivation as a result. This is further supported by other research that found that professional nurses experience different emotional and/or physical disorders as a result of stressors in the workplace. These emotional disorders include compassion fatigue, post-traumatic stress disorder (PTSD), secondary traumatic

stress (STS) and even burnout (Klopper *et al.,* 2012:686; Lombardo & Eyre, 2011:3; Özden *et al.,* 2013:443; Steenkamp, 2013:82-91) It was also found that because trauma nurses are more often than not the first line of contact with many of the above-mentioned stressors, they are left with feelings of depression, sadness, fear, shock, sympathy and anger (Van der Wath *et al.,* 2013:2249).

Professional nurses have found many ways by means of which to cope with their workplace stressors. One of these ways is to share their emotions and experiences with their partners and families (Laal & Aliramaie, 2010:180; McDonnell *et al.,* 2013:644; Rimé *et al.,* 1998:255), finding support from and comfort with the ones they love and trust (McDonnell *et al.,* 2013:644). This coping skill is called venting or emotional sharing. In this study, venting will be used when referring to emotion sharing (Lohr, 2007; Nils & Rimé, 2012:672). Research found that when experiencing an emotional or stressful event, 80% to 95% of people have the urge to talk about what has happened and the emotions they experienced during the event (Rimé *et al.,* 1998; Nils & Rimé, 2012:672; Zech & Rimé, 2005:270). Research also found that culture and/or the type of emotion being shared does not influence the urge to vent (Singh-Manoux & Finkenauer, 2001; Rimé *et al.*, 1998).

However, it was found that the persons venting will initially experience emotional relief, but that the "listener" plays a very important role in the long-term emotional recovery of the person venting (Lepore *et al.,* 2004:360; Zech & Rimé, 2005:283; Frédéric & Rimé, 2012:672). Lepore *et al*. (2004:360) conclude that merely verbalising/talking about the experienced emotions cannot fully resolve emotional stress, although it temporarily relieves the emotional stress. Nevertheless, when the listener actively listens or plays a supportive role (for example social support, understanding and validation), the act of venting does alleviate emotional stress (Nils & Rimé, 2012:679; Brans *et al.,* 2013:1036). In consequence, if the nurse vents to his or her partner, the partner takes on an active listing role and needs to take care of the professional nurse while at the same time has to cope with his or her own emotions.

Coping

Coping is an extremely broad topic. In this review, the researcher examined different aspects regarding how people cope in their day-to-day lives and in relationships. One of this study's aims is to make recommendations on how to strengthen the resilience of professional nurses' partners. In order to accomplish this, literature was also examined and reviewed to show the link between strengthened coping skills and its direct influence on the resilience of

a person. Coping is considered one of the core concepts in health psychology and is strongly associated with the control of emotions throughout a stressful period. It is thus important to fully understand the concept. This study focuses especially on how the partners of professional nurses cope with the traumatic information that is vented to them in their relationships.

Chesney *et al*. (2006:423) define coping as behavioural or cognitive efforts to manage situations that are appraised as stressful, where the external and/or internal demands of the situation exceed the person's resources. Coping has also been defined as a response aimed at diminishing the physical, emotional and psychological burden that is associated with stressful life events (Tuncay *et al*., 2008:6). Therefore coping is the interaction between a person and a situation and depends on a person's perceived ability to manage the stressor (Meehan *et al*., 2007).

Coping is an active process and comprises different types of coping mechanisms. The two types of coping mechanisms that play an important role in how a person copes after hearing about trauma or after experiencing a stressful event , these are adaptive and maladaptive coping mechanisms (Stuart, 2013:52; White *et al*., 2011:260). Adaptive coping mechanisms are seen as a more positive way of coping, since it deals with the stressors directly in order to solve or alleviate the stress (White *et al*., 2011:260). Maladaptive coping mechanisms, on the other hand, are seen as more negative in some instances, since it is used to avoid stress and may prevent progress towards accepting and resolving stress (White *et al*., 2011:261). Chesney *et al*. (2006:422) found that maladaptive coping occurs when people fail to resolve or manage their underlying stressors. It is when a person responds to uncontrollable stressors by applying primarily problem-focused strategies, or when a person responds to controllable stressors by primarily applying emotion-focused strategies.

Folkman and Lazarus (1980:230; 1985:167) initially identified only two types of coping, namely emotion-focused coping and problem-focused coping. This is also supported by the findings of Chesney *et al*. (2006:422). Emotion-focused coping is when people try to process their emotions by means of acting and thinking. It includes trying to decrease the negative emotional responses that are linked to stressors such as fear, embarrassment, anxiety, excitement, depression and frustration. Emotion-focused coping is usually used when the source that causes the stress is outside your control (Chesney *et al*., 2006:442; McLeod, 2009). The following coping techniques that belong to the emotion-focused strategy will be discussed: spirituality, distraction, meditation, emotional disclosure, journaling, substance

abuse and denial of negative thoughts or emotions. McLeod (2009) describes spirituality as praying for guidance and strength, connecting to your spiritual side and using that to manage your emotions or to find meaning (Zeidner & Hammer, 1992). Distraction is to keep your mind off the problem by keeping yourself busy. Meditation means to be more mindful. Emotional disclosure or social support is when a person feels the need to express their feelings by either talking to family and friends or writing about what caused the feelings (Galor, 2015). Writing about one's feelings also includes journaling, where a person keeps a journal of the happenings of his or her day and of what they are thankful for (Cheng *et al.,* 2015:178). Substance use and abuse are also part of emotion-focused coping, for example comfort eating, drinking alcohol, smoking or even drug use, to relieve the stressors for a short period of time (Galor, 2015). Suppressing or denial of negative thoughts or emotions implies that a person pretends that the stressor does not exist or suppresses the feelings that the stressor invokes (Galor, 2015; McLeod, 2009).

Problem-focused coping is a way of acting that focuses on changing the problematic aspects of stressful events (Chesney *et al*., 2006:442; McLeod, 2009). This coping mechanism is applied to remove or reduce the cause of the stressor (Bolger, 1990:525). This is also known as active coping, since a person actively faces the problem to address and change the it by using any of the following methods: planning, problem solving, emotional expression and/or emotional processing (Compas *et al*., 2001:117; Gunlicks-Stoessel & Powers, 2009:361; Skinner *et al*., 2003:234-235).

As research developed over the years in the field of coping techniques, new strategies were identified, as well as different strategies that people use to cope in life. In research done by Bolger (1990:525), he identified six types of coping techniques that people mainly use. It is important to take note of these techniques in order to identify them in this study. These techniques will now be discussed to gain better insight and understanding with regard thereto.

The first coping technique that Bolger (1990:525) identifies is problem-focused coping that the researcher already discussed above. The five remaining techniques are seeking support, focusing on the positive, distancing, wishful thinking and self-blame.

Seeking support is when a person turns to his or her partner of family for support in alleviating the stress. Seeking support includes just being able to vent or share their thoughts and emotions and/or seeking someone else's advice (Bolger, 1990:525; Compas *et al*., 2001:117; Gunlicks-Stoessel & Powers, 2009:361; Skinner *et al*., 2003:234-235).

Focusing on the positive means reappraising the situation in a positive way. In other words, to see the silver lining and to discern the positive in situation and focus on that (Bolger, 1990: 525; Galor, 2015; McLeod, 2009).

When people apply distancing, they minimise the threat by detaching themselves psychologically from the stressful situation. Ways of detachment include keeping your mind and body busy by reading, practising hobbies and/or spending time with friends (Bolger, 1990:525; Compas *et al*., 2001:117; Galor, 2015; Gunlicks-Stoessel & Powers, 2009:361; McLeod, 2009; Skinner *et al*., 2003:234-235).

Wishful thinking is to fantasise about escaping or avoiding the situation. It is to imagine that what happened or is still happening is not real (Bolger, 1990:525; Compas *et al*., 2001:117; Gunlicks-Stoessel & Powers, 2009:361; Skinner *et al*., 2003:234-235).

Self-blame is when you take the blame for what happened on yourself (Bolger, 1990:525; Compas *et al*., 2001:117; Gunlicks-Stoessel & Powers, 2009:361; Skinner *et al*., 2003:234-235).

All these coping mechanisms play an important part in determining how a person would cope in stressful situations or when listening to narratives of traumatic events.

Cognitive-focused coping is one of the more recent discoveries made, and is more focused on reflection and positive review. It refers to what people think and not to what they actually do in order to handle the stressful event and subsequent negative emotions (Garnefski *et al.*, 2001:1313-1314). In most cases, the partner of a professional nurse can do little substantial when listening to traumatic information, but has to deal with what he or she heard by thinking it through.

Skinner *et al*. (2003:235) and Campas *et al*. (2001:117) established yet another important coping technique, namely disengagement. People who apply disengagement attempt to avoid the stressor and associated emotions by means of withdrawal, avoidance and denial.

We daily apply coping to all aspects of our lives. Important for this study is to see how people cope in their relationships. Researchers found that individuals who experience stress in their relationships or family lives and manage to cope well with that stress, improve their relationships and family support and reduce family conflict (Neff & Broady, 2011:527). It is thus important for partners to have good coping skills in order to support each other in times

of stress or, as in the case of this study, when partners need to support professional nurses by listening to them when they vent traumatic information. When a couple use adaptive coping mechanisms in their relationship and receive sufficient support from one another, their physiological stress will be reduced (Gunlicks-Stoessel & Powers, 2009:631; Gunnar, 1994:180). The ultimate goal is for a couple to have stronger coping skills as individuals and as a couple, enabling them to not just cope better, but also to live life to the full. This will also make them more resilient in themselves and in their relationship.

Laviola and Macrì (2013:68-69) mention that the way in which people control their stressors has a direct effect on whether they will build resilience or not. Research found that building your adaptive coping mechanisms will also contribute to increasing your resilience (Laviola & Macri, 2013:68-69). This could aide people who frequently experience stressful events, such as the partner of a professional nurse who often has to listen to the nurse venting traumatic information. Learning to cope with this will enable the partner to more effectively deal with the information. In addition it serves as experienced gained when having to cope with other stressful experiences in life. Experience in dealing effectively with moderate-level stressors may protect partners against the potentially harmful effects of compounding emotions as a result of unresolved stressors (Updegraff & Taylor, 2002). Dealing with stressors or protecting oneself by using adaptive coping strategies include having knowledge about and using more of these strategies, having confidence in one's ability to deal with events as a result of previous experience and knowing how to correctly evaluate potential threats (Updegraff & Taylor, 2002). In other words, using coping mechanisms to build resilience toward stress (Laviola & Macri, 2013:82).

Resilience

Resilience is the human capacity to adapt, thrive and "maintain relatively stable, healthy levels of psychological functioning" in response to potentially traumatic events (Bonanno, 2004:20). According to the Concise Oxford English Dictionary (2011:1224), a resilient person is "able to withstand or recover quickly from difficult conditions". Resilient people can "bounce back" from setbacks and continue with their lives, even thrive during times of challenge or change (Dyer & McGuinness 1996:227; Van Kessel, 2013:125). Higher levels of resilience could thus empower people to cope and survive. Seeing that this study is a sub-study of the RISE project, it is important to distinguish the value of resilience and to have an understanding of its place in the current study in order to assist in improving the resilience of the risk group, who is the partners of the professional nurses in this study.

Stressful life events afford one the opportunity to grow by mobilising previously untapped coping mechanisms and increasing confidence in one's ability (Updegraff & Taylor, 2002). Individuals who are exposed to moderately stressful experiences and who have the initial resources necessary to overcome those stressors, develop a resilience to fight the harmful effects of later stress (Neff & Broady, 2011:1065)

It has been identified that resilient people possess the following personality traits: they use effective coping strategies, they have a firm understanding of reality, they have a deep and meaningful belief system and they have the ability to improvise (Lees, 2009). Additionally, resilient people have a realistic perception of the stressful situation in which they find themselves and can identify aspects that they can either influence or change in the situation or in themselves. Resilient people have an astute awareness and tolerance of feelings; of both their own and that of others. They furthermore have a strong belief in the future (Schäfer *et al*., 2015:135). These characteristics give us clues as to the process of developing resilience in oneself. Schäfer *et al*. (2015:135) also found that being able to control your own attention may enable an individual to better focus on the stressors, empowering the individual to determine which internal and/or external stimuli to attend to first, thus promoting adaptive emotion control and choosing better coping techniques. This is an important concept to understand, seeing that the researcher will ultimately make recommendations on how to strengthen the coping techniques and resilience of the partners of professional nurses.

Resilience involves an active/dynamic process that includes the capacity to endure, to positively adapt to and to rebound from significant adversities, crises and challenges and, through this process, to grow stronger and more resourceful (Luthar *et al.,* 2000; Walsh, 2006:545). Some people become distressed or perform poorly when under stress, whereas others remain resilient. Coping theorists assume that these outcomes result from people's coping efforts to change the stressful situation or to control their emotional reactions (Bolger, 1990:525). Updegraff and Taylor, 2002 suggest that a strong sense of self may provide the basis for resilience when experiencing stressful events. A sense of coherence about one's life and a hardy personality have all been described as valuable resources for coping with stress (Updegraff & Taylor, 2002). Coping successfully with adversity has the benefit of enhancing resilience, which in turn enables one to better cope with future adversities (Warner, 2011:53). Warner (2011:53) also found that having a strong sense of purpose and meaning in life beyond one's self and by believing and having faith it can develop personal resilience. Creative problem-solving in the face of adversity requires being open-minded and

flexible, as well as being willing to consider different views. People who want to enhance their resilience should also be realistically optimistic (Warner, 2011:53).

If the partners of professional nurses strengthen their coping techniques, it will spill over and strengthen their resilience as well, which in the long term will also help the professional nurses to cope better in view of the fact that they are given the social support that they need.

Resilience is a dynamic process, and current definitions of resilience include three orientations namely, trait-, outcome- and process-orientated.

Trait-orientated resilience suggests that a person's resilience is seen a personal trait or characteristic that assists the individual in coping with difficulty, in adjusting well and in developing further. Empirical evidence has shown that lower levels of trait resilience is associated with an increased risk of developing mental disorders after stressful life events. It also leads to anxiety, depression and substance abuse (Schäfer *et al*., 2015:135). This understandably also applies to the partners of professional nurses partner with regard to how they react and cope with the traumatic information vented to them. If a partner, for example, has the tendency to get over emotional when listening to the professional nurse and he/she is not able to cope with the information, it may have an adverse effect on the partner emotionally. O*utcome-orientated* resilience, on the other hand, is a function or behaviour outcome that helps individuals to overcome and to recover from adversity (Hu *et al.*, 2014:20). O*utcome-orientated* resilience therefore focuses more on what a person is doing to overcome the effects of a specific situation. Lastly, *process-oriented* resilience is a dynamic process in which individuals actively adapt to and recover rapidly from major adversities. Hu *et al,* (2015:20) describe resilience as a process during which people use not just one facet of themselves, but a combination of who and what they are, for example coping mechanisms, life experience and knowledge, to survive a traumatic event and to go on with life. *Process-oriented* resilience thus means that all facets are used together to enhance a person's resilience. .

Being in a relationship every couple has coping techniques and resilience traits that are peculiar to the relationship. Venter and Snyders (2009:63) undertook a study to research resilience in intimate relationships. They found that resilience in intimate relationships can be defined as the ability of a couple to endure adversity. "It involves the relational capacity to adapt, grow and recover from adversities and it includes relational processes that allow the couple as a system to rebound from shared difficulties and become more resourceful". Relational resilience refers to how couples safeguard and protect their relationships against

stressors by using their strengths as a couple to protect themselves against these challenges. In other words, instead of focusing on an individual's ability to adapt to stress, relational resilience focuses on supported vulnerability, mutual empathic involvement, relational confidence and relational awareness (Jordan, 1992). Walsh (1996:257) also supports this notion when stating that couples' resilience is an interactive process that includes coping mechanisms such as good communication and effective problem-solving; it involves community resources as well as an affirming belief system (Walsh, 1996). Walsh (1996) states that the key to mastering stressors as a couple is to use each partner's coping mechanisms simultaneously or in a combination, enabling the couple to work as one in solving the problem. Mastering stressors collectively can deepen the partners' bond and give them confidence that they can face future stressors together (Walsh, 1996:257). The first noted definition of "couple coping" only emerged in the early 1990s, when researchers started to extend the stress and coping paradigm to committed couples, families and communities (Bodenmann, 2005:33). In this study, the researcher will mainly investigate the dyadic coping model as a model used for couple coping. According to Bodenmann (2005:33), "dyadic stress is defined as a specific stressful encounter that affects both partners either directly or indirectly and triggers the coping efforts of both partners within a defined timeframe and a defined geographic location". A dyadic coping model was conceptualised that addresses the interaction between each partner's individual coping efforts in the context of marriage. A dyadic coping process implies that both partners are involved (Bodenmann, 2005:33), since the coping efforts of each partner is focused on the better functioning of the other partner and the relationship. According to this dyadic coping model, the coping process in a couple's relationship is triggered when one of the partners seeks support, followed by either a positive or negative behaviour of the other partner (Chow & Tan, 2014:175). Positive dyadic coping implies that the partner seeking support finds validation, emotional support and instrumental help with the other partner. Positive dyadic coping may also involve collaborative problem solving and mutual consolation. Negative dyadic coping involves one partner's denial of the problem, criticism, avoidance and sarcasm (Chow & Tan, 2014:175). The dyadic coping model suggests that the positive and negative behavioural exchanges are inherently "dyadic", since both partners are involved in the coping process, which in turn have an effect on their relationship resilience.

Another term that is also commonly used in research is collaborative coping. This term refers to the active engagement of spouses in combining resources and in joint problem solving and coping (Berg *et al*., 2008).Collaborative coping falls in the same category as dyadic coping. Active problem solving may assist individuals in dealing with stressful events. The

active engagement inherent in collaborative coping has been associated with a reduced amount of depressive symptoms and more optimistic moods. According to Berg *et al*. (2008), collaborative coping may be associated with perceptions that one is effective in coping with stressful events, consistent with a couple's belief that "two heads are better than one".

It is thus understood that all people have their individual coping mechanisms as well as their individual ways of being resilient in their own lives. However, as soon as they enter into a relationship, they form new combined ways of coping together as a couple and building the relationship's resilience. It is thus important to view resilience as a process. It should be viewed as being built on the complex interaction of events and life experiences at individual, family and community level. As is evident from the discussions above, nurses work in highly stressful circumstances. In doing their jobs, they have their own unique ways of coping with or bouncing back from traumatic events and of sharing information with their partners. Exploring the different ways in which individuals and couples cope with stressful events gave the researcher sufficient background on which to build further in the study.

1.7.4 Methodological Assumptions

The methodological assumptions of this study are based on the Botes research model (1995:6). The Botes research model comprises three interlinking levels of nursing activities (Botes, 1995:8).

The first level represents the practice of nursing that endeavours to draw from nursing problems in practice. In this study, nursing practice is related to the coping experience of the partners of professional nurses where the partners may be exposed to the professional nurses venting traumatic information of events that they may have experienced at work to them.

The second level of the Botes model involves research and theory development. In this study, the researcher studies the coping experiences of partners of professional nurses venting traumatic information to them in order to make recommendations to assist in strengthening the partners' resilience.

The third level entails the paradigmatic perspective of the researcher. The paradigmatic perspective includes the researcher's meta-theoretical, theoretical and methodological

assumptions that influence the nursing practice, the research methodology and ultimately the interpretation of the data (Botes, 1995:4-8).

1.8 Research Design and Method

An outline of the research design and method is now provided.

1.8.1 Research Design

A research design is the blueprint for conducting a study. It directs the choice of the population, sampling methods, data collection and data analysing procedure. It helps to maximise the control over factors that could interfere with the trustworthiness of the study's findings (Burns & Grove, 2009:218). A qualitative design with an interpretive descriptive approach was used to explore, interpret and describe the coping experiences of partners of professional nurses venting traumatic information to them in order to make recommendations to assist in strengthening the partners' resilience.

1.8.1.1 Qualitative design

A qualitative research design explores an occurrence that happens in the "real world" (Leedy & Ormrod, 2005:133). Using a qualitative design as described by Brink *et al.* (2006:113) allows the researcher the freedom to study the event and to fully understand how the partners of professional nurses cope with being exposed to traumatic information via venting. This approach allowed the partners to describe their coping experiences in their own words and assisted the researcher in understanding the meaning and impact of venting on the partners' lives (Brink *et al.,* 2006:113).

1.8.1.2 Interpretive description

The researcher applied an interpretive descriptive approach to observe particular patterns of human behaviour (Thorne, 2008:35). Thorne also states that by using this approach, a researcher can explore the experiences of people that require better understanding by doing some "explanatory" interpretive analysis. Such an analysis assists in determining the aspects that require further study, how such a study might be conducted and what one might possibly do in the meantime in order to work with those patterns in the everyday world of practice (Thorne, 2008:33-35). Interpretive description research, as explained by Hunt

(2009:1285), is the examination of an occurrence with the goal of identifying themes and patterns among subjective perspectives, while also accounting for variations between individuals. This type of research was an appropriate approach to follow in this study to explore the coping experiences of the partners of professional nurses.

1.8.2 Research Method

The research method consisted of population, sampling and sampling size, data collation, data analyses and trustworthiness.

1.8.2.1 Population

The targeted population of this study was the partners of professional nurses. They had to be in a relationship with a professional nurse working in a casualty unit in one of the two private hospitals in Gauteng province. Gauteng province was used due to the researcher staying in Gauteng.

1.8.2.2 Sampling and sample size

This study was conducted on the partners of professional nurses working in casualty units in one of two private hospitals in Gauteng. The researcher used a purposive sampling method to select participants to represent the population for this study. According to Brink *et al.* (2006:134), the advantage of purposive sampling is that it allows the researcher to select a sample group that is more likely to provide the needed information about the coping experience being studied. Sample size (N=14; n=10) was determined once the researcher was confident that the number of participants represented the population as close as possible and when information saturation was reached. The final response rate was 71.42% of the total sampling size.

The following inclusion criteria were identified:

- a partner of a professional nurse practicing in a casualty unit in one of two private hospitals in Gauteng;
- no discrimination against the partner in terms of ethnicity, age, gender, or being married or unmarried;
- participants must be able to understand and communicate in English or Afrikaans; and

- both the partner and the professional nurse see themselves as a “couple” in a relationship.

1.8.2.3 Pilot study

The researcher conducted a pilot study of the proposed research study before starting with data collection. A pilot study is seen as a minor study that is based on the proposed study in order to bring forth any difficulties that may be experienced while conducting the study. It is thus done to improve and refine the research method before the official study is conducted (Burns & Grove, 2005:42).

The pilot study was conducted to determine whether the proposed interview schedule would be appropriate and whether the participants would understand the interview questions. The pilot study included two partners of two professional nurses who had the same characteristics as the proposed population studied. For the pilot study, the participants had to comply with the following requirements:

- be a partner of a professional nurse working in a casualty unit;
- volunteered to participate; and
- signed an informed consent form.

The researcher kept to the following steps during the pilot study: The researcher compiled a semi-structured interview schedule. The schedule, together with the questions, was sent to the researcher’s promoters for evaluation; recommendations were made to add more questions in order to ensure that the research question is fully answered and that the aim and objectives of the study are met.

The researcher then posted a notice in her workplace requesting volunteers to participate in the pilot study. Two professional nurses who have partners were willing to ask their partners whether they wanted to participate in the pilot study. The researcher then contacted both these partners telephonically. The researcher arranged with the partners to meet with her in her office at a time that best suited them. In the meantime the researcher sent a copy of the informed consent to the partners by e-mail. The researcher requested the partners to read through the informed consent and to make notes of anything that was unclear to them or that they may think is of importance to the study. Thereafter the researcher met with each partner respectively at a convenient time in her office. The researcher explained the study to the partners and asked for their informed consent. The researcher affirmed the partners’ written consent to participate in the pilot study. She reminded them that their participation was

voluntary and that they could withdraw at any time without any consequence. She also reminded them that the semi-structured interviews would be voice recorded and the recordings transcribed and analysed in order to determine whether the interviews could be improved in any way.

After the semi-structured individual interviews have been conducted, both partners were of the opinion that the questions were sufficient and that they clearly understood what was expected of them. Each partner was asked all the questions. They were also asked to convey how they understood the questions and then to answer them. The following questions were asked in each of the interviews:

1. how long have you been in your current relationship;
2. how did you cope in the beginning of your relationship with the professional nurse venting traumatic information;
3. has your way of coping changed over the years? If yes, how;
4. why do you think partners of professional nurses need to be resilient;
5. what personal strengths do you have that enable you to be resilient;
6. do you think partners of professional nurses need to be more resilient than partners of people in other professions; and
7. what advice would you give other partners to help them become more resilient?

The communication techniques that the researcher used included reflection and summarising during the semi-structured interviews. The overall responses of the participants were good. Both participants understood the questions well, but asked the researcher during the interview to explain the term “resilience” again. For that reason, in the study, the researcher added the term to the informed consent form (Appendix A). Before each interview the researcher also again verbally explained the term “resilience” to the participants.

The researcher also noted during the pilot study that the interview did not last as long as expected and that she could employ more communication techniques during the interviews. Hence the researcher explored deeper during the subsequent interviews by asking the participants to describe their experiences in more detail. The researcher also reflected and clarified more to ensure that she understood the true meaning of what the participants said. However, the information that the researcher gathered from both the participants during the interviews was rich and sufficient.

The researcher also found that the field notes she made during the interview was done very hastily. The researcher realised that she would need more structured notes. In order to

achieve this, she prepared a paper with the headings “descriptive notes” and “reflective notes” to use during the interviews. None of this data was included in the data analysing proses.

1.8.2.4 Data collection

The researcher obtained ethical approval from the North-West University’s (NWU) Health Research Ethics Committee (HREC). The researcher then applied for approval at two private hospitals in Gauteng to conduct the study in their facilities. Once approval was granted from the head offices of both the private hospitals, the researcher identified a primary mediator at each of the units, who was either the unit manager or the chief professional nurse of the particular casualty unit. The researcher could only approach the professional nurses after handover each day. The unit managers arranged with all the professional nurses to meet with the researcher just after handover. They gathered in a convenient area - the boardroom and ward office respectively. The researcher then explained the study to the professional nurses and afterwards gave all professional nurses who were in a relationship and willing to ask their partners to participate an envelope with an informed consent letter. The professional nurses took the envelopes home in order for their partners to complete the informed consent forms. The professional nurses whose partners were willing to participate then returned the sealed envelopes with the completed informed consent forms to the respective unit manager. The researcher collected all the envelopes with the completed informed consent forms from the unit managers and made initial telephonic contact with the participants. Subsequently the researcher made telephonic contact with each participant to arrange a suitable date and time to meet at the respective private hospital for a semi-structured interview. Prior to scheduling the interviews, the researcher arranged for suitable venues with the particular unit manager or chief professional nurse of each facility. The researcher ensured that comfortable, private venues were selected, where the scheduled interviews would not be interrupted (Botma *et al*., 2010:203). A conference room and/or office that were available at the facility on the day of the interview were used.

The researcher prepared an interview schedule for the semi-structured interviews (Appendix B). As mentioned previously, the schedule was tested in the pilot study for appropriateness (Botma *et al.,* 2010:208-209), and it was indeed found to be appropriate. The researcher familiarised herself with the questions to ensure an orderly run of events during the interview (Botma *et al.,* 2010:2010). The researcher made the necessary preparations to voice record each interview (Botma *et al*., 2010:212). On the day of the interview, the researcher welcomed the participant and briefly explained the structure of the interview and the purpose

of the research. The researcher then obtained the participant's verbal consent to record the interview. Ethical considerations were also mentioned again to ensure that participants were completely willing to participate and knew that they could leave at any stage of the interview. The researcher further ensured that they knew that provision was made for emotional support if they should need it (Botma *et al*., 2010:212). The researcher explained this in English or Afrikaans, depending on the language preference of the participant. Finally, all participants were reminded to make sure that they signed the informed voluntary consent forms before participation.

The researcher conducted semi-structured individual interviews with the partners of professional nurses to obtain detailed information and facts, and to probe for more clarity on the specific set of topics (Brink, 2006:152; Botma *et al.,* 2010:208-209; De Vos *et al.,* 2011:296). All the interviews were voice recorded with the participants' consent. Specific questions were developed that focuses on answering the research questions.

The researcher made field notes during and after each interview to ensure rich data collection (Botma *et al*., 2010:212). The aim of these notes is to gain a better understanding of what was observed during the interviews (Botma *et al.,* 2010:217-219). All questions were asked in a polite and conversational manner. Communication techniques such as exploring, clarifying, reflecting and summarising were used, as described by Kreigh and Perko (1983:250-254).

The number of semi-structured interviews was determined by the number of partners willing to participate and who adhered to the inclusion criteria. Data saturation of how partners were coping, as well as interlinking themes between participants' coping experiences, became apparent from the seventh interview (Botma *et al*., 2010:211). Fourteen professional nurses were in a relationship; 10 of the partners were willing to participate in the interviews (N=14; n=10).

All the data was transcribed, coded and stored on a computer that was password-protected. Hard copies of the data, as well as computer data that has been saved on a disc, were locked in a cabinet in a locked room. Once recorded data was transcribed it was deleted from the audiotape. Hard copies of the data, as well as electronic data, will be stored for seven (7) years in the North-West University (Potchefstroom Campus) archives. All data has been stored in the office of the INSINQ Focus Area Directors of the North-West University's Nursing faculty in a locked cabinet. All other hard copies were shredded and disposed of after data analysis.

1.8.2.5 Data analysis

The digital recordings were transcribed verbatim for analysis by the researcher and a co-coder. The field notes were also analysed and compared (Burns & Grove, 2005:543). Data analysis was done by using the eight steps of Tesch's data analysis method (Creswell, 2009:186; Creswell, 2003:192-193). The researcher will now discuss the eight steps of Tesch's open coding technique.

- First the researcher carefully reads all the transcriptions to obtain a sense of the whole, all the while writing down some of the ideas that arise.
- Thereafter the researcher takes a transcript of interest and asks, "What is this about?" The researcher reads through the transcript, looking for the deeper message and underlying meaning, all the while writing down thoughts that come to mind in the margin.
- The researcher then reads through all the transcriptions with the same question in mind and writes down a list of themes/topics that come to mind. Afterwards the researcher organises these themes/topics.
- The researcher then takes the list of topics and derives subtopics that are used as codes next to the appropriate segments in the text, all the while observing whether new categories and codes emerge.
- Topics are then converted into categories and categories are linked in order to shorten the list.
- The final decisions about the abbreviations for each category are then made, after which the codes are listed in alphabetical order.
- Data is then categorised by arranging the data materials that belong together and paraphrasing it (doing preliminary analysis).
- Lastly, recoding is done.

The researcher set up a work protocol that was also given to the co-coder together with all the field notes and transcriptions (Appendix C). The co-coder independently analysed the data, after which the researcher and the co-coder met to discuss and agree on common themes as well as the results.

1.9 TRUSTWORTHINESS

Trustworthiness can be measured by way of the following criteria: credibility, transferability, dependability and confirmability (De Vos *et al.,* 2011:346-347). Please see Table 1.1 for the discussion on the above mentioned categories.

Table 1.1: TRUSTWORTHINESS

CRITERION	DESCRIPTION	TECHNIQUES APPLIED IN THIS STUDY	APPLICATION TO THIS STUDY
Truth value	Credibility is the way in which research is conducted to ensure that the findings obtained are genuine (Klopper & Knobloch, 2010:323)	**Credibility** - Prolonged engagement	Prolonged engagement means that adequate time was spent on data collection (Klopper & Knobloch, 2010:323; Creswell, 2003:196). The researcher spent a great deal of time reading up on and interpreting the research topic. The researcher also consulted existing literature on the topic of the study and completed a full literature review. The researcher spent sufficient time on collecting the data by means of semi-structured individual interviews, as well as on analysing this data. The researcher asked all questions in such a manner during the interviews as to not provoke social desirability. Interviews were conducted in a way that encouraged honesty. The researcher guaranteed the confidentiality of all the participants (Botma *et al.,* 2010:234).
		- Persistent observation	Persistent observation is the method by which a researcher continuously pursues to interpret in different ways (Klopper & Knobloch, 2010:323). The researcher adhered to persistent observation by giving her full attention to and meticulously observing the participants while conducting the semi-structured individual interviews. This enabled the researcher to make detailed field notes and to set aside a few minutes after each interview to reflect on what she has learned from a particular interview. In addition, during the process of data collection and analysis, the researcher aimed to bracket or suspend all previous assumptions and beliefs in order to be completely open to and submerged in the phenomenon (Brink *et al.,* 2006:113).
		- Peer debriefing	Peer debriefing is when experts in the particular research field or the phenomenon under study examine the research process that is followed, thus asking questions and in so

			doing also review and analyse the research process (Klopper & Knobloch, 2010:323). The researcher's study leaders are specialists in the field of research and resilience. The proposal of the study was also panel reviewed. The researcher further used a co-coder to analyse the semi-structured individual interviews during data analysis process.
Applicability	**Applicability answers the question of whether the findings of a particular study can be transferred and generalised to other contexts and/or to a larger population (Klopper & Knobloch, 2010:323)**	**Transferability** - Thick description	A thick description is a detailed description of the background against which the research study takes place (Botma *et al*., 2010:234). The researcher used thick descriptions throughout the study (Botma *et al*., 2010:234). The researcher also gave step-by-step descriptions of all the facets of conducting the study and of the data analysis process. The researcher also conducted an in-depth literature review. The researcher structured a detailed database throughout the study. In addition, the researcher applied international standards for research so that the findings may be used in other relevant studies (De Vos *et al*., 2011:322).
		- Data saturation	Saturation of data occurs when additional sampling provides no new information (Klopper & Knobloch, 2010:324). This study included 10 participants. Data saturation started to occur during the seventh interview. The researcher, however, decided to conduct all 10 interviews to ensure complete data saturation.
		- Purposive sampling	The advantage of purposive sampling, according to Brink *et al*. (2006:134), is that it allows the researcher to select a sample group that is more likely to give the needed information for the phenomenon under study. In this research study, purposive sampling was used seeing that it was aimed at a very specific target group. Purposive sampling also facilitated the selection of participants, since inclusion criteria were set up at the onset of the study.

Consistency	**Consistency is described as the ability to reproduce the study with a similar population, in a comparable context and to obtain equivalent results (Klopper & Knobloch, 2010:332)**	**Dependability** - Inquiry audit	The researcher used the services of a co-coder. In addition, the study leaders peer reviewed the study throughout the process (Botma *et al.*, 2010:234). The researcher achieved dependability by having clear descriptions of the methods used in gathering, analysing and interpreting the data. The researcher also provided precise and comprehensive reporting of the data. In addition, the researcher documented the research process and findings in such a way that other researchers would be able to follow the research steps of this study without error (De Vos *et al.,* 2011:346).
Neutrality	**Neutrality is when no personal bias, perceptions and/or intensions held by the researcher influence any of the following steps of the research: data collection and data analysis and interpretation; the researcher thus remains impartial throughout the study (Klopper & Knobloch, 2010:323).**	**Confirmability**	To ensure confirmability in this study, the researcher asked the study leaders to review the findings, conclusions and recommendations made by the researcher to ascertain that it was supported by the data and that the researcher's interpretation of the data was relevant (Botma *et al*., 2010:235). The researcher also bracketed all her own preconceived ideas and conceptions with regard to the study in order to remain neutral throughout the data collection and analysis process.

1.10 ETHICAL CONSIDERATIONS

The researcher ensured that all ethical principles were adhered to fully when working with the participants in order to protect the participants' rights at all costs. Firstly, the RISE study representatives granted their approval that the researcher could conduct this study as a sub-study of the RISE project ethical number NWU-00036-11-A1 (Appendix D and E) . After obtaining this approval, the proposal was sent for full ethical approval by the Health Research Ethical Committee ethical number NWU-00036-11-S1 (Appendix F) On obtaining the committee's approval, the consent of the two private hospitals in Gauteng was obtained to conduct the research in their facilities (Appendix G). The researcher will now discuss the ethical considerations that were proposed to keep the study in line with the ethical standards of the RISE project.

Koen and Du Plessis (2011:10) maintain that the ethical principles of respect, justice and beneficence must be applied to all interaction with the participants. The researcher achieved this by acknowledging the participants as autonomous beings and by providing them with sufficient information about the purpose and objectives of the research as well as the possible benefits and risks involved. The research also ensured the participants' right to justice by giving all suitable participants the same fair and equal opportunity and option to choose whether they would like to participate or not in the prospective study. The basic principles of respect for all people, beneficence and justice were upheld at all times (Botma *et al.,* 2010:277).

Koen and Du Plessis (2011:11) state that contact with participants must only be made through custodians such as ministers of religion or nurse managers. In this research study, the researcher used the unit manager or the chief professional nurse as the primary custodian to make contact with the professional nurses. The professional nurses then became the secondary custodians through whom the researcher made contact with their partners. The researcher took "the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment, and the right to protection from discomfort and harm" into account during the entire course of the research (Burns & Grove, 2009:189).

1.10.1 Right to Self-determination

All the partners were treated autonomously; the researcher acknowledged their right to make their own decisions about participation in the research at all times. According to Koen and Du Plessis (2011:10), the participants must be afforded the opportunity to participate on a voluntary basis, to withdraw at any time without punishment and to give informed consent. According to Koen and Du Plessis (2011:11), the participants must be assured of their right to self-determination (Brink *et al.,* 2006:37). The researcher honoured this right by informing the potential participants of the purpose, nature and implications of this study (Jooste, 2010:279), thus enabling the participants to choose whether they wanted to participate in the study or not. The researcher obtained the participants' informed consent that was obtained by means of a letter in which she explained the purpose of the study, and outlined the way in which the interviews would be conducted. The aim and objectives, as well as the possible advantages and disadvantages of the study, were also explained in the letter (Burns & Grove, 2009:181-190). The participants were given seven days to fully familiarise themselves with all the information. Data was collected by means of conducting semi-structured interviews, asking open-ended questions and making field notes. The participants gave their informed consent prior to the onset of the interviews to digitally record the interviews.

1.10.2 Right to Privacy

The researcher respected the participants' right to privacy by conducting each interview in a private venue and by closing the door during each interview. The researcher also assured the participants of their right to privacy by giving them the option to disclose or not disclose personal information. The researcher ensured that the participants' disclosed personal information was kept safe by keeping all collected data confidential. All the data was coded and stored on a computer that is password-protected. All hard copies of the data, as well as computer data that was saved on a disc, these were locked in a cabinet in a locked room. Once recorded data was transcribed it was deleted from the audiotape. Hard copies and electronic data will be stored for seven (7) years in the North-West University (Potchefstroom Campus) archives. All data was stored at the INSINQ Focus Area Directors office of the North-West Universities Nursing faculty in a locked cabinet. The researcher also explained to each participant that the results of the research may be published, but that their names and the names of the facilities at which their nursing partners work will be kept confidential at all times.

1.10.3 Right to Anonymity and Confidentiality

The researcher respected the participants' right to anonymity and confidentiality. According to Koen and Du Plessis (2011:10), the names of the participants must be kept confidential and the research data must be anonymous. Accordingly, the researcher did not use any of the participants' names at any stage. The researcher ensured the participants' anonymity further by giving them each a code name for use during data collection and data analysis. All data was protected by storing it in a safe place for data analysis, as mentioned above. The confidentiality of the research data was further ensured by requesting the person who acted as co-coder of the interviews (annexure) to sign a confidentiality declaration.

1.10.4 Right to Fair Treatment

The researcher ensured fair selection and treatment by allowing all participants who met the inclusion criteria to take part in the study. The researcher treated all the participants with respect at all times. The researcher adhered to the conditions and data collection procedures on which the participants agreed when they gave their written consent.

1.10.5 Right to Protection from Discomfort and Harm

The researcher respected the participants' right to protection from discomfort and harm by providing each participant with a fully informed consent form beforehand that explained the possible risks of the study and that they may experience emotional discomfort. However, to ensure that non-maleficence prevailed, the researcher ensured that the participants suffered no emotional or psychological harm by giving the participants the opportunity to attend debriefing sessions after each interview if they needed to (Jooste, 2010:279).

1.11 RESEARCH REPORT OUTLINE

The report is presented in an article format as described in the A Rules, 14.4.2, of the North-West University and includes the following:

Section 1

Overview of the study

Section 2

Manuscript: “Coping experiences of partners of professional nurses venting traumatic information to them”, to be submitted to Health SA Gesondheid. The researcher followed the instructions for authors as far as possible. The researcher adhered to the publisher’s style guide for authors as best she could, but agree to ensure that the shortened article to be submitted to Health SA Gesondheid adheres to all the technical requirements.

Section 3

Conclusions, recommendations and limitations of the study

1.12 SECTION SUMMARY

In this section, the researcher discussed the introduction and background, problem statement, research questions, research objectives and the research assumptions of the study. The researcher then outlined the research design and methods, trustworthiness and ethical considerations, and gave a brief overview of the rest of the study. In concluding this section, the researcher portrayed the significance of the gap in research with regard to the coping experiences of partners of professional nurses venting traumatic information to them.

1.13 REFERENCES

Aycock, N. & Boyle, D. 2008. Interventions to manage compassion fatigue in Oncology nursing. *Clinical Journal of Oncology Nursing,* 13(2):183-186.

Berg, C.A., Wiebe, D.J., Butner, J., Bloor, L., Bradstreet, C., & Upchurch, R. 2008. Collaborative coping and daily moods in couples dealing with prostate cancer. *Psychology of aging*, 23(3):505-516.

Bester, C.L. & Engelbrecht, M.C. 2009. Job satisfaction and dissatisfaction of professional nurses in primary health care facilities in the Free State province of South Africa. *Africa Journal of Nursing and Midwifery*, 11(1):104-117.

Bodenmann, G. 2005. Dyadic coping and its significance for marital functioning. In T. Revenson, K. Kayser, & G Bodenmann (Eds.), Couples coping with stress: emerging perspectives on dyadic coping (pp. 35-50). Washington: American Psychology Association.

Bolger, N. 1990. Coping as a personality process: A prospective study. *Journal of Personality and Social Psychology*, 59(3):525-537.

Bonanno, G.A. 2004. Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1):20-28.

Botes, A.C**.** 1995. A model for research in nursing. Johannesburg: Rand Afrikaans University.

Botma, Y., Greef, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town:Pearson Education South Africa.

Brans, K., Van Mechelen, I., Rim, B. & Verduyn, P. 2013. The relation between social sharing and the duration of emotional experience. *Cognition & Emotion,* 27(6):1023-1041.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2006. Fundamentals of research methodology for healthcare professionals. 2nd ed. Cape Town: Juta & Co.

Buchan, J. 2006. The impact of global nursing migration on health services delivery. Policy, Politics, & Nursing Practice**,** 7(3):16-25.

Burns, N. & Grove, S. K. 2005. *The practice of nursing research: conduct, critique and utilization. 5th ed*. Missouri: Saunders Elsevier.

Burns, N. & Grove, S.K. 2009. The practice of nursing research: appraisal, synthesis and generation of evidence. 6th ed. St Louis: Saunders Elsevier.

Campbell, S.B. & Renshaw, K.D. 2012. Distress in spouses of Vietnam veterans: association with communication about deployment experiences. *Journal of Psychology,* 26(1):18-25.

Carll, E.K. 2000. Violence our lives: impacted on workplace, home and community*.* Boston: Allyn & Bacon.

Carson, J., Bartlett**,** H. & Croucher**,** P. 1991. Stress in community psychiatric nursing: a preliminary investigation. *Community Psychiatric Nursing Journal*, 11(1):8-12.

Cheng, S.T., Tsui, P.K. & Lam, J.H. 2015. Improving mental health in health care practitioners: randomized controlled trial of a gratitude intervention. *Journal of consulting and clinical psychology*, 83(1):177-186

Chesney, M.A., Neilands, T.B., Chamber, D.B., Taylor, J.M. & Folkman, S. 2006. A validity and reliability study of the coping self-efficacy scale. *British Journal of Health Psychology*, 11(1):421-437.

Chow, C.M. & Tan**,** C.C. 2014. Interpersonal coping styles and couple relationship quality: similarity versus complimentary hypotheses. *European Journal of social psychology,* 44(1):175-186.

Coffey, M. & Coleman, M. 2001. The relationship between support and stress in forensic community mental health nursing*. Journal of Advanced Nursing.* 34(3):397-407

Compas, B.E., Connor-Smith, J.K., Saltzman, H., Harding Thomsen, A.& Wadsworth, M.E. 2001. Coping with stress during childhood and adolescence: problems, progress, and potential in theory and research*. Psychological Bulletin*,127(1):87-127.

Crabbe, J.M., Bowley, D.M.G., Boffard, K.D., Alexander, D.A. & Klein, S. 2004. Are health professionals getting caught in the crossfire? The personal implications of caring for trauma victims. *Emergency Medicine Journal*, 21(5):568-572.

Creswell, J.W. 2003. Research design: qualitative, quantitative, and mixed methods approaches. 2nd ed. Thousand Oaks: Sage Publications.

Creswell, J. W. 2009. Research design: Qualitative, quantitative, and mixed methods approaches. 3rd ed. Thousand Oaks: Sage Publications.

Davhana-Maselesele, M. & Igumbor, J.O. 2008. The impact of caring for persons living with HIV and AIDS on the mental health of nurses in the Limpopo Province. *Curationis*, 31(2):67-73.

Delobelle, P., Rawlinson, J.L., Ntuli, S., Malatsi, I., Decock, R. & Depoorter, A.M. 2009. HIV/AIDS knowledge, attitudes, practices and perceptions of rural nurses in South Africa. *Journal of Advanced Nursing*, 65(5):1061-1073

Dennill, K., King, L. & Swanepoel, T. 1999. Aspects of primary health care in South Africa. 2nd ed. Halfway House: Thompson.

De Wet, K. & Du Plooy, S. 2012. 'We are left in the cold': nurses' perceptions and responses to antiretroviral treatment roll-out in the Free State, South Africa. *Journal of Social Aspects of HIV/AIDS*, 9(1):30-40.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2011. Research at grass roots: for the social sciences and human service professions. 4th ed. Pretoria: Van Sc.

Dictionary.com. 2015. Coping. http://dictionary.reference.com/browse/coping Date of access: 15 May. 2015.

Dolan, N. 1987. The relationship between burnout and job satisfaction in nurses. *Journal of Advanced Nursing,* 12(1):3-12.

Dyer, J.G. & McGuinness, T.M. 1996. Resilience: analysis of the concept. *Arch Psychiatr Nurs,* 10(1):276-282.

Fagin, L., Brown, D., Bartlett, H., Leary, J. & Carson, J. 1995. The Claybury community psychiatric nurse stress study: is it more stressful to work in hospital or the community? *Journal of Advanced Nursing***,** 22(1):347-358.

Figley, C.R. 1988. Burnout in families: the systemic cost of caring. Florida: CRC Press LLC.

Figley, C. R. 1999. Compassion fatigue: toward a new understanding of the costs of caring. (*In* Stamm, B.H., *ed.* Secondary traumatic stress: Self care issues for clinicians, researchers, & educators. Baltimore, MD:Sidran Press.p. 3-28).

Figley, C.R. & Figley, K.R. 2009. Stemming the tide of trauma systemically: the role of family therapy. *The Australian and New Zealand Journal of family therapy,* 30(3):173-182.

Fletcher, G.J.O., & Kerr, P.S.G. 2010. Through the eyes of love: reality and illusion in intimate relationships. *American Psychological Association*, 136(4):627-658.

Folkman, S. & Lazarus, R.S. 1980. An analysis of coping in a middle-aged community sample. *Journal of health & social behavior*, 21(1):219-239.

Folkman, S. & Lazarus, R.S. 1985. If it changes it must be a process: study of emotion and coping during three stages of a college examination. *Journal of personality & social psychology*, 48(1):150-170.

Frédéric, N. & Rimé, B. 2012. Beyond the myth of venting: social sharing modes determine the benefits of emotional disclosure. *European journal of social psychology,* 42(1):672-681.

French**,** S.E., Lenton**,** R., Walters**,** V. & Eyles**,** J. 2000. An empirical evaluation of an expanded nursing stress scale source. *Journal of Nursing Measurement,* 8(2):161-178.

Galor**,** S. 2012. Emotion-focused coping strategies. https://drsharongalor.wordpress.com/2012/03/31/emotion-focused-coping-strategies/ Date of access: 19 Jun. 2015.

Garnefski, N., Kraaij, V. & Spinhoven, P. 2001. Negative life events, cognitive emotion regulation and emotional problems. *Personality and Individual Differences*, 30(1):1311-1327.

Gibson, D. 2004. The gaps in the gaze in South African hospitals. *Social science and medicine,* 59:2013-2024.

Goff, B.S.N., Reisbig, A.M.J., Bole, A., Scheer, T., Hayes, E., Archuleta, E., Archuleta, K.L., Henry, S.B., Hoheisel, C.B., Nys, B., Osby, J., Sanders-Hahs, E., Schwerdtfeger, K.L. & Smith, D.B. 2006. The effects of trauma on intimate relationships: a qualitative study with clinical couples. *American journal of Orthopsychiatry,* 76(4): 451-460.

Gonzaga, G.C., & Haselton, M.G. 2008. The evolution of love and long-term bonds. In J. P. Forgas & J. Fitness (Eds.)**,** *Social relationships: cognitive, affective, and motivational processes:* 39–54. Hove, England: Psychology Press.

Görgens-Ekermans, G. & Brand, T. 2012. Emotional intelligence as a moderator in the stress–burn out relationship: a questionnaire study on nurses. *Journal of Clinical Nursing***,** 21(1):2275-2285.

Guidroz, A.M., Wang, M. & Perez, L.M. 2012. Developing a model of source-specific interpersonal conflict in health care. *Stress and Health*. 28(1):69-79.

Gunnar, M.R. 1994. Psychoendocrine studies of temperament and stress in early childhood: expanding current models. (*In* Bates, J.E. & Wachs, T., *ed.* temperament: individual differences at the interface of biology and behaviour. New York: American Psychiatric Press. p. 175-198).

Gunlicks-Stoessel, M.L. & Powers, S.I. 2009. Romantic partners' coping strategies and patterns of cortisol reactivity and recovery in response to relationship conflict. *Journal of Social and Clinical Psychology*, 28(5):630-649.

Hall, E.J. 2004. Nursing attrition and the work environment in South African health facilities. *Curationis*, 27(1):29-36.

Hattingh, S., Dreyer, M. & Roos, S. 2010. Aspects of community health. 3rd ed. Cape Town: Oxford University Press.

Holdsworth, N. 2009. Compassion fatigue, vicarious trauma, secondary trauma, burnout. http://www.ejhealing.com/Documents/Compassion%20fatigue.pdf Date of access: 1 Jun. 2012.

Hunt, M.R. 2009. Strengths and challenges in the use of interpretive description: reflections arising from a study of the moral experience of health professionals in humanitarian. *Qualitative Health Research,* 19(9):1284-1292.

Hu, T., Zhang, D., & Wang, J. 2015. A meta-analysis of the trait resilience and mental health. *Personality and individual differences,* 76(1):18-27.

International Council of Nursing.. 2010. Nurse. http://www.icn.ch/about-icn/icn-definition-of-nursing/ Date of access: 12 Mar. 2013.

Jackson, D., Firtko, A. & Edenborough, M. 2007. Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *Journal of Advanced Nursing*, 60(1):1-9.

Jinbo, F., Changjian, Q., Huiqiong, X. & Guiying, Y. 2012. A model for predicting acute and chronic fatigue in Chinese nurses. *Journal of Advanced Nursing*, 69(3):546-558.

Johnston, D.W., Jones, M.C., Charles, K., McCann, S.K. & McKee, L. 2013. Stress in nurses: stress-related affect and its determinants: *The Society of Behavioral Medicine*, 45:348-356.

Jooste, K., ed. The principles and practice of nursing and health care: ethos and professional practice, management, staff development, and research. Pretoria: Van Schaik Publishers. P. 317-334)

Jordan, J.V. 1992. Relational resilience. Electronic version. http://www.wellesleystonecenter.com/pdf/previews/preview_57sc.pdf Date of access: 20 Jul. 2015

Kagee, A., Nothling, J., & Coetzee, B. 2012. The perspectives of users of antiretroviral therapy on structural barriers to adherence in South Africa. *South African Family Practice.* 54(6):540-544.

Klopper, H. & Knobloch, S. 2010. Validity, reliability and trustworthiness. (*In* Jooste, K., *ed.* The principles and practice of nursing and health care: ethos and professional practice, management, staff development, and research. Pretoria: Van Schaik Publishers. P. 317-334).

Klopper, H.C., Coetzee, S.K., Pretorius, R. & Bester, P. 2012. Practice environment, job satisfaction and burnout of critical care nurses in South Africa. *Journal of Nursing Management*, 20(1):685-695.

Koen, M.P. & Du Plessis, E. 2011. Strengthening the resilience of health caregivers and risk groups. Potchefstroom: NWU.

Koen, M.P., Van Eden, C. & Wissing, M.P. 2010b. The stories of resilience in professional nurses, submitted, 2010.

Koen, M.P., Van Eeden, C. & Wissing, M.P. 2011. The prevalence of resilience in professional nurses, *Health SA Gesondheid,* 16(1):1-11.

Komachi, M.K., Kamibeppu, K., Nishi, D. & Matsuoka, Y. 2012. Secondary traumatic stress and associated factors among Japanese nurses working in hospital. *International Journal of Nursing Practice*, 18(1):155-163.

Kowalski, C., Ommen, O., Driller, E., Ernstmann, N., Wirtz, M. A., Köhler, T. & Pfaff, H. 2010. Burnout in nurses – the relationship between social capital in hospitals and emotional exhaustion. *Journal of Clinical Nursing*, 19(1):1654-1663.

Kreigh, H.Z. & Perko, J.E. 1983. Psychiatric and mental health nursing: a commitment to care and concern. Virginia: Robert J Brady.

Laal, M. & Aliramaie, N. 2010. Nursing and coping with Stress. *International Journal of Collaborative Research on Internal Medicine & Public Health*, 2(5):168-181.

Laviola, G. & Macrì, S., *eds*. 2013. Adaptive and maladaptive aspects of developmental stress. Heidelberg: Springer.

Lees, N.F. 2009. The ability to bounce back: the relationship between resilience, coping, and positive outcomes. http://mro.massey.ac.nz/bitstream/handle/10179/1173/Thesis%20Full.pdf?sequence=1 Date of access: 15 Feb 2013.

Leedy, P.D. & Ormrod, J.E. 2005. Practical research: planning and design. 8th ed. New Jersey: Pearson Education.

Lepore, S.J., Fernandez-Berrocal, P., Ragan, J. & Ramos, N. 2004. It's not that bad: social challenges to emotional disclosure enhance adjustment to stress. *Anxiety, Stress & Coping: An international journal*, 17(1):341-361.

Lohr, J.M. 2007. Angry? Breathing beats venting. http://www.physorg.com/news91899145.html Date of access: 12 Jul. 2012.

Lombardo, B. & Eyre**,** C. 2011. Compassion fatigue: A nurse's primer. *Online journal of issues in nursing***,** 16(1):3-12.

Luthar, S., Ciccheti, D., & Becker, R. 2000. The construct of resilience: a critical evaluation and guidelines for future work. *Child development*, 71:543-562.

McDonnell, N.J., Kaye, R.M., Hood, S., Shrivastava, P. & Khursandi, D.C.S. 2013. Mental health and welfare in Australian anaesthetists*. Anaesth Intensive Care**,*** 41(1):641-647

McLeod, S.A. 2009. Emotion focused coping. www.simplypsychology.org/stress-management.html#em Date of access: 19 Jun. 2015

Meehan, S., Peirson, A. & Fridjhon, P. 2007. Suicide ideation in adolescent South Africans: the role of gender and coping strategies. *Journal of Psychology*, 37(3):552-575.

Merriam-Webster dictionary. Partner. http://www.merriam-webster.com/dictionary/partner Date of access: 1 Feb. 2013.

Neff, L.A., & Broady, E.F. 2011. Stress resilience in early marriage: can practice make perfect? *Journal of personality and social psychology*, 101(5):1050-1067.

Neff, L.A. & Karney. B.R. 2007. Stress crossover in newlywed marriage: A longitudinal and dyadic perspective*. Journal of marriage and family*, 69(1):594-607.

Nils, D. & Rimé, B. 2012. Beyond the myth of venting: social sharing modes determine the benefits of emotional disclosure*. European journal of social psychology*, 42(1):672-681.

Oliveira, J.D.C., Pessoa Júnior, J.M., Miranda, F.A.N., Cavalcante, E.S. & Almeida, M.G. 2014. Stress of nurses in emergency care: a social representations study. *Online Brazilian journal of nurses,* 13(2):146-53.

Online Oxford Dictionaries. 2013. Partner. http://oxforddictionaries.com/definition/english/partner Date of access: 1 Feb. 2013.

Online Oxford Dictionaries. 2013. Vent. http://oxforddictionaries.com/definition/english/vent?q=venting#vent Date of access: 5 Apr. 2013.

Oosthuizen, D. 2012. The portrayal of nursing in South African newspapers: a qualitative content analysis. *Africa journal of nursing and midwifery***,** 14(1):49-62.

Özden, D., Karagöglu, Ş & Yildirim, G. 2013. Intensive care nurses' perception of futility: job satisfaction and burnout dimensions. *Nursing ethics,* 20(4):436-447.

Powers, S. I., Pietromonaco, P. R., Gunlicks, M. & Sayer, A. 2006. Dating couples' attachment styles and patterns of cortisol reactivity and recovery in response to a relationship conflict. *Journal of personality and social psychology*, 90(1):613–628.

Rafferty, A. M., Clarke, S. P., Coles, J., Ball, J., James, P., McKee, M., & Aiken, L. H. 2007. Outcomes of variation in hospital nurse staffing in english hospitals: Cross-sectional analysis of survey data and discharge records. *International journal of nursing studies,* 44(1):175-182.

Rimé, B., Paez, D., Basabe, N., & Martinez, F. 2010. Social sharing of emotion, post-traumatic growth and emotional climate: follow-up of Spanish citizens' response to the collective trauma of March 11th terrorist attacks in Madrid. *European journal of social psychology*, 40(1):1029–1045.

Rimé, B., Finkenauer, C., Luminet, O., Zech, E. & Philippot, P. 1998. Social sharing of emotion: new evidence and new questions. (*In* Stroebe, W. & Hewstone, M., *eds*. European review of social psychology. Chichester: Wiley. p. 225-258).

Schäfer, J., Wittchen, H., Höfler, M., Heinrich, A., Zimmermann, P., Siegel, S. & Schönfeld, S. 2015. Is trait reliance characterised by specific patterns of attentional bias to emotional stimuli and attentional control? *Journal of behavioural therapy and experimental psychiatry*, 48(1):133 -139.

Singh-Manoux, A. & Finkenauer, C. 2001. Cultural variations in social sharing of emotions: an intercultural perspective on a universal phenomenon. Journal of cross-cultural psychology**,** 32(1):647-661.

Skinner, E.A., Edge, K., Altman, J. & Sherwood, H. 2003. Searching for the structure of coping: a review and critique of category systems for classifying ways of coping. *Psychological bulletin***,** 129(1):216-269.

Smit, R. 2005. HIV/AIDS and the workplace: perceptions of nurses in a public hospital in South Africa. Journal of advanced nursing**,** 51(1):22-29.

Snelgrove, S.R. 1998. Occupational stress and job satisfaction: a comparative study of health visitors, district nurses and community psychiatric nurses*. Journal of nursing management,* 6(1):97-104.

South African Nursing Council. Scope of practice. Government notice No 2598, as amended by No R. 1469, No R. 2676 and No R. 260.

Steenkamp, J.G. 2013. Investigating the psychological and social predictors of burnout among nurses. Stellenbosch: Stellenbosch University. (Thesis - Master).

Stuart, G.W. 2013. Principles and practice of psychiatric nursing. 10th ed. Missouri: Mosby Elsevier.

Sullivan, P.J. 1993. Occupational stress in psychiatric nursing. *Journal of advanced nursing***,** 18(1):591-601.

Suresh, P., Matthews, A. & Coyne, I. 2013. Stress and stressors in the clinical environment: a comparative study of fourth-year student nurses and newly qualified general nurses in Ireland: *Journal of clinical nursing*, 22(1):770–779.

Thorne, S. 2008. Interpretive description. California: Left Coast Press.

Tolpin, L., Cohen, L., Gunthert, K., & Farrehi, A. 2006. Unique effects of depressive symptoms and relationship satisfaction on exposure and reactivity to daily romantic relationship stress*. Journal of social and clinical psychology,* 25(1):565–583.

Towler, A.J. & Stuhlmacher, A.F. 2013. Attachment styles, relationship satisfaction, and well-being in working women. *The Journal of Social Psychology*, 153(3):279-298.

Tuncay, T., Musabak, I., Gok, D.E. & Kutlu, M. 2008. The relationship between anxiety, coping strategies and characteristics of patients with diabetes. *Health and quality of life outcomes*, 6(79):1-9.

Updegraff, J.A., & Taylor, S.E. 2000. From vulnerability to growth: positive and negative effects of stressful life events. (*In* Harvey, J. & Miller, E., *eds.* Loss and trauma: general and close relationship perspectives. Philadelphia:Brunner-Routledge. p.3-28).

Van der Colff, J.J. & Rothmann, S. 2014. Burnout of registered nurses in South Africa. *Journal of nursing management*, 22(1):630-642.

Van der Wath, A., Van Wyk, N. & Janse van Rensburg, E. 2013. Emergency nurses' experiences of caring for survivors of intimate partner violence. *Journal of advanced nursing,* 69(10):2242-2252.

Van Dyk, A.C. 2007. Occupational stress experienced by caregivers working in the HIV/AIDS field in South Africa. *African journal of AIDS research***,** 6(1):49-66.

Van Kessel, G. 2013. The ability of older people to overcome adversity: A review of the resilience concept. *Geriatric nursing*, 34(1):122-127.

Venter, N., & Snyders, R. 2009. Resilience in intimate relationships. *Sabinet online*, 5(1):63:85.

Walsh, F. 1996. The concept of family resilience: crisis and challenge. *Family process*, 35(3):261-281.

Walsh, F. 2006. Strengthening family resilience. 2nd ed. New York: Guilford Press.

Warner, R. 2011. Building personal resilience of staff to ensure successful organisational change. *Convergence*, 8(2):50-53.

White, L., Duncan, G. & Baumle, W. 2011. Foundations of basic nursing. 3rd ed. New York: Delmar.

World Health Organization. 1948. Constitution of the World Health Organisation. Geneva. http://www.who.int/about/definition/en/print.html Date of access: 25 May**.** 2013.

Zech, E. & Rimé, B. 2005. Is talking about an emotional experience helpful? Effects on emotional recovery and perceived benefits. Clinical psychology & psychotherapy**,** 12(1):270–287.

Zeidner, M. & Hammer, A.L. 1992. Coping with missile attack: resources, strategies, and outcomes. *Journal of* personality, 60(1):709-746.

SECTION 2

MANUSCRIPT:

Coping experiences of partners of professional nurses venting traumatic information to them.

Authors note:

The following manuscript will be submitted to “Health SA Gesondheid” and will be formatted according to the authors’ guidelines (Appendix H and I), with the exclusion of line numbering.

Coping experiences of partners of professional nurses venting traumatic information to them

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ABSTRACT

Background: Professional nurses who are employed in trauma units face many stressors in their workplace and apply different methods to cope with this stress. One of these methods is to vent their traumatic information to their partners and other family members. The researcher could not find any current studies on how partners of these professional nurses cope with traumatic information being vented to them.

Objective: To explore and describe how partners of professional nurses cope with the professional nurse venting traumatic information to them.

Method: A qualitative research method with an interpretive descriptive inquiry design was used to explore, interpret and describe the coping experiences of the partners. Purposive sampling was used to select partners (N=14; n=10) to partake in semi-structure interviews. Tesch's eight steps of open coding were used to code each transcription and to analyse the data. An independent experienced co-coder analysed the data using a protocol; consensus was reached between the researcher and the co-coder on the themes and sub-themes that emerged from the data.

Results: Four main themes were identified from the data. 1) How partners experience traumatic information that the nurses vent to them. 2) Partners' personal coping skills and strategies. 3) Reciprocal communication and relationship support between partners and nurses. 4) Partners need resilience in dealing with the professional nurses' occupation.

Conclusion: It was found that partners employ many different ways to cope with traumatic information. It is also essential for partners to develop their resilience in view of the fact that they fulfil a supportive role in their relationship with the professional nurse. Recommendations were formulated to strengthen their coping skills in order to build better resilience. This will consequently also improve the support they afford the professional nurses.

Keywords: partner, professional nurse, venting, coping, resilience

OPSOMMING

Agtergrond: Professionele verpleegkundiges wat in trauma-eenhede werk, word aan baie verskillende stressors in hul werkplek blootgestel. Tog hanteer professionele verpleegkundiges hierdie stressors op verskillende maniere. Een van die metodes wat professionele verpleegkundiges gebruik is om teenoor hul lewensmaats te “vent” of stoom af te blaas oor die dag; sodoende deel hulle die traumatiese inligting van die dag met hul lewensmaats.. Die navorser kon egter geen hedendaagse studies vind oor die lewensmaats van professionele verpleegkundiges se hantering van die traumatiese inligting wat hulle aanhoor nie.

Doelwitte: Die doel van die studie is om die lewensmaats van professionele verpleegkundiges se hantering van die uitwoed (“venting”) van traumatiese inligting te verken en te beskryf.

Metode: 'n Kwalitatiewe metode met 'n interpretatiewe beskrywende ondersoek-benadering is gebruik om te verken, te interpreteer en te beskryf hoe lewensmaats die traumatiese inligting hanteer. Doelbewuste steekproefneming is gebruik om lewensmaats te kies (N = 14; n = 10) om aan die studie deel te neem. Die navorser het semi-gestruktureerde onderhoude met die lewensmaats gevoer. Tesch se agt stappe van oopkodering is gebruik om elke transkripsie te kodeer en die data te analiseer. ‘n Onafhanklike, ervare mede-kodeerder het die data met die hulp van 'n protokol wat die navorser verskaf het, ontleed; konsensus is oor die temas en sub-temas wat uit die data na vore gekom het, bereik.

Resultate: Die volgende vier hooftemas is uit die data geïdentifiseer: 1) Hoe lewensmaats die traumatiese inligting wat hulle by die professionele verpleegkundiges hoor, ervaar; 2) Die lewensmaats se persoonlike hanteringsvaardighede en -strategieë; 3) Wedersydse kommunikasie en verhoudingsondersteuning tussen die lewensmaats en die professionele verpleegkundiges; en 4) Lewensmaats het veerkragtigheid nodig om die professionele verpleegkundiges se beroepe te kan hanteer.

Gevolgtrekking: Die navorser het gevind dat lewensmaats die traumatiese inligting op baie verskillende maniere hanteer. Verder het die lewensmaats 'n groot behoefte om hul veerkragtigheid te ontwikkel as gevolg van die ondersteunende rol wat hulle in hul verhoudings met die professionele verpleegkundiges vervul. Die navorser het aanbevelings

geformuleer om die hanteringsvaardighede van ander lewensmaats te versterk sodat, oor die lang termyn, hulle veerkragtigheid ook versterk kan word.

Sleutelwoorde: lewensmaat, professionverpleegkundige, uitwoed (venting van emosies), hanteringsvaardighede, veerkragtigheid.

INTRODUCTION

Resilience is the human capacity to adapt, thrive and "maintain relatively stable, healthy levels of psychological functioning" in response to potentially traumatic events (Bonanno 2004). This study explored and described how partners cope with professional nurses venting traumatic stories to them. How partners "bounce back" from what they hear with the aim of still fulfilling the important role of supporting the professional nurses who work in trauma units (Dyer & McGuinness 1996). However, no studies were found on the experience of being the partner of a professional nurse and how such a partner copes after listening to accounts of traumatic events that the professional nurse experienced during her shift in the trauma unit. This study is thus unique in its objective to determine how partners cope and how their coping could assist other partners.

Setting

In the section to follow, the full background and context of the study will be discussed with the aim of clarifying all aspects of this study.

Key focus

This study aims to explore and describe the coping experiences of partners of professional nurses venting traumatic information to them in order to make recommendations to strengthen the partners' resilience.

Background

Nursing is not just a profession but also a calling. Nurses enter the nursing profession with the hope that they will make a difference in the lives of their patients by caring for and meeting the patients' physical, emotional, mental and spiritual needs (Lombardo & Eyre 2011). However, this is not always the reality of the profession. Although nursing does have a side that rewards, studies have shown that a significant part of nursing can be unrewarding and stressful (Komachi, Kamibeppu, Nishi & Matsuoka 2012; McIntosh & Sheppy 2013). As mentioned previously, professional nurses are confronted daily with many different stressors in their workplace such as conflict with physicians, problems with peers and supervisors, discrimination, heavy workload, long working hours, having insufficient resources with

which to perform their work productively, a shortage of equipment and supplies, dealing with difficult patients, traumatic situations, sickness, dying patients, death and families (Suresh, Matthews & Coyne 2013; Johnston, Jones, Charles, McCann & Mckee 2013; Jinbo, Changjian, Huiqiong & Guiying 2012; French, Lenton, Walters & Eyles 2000). Some specialised nursing such as trauma nursing, midwifery, intensive care and theatre nursing is known to cause professional nurses even more stress and trauma due to the highly stressed nature of the environments (Van der Wath, Van Wyk & Janse van Rensburg 2013).

Since trauma nurses' environment is filled with daily challenges, they must be able to think on their feet to save lives. They are often the first line of contact when a patient arrives at the hospital (Oliveira, Pessoa Junior, Miranda, Cavalcante & Almeida 2014). Professional nurses also see patients when at their most vulnerable; they arrive with broken bodies, broken souls and/or are severely traumatised. This situation calls on professional nurses to not only deal with their primary responsibility of attending to the patient who was the victim of a traumatic event such as an accident, abuse or severe illness, but to also attend to the families who anxiously await news (Oliveira *et al.* 2014; Van der Wath *et al.* 2013).

Many researchers have studied professional nurses, focusing on how they experience their workplaces, on their work satisfaction and also on how they cope with work stressors, since these are very prominent challenges and concerns when working as a professional nurse (Teo, Pick, Newton, Yeung & Change 2013). These stressful experiences often create scenarios that professional nurses could experience as a traumatic event, leaving them with feelings and thoughts of helplessness (Komachi *et al.* 2012). When professional nurses are constantly bombarded with and exposed to these types of stressors, it may cause many different emotional or psychological disorders among them, such as compassion fatigue, post-traumatic stress disorder (PTSD), secondary traumatic stress (STS) and burnout (Özden, Karagoglu & Yildrim 2013; Klopper, Coetzee, Pretorius & Bester 2012; Lombardo & Eyre 2011). Consequently, professional nurses apply different techniques to cope with what happens at work. One of these means of coping is to share their experiences with other colleagues and family members (Laal & Aliramaie 2010), but especially with their partners, for the reason that their partners are their first contact after a day's work. The professional nurses then take comfort in confiding in their partners, who make them feel safe and cared for

(Laal & Aliramaie 2010). Therefore partners do not only share in what was pleasurable at work, but also in what was hard or even traumatic.

Venting, also known as social sharing, is recognised as one of the primary ways of coping and also of connecting with people (Lohr 2007; Nils & Rimé 2012). When venting to a partner with whom one has an emotional connection, the partner not only listens but also connects emotionally and sympathises with the person venting.

When professional nurses vent traumatic experiences, they also expose their partners to the traumatic event; this is known as secondary trauma. Secondary trauma can be described as behaviour and emotions resulting from knowledge about a traumatising event experienced by a significant other, or by identifying with the experiences and feelings of a direct victim [in this study the professional nurses working in a trauma unit] (Holdsworth 2009; Carll 2000; Figley 1999; Figley 1988). However, not much is known about the effect of this phenomenon on the partners of professional nurses. According to Figley and Figley (2009), the partners will become empathetically involved, reliving the event with the professional nurses; this may cause the partners to be indirectly traumatised by the exchange of information. This can potentially have a profound effect on the partners in terms of their own emotional and physical lives. The opposite of this is, however, also true; partners may be resilient and able to cope very well with what they have been told.

Resilience is the human capacity to adapt, thrive and "maintain relatively stable, healthy levels of psychological functioning" in response to potentially traumatic events (Bonanno 2004). Having to cope with traumatic information can be stressful at times. Studies have shown that couples who suffer from high levels of stress experience their relationships as less satisfactory (Neff & Karney 2007). However, even though many relationships crumbled under stress, others were unharmed and even grew more resilient in terms of facing future stressors. It was suggested that stressful events could afford both individuals, as well as the relationship, the opportunity to improve their coping skills and resilience (Neff & Broady 2011). This study is a sub-study of the RISE study (strengthening the resilience of health caregivers and risk groups) (Koen & Du Plessis 2011). Various research has proven the importance hereof, since it was found that relationships are a very important source of life

satisfaction, happiness and general well-being for both parties (Koen & Du Plessis 2011; Powers, Pietromonaco, Gunlicks & Sayer 2006; Tolpin, Cohen, Gunthert & Farrehi 2006). This could ultimately assist both in using their coping skills to increase their confidence and strengthen their resilience as well as that of their relationship

Trends

Coping is an extremely extensive topic that is applicable to many settings (Kato 2015). No research could be found on how partners cope with traumatic information. Thus the researcher looked at the general coping concept in relationships and of people hearing about traumatic information.

Coping is defined by Chesney, Neilands, Chamber, Taylor & Folkman (2006) as a behavioural or cognitive effort to manage situations that are seen as stressful. Where the external and/or internal demands of the situation exceed the person's resources. Coping has also been defined as a response aimed at diminishing the physical, emotional and psychological burden that is associated with stressful life events (Tuncay, Musabak, Gok & Kutlu 2008). Therefore coping is the process of interaction between a person, the situation and is dependent on a person's perceived ability to manage the stressor (Meehan, Peirson & Fridjhon 2007).

Coping is an active process and exists out of different types of coping mechanisms. There are two main categories under which coping mechanisms fall that play an important role in how a person copes after hearing about trauma or after going through a stressfull situation. These coping mechanisms are called adaptive and maladaptive coping mechanisms (Stuart 2013; White, Duncan & Baumle 2011). Adaptive coping mechanisms deal with the stressors directly to solve the stress or elevate it. Adaptive coping is also seen as the more positive way of coping as it deals with the stressors (White *et al*. 2011). Whereas, maladaptive coping mechanisms are seen to be more negative in some instances, this is coping were the stressor is avoided and may prevent progress towards resolving and accepting stress (White *et al*. 2011). Chesney *et al.* (2006) found that maladaptive coping occurs when people fail to deal with or manage their underlying stressors.

We daily apply coping to all aspects of our lives. Important for this study is to see how people cope in their relationships. Researchers found that individuals who experience stress in their relationships or family lives and manage to cope well with that stress, improve their

relationships and family support and reduce family conflict (Neff & Broady 2011). It is thus important for partners to have good coping skills in order to support each other in times of stress or, as in the case of this study, when partners need to support professional nurses by listening to them when they vent traumatic information. When a couple use adaptive coping mechanisms in their relationship and receive sufficient support from one another, their physiological stress will be reduced (Gunlicks-Stoessel & Powers 2009; Gunnar 1994). The ultimate goal is for a couple to have stronger coping skills as individuals and as a couple, enabling them to not just cope better, but also to live life to the full. This will also make them more resilient in themselves and in their relationship.

Laviola and Macrì (2013) mention that the way in which people control their stressors has a direct effect on whether they will build resilience or not. Research found that building your adaptive coping mechanisms will also contribute to increasing your resilience (Laviola & Macri 2013). This could aide people who frequently experience stressful events, such as the partner of a professional nurse who often has to listen to the nurse venting traumatic information. Learning to cope with this will enable the partner to more effectively deal with the information. In addition it serves as experienced gained when having to cope with other stressful experiences in life. Experience in dealing effectively with moderate-level stressors may protect partners against the potentially harmful effects of compounding emotions as a result of unresolved stressors (Updegraff & Taylor 2002). Dealing with stressors or protecting oneself by using adaptive coping strategies include having knowledge about and using more of these strategies, having confidence in one's ability to deal with events as a result of previous experience and knowing how to correctly evaluate potential threats (Updegraff & Taylor 2002). In other words, using coping mechanisms to build resilience toward stress (Laviola & Macri 2013).

Research objective

To explore and describe how partners of professional nurses cope with the professional nurses venting traumatic information to them.

Problem statement

The nursing profession is often a demanding, stressful and even a traumatic work environment (Suresh *et al.* 2013; Johnston *et al*. 2013; Jinbo *et al.* 2012; Laal & Aliramaie

2010). This is due to the different stressors and traumas to which professional nurses are exposed to every day. These stressors include having to deal with difficult patients, sickness, dying patients, death and families (Komachi *et al.* 2012; McIntosh & Sheppy 2012). Professional nurses working in a trauma unit, in particular, experience this, given that a high levels of stress is part and parcel of trauma units (Oliveira *et al*. 2014). According to Laal and Aliramaie (2010), nurses can cope with stress in many ways, of which one is nurses finding safety and relief through venting their traumatic experiences to their families or partners.

The partners of professional nurses find themselves in a difficult situation, seeing that they are often the professional nurses' first line of contact after a day's work. Often both partners exchange stories and thoughts about their day at work. The professional nurse's venting of traumatic information to his/her partner, who then empathises with the professional nurse, may expose also the partner to the traumatic information. Holdsworth (2009) explains that when traumatic information is shared, the person listening may experience feelings of being emotionally overwhelmed. If this happens often, it can cause the listener to develop stress disorders such as secondary trauma, emotional fatigue or even burnout (Holdsworth 2009). Research lacks in the area of understanding the coping skills that partners use when professional nurses vent traumatic information to them.

Contribution to field

The contribution of this research is embedded in the benefits it affords both the partners of professional nurses and the professional nurses themselves. The partners who participated in the study may benefit by being empowered to identify their coping skills and to strengthen them, which in turn will strengthen their resilience. Implementing the recommendations to strengthen the coping skills of partners may also benefit the professional nurses in that a stronger support system is built at home, enabling them to be more resilient in the workplace.

RESEARCH METHOD AND DESIGN

Materials

Data was collected by conducting semi-structured individual interviews with the partners of professional nurses working in trauma units.

Setting

This study was conducted in the emergency units of two private hospitals in the Gauteng Province. Professional nurses who were working in the unit at that time were approached. Fourteen professional nurses were involved in a relationship at the time; 10 of the professional nurses' partners volunteered to take part in the study. English is the predominant language spoken in the unit.

Design

A qualitative design with an interpretive descriptive approach was used to explore, interpret and describe the coping experiences of partners of professional nurses venting traumatic information to them. This specific design was used to search for meaning and to gain an understanding (Thorne 2008) of the experiences of partners of professional nurses. This approach also assisted the researcher in observing patterns of human behaviour (Thorne, 2008). According to Hunt (2009), the interpretive description approach examines an occurrence with the goal of identifying themes and patterns among subjective perspectives, while also accounting for variations between individuals. This approach was thus suitable for this study that explored a mutual coping pattern between partners.

Procedure

The researcher obtained ethical approval from the Health Research Ethics Committee (HREC) of the North-West University (NWU) NWU-00036-11-S1 under the RISE study NWU-00036-11-A1, (strengthening the resilience of health caregivers and risk groups). She also obtained ethical consent from the ethical board of the private hospital group. Before commencing data collection, the researcher gained entry to the facilities (Botma, Greef, Mulaudzi & Wright 2010) by contacting the unit managers and/or chief professional nurses of the two private hospitals. The head office of the private hospital group was contacted to obtain approval to continue with the study. Head office required a written letter of permission from the unit managers and/or chief professional nurses. After obtaining the required letters, the head office ethical board granted the researcher full consent. The researcher then identified the primary mediator. This person was the unit manager of each the emergency unit. The mediator arranged with the professional nurses of each shift to meet with the researcher after handover. The researcher then explained the research to the professional

nurses and handed them informed consent forms in a sealed envelope that their partners needed to complete. This process made the professional nurses the secondary mediators; they relayed the information to their partners so that the partners could make a decision with regard to taking part in the study. All professional nurses were asked to return the signed informed consent forms including their partners' details, sealed in an envelope.

The researcher contacted the respective unit manager/chief professional nurse after seven days to collect the informed consent forms and to thank them for their help in collecting of the forms. Purposive sampling was used. The sample size (N=14; n=10) was determined once the researcher was confident that the number of participants represented the population as close as possible and when information saturation was reached. The researcher made telephonic contact with each participant to arrange a suitable date and time to meet at the respective private hospital for a semi-structured personal interview. Prior to scheduling the interviews, the researcher arranged for suitable venues with the particular unit manager or chief professional nurse of each facility. The researcher ensured that comfortable, private venues were selected, where the scheduled interviews would not be interrupted (Botma *et al*. 2010). Conference rooms and/or offices in the facility were used.

The researcher prepared an interview schedule for the semi-structured interviews and made preparations to voice record each interview (Botma *et al*. 2010). The researcher welcomed the participant and again briefly explained the structure of the interview and the purpose of the research. The researcher then obtained the participant's verbal consent with regard to his or her willingness to participate and be voice recorded. Ethical considerations were also mentioned again to ensure that participants were completely willing to participate and knew that they could leave at any stage of the interview. The researcher also informed them that emotional support would be provided if they needed it (Botma, *et al*. 2010). The researcher explained all of this in either English or Afrikaans, depending on the participant's home language. Finally, all partners were reminded to ensure that they indeed signed the informed consent forms voluntary before participation.

A semi-structured personal interview was conducted with each participant. The researcher made field notes during and after each interview to ensure rich the data collection (Botma *et*

al. 2010). All questions were asked in a polite and conversational manner. Communication techniques such as exploring, clarifying, reflecting and summarising were used, as described by Kreigh and Perko (1983).

Data analysis

The digital recordings were transcribed verbatim for analysis by the researcher and a co-coder. The field notes were also analysed and compared (Burns & Grove 2005). Data analysis was done by using the eight steps of Tesch's data analysis method (Creswell 2009; Creswell 2003). Tesch's eight steps of open coding were used to code each transcription.

RESULTS

The findings of this research originated from the participants' responses during their semi-structured interviews. Four main themes emerged from the data (see table 2.1). The main objective of the study was to explore and describe the coping experiences of partners of professional nurses venting traumatic information to them. The four themes that emerged from the interviews with the nurses' partners were then further divided in to sub-themes that are applicable to the objective of the study. The main themes and sub-themes are described in table 2.1.

Table 2.1: Overview of the main themes and sub-themes

Main themes	Sub-themes
1. How partners experience traumatic information vented to them by the nurses.	1. Partners' primary experience of the shared traumatic information • Shocked • Did not pay attention • Interested and excited 2. Secondary experience and behaviour of shared traumatic information • Desensitised • Adapted to become more resilient • Gained enjoyment and knowledge by listening to the information

2. Partners' personal coping skills and strategies.	1. Coping activities • Physical activities • Detachment • Research about information shared • Personality traits • Personal control and boundaries • Compartmentalise 2. Support system • Personal support • Support for others • Life experience
3. Reciprocal communication and relationship support between partner and nurse.	1. Effective communication 2. Relationship support • Emotional support • Interpersonal relationship support
4. Partners need resilience in dealing with the professional nurses' occupation.	1. Changed support systems • Lack of support between nurses 2. Nurses' job description • Different from other professions; more traumatic

Theme 1: How partners experience traumatic information vented to them by the nurses

The participants explained how they experience listening to traumatic information vented to them by the nurses (their partners). The participants' initial experiences included the following: half of the participants expressed the feeling of being shocked (five reports); only one participant did not pay any attention to the information (one report); and the other participants found the information interesting and exciting to listen to (four reports). The following quotes denote this theme. The codes used to identify the different participants are indicated alphabetically (Prt A to Prt J).

> "... in the beginning I [the partner] was more shocked about the things she [the professional nurse] told me ..." (Prt F).

> "... so I didn't give a lot of attention to the information ..." (Prt E).

> "Well at first I [the partner] found it a bit exciting actually. I enjoyed all the stories she [the professional nurse] would tell" (Prt H).

Literature confirms that most people's initial response to traumatic information is shock (Tolpin *et al.* 2006). Collins and Long (2003) further mention that some people who do not contend with traumatic information on a daily basis choose to ignore such information in an attempt to protect themselves. It is also evident from Davis and McLeod's research (2003) that in the day and age we live in, we crave sensational information. It is thus no wonder that most of the time partners find the traumatic information that the nurses share sensational and out of the ordinary.

The participants reported specific behaviours as a means of coping while trying to adapt to their initial experiences of the traumatic information. These behaviours included becoming desensitised (three reports), becoming more resilient (three reports) and gaining enjoyment and knowledge by listening to the professional nurses (two reports).

> "I [the partner] got more and more desensitised to what she [professional nurse] would tell me" (Prt G).

> "... actually dating a nurse you become more resilient in life" (Prt F).

> "... I [the partner] have learned over time what happens at work and what needs to happen in specific trauma situations, and so I can talk with her [the professional nurse] about it and ask her question about it" (Prt J).

Literature reports that people who are exposed to traumatic information over a prolonged period of time become desensitised to the information as a way to cope with it (Foa & Hearst-Ikenda, 1996). Neff and Broadly (2011) found that people who are exposed to moderate

stressors and learn from the experience, gain the ability to become more resilient and to even change their view of the stressor into an informative understanding.

Theme 2: Partners' personal coping skills and strategies

The participants indicated different coping skills for managing the traumatic information that was vented to them. The following coping skills were identified: partaking in physical activities (five reports); detaching oneself from your own feelings (one report); compartmentalising the feelings (one report); setting boundaries with regard to what can and may be talked about (three reports); and doing research on the information shared by the professional nurses (two reports). In addition, some of the participants were of the opinion that coping mechanisms depended on certain personality traits such as having an open personality (one report), having a strong personality (three reports), being analytical (two reports) and being practical (one report). Other participants felt that their life experience help them to cope better with traumatic information (two reports). The following quotes best represents this theme:

> "It helps to walk and get some of my own frustration out; away from life and work and all that but also outside is a calming place. I find nature to be a very good way to connect and destress" (Prt F).

> "I [the partner] don't get emotionally involved in the details, and I detach from the information she [the professional nurse] gives me and rather deal with her and her emotions ..." (Prt H).

> "... to have strongest personality trait would be to firstly and compartmentalise different parts of your life ..." (Prt D).

> "So the first thing I [the partner] did was set boundaries" (Prt D).

> "I [the partner] have had that interest and would read up about CPR and medical things ..." (Prt G).

"I [the partner] learned about what happens at her [the professional nurse] work and what needs to be done; by doing this I can now ask her more questions about her day and learn more" (Prt J).

"… a strong personality handles the information better and easier" (Prt E).

"... life experience taught me a lot about how to cope ..." (Prt E).

A vast amount of literature confirms that physical activity not only helps one to cope more effectively with daily stressors, but it also promotes one's physical and mental health (Thome & Espelage 2004). Additionally, literature identified the following adaptive and maladaptive coping mechanisms that people use in stressful situations: detachment, compartmentalising of feelings, boundary setting and gathering information about the traumatic event (Bolger 1990; Compas, Connor-Smith,Saltzman,Hardingb & Wadsworth 2001; Galor 2015; Gunlicks-Stoessel & Powers 2009; Skinner, Edge, Altman & Sherwood 2003). Klimstra, Luyckx, Branje, Teppers, Goossens & Meeus (2013) support the participants' view that specific personality traits enable one to cope with traumatic information or events. Hu, *et al.* (2015:20) hold forth that it all starts by gaining maturity in life [life experience]. Such experience will assist a person in managing stressful situations more effectively.

Theme 3: Reciprocal communication and relationship support between partner and nurse

Participants reported that the dynamics of their relationships with the professional nurses also played an important role in how they coped with traumatic information. All the participants strongly felt that effective communication between themselves and the professional nurses is a fundamental aspect in the entire process (six reports). The following quotes support this theme:

"And learn how to listen" (Prt G).

"Good communication. Just open the line of communication" (Prt A).

"... communicating is important ..." (Prt F).

Literature confirms that effective communication between partners may have a significant impact on relationship satisfaction (Peterson 1997). Effective communication does not only involve conveying a clear message, but also being able to listen actively to what is being said (Peterson 1997).

The participants emphasised the importance of interrelationship support when it comes to having to cope with stressful events. The participants explained the importance of this aspect as follows: partners would find a sense of belonging by giving the nurses emotional support (three reports); other participants felt that giving emotional support to the nurses helped their relationship (two reports); both partners must make an effort to spend time together (one report); and some of the participants felt strongly about supporting the professional nurses by showing them affection (four reports). The following quotes illuminate this theme:

"The fact that she [the professional nurse] is now giving [information] without me asking gives me a sense of purpose like I'm her protector" (Prt H).

"… it helps the relationship to be understanding and supportive (Prt A).

"You [the partner] got to have time for her [the professional nurse], make time; they work different hours to what you do" (Prt I).

"Um, ja, just show her [the professional nurse] you love her" (Prt J).

"... or even just take her [the professional nurse] out, run her a bath; that way I [the partner] did something to make it better for her ..." (Prt H).

Johnson (2002) reports that being in a relationship has many aspects that can make a partner feel fulfilled in and satisfied with the relationship. Research found that relationship satisfaction increases when partners feel that they have a definite role or a purpose to fulfil in the relationship. Literature also highlights the following relationship principles: Partners

should plan to spend quality time with one another and know what their own and their partner's love languages are in order to show effective affection (Johnson 2002; Chapman 2015).

Theme 4: Partners need resilience in dealing with the professional nurses' occupation

The participants indicated that, due to certain distinctive traits of the professional nurses' occupation, they needed to be more resilient in their relationships with the professional nurses. The participants provided the following reasons for why they felt they should be more resilient: Many of the participants felt that the nurses lack proper support in the workplace and that they (the participants) had to fulfil this role (six reports). Participants unanimously agreed that the nursing profession is a highly stressful and traumatic environment. They therefore need to be more resilient since they are being exposed to traumatic information in their relationships with the professional nurses (10 reports). The following quotes relate to this theme:

> "Yes, you are the one that they confide in and share events from work that they might not even share with colleagues ..." (Prt A).
>
> "You see you are the only one some days that they can talk to ..." (Prt G).
>
> "... because partners of other professions don't hear about horror stories that happened at the work of a nurse ..." (Prt B).
>
> "Other professions don't bring so much stories with them home ..." (Prt E).
>
> Also it's not like other professions; nurses work with real people and their lives so it's much more life and death" (Prt G).
>
> "Yea, in a way a partner of any person in the medical profession that deals with guts and gore needs to have a stomach to deal with this" (Prt H).

Literature confirms that professional nurses face a variety of stressors in their workplace. A number of studies also showed that the lack of support from management and colleagues in the work environment is an eminent stressors (De Wet & Du Plooy 2012; Delobelle, Rawlinson, Ntuli, Malatsi, Decock & Depoorter 2009; Van Dyk 2007). Nurses are believed to experience more stress than people in most other professions due to the nature of their profession (Van der Colff & Rothman 2014). Literature further reports that stressors to which nurses are exposed may include death and dying patients, as well as other stressors such as an excessive and unfair workload, shift work, feeling that one's work is not valued, sleep deprivation, prolonged working hours, dealing with difficult patients, infectious and dangerous occupational risks, professional conflict between staff, lack of job control, role ambiguity, a mismatch between training and job requirements, conflict with other roles and a shortage of staff (Cheng, Tsui & Lam 2015).

ETHICAL CONSIDERATIONS

The research was conducted under the ethical approval number NWU-00036-11-S1, which was obtained from the Health Research Ethical Committee of NWU. Approval was also granted from the RISE study, ethical number NWU-00036-11-A1, to conduct this study as a sub-study of the RISE project. The researcher took the participants' right to self-determination, their right to privacy, their right to anonymity and confidentiality, their right to fair treatment and their right to protection from discomfort and harm into account throughout the research (Burns & Grove 2009).

Potential benefits and hazards

This study has no financial or remuneration benefits. However, a direct benefit that may affect the participants is developing a deeper understanding of their own coping skills. The results of this study feeds into the need to understand the coping experiences of partners of professional nurses, and may assist in strengthening their coping skills and resilience.

A possible risks of the study was that the participants could experience emotional discomfort when sharing their experiences. To ensure that non-maleficence prevailed, the researcher ensured that no emotional or psychological harm was done to the participants by giving the

participants the opportunity to attend debriefing sessions after each interview, if they needed to (Jooste 2010).

Recruitment procedure

The researcher ensured fair selection and treatment in the way she interacted with the participants by allowing all participants who met the inclusion criteria to take part in the study. The researcher treated all the participants with respect at all times. The recruitment procedure was fully discussed under "procedures".

Informed consent

The researcher respected the participants' right to protection from discomfort and harm by providing each participant with a fully informed consent form before the interviews. Informed consent was furthermore reconfirmed on the day of the interview. The researcher brought the signed copy of each participant's consent form along and verbally went through the consent form again.

Data Protection

The researcher respected the participants' right to privacy by conducting each interview in a private venue with the door closed. The researcher also explained to each participant that the results of the research may be published, but that their names and the names of the facilities at which their nursing partners' work will be kept confidential at all times. The participants' right to anonymity and confidentiality was respected at all times. The researcher did not use any of the participants' names at any stage when transcribing the data. Code names were used. All data was protected by storing it in a safe place for data analysis. The confidentiality of the research data was further ensured by requesting the person who acted as co-coder of the interviews to sign a confidentiality declaration.

All the data was coded and stored on a computer that is password-protected. All hard copies of the data, as well as computer data that was saved on a disc, were locked in a cabinet in a locked room. Once recorded data was transcribed, it was deleted from the audiotape. Hard copies and electronic data will be stored for seven (7) years in the North-West University

(Potchefstroom Campus) archives. All data was stored at the INSINQ Focus Area Directors office of the North-West Universities Nursing faculty in a locked cabinet.

TRUSTWORTHINESS

Validity

Trustworthiness can be measured by way of the following criteria: credibility, transferability, dependability and confirmability (De Vos, Strydom, Fouché & Delport. 2011). Credibility was achieved by completing a comprehensive literature review. The researcher's supervisor and other peers also reviewed and verified the findings. In addition, during the process of data collection and analysis, the researcher bracketed or suspended all previous assumptions and beliefs in order to be completely open to and submerged in the phenomenon (Brink, Van der Walt & Van Rensburg 2006). The researcher ensured all participants' confidentiality by not using their names but code names (Botma *et al*. 2010).

Transferability was achieved by using thick/dense descriptions throughout the study (Botma *et al*. 2010). The researcher also structured a detailed database during the course of the study. In addition, the researcher applied international standards for research so that findings may be used in other relevant studies (De Vos *et al.* 2011).

The researcher achieved dependability by having clear descriptions of the methods used in gathering, analysing and interpreting the data. The researcher also provided precise and comprehensive reporting of the data. In addition, the researcher documented the research process and findings in such a way that other researchers would be able to follow the research steps of this study without error (De Vos *et al.* 2011). The researcher also used the services of a co-coder. In addition, the study leaders peer reviewed the study throughout the process (Botma *et al*. 2010). To ensure confirmability in this study, the researcher asked the study leaders to review the findings, conclusions and recommendations made by the researcher to ascertain that it was supported by the data and that the researcher's interpretation of the data was relevant (Botma *et al*. 2010).

DISCUSSION

Outline of the results

In light of the fact that literature lacks on the topic of this research study, the findings of the study can be used as a helpful foundation for a variety of other research projects. In studying the ways in which partners cope with traumatic information, the researcher found that there is not one specific strategy that partners follow to cope, but rather that different aspects contribute to their effective coping. The researcher would like to highlight that it is important to focus on people's initial reactions to traumatic information and to start teaching effective coping without delay. If partners do not have effective coping skills, they often adopt maladaptive coping skills in order to cope with the information, which can, in the long-term, negatively impact on the partner and the relationship.

Theme 2 showed that it is true to human nature to adapt rapidly and to learn how to cope with situations more effectively. It was shown that a person [the partner] builds his/her coping skills from many different aspects and facets of a single life. Literature shows that by doing this and by building on these coping mechanisms, one can improve resilience and better cope with stressful events in the future. It was also noted that a person [the partner as well as the professional nurse] not only copes as a result of internal coping skills, but also as a result of fulfilling a supportive role or being supported by others. It was found that by gaining life experience when going through stressful situations, a person [the partner] learns new coping skills that assist in becoming more resilient.

Theme 3 also highlighted that the dynamics which are part of an intimate relationship play an important part in how partners cope with traumatic information. It was observed that if the partners in a relationship have effective coping skills, it is indeed transferred to their personal and work lives, enabling them to cope better with stressors. It was also established that partners felt the need for specific systems in a relationship such as effective communication, quality time, mutual support, relationship roles and knowledge, all of which are seen as means of showing affection to the other partner.

Theme 4 highlighted the importance of being resilient for the sake of one's partner. The reality of what professional nurses are exposed to every day was brought to light. It was

evident that the stressors to which professional nurses are exposed do not affect them alone, but also their partners with whom they share this information, and who then also need to deal with it. Professional nurses lack support in the workplace. As a result they seek that the support they need from their partners, who have to deal with that responsibly.

LIMITATIONS OF THE STUDY

- The study was only conducted in two private hospital facilities in Gauteng, thus limiting this study's findings to these specific settings and to only emergency nurses and their partners. However, the information can be extrapolated to other settings and nurses by making minor adjustments.
- Since only male participants volunteered to take part in the study, the viewpoints of female partners were not obtained.
- It was difficult to find willing participants for the study, even though data saturation was obtained.

Recommendations

Recommendations to improve nursing practice

It is essential to improve the support structures of nurses who work in an emergency care unit;

- They should be afforded the opportunity to be debriefed at the hospital. Support sessions could also be convened so that the nurses can talk about what had happened at work.
- Monthly "emotional check-in sessions" should be scheduled with the sister in charge during which any ongoing problems can be discussed and, if need be, referred to a pshycologist or counsellor to facilitate emotional problems.
- Hospital personnel should conduct a workshop for family members every four months to discuss different topics such as effective coping, communication skills and boundary setting, among others.

Recommendations for research

The researcher identified a gap in research regarding the partners and families of professional nurses in this study; therefore she suggests the subsequent topics for future research.

- Research should be conducted on the comparison between emotional intelligence and adaptive coping mechanisms in partners of professional nurses.
- Are stress disorders prevalent in the families and partners of professional nurses, for example secondary stress disorders or post-traumatic stress disorder?
- How resilient are the partners of professional nurses? And, if partners should attend a workshop on the practical skills of coping, would it increase the partners' resilience?

Recommendations for nursing education

- The availability and frequency of debriefing sessions should be considered at undergraduate level so that when they start off in practice they would be accustomed to use this service more often.
- More workshops should be available at undergraduate level, from the first year, in order to train the professional nurses to cope with the traumatic events in the profession as well as to develop healthy adaptive coping skills.
- Workshops should be considered to enhance professional nurses' skills with regard to the following topics: building resilience, adaptive coping mechanisms, how to deal with death, effective communications skills when talking to your family and friends, and how to deal effectively with stress and trauma in the workplace.

Recommendation for policy

- Develop an instrument to monthly evaluate the emotional well-being of staff members.
- Develop a guideline to be followed when a professional nurse was exposed to a traumatic event.
- Develop policies on the management of professional nurses' emotional well-being.

CONCLUSION

Although many of the partners' responses specifically point to how they cope with the traumatic information they hear from their nurse partners, they mainly feel that they need to be more resilient, which is directly linked to the nature of the nursing profession. The partners unanimously agreed that the nursing profession is a highly stressful and traumatic environment and that they need to be more resilient if they want to cope and effectively

support the professional nurses. In closing this study, it is truly important to recognise the importance of the interpersonal relationship between a professional nurse and his/her partner in all aspects of their lives.

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Competing Interest

The author of this study declares that there were no financial incentives or relationship(s) that may have inappropriately influenced her in writing this article.

Author's contribution

M. conducted the research and wrote the article based on a dissertation for a master's degree in nursing science. T (North-West University) acted as supervisor and M.P (North-West University) as co-supervisor.

REFERENCES

Bolger, N., 1990, 'Coping as a personality process: A prospective study', *Journal of Personality and Social Psychology* 59(3):525-537.

Bonanno, G.A., 2004, 'Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events?', *American Psychologist* 59(1):20-28.

Botma, Y., Greef, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. *Research in health sciences*, Cape Town:Pearson Education South Africa.

Brink, H., Van der Walt, C. & Van Rensburg, G., 2006, *Fundamentals of research methodology for healthcare professionals*, 2nd ed., Cape Town: Juta.

Burns, N. & Grove, S. K, 2005, *The practice of nursing research: conduct, critique and utilization, 5th ed*, Missouri: Saunders Elsevier.

Burns, N. & Grove, S.K., 2009, *The practice of nursing research: appraisal, synthesis and generation of evidence*, 6th ed., St Louis: Saunders Elsevier.

Carll, E.K., 2000, *Violence our lives: impacted on workplace, home and community*, Boston: Allyn & Bacon.

Chapman, G., 2015, *The 5 love languges , the secret to love that lasts*, Chicago: Northfield Publishing.

Cheng, S.T., Tsui, P.K. & Lam, J.H., 2015, 'Improving mental health in health care practitioners: randomized controlled trial of a gratitude intervention', *Journal of consulting and clinical psychology* 83(1):177-186.

Chesney, M.A., Neilands, T.B., Chamber, D.B., Taylor, J.M. & Folkman, S., 2006, 'A validity and reliability study of the coping self-efficacy scale', *British Journal of Health Psychology* 11(1):421-437.

Collins, S. & Long, A., 2003, 'Too tired to care? The psychological effects of working with trauma,. *Journal of Psychiatric and Mental Health Nursing* 10:17-27.

Compas, B.E., Connor-Smith, J.K., Saltzman, H., Harding Thomsen, A.& Wadsworth, M.E., 2001, 'Coping with stress during childhood and adolescence:problems, progress, and potential in theory and research',. *Psychological Bulletin* 127(1):87-127.

Creswell, J.W., 2003, *Research design: qualitative, quantitative, and mixed methods approaches*, 2nd ed., Thousand Oaks: Sage Publications.

Creswell, J. W., 2009, *Research design: Qualitative, quantitative, and mixed methods approaches*, 3rd ed., Thousand Oaks: Sage Publications.

Davis, H. & McLeod, S.L., 2003, 'Why humans value sensational news An evolutionary perpective', *Evolution and human behaviour* 24(3):208-216.

Delobelle, P., Rawlinson, J.L., Ntuli, S., Malatsi, I., Decock, R. & Depoorter, A.M., 2009, 'HIV/AIDS knowledge, attitudes, practices and perceptions of rural nurses in South Africa', *Journal of Advanced Nursing* 65(5):1061-1073.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., 2011, *Research at grass roots: for the social sciences and human service professions*, 4th ed., Pretoria: Van Sc.

De Wet, K. & Du Plooy, S., 2012, 'We are left in the cold': nurses' perceptions and responses to antiretroviral treatment roll-out in the Free State, South Africa, *Journal of Social Aspects of HIV/AIDS* 9(1):30-40.

Dyer, J.G. & McGuinness, T.M., 1996, 'Resilience: analysis of the concept', *Arch Psychiatr Nurs* 10(1):276-282.

Figley, C.R., 1988, *Burnout in families: the systemic cost of caring*, Florida: CRC Press LLC.

Figley, C. R., 1999, *Compassion fatigue: toward a new understanding of the costs of caring*, (*In* Stamm, B.H., *ed.* Secondary traumatic stress: Self care issues for clinicians, researchers, & educators. Baltimore, MD:Sidran Press.p. 3-28).

Figley, C.R. & Figley, K.R., 2009, 'Stemming the tide of trauma systemically: the role of family therapy', *The Australian and New Zealand Journal of family therapy* 30(3):173-182.

Foa E.B & Hearts- Ikenda D., 1996, Handbook of dissociation: Theoretcal, Empirical and Clinical Perspectives, edited by Latty K Michelson and William J Ray, plenum press New York.

French, S.E., Lenton, R., Walters, V., & Eyles, J., 2000, 'An empirical evaluation of an expanded nursing stress scale source*', Journal of Nursing Measurement 8*(2):161–178.

Galor, F.S., 2012, Emotion-focused coping strategies, https://drsharongalor.wordpress.com/2012/03/31/emotion-focused-coping-strategies/ Date of access: 19 Jun. 2015.

Gunlicks-Stoessel, M.L. & Powers, S.I., 2009, 'Romantic partners' coping strategies and patterns of cortisol reactivity and recovery in response to relationship conflict', *Journal of Social and Clinical Psychology* 28(5):630-649.

Gunnar, M.R., 1994, P*sychoendocrine studies of temperament and stress in early childhood:* expanding current models, (*In* Bates, J.E. & Wachs, T., *ed.* temperament: individual differences at the interface of biology and behaviour, New York: American Psychiatric Press. p. 175-198).

Holdsworth, N., 2009, Compassion fatigue, vicarious trauma, secondary trauma, burnout, http://www.ejhealing.com/Documents/Compassion%20fatigue.pdf Date of access: 1 Jun. 2012.

Hu, T., Zhang, D., & Wang, J., 2015, 'A meta-analysis of the trait resilience and mental health', *Personality and individual differences* 76(1):18-27.

Hunt, M.R., 2009, 'Strengths and challenges in the use of interpretive description: reflections arising from a study of the moral experience of health professionals in humanitarian', *Qualitative Health Research* 19(9):1284-1292.

Jinbo, F., Changjian, Q., Huiqiong, X. & Guiying, Y., 2012. 'A model for predicting acute and chronic fatigue in Chinese nurses', Journal of Advanced Nursing 69(3):546-

558.Johnson, S.M., 2002, *Emotionally focused couple therapy with trauma survivors, strengthening attachment bonds*, New York:Guilford.

Johnston, D.W., Jones, M.C., Charles, K., McCann, S.K., & McKee, L., 2013, 'Stress in nurses: stress-related affect and its determinants' *The Society of Behavioral Medicine* 45:348-356.

Jooste, K., *ed*., 2010, The principles and practice of nursing and health care: ethos and professional practice, management, staff development, and research. Pretoria: Van Schaik Publishers. P. 317-334)

Kato, T., 2015, 'Frequently Used Coping Scales: A Meta-Analysis', *Stress Health* 31(1):315-323.

Klimstra, T.A., Luyckx, K., Branje, S., Teppers, E., Goossens, L. & Meeus W.H.J., 2013, 'Personality traits, interpersonal identity, and relationship stability: longitudinal linkages in late adolescence and young Adulthood' *Journal of Youth Adolescence* 42(1):1661-1673.

Klopper, H.C., Coetzee, S.K., Pretorius, R. & Bester, P., 2012, 'Practice environment, job satisfaction and burnout of critical care nurses in South Africa, *Journal of Nursing Management* 20(1):685-695.

Koen, M.P. & Du Plessis, E., 2011, Strengthening the resilience of health caregivers and risk groups. Potchefstroom: NWU.

Komachi, M.K., Kamibeppu, K., Nishi, D. & Matsuoka, Y., 2012, 'Secondary traumatic stress and associated factors among Japanese nurses working in hospital', *International Journal of Nursing Practice* 18(1):155-163.

Kreigh, H.Z. & Perko, J.E., 1983, *Psychiatric and mental health nursing: a commitment to care and concern*, Virginia: Robert J Brady.

Laal, M. & Aliramaie, N., 2010, 'Nursing and coping with Stress', *International Journal of Collaborative Research on Internal Medicine & Public Health* 2(5):168-181.

Lohr, J.M., 2007, Angry? Breathing beats venting. http://www.physorg.com/news91899145.html Date of access: 12 Jul. 2012.

Lombardo, B. & Eyre, C., 2011, 'Compassion fatigue: A nurse's primer', *Online journal of issues in nursing* 16(1):3-12.McIntosh, B., & Sheppy, B., 2013, 'Effects of stress on nursing integrity', *Art & Science Nursing Standard 27*(25):35-39.

Meehan, S., Peirson, A. & Fridjhon, P., 2007, 'Suicide ideation in adolescent South Africans: the role of gender and coping strategies', *Journal of Psychology* 37(3):552-575.

Neff, L.A., & Broady, E.F., 2011, 'Stress resilience in early marriage: can practice make perfect?', *Journal of personality and social psychology* 101(5):1050-1067.

Neff, L.A. & Karney. B.R., 2007, 'Stress crossover in newlywed marriage: A longitudinal and dyadic perspective', *Journal of marriage and family* 69(1):594-607.

Nils, D. & Rimé, B., 2012, 'Beyond the myth of venting: social sharing modes determine the benefits of emotional disclosure', *European journal of social psychology* 42(1):672-681.

Oliveira, J.D.C., Pessoa Júnior, J.M., Miranda, F.A.N., Cavalcante, E.S. & Almeida, M.G., 2014, 'Stress of nurses in emergency care: a social representations study', *Online Brazilian journal of nurses* 13(2):146-53.

Özden, D., Karagöglu, Ş & Yildirim, G., 2013, 'Intensive care nurses' perception of futility: job satisfaction and burnout dimensions', *Nursing ethics* 20(4):436-447.

Peterson, M.S., 1997, 'Personnel interviewers' perceptions of the importance and adequacy of applicants' communication skills', *Communication Education* 46(4):287-291.

Powers, S. I., Pietromonaco, P. R., Gunlicks, M. & Sayer, A., 2006, 'Dating couples' attachment styles and patterns of cortisol reactivity and recovery in response to a relationship conflict', *Journal of personality and social psychology* 90(1):613–628.

Skinner, E.A., Edge, K., Altman, J. & Sherwood, H., 2003, 'Searching for the structure of coping: a review and critique of category systems for classifying ways of coping', *Psychological bulletin* 129(1):216-269.

Stuart, G.W., 2013, *Principles and practice of psychiatric nursing*, 10th ed., Missouri: Mosby Elsevier.

Suresh, P., Matthews, A. & Coyne, I., 2013, 'Stress and stressors in the clinical environment: a comparative study of fourth-year student nurses and newly qualified general nurses in Ireland, *Journal of clinical nursing* 22(1):770–779.

Teo, S.T.T., Pick, D., Newton C.J., Yeung, M.E., & Change, E., 2013, 'Organisational change stressors and nursing job satisfaction: the mediating effect of coping strategies', *Journal of Nursing Management* 21:878-887.

Thome, J. & Espelage, D.L., 2004, 'Relations among exercise, coping, disordered eating, and psychological health among college students', *Eating Behaviors* 5(1):337-351.

Thorne, S., 2008, *Interpretive description*, California: Left Coast Press.

Tolpin, L., Cohen, L., Gunthert, K., & Farrehi, A., 2006, 'Unique effects of depressive symptoms and relationship satisfaction on exposure and reactivity to daily romantic relationship stress', *Journal of social and clinical psychology* 25(1):565–583.

Tuncay, T., Musabak, I., Gok, D.E. & Kutlu, M., 2008, 'The relationship between anxiety, coping strategies and characteristics of patients with diabetes', *Health and quality of life outcomes* 6(79):1-9.

Updegraff, J.A., & Taylor, S.E., 2000, *From vulnerability to growth: positive and negative effects of stressful life events*, (*In* Harvey, J. & Miller, E., *eds.* Loss and trauma: general and close relationship perspectives. Philadelphia:Brunner-Routledge. p.3-28).

Van Dyk, A.C., 2007, 'Occupational stress experienced by caregivers working in the HIV/AIDS field in South Africa', *African journal of AIDS research* 6(1):49-66.

Van der Colff, J.J. & Rothmann, S., 2014, 'Burnout of registered nurses in South Africa', *Journal of nursing management* 22(1):630-642.

Van der Wath, A., Van Wyk, N. & Janse van Rensburg, E., 2013, 'Emergency nurses' experiences of caring for survivors of intimate partner violence', *Journal of advanced nursing* 69(10):2242-2252.

White, L., Duncan, G. & Baumle, W., 2011, *Foundations of basic nursing*, 3rd ed., New York: Delmar.

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SECTION 3

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

SECTION 3
CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

3.1 INTRODUCTION

This final chapter includes the conclusions, recommendations and limitations of the study. The conclusions of the study determine whether the study's objectives were accomplished. The recommendations will add value to both hospitals and the nursing profession's body of knowledge. No study is complete without drawing attention to its limitations, since the limitations may open a door for future research in the same field of knowledge.

Consequently the conclusions drawn from both the literature and empirical data will be discussed first in this chapter. Secondly, the researcher will discuss the recommendations that were drawn from the results. The recommendations will include information that may be helpful to the nursing practice, nursing training or educational institutions, as well as future nursing research. If these recommendations are implemented it can in the long run not only help strengthen the resilience of the partner but also that of the professional nurse. In the last section of this chapter, the researcher will describe the limitations that she came across while conducting the study. The researcher will then portray her personal reflection on the journey that was this study, before she concludes the chapter with a summary.

3.2 CONCLUSIONS

The objective of the study was to explore and describe the coping experiences of partners of professional nurses venting traumatic information to them.

It is evident from the discussion in section 2 that the study's objective has been achieved. The researcher design was purposefully planned to achieve the study's objective, and the conclusions that can be drawn from the qualitative results are proof that the research was indeed successful. The semi-structured interview technique enabled the researcher to draw rich descriptions from the participants about how they cope with traumatic information ventilated to them by their nurse partners.

Therefore, to reach the objective of exploring and describing the coping experiences of partners of professional nurses, it was necessary to gain an understanding of how the partners experienced listening to these traumatic information. The participants' most common experience was that of being shocked. Then followed that they found the information interesting, and lastly one participant responded that he tried to block out the information and to not pay any attention to it. As a result of these initial experiences, the participants explained that they started expressing it by means of certain behaviour in order to deal with the information; they attempted to desensitise themselves or to become more resilient. Some of the participants stated that they even started to enjoy hearing the stories and felt that it assisted them in gaining more knowledge about their partners' jobs.

Three partners expressed that they applied different coping skills to manage the traumatic information, with the most popular method being to partake in physical activities in order to deal with the stress. Even though they partake in different physical activities, the common element is "being active". Numerous literature supports the use of physical activity to not only de-stress but to also build relationships, especially between domestic partners health (Thome & Espelage, 2004:339). Two partners indicated that they cope by doing research or by gaining more information about certain aspects that the nurses shared. They felt that knowing more about the subject may enable them to better understand the situation or information when the professional nurse share it, which in turn will make them more supportive of the professional nurses. Researching a subject not only extends their general knowledge, but it could also prevent them from feeling the initial shock. The participants also mentioned other coping skills such as becoming detached or compartmentalising the information. It is understandable that the partners of professional nurses would use such coping skills, since they may feel that the traumatic information becomes a burden that they carry around and that affect their daily lives. It must be noted that even though the professional nurses received training on how to manage traumatic events, their partners have no training. It is also impossible to expect nurses not to vent at home, as talking about one's daily work activities is such a normal and healthy aspect of any relationship. Some of the participants focused on their own personality traits and life experiences and explained that they used these competencies as coping mechanisms.

Communication was the one coping skill that all participants had in common. Even though some of their coping skills leaned towards avoidance and others towards embracing, the participants all realised that good communication is essential in their relationships. Although venting might be seen as a healthy way to connect with one's partner, and feeling

comfortable enough in the relationship to talk about one's day, the fact remains that someone talking about traumatic events on a daily basis, may not be ideal for building a healthy relationship. Research on relationships explains that communication should always be present (Peterson, 1997:288). However, learning how to communicate, even if the message or information is traumatic in nature, is as important for the sender as it is for the receiver (Peterson, 1997:288). Protecting the receiver from any traumatic information should be a priority, although it is evident from the participants' responses that they feel it is their duty to provide emotional support to the nurses. The participants perceive this emotional support as a means to improve their relationship, since they give the nurses a platform from which to vent.

Although many of the results drawn from the participants' responses are specific to how they manage the traumatic information they hear from the professional nurses, their main aim is to become more resilient, which is directly linked to the nature of the nursing profession. Many of the participants felt that the nurses lack support in their workplace and that they convert their relationships into the support system they need. Again this may seem positive, but it may not be healthy for the relationship in the long-term. The participants unanimously agreed that the nursing profession is a highly stressful and traumatic environment and that they need to be more resilient if they want their relationships with the professional nurses to survive.

All the information provided by the participants and the insight the researcher gained into how these participants tend to cope with the professional nurses venting traumatic information to them, guided her in the formulation of the recommendations. The researcher also believes that in implementing these recommendations the resilience of the partners as well as the professional nurses could be increased.

3.3 RECOMMENDATIONS

The researcher formulated recommendations for nursing practice, future research, nursing education and lastly for nursing policies.

3.3.1 Recommendations to improve nursing practice

- Improve the support structures of nurses who work in an emergency care unit; for instance they should be afforded the opportunity to be debriefed at the hospital.

Support sessions could also be convened so that the nurses can talk about things that had happened at work.

- Schedule monthly “emotional check-in sessions” with the sister in charge during which any ongoing problems can be discussed and, if need be, they can be referred to a psychologist or counsellor to facilitate emotional problems.
- Hospitals should conduct a workshop for family members every four months to discuss different topics such as, effective coping, communication skills and boundary setting, among others.
- Hospitals should organise a support group for the family members and partners of professional nurses so that family members and partners can talk freely and find solutions for difficulties in their relationships.
- Discuss the findings of this study in a workshop to assist others in coping better and in building resilience.

3.3.2 Recommendations for research

The researcher identified a big gap in research regarding the partners and families of professional nurses in this study; therefore she suggests the subsequent topics for future research.

- Research should be conducted on the comparison between emotional intelligence and adaptive coping mechanisms in partners of professional nurses.
- Are stress disorders prevalent in the families and partners of professional nurses, for example secondary stress disorders or post-traumatic stress disorder?
- How resilient are the partners of professional nurses? And, if partners should attend a workshop on the practical skills of coping, would it increase the partners’ resilience?
- Research on how a supportive partner at home affects the working resilience or performance of a professional nurse.
- Research on how partners cope in their relationships with other nursing specialties, for instance intensive care unit, midwifery, community nursing.

3.3.3 Recommendations for nursing education

The subsequent recommendations were made towards improving nursing education:

- The availability and frequency of debriefing sessions should be considered at undergraduate level so that when they start off in practice they would be accustomed to use this service more often.
- More workshops should be available at undergraduate level, from the first year, in order to train the professional nurses to cope with the traumatic events in the profession as well as to develop healthy adaptive coping skills.
- Workshops should be held as refresher courses or on CPD points with regard to the following topics: building resilience, adaptive coping mechanisms, how to deal with death, effective communications skills when talking to your family and friends, and how to deal effectively with stress and trauma in the workplace.
- Sisters in charge should attend a yearly course on counselling, in order to stay abreast of the latest developments is the field, and to enable them to manage difficult situations in the unit.
- Workshops should be formulated for the family and partners of professional nurses on the following topics: effective communication skills, how to set healthy boundaries in your relationship and adaptive coping mechanisms.

3.3.4 Recommendation for policy

These recommendations are made to assist in policy making in order to improve the well-being of professional nurses and their families.

- Develop an instrument to monthly evaluate the emotional well-being of staff members.
- Develop a guideline to be followed when a professional nurse was exposed to a traumatic event.
- Develop policies on the management of professional nurses' emotional well-being.

3.4 LIMITATIONS OF THE STUDY

- The study was only conducted in two private hospital facilities in Gauteng, thus limiting this study's findings to these specific settings and to only emergency nurses and their partners. However, the information can be extrapolated to other settings and nurses by making minor adjustments.
- Since only male participants volunteered to take part in the study, the viewpoints of female partners were not obtained.
- It was difficult to find willing participants for the study, even though data saturation was obtained.
- The researcher believes that the data could have been richer. For instance, the participants could have completed a questionnaire on resilience as well as the COPE questionnaire before conducting the interviews in keeping with identified questions.

3.5 PERSONAL JOURNEY OF THE RESEARCHER

It was an absolute privilege for the researcher to have had the opportunity to do this research; I gained valuable experience and it has been an amazing journey.

When starting the study, time management posed a great challenge; it was not easy to manage class and working part-time. Looking back on the process of the research, the researcher regrets not spending more time on the initial process and planning phase and not mobilising all the available resources, which caused much frustration and anxiety.

The data collection process was challenging since the researcher was not working in the hospital anymore; building trust with the professional nurses took time. This initially made it very difficult to obtain feedback, but once the trust was established the data collection process ran smoothly and was very enriching.

Committing the information to paper was truly a learning curve that will stay with the researcher for the rest of her life. The guidance and patience of study leaders and loved ones gave her the courage to complete the study. This again emphasised the importance of support.

Listening to these partners' experiences, the researcher once again realised the challenges that professional nurses are facing every day, as well as the impact it has on their personal lives. Their adverse working conditions cannot be ignored; interventions should be put in place to give them the support they really need in order to balance their professional and personal lives. Another reality struck the researcher: that the nursing profession not only has an impact on the nurses but on their families as well. Not only is this an area that is wide open for great development to better the lives of both the nurses and their partners, but in the long-term also an opportunity to improve the health care profession by having well-trained, supported and resilient nurses.

Above all, this journey brought the researcher closer to God; without His grace she would not have had the resilience to complete the journey and to conclude valuable recommendations for professional nurses.

3.6 SUMMARY

In this chapter, the researcher reflected on the objective of this study by evaluating the study. The researcher discussed the limitations of the study, as well as the recommendations that she thought to be of importance. In closing this study, it is truly important to recognise the importance of the interpersonal relationship between a professional nurse and his/her partner in all aspects of their life's. Professional nurses need to become more aware of the way in which they share their experiences with their partners in order to have a holistic and healthy relationship. The partners of professional nurses also need to discover the strategies that work e15ffectively for them in their relationships. This is the only way in which to establish and maintain healthy relationships in the long-term.

3.7 REFERENCES

Peterson, M.S. 1997. Personnel interviewers' perceptions of the importance and adequacy of applicants' communication skills. *Communication Education,* 46(4):287-291.

Thome, J. & Espelage, D.L. 2004. Relations among exercise, coping, disordered eating, and psychological health among college students. *Eating Behaviors,* 5(1):337-351.

APPENDIXES

A TO F

APPENDIX A- INFORMED CONCENT FORM

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Tel: 018299-1111/2222
Web: http://www.nwu.ac.za

Consent Form

Tel: 074 898 0350
Email: melniewh@gmail.com

March 2014

To whom it may concern

TITLE OF STUDY

Coping of partners of professional nurses venting their traumatic information

1. INTRODUCTION

I am currently a Masters candidate at the North-West University, Potchefstroom campus. You are kindly invited to participate in this research study. The information in this letter will assist you to understand this study, before deciding if you want to participate or not. If you have any queries, please feel free to contacted me – Melanie Wehner

2. THE NATURE AND PURPOSE OF THIS STUDY

Up to date there have been minimal research studies done on the partners of professional nurses. This study aims to explore and describe the coping experiences of how partners are coping with the professional nurses venting traumatic information to them in order to recommend guidelines to strengthen the coping skills and resilience of the partner.
You are being asked to partake in this study because you are currently in a relationship with a professional nurse that is working in the Gauteng aria and you have the first hand experience on how you are coping when a professional nurse vents traumatic information to you. You are a very important source of information to assist me in understanding your coping experiences better.

3. EXPLANATION OF PROCEDURES

The objective of this study is to explore and describe how partners of professional nurses cope with the professional nurse venting their traumatic information. Semi-structured individual interviews will be held with each participants were specific questions will be asked focusing on how partners are coping. Al interviews will be voice recorder for data analyzing purposes. The duration of an interview is estimated to be 30min to an hour.

4. RISKS AND DISCOMFORT INVOLVED

There are minimal risks in participating in this interview. You may experience some emotional discomfort thus, should any of the questions asked during the interview make you uncomfortable you do not need to answer them. Also should the interview cause you any emotional discomfort a debriefing session will be available after your interview. Also you may experience that some of your privacy may be lost during the interview but your name will never be made known and al your data will be handled as confidential as possible. Al information will be protected by locking it up and any digital notes will be stored on a password protected computer.

1

5. POSSIBLE BENEFITS OF THE RESEARCH STUDY

You may benefit in this study by getting a deeper understanding of your own copping mechanisms that you have developed over time. The findings of this study will also be given back to all participants and may thus also help you strengthening your own copping skills by seeing the coping strategies of other partners.

Also the findings of this study may prove beneficial to other partners of professional nurse. The results of this study feed into our need to understand how partners are coping and so may help strengthen the coping skills and resilience of the partners.

6. YOUR RIGHTS AS PARTICIPANT

Participation in this interview is entirely voluntary. You can refuse to participate at any stage without any reason, without any penalty against you. The participant's withdrawal will not affect them in any way.

7. ETHICAL APPROVAL

The researcher received written approval from the Research Ethics Committee of North-West University. Copies of the approval are available at your request.

8. INFORAMTION AND CONTACT PERSON

The contact person is Ms. Melanie Wehner (0748980350) or melaniewh@gamail.com

9. COMPENSATION

There is no compensation for participation in this study. Your participation is voluntary.

10. CONFIDENTIALITY

All the information obtained during this interview will be kept confidential and anonymous. Once the data has been processed al participants will be given code names and there will be no identity to you as well as stated above all notes will be kept in a locked draw or on a password protected computer.

Please complete the voluntary consent.

Kind regards,

Melanie Wehner

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PARTICIPATION IN THIS RESEARCH IS VOLUNTARY.

You are free to decline to be in this study, or to withdraw at any point even after you have signed the form to give consent without any consequences.

I confirm that the interviewer who I give consent to explain to me the:

- nature of this study;
- the risks and discomforts; and
- benefits of this study.

Should you be willing to participate you are requested to sign below:

I _____ hereby voluntarily consent to participate in the above mentioned study. I am not coerced in any way to participate and I understand that I can withdraw at any time should I feel uncomfortable during the study. I also understand that my name will not be disclosed to anybody who is not part of the study and that the information will be kept confidential and not linked to my name at any stage. I also understand what I might benefit from participation as well as what might be the possible risks and should I need further discussions someone will be available.

_____	_____
Date	Signature of the participant
_____	_____
Date	Signature of the person obtaining consent

APPENDIX B- INTERVIEW SCHEDULE

Semi structured interview.

RESEARCH TOPIC:

"The coping experiences of partners of professional nurses venting traumatic information."

You are very welcome here today. Thank you for your willingness to participate in this research and taking this time to talk to me. It is highly appreciated. Please make yourselves comfortable.

As you already know, the purpose of this research is to investigate how you are coping with your partners (the professional nurse) sharing there traumatic information with you.

The intention is to explore your strengths and coping abilities in order to recommend guidelines to strengthen the coping skills and resilience of other partner.

Please ensure that you have signed a consent form and remember as stated in the consent form that your participation is voluntary. You may decide to withdraw at any time without any implications.

The interview will be voice recorded and the recordings will be transcribed and analysed. In the transcription your names will not be used. Please also note that you will not be receive money or other compensation for participating in this interview. Please also note that if you feel that you need debriefing after your interview there is a debriefing sessional available.

The purpose of this interview is so that I can learn from you, on what your strengths, coping experiences and resilience in your relationship. This will help me in my recommendations for guidelines that could help other partners to strengthen their coping skills and resilience.

All that is said in this interview is confidential. Your name will not be used, also please when referring to your partner don't uses his/hers name or the facility he/she is working at. Please speak loud and clear.

Remember that all contributions are valued and there is no wrong answer.

Definition of resilience

Resilience is the human capacity to adapt, thrive, and "maintain relatively stable, healthy levels of psychological functioning" in response to potentially traumatic events (Bonanno, 2004:20). Thus talking about coping or resilience it means the same thing in this study.

Questions

- How long have you been in your current relationship?
- How did you cope in the beginning of your relationship with the professional nurse venting traumatic information?
- Has your way of coping changed over the years? If yes how?
- Why do you think partners of professional nurses need to be resilient?
- What personal strengths do you have that enables you to be resilient?
- Do you think partners of professional nurses needs to be more resilient than partners of other professions?
- What advice would you give other partners to help them to be more resilient?

Please remember that you can contact me if you feel you need any emotional support as a result of participating in this research. There are debriefing sessions available.

"Thank you for your participation. Your contribution is high appreciated"

APPENDIX C- INTERVIEW TRANSCRIPTION

Interview: 3
Participant: C

Interviewer: How long have you been in a relationship with a professional nurse?

Respondent C: Um I have known her since 2007 but she only became a professional nurse in 2011. We got married in 2012 so we have now been married for 3 years.

I: O Ok, How did you cope in the beginning of your relationship with your wife venting traumatic information to you?

RC: Well at first I was a bit shocked about the things that they were exposed to especially considering she was still so young when we met. They saw bodies, had to clean up the bodies of people who die in hospital of natural causes. This is not even trauma. The thing that was odd about it is that she didn't like cleaning and washing the bodies and putting them away but she had no problem working with trauma. So to me it was a bit of an eye opener hearing someone at the age of 19 going through all of this but at the same time I realised that she can't learn what she must learn if she doesn't go through this.

I: So how did you cope in the beginning when she came and spoke to you?

R: It was almost as if I wasn't taking in the things she was telling me. I have some traumatic experiences and I'm older than she is so I have had a bit more life experience, seen a few things before she saw them – of course not on the same scale as what she saw. I just mentally blocked it off. She would tell me and I know she would be going through something bad or that this would be a traumatic experience for her, but I felt no trauma afterwards.

I: I hear you,have your coping mechanisms changed over the years from when your relationship started to now?

R: Yes. When I met her as a student she had this entire network of nurses around her that went through the same trauma as she went through and she would have them to speak to and then ease through the process. Nowadays it's not that simple because she doesn't have that entire network of nurses around her that she sees 24 hours a day. Now mostly it's me who has to deal with all of that afterwards. So coping with it and talking about it and dealing with it has changed quite a bit actually. On my side it hasn't changed that much except that now if there is trauma she is with me 24 hours a day, I see her go through this.

I: So you are basically now her support structure where beforehand she had other people to share and vent to. correct?

R: Yes I'm her baseline support

I: Why do you think that partners of professional nurses need to be resilient?

R: Of all the things that they see and do and experience, except for the fact that you don't experience it personally, when they do come home and share this with you, knowing that someone that you love has gone through this obviously does take a bit of a toll on you. You do adapt to it. Being human is an amazing

thing so you learn and you adapt to it and learn different coping mechanisms through this, also what works for her and what works for me. For example if she is crying and I say "get over it" but the crying increases, that's usually a bad sign. So whatever you do, get the crying to stop. That is the main thing first. And I think in my opinion that crying with her is not going to help the situation so you have to be a little bit resilient or strong throughout the situation to help her get through it.

I: you previously mentioned that you have a bit more life experience, and fnd that this helps you cope, what other personal strengths to you have that helps you be more resilient?

R: um just having more life experience, learning to deal with things a little bit differently than someone who had just left school. It helped because you get exposes to a bit more things, being older you see a bit more things. The first time that she had to deal with a dead body, I remembered what it was like for me to see a dead person for the first time. So I had that to fall back on, some of that experience. Not that it helped me all that much but at least I did have it and it helped me to understand her better.

I: Do you think that the partners of professional nurses need to be more resilient than people whose partners are in other professions? If so, why?

R: yes, I think you get numbed down somewhat. If a lawyer came home and said that a client died at their office, the partner would treat it completely different than a nurse coming home saying that they had a stab wound and that person didn't make it. It does boil down to where they work, you expect these sort of things to happen around a nurse. Learning about someone getting stabbed or shot or dying in a car accident, hearing about it so often through the news and with it happening so often, it's not that traumatic anymore. Where if something bad happens at a lawyer's office it's something completely different because it's a new experience for them. So yes to keep going on in the relationship you need to be more resilient.

I: What advice would you give a partner of such a person in order to help them be more resilient?

R: I don't know, because I think that every situation really needs a different take on it. You have to play it by ear. Just hit the ball that life throws at you because if a child dies it's always more traumatic than when an adult or an older person passes away. Not even your wife as a nurse will react the same with one person dying as opposed to the other one. You need to be able to adapt to the trauma as much as she needs to work through the trauma. One day a pat on the back and "stay strong girl" might do the trick and the next she needs to take the day off work and needs your support. You need to keep your eyes and ears open to see the signs and know what would be best in which situation and how to handle it.

Interview: 3
Participant: C

I: We are at out end of our session, thank you so much for your time and for participating.

APPENDIX D- ETHICAL APPROVAL OF RISE

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Ethics Committee
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ETHICS APPROVAL OF PROJECT

The North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby approves your project as indicated below. This implies that the NWU-RERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Strengthening the resilience of health caregivers and risk groups.

Project Leader: Prof MP Koen & Prof E du Plessis

Ethics number:

N	W	U	-	0	0	0	3	6	-	1	1	-	A	1
Institution				Project Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Approval date: 2011-05-13 **Expiry date**: 2016-05-12

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The project leader (principle investigator) must report in the prescribed format to the NWU-RERC:*
  - *annually (or as otherwise requested) on the progress of the project,*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
- *The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-RERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-RERC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the project;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the project are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the NWU-RERC or that information has been false or misrepresented,*
    - *the required annual report and reporting of adverse events was not done timely and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Linda du Plessis

Digitally signed by Linda du Plessis
DN: cn=Linda du Plessis, o=North-West University, ou=Vice-Rector: VTC, email=Linda.duPlessis@nwu.ac.za, c=ZA
Date: 2015.05.21 19:50:40 +02'00'

Prof Linda du Plessis
Chair NWU Research Ethics Regulatory Committee (RERC)

APPENDIX E- CONFERMATION OF ETHICAL CLEARANCE

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To whom it may concern

Dear Sir/Madam

Confirmation of ethical clearance

Regarding the research:
Coping experiences of partners of professional nurses venting traumatic information.

Melanie Wehner 23887109
Supervisor: Dr T. Rabie
Co-Supervisor: Prof. M.P. Koen

This research will focus on exploring and describing the coping experiences of partners of professional nurses who vent traumatic information to them in order to recommend guidelines to strengthen the coping skills and resilience of the partner. In view of this general aim, the following is a specific objective for this study:

- To explore and describe how partners of professional nurses cope with the professional nurse venting traumatic information to them.

This research is a sub-study in an overarching research project, entitled: *Strengthening the resilience of health caregivers and risk groups*, with ethical clearance from the Ethics Committee of the North-West University (Ref no NWU-00036-11-S1). The co-investigators are Prof MP Koen and Dr E du Plessis.

Background information and link with sub-study:

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 overarching 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

Within this overarching research project, Melanie Wehner (23887109) intends to focus on partners of professional nurses, as mentioned above. The results of this sub-study will contribute to reaching the objectives of the overarching project, because it will explore and describe the coping experiences of how partners are coping with professional nurses venting traumatic information to them thus using this information to recommend guidelines that could strengthen partner coping skills and resilience. This will inform the development of a multi-faceted approach to strengthen resilience. The methodology and ethical aspects of Melanie Wehner study is congruent with the methodology and ethical aspects of the approved overall study on resilience. We therefore confirm that the sub-study of Melanie Wehner is covered by the above-mentioned ethical clearance.

Yours sincerely

Prof MP Koen
Co-investigator

Dr E du Plessis
Co-investigator

APPENDIX F- NWU ETHICAL APPROVAL

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

Private Bag X6001, Potchefstroom
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Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za

Dr T. Rabie
Nursing Undergraduate

Faculty of Health Sciences
Tel: 018 299-2092
Fax: 018 299-2088
Email: Minrie.Greeff@nwu.ac.za

26 March 2014

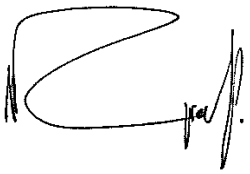
Dear Dr T. Rabie

Ethics Application: NWU-00036-11-S1

"Coping experiences of partners of professional nurses venting traumatic information"

Thank you for the amendments made to the application, entitled "**Coping experiences of partners of professional nurses venting traumatic information**". The application has been approved under the umbrella project "**Strengthening the resilience of health caregivers and risk groups**".

Yous sincerely



Prof Minrie Greeff
Research Ethics Committee (Humans) Chairperson

Original details: Prof Minrie Greeff(10187308) C:\Users\13210572\Documents\ETIEK\2011 ETHICS\NWU-00036-11-A1 Addisionele Versoek 7.docm
26 March 2014

File reference: NWU-00036-11-S1

APPENDIX G- HOSPITAL ETHICAL APPROVAL

RESEARCH OPERATIONAL COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2014-0037

Ms Melanie Wehner

E mail: Melaniewh@gmail.com

Dear Ms Wehner

RE: COPING EXPERIENCES OF PARTNERS OF PROFESSIONAL NURSES VENTING TRAUMATIC INFORMATION

The above-mentioned research was reviewed by the Research Operational Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information with regards to Company will be treated as confidential.

iii) Company's name will not be mentioned without written consent from the Committee.

iv) All legal requirements with regards to patient rights and confidentiality will be complied with.

v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability

vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist

vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)

viii) Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

Anonymous

ix) A copy of the research report will be provided to Company once it is finally approved by the tertiary institution, or once complete.

x) Company has the right to implement any Best Practice recommendations from the research.

xi) Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.

xii) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER.

We wish you success in your research.

Yours faithfully

Prof Dion du Plessis
Full member: Research Operational Committee & Medical Practitioner evaluating research applications as per Company Policy

Shannon Nell
Chairperson: Research Operational Committee
Date: 11/04/2014

This letter has been anonymised to ensure confidentiality in the research report.
The original letter is available with author of research

Anonymous

APPENDIX H- AUTHORS' GUIDELINESS HEALTH SA

HEALTH SA
HEALTH SA GESONDHEID

Original Research (Empirical Research)

Structure adherence
Please ensure that you keep to this structure when formulating your article to the journal

HOUSE STYLE

Abbreviations
Abbreviations should be used as sparingly as possible. They can be defined when first used or a list of abbreviations can be provided preceding the acknowledgements and references.

Typography

- Please use 1.5 line spacing.
- Font size in 12pt
- Type the text unjustified, without hyphenating words at line breaks.
- Insert line numbers
- Use hard returns only to end headings and paragraphs, not to rearrange lines.
- Capitalise only the first word, and proper nouns, in the title.
- All pages should be numbered.
- First heading: FIRST HEADING (upper case, bold, and 14pt) ; Second heading: Second heading (normal case, bold, 14pt); Third heading: Third heading (normal case, bold, 12pt); Fourth heading: Fourth heading (normal case, bold, running in-text and separated by a colon)
- Use the *Health SA Gesondheid* reference format.
- Footnotes to text should not be used.
- Greek and other special characters may be included. If you are unable to reproduce a particular special character, please type out the name of the symbol in full.
- Place headings in bold caps; separated by space; no numbering. If additional levels of headings are used: secondary heading in bold no caps; third heading as normal.
- For quotations use single quote marks. For quotes within quotes use double marks. Quotations of more than 30 words are to be indented. Do not use quotation marks for indented quotes unless direct speech e.g. interviewee response.
- In the text (but not the references) titles of books should be in italics and titles of articles in quotation marks.
- Foreign language words should be given in italics unless they are part of normal usage, example et al.
- Use en dashes (or two hyphens) in text and single hyphens in ranges of numbers, dates etc.
- Format dates as follows: '20th century,' except at the beginning of sentences; hyphenate when used adjectivally; '1960s'; '10 October 2006.'
- Spell out 'per cent/ percentage' except in cases of exact statistical usage.
- Spell out the numbers one to nine, from 10 on use numerals, except at the beginning of a sentence – which should be avoided.
- Use a space for thousands (10 000 and above).
- Use decimal points (not decimal commas).
- Units should follow the SI standard.
- Avoid Americanisms (use 's' not 'z')

Please ensure that all special characters used are embedded in the text, otherwise they will be lost during conversion to PDF.
Tables: Tables should be self-explanatory, clearly organised and supplemental to the text of the manuscript. Each table should include a clear descriptive title on top and should be numbered in Arabic numerals (1, 2, etc) in order of its appearance as called out in text. Tables must be inserted in the correct position in the text, and uploaded separately as supplementary files each in their own excel sheet. Authors should place explanatory matter in footnotes, not in the heading. Explain all nonstandard abbreviations in table footnotes. For footnotes use the following symbols, in sequence: *,†,‡,§,||,,**,††,‡‡.

Figures: All figures must be inserted in the appropriate position of the electronic document, or uploaded separately as supplementary files. Symbols, lettering and numbering (in Arabic numerals e.g. 1, 2, etc. in order of appearance in the text) should be placed below the figure, clear and large enough to remain legible after the figure has been reduced. Figures must have clear descriptive titles. **Figure legends:** The legends should be included in the main manuscript text file immediately following the references, rather than being a part of the figure file. For each figure, the following information should be provided: Figure number (in sequence); short title of figure (maximum 15 words); detailed legend, up to 50 words.

Photographs and images: If photographs of patients are used, the human subject should not be identifiable and use of the picture should be authorised by an enclosed written permission from the subject. The position of photographs and images should be clearly indicated in the text. Electronic images should be saved as either .jpeg or .gif files. All photographs should be scanned at a high resolution (300dpi, print optimised). Provision is made to upload individual images on the website as supplementary files. Please number the images appropriately.

Permission: Permission should be obtained from the author and publisher for the use of quotes, illustrations, tables, and other materials taken from previously published works which are not in the public domain. The author is responsible for the payment of any copyright fee(s) if these have not been waived. Letters of permission should accompany the manuscript. The original source(s) should be mentioned in the figure legend or as a footnote to a table.

COVER PAGE – first page

☐ **Title** (fourth-level heading)
The articles full title should contain a maximum of 95 characters.

☐ **Short title** (fourth-level heading)
Derived from the title of the article, provide a short title of 50 characters or less.

☐ **Research significance** (fourth-level heading)
Indicate the significance of the work being reported.

☐ **Author(s) details** (fourth-level heading)
State the full name(s) and title(s) of all participating author(s) including their positions, affiliations and contact details, which includes postal address, email, telephone and cell number) of each author.

☐ **Corresponding author** (fourth-level heading)
Indicate the author to whom all correspondence should be made. This author will liaise with the journal and take the responsibility to responding to all queries related to the article.

☐ **Author contribution** (fourth-level heading)
Include a paragraph briefly summarising the nature of the contribution made by each of the authors listed using initials, along the lines of the following:

> J.K. was the project leader, L.M.N. and A.B. were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. made conceptual contributions and S.T., U.V. and C.D. performed some of the experiments. S.M. and V.C. prepared the samples and calculations were performed by C.S., J.K. and U.V. wrote the manuscript.

☐ **Reviewers** (fourth-level heading)
Provide three names and full contact details (including email) of potential reviewers to evaluate the work. These reviewers should not be people with whom the researcher(s) has recently collaborated or published.

☐ **Keywords** (fourth-level heading)
Provide five keywords to the article, in alphabetical order and separated by a semi-colon. Avoid general and plural terms and multiple concepts (avoid, for example, "and", "of"). Be sparing with abbreviations: only abbreviations firmly established in the field may be used. These keywords will be used for indexing purposes.

ARTICLE STRUCTURE – second page and onwards

☐ **Abstract** (first-level heading)
In English, not more than 300 words. All original and review articles should include an abstract. The abstract for an Original Research article should consist of five paragraphs focussing on the Background, Objectives, Method, Results and Conclusion. All articles must contain an abstract translated into Afrikaans called 'Opsomming', not more than 300 words which forms part of the article Abstract.

☐ **Introduction** (first-level heading)
The introduction contains two subsections; namely the background section and the literature review.

☐ **Setting** (second-level heading)
The setting section should be written from the standpoint of readers that is without specialist knowledge in that area and must clearly state - and, if helpful, illustrate - the setting to the research and its aims in the context of previous work bearing directly on the subject. The setting section to the article normally contains the following five elements:

☐ **Key focus** (third-level heading)
A thought-provoking introductory statement on the broad theme or topic of the research.

☐ **Background** (third-level heading)
Providing the background or the context to the study (explaining the role of other relevant key variables in this study);

☐ **Trends** third-level heading)
Cite the most important published studies previously conducted on this topic or that has any relevance to this study (provide a high-level synopsis of the research literature on this topic).

☐ **Objectives** (third-level heading)
Indicate the most important controversies, gaps and inconsistencies in the literature that will be addressed by this study. In view of the above trends, state the core research problem and specific research objectives that will be addressed in this study and provide the reader with an outline of what to expect in the rest of the article.

☐ **Contribution to field** (third-level heading)
Explanation of the study's academic (theoretical & methodological) or practical merit and/or importance (provide the value-add and/or rationale for the study).

☐ **Research Method and Design** (first-level heading)
The methods should include:

☐ **Materials** (second-level heading)
Describe the type of organism(s) or material(s) involved in the study.

☐ **Setting** (second-level heading)
Describe the site and setting where your field study was conducted.

☐ **Design** (second-level heading)
Describe your experimental design clearly, including a power calculation if appropriate. Note: Additional details can be placed in the online supplementary location.

☐ **Procedure** (second-level heading)
Describe the protocol for your study in sufficient detail (clear description of all interventions and comparisons) that other scientists could repeat your work to verify your findings.

☐ **Analysing** (second-level heading)
Describe how the data were summarised and analysed, additional details can be placed in the online supplementary information.

☐ **Results** (first-level heading)
This section provides a synthesis of the obtained literature grouped or categorised according to some organising or analysis principle. Tables may be used or models may be drafted to indicate key components of the results of the study.

- Organise the results based on the sequence of Tables and Figures you will include in the manuscript
- The body of the Results section is a text presentation of the key findings which includes references to each of the Tables and Figures
- Statistical test summaries (test name, *p*-value) are usually reported parenthetically in conjunction with the biological results they support, use SI units

- Present the results of your experiment(s)/research data in a sequence that will logically support (or provide evidence against) the hypothesis, or answer the question, stated in the Introduction

Note: All units should conform to the SI convention and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

☐ **Ethical considerations** (first-level heading)

Papers based on original research must adhere to the Declaration of Helsinki on "Ethical Principles for Medical Research Involving Human Subjects" and must specify the recognised ethics committee from which approval for the research was obtained. Case studies must have the consent of the patient(s) or waiver of consent approved by an ethics committee.

☐ **Potential benefits and hazards** (second-level heading)

What risks to the subject are entailed in involvement in the research? Are there any potential physical, psychological or disclosure dangers that can be anticipated? What is the possible benefit or harm to the subject or society from their participation or from the project as a whole? What procedures have been established for the care and protection of subjects (e.g. insurance, medical cover) and the control of any information gained from them or about them?

☐ **Recruitment procedures** (second-level heading)

Is there any sense in which subjects might be 'obliged' to participate – as in the case of students, prisoners, or patients – or are volunteers being recruited? If participation is compulsory, the potential consequences of non-compliance must be indicated to subjects; if voluntary, entitlement to withdraw consent must be indicated and when that entitlement lapses.

☐ **Informed consent** (second-level heading)

Where appropriate, consent of participants MUST be requested and put in terms easily comprehensible to lay persons. This should ideally be both ORALLY and in WRITING. An information sheet setting out factors relevant to the interests of participants in the study must be written in like terms and handed to them in advance of seeking consent. They must be allowed to retain this sheet.

☐ **Data protection** (second-level heading)

The project should comply with the requirements of current data protection legislation and how this is accomplished should be disclosed to participating subjects and those monitoring the research procedure. This should include proposed data storage arrangements, degree of security etc. And whether material facts have been withheld (and when, or if, such facts will be disclosed).

☐ **Trustworthiness** (first-level heading)

This refers to the findings of the study being based on the discovery of human experience as it was experienced and observed by the participants.

☐ **Reliability** (second-level heading)

Reliability is the extent to which an experiment, test, or any measuring procedure yields the same result on repeated trials. Without the agreement of independent observers able to replicate research procedures, or the ability to use research tools and procedures that yield consistent measurements, researchers would be unable to satisfactorily draw conclusions, formulate theories, or make claims about the generalisability of their research.

☐ **Validity** (second-level heading)

Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. While reliability is concerned with the accuracy of the actual measuring instrument or procedure, validity is concerned with the study's success at measuring what the researchers set out to measure. Researchers should be concerned with both *external* and *internal* validity. External validity refers to the extent to which the results of a study are generalisable or transferable. Internal validity refers to (1) the rigor with which the study was conducted (e.g. the study's design, the care taken to conduct measurements, and decisions concerning what was and wasn't measured) and (2) the extent to which the designers of a study have taken into account alternative explanations for any causal relationships they explore. In studies that do not explore causal relationships, only the first of these definitions should be considered when assessing internal validity.

☐ **Discussion** (first-level heading)

This section normally contains the following four elements. It is suggested that sub-headings are used in this section.

☐ **Outline of the results** (second-level heading)

Restate the main objective of the study and reaffirm the importance of the study by restating its main contributions; Summarise the results in relation to each stated research objective or research hypothesis; link the findings back to the literature and to the results reported by other researchers; provide explanations for unexpected results.

☐ **Practical implications** (second-level heading)
Reaffirm the importance of the study by restating its main contributions and provide the implications for the practical implementation your research.

☐ **Limitations of the study** (first-level heading)
Point out the possible limitations of the study and provide suggestions for future research.

☐ **Recommendations** (second-level heading)
Provide the recommendations emerging out of the current research.

☐ **Conclusion** (first-level heading)
This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance, with a recommendation for future research (implications for practice). Provide a brief conclusion that restates the objectives; the research design; the results and their meaning.

☐ **Acknowledgements** (first-level heading)
If, through your study, you received any significant help in thinking up, designing, or carrying out the work, or received materials from someone who did you a favour by supplying them, you must acknowledge their assistance and the service or material provided. Authors *always* acknowledge outside reviewers of their drafts and any sources of funding that supported the research. Please list the source(s) of funding for the study, for each author, and for the manuscript preparation in the acknowledgements section.

☐ **Competing Interests** (second-level heading)
A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organisations that can potentially prevent you from executing and publishing unbiased research. Authors should disclose any financial competing interests but also any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript. Where an author gives no competing interests, the listing will read 'The authors declare that they have no financial or personal relationship(s) which may have inappropriately influenced them in writing this paper.'

☐ **Authors' contributions** (second-level heading)
In order to give appropriate credit to each author of a paper, the individual contributions of authors to the manuscript should be specified in this section. An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study.
Contributions made by each of the authors listed, along the lines of the following (author initials):

J.K. was the project leader, L.M.N. and A.B. were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. made conceptual contributions and S.T., U.V. and C.D. performed some of the experiments. S.M. and V.C. prepared the samples and calculations were performed by C.S., J.K. and U.V. wrote the manuscript.

☐ **References** (first-level heading)

- Please avoid excessive referencing. References begin on a separate page. References cited in the text should all be included in the list at the end of the paper. Your reference list should appear at the end of your assignment/report with the entries listed in the same order that they were cited in the text.
- Please see the journals full House Style Guide for Harvard Referencing
- It is very important that you use the right punctuation and that the order of details in the reference is also correct.
- Only first words of the article title and words that normally begin with a capital letter are capitalised.
- Authors are responsible for the accuracy of all references.

HARVARD Reference Style Guide

Notes: Please "copy" the title of a book/an article/whatever (as far as the spelling of words such as "behavior"/"behavioral" are concerned (and this also goes for direct quotations) exactly as in the original.

- When referring to any work that is NOT a journal, such as a book, article, or Web page, capitalise only the first letter of the first word of a title and subtitle, the first word after a colon or a dash in the title, and proper nouns. Do not capitalise the first letter of the second word in a hyphenated compound word.
- Capitalise all major words in journal titles.
- If within the same paragraph, reference is made to **the same author(s) for a second and further time(s)**, the year of publication is omitted in the second and further references - as long as it does not lead to confusion.
- Always cite page numbers within in-text citation – even if paraphrasing - example: Hallinan (2000:66)

Multiple publications; same author

- Same author; **different years**
  Normal conventions (author, year, title, etc).
- Same author; **same year**
  More than one reference by an author in the same year: these are distinguished in **order of publication** using a lower-case alphabetical suffix after the year of publication (eg 1988a, 1988b, 1988c, etc). The same suffix is used to distinguish that reference for the in-text citations.

Order of Listing

The List of References is ordered **alphabetically** by primary authors' surnames.

- Multiple authors.
  - Use the sequence of authors' surnames exactly as given in the publication. The primary author, ie, major contributor, is listed first by the publisher.
- Same author:
  - different years: list the author's references chronologically, starting with the earliest date.
  - same year: use an alphabetical suffix (eg 1983a, 1983b).

Compiled by OpenJournals Publishing

Books	In-Text Example	Reference List Example
Single Author	(Doss 2003)	Doss, G., 2003, *IS project management handbook*, Aspen Publishers, New York. Karskens, G., 1997, *The rocks: Life in early Sydney*, Melbourne University Press, Carlton.
Two Author	(Laudon & Laudon 2003)	Laudon, K.C. & Laudon, J.P., 2003, *Essentials of management information systems: Managing the digital firm*, Prentice Hall, Upper Saddle River, N.J.
Three authors	**In-text: initially** (Coveney, Ganster & King 2003) **In-text: thereafter** (Coveney *et al*. 2003)	Coveney, M., Ganster, S. & King, D., 2003, *The strategy gap: Leveraging technology to execute winning strategies*, Wiley, Hoboken, N.J.
Corporate author	**In-text: initially** (Department of Foreign Affairs and Trade 2002) **In-text: thereafter** (DFAT 2002)	Department of Foreign Affairs and Trade, 2002, *Connecting with Asia's tech future: ICT export opportunities*, Economic Analytical Unit, Commonwealth Government, Canberra.
Book Editor	(ed. Shaw 2003)	Shaw, M.J. (ed.), 2003, *E-business management: Integration of Web technologies*

	Shaw (ed. 2003:87) indicates that '… Current essays edited by Shaw (2003) suggest …	*with business models*, Kluwer Academic, London. Schuman, N.A., 2001, Psalm 91: Tekst, context, en een diversiteit aan herlezingen, in P. Post, G. Rouwhorst, T. Sheer, R. Steensma, & L. Tongeren (reds.), *Jaarboek voor liturgieonderzoek deel*, vol. 17, pp. 237-256, Groningen, Instituut voor Liturgie-wetenschap. Spieckermann, H., 2003, Hymnen im Psalter – Ihre Funktion undn ihre Verfasser, in Zenger, E. (Hrsg.), *Ritual und poesie*, pp. 90-136. Freiburg, Herder.
Book collection/ One volume of multi-volumn work	(eds. Hudson & Bolton 1997) Hudson and Bolton (eds. 1997:32) stated that '…'.	Hudson, W. & Bolton, G. (eds.), 1997, Creating Australia: Changing Australian history, Allen & Unwin, Sydney.
Chapter: single author	(Howard 1998)	Howard, S., 1998, 'Verbal Protocol Analysis', in B. Henderson-Sellers, A. Simons & H. Younessi (eds.), *The open process specification*, pp. 272-274, Addison Wesley, Sydney.
Chapter: three authors	**In-text: initially** (Johnston, Mak & Kurnia 2001) **In-text: thereafter** (Johnston *et al.* 2001)	Johnston R.B., Mak H.C. & Kurnia S., 2001, 'The contribution of Internet Electronic Commerce to advanced supply chain reform - a case study', in S. Barnes & B. Hunt (eds.), *E-Commerce and V-Business*, pp. 232-249, Butterworth-Heinemann, Oxford.
Four or more authors but equal to six. **See reference on how to cite more than 6 authors in this reference guide below**	A comprehensive study conducted in 1998 indicated that business in Australia is growing exponentially (Jones *et al.* 1999). *Or* Jones *et al.* (1999:34) suggested in their comprehensive study that '…'. **Note: If there is another reference starting with Jones, for example, Jones, Larsen, Green and Matthews, the names of all the authors should be given in both cases to avoid confusion.**	Jones, P., Smith, A., Hudson, T., Etherton, J., Connelly, W. & Gardener, J., 1999, *Business management for the new era*, Wyland Publishing, Adelaide. **Note: Use *et al.* in all in-text entries. Include all of the authors in the reference list.**
Article cited in a book		Oppenheim, P.L., 1981, 'Power politics', *Journal of Power Engineering* 1(3), 19-26, quoted in Strong, K., 1985, *Advances in power engineering*, Springer-Verlag, Berlin, p. 70.
Second, further or revised editions		Dyson, G.G.H., 1977, *The mechanics of athletics*, 7th edn., Homes and Meier, New York. Cohen, J., 1977, *Statistical power analysis for the behavioural ciences*, rev. edn., Academic Press, New York.

Translated works		Bakhtin, M., 1984, *Rabelais and his world*, transl. H. Iswolsky, Indiana University Press, Bloomington. Izedinova, S.V., 1977, *A few months with the Boers: The war reminiscences of a Russian nursing sister*, transl. C Moody, Perskor, Johannesburg.
Multiple works—same author	University research (Brown 1982, 1988) has indicated that ... *or* Recent reports (Napier 1993a, 1993b) indicate that ... **Note: When using two studies by the same author in different years, paraphrasing is essential. Place in chronological order—oldest first.** Ideas by Napier (1993b) were implemented ... **Note: You may use direct quotes when using the sources separately.** **Add a, b, c, etc. to differentiate between works in the same year by using the alphabetical order of the title.**	Brown, P., 1982, *Corals in the Capricorn group*, Central Queensland University, Rockhampton. Brown, P., 1988, *The effects of anchors on corals*,Central Queensland University, Rockhampton. Napier, A., 1993a, *Fatal storm*, Allen & Unwin, Sydney. Napier, A., 1993b, *Survival at sea*, Allen & Unwin, Sydney.
Works by different authors—same family name—same year	A. Carter (1999) proposed that class size seriously limited creativity in the lower school. Further investigation proved there were notable weaknesses in this claim (Carter, T 1999). **Note: As a general rule, it is advisable to paraphrase in this instance.**	Carter, A., 1999, *Issues in Australian education*, Cherokee Publications, Brisbane. Carter, T., 1999, *Creativity in the classroom*, Watkins & O'Hara Publishers, Darwin.
Second or later edition with an author	Group dynamics has been identified as ... (Johnston 1993). *Or* A recent theory (Johnston 1993:5) on group dynamics states that '...'.	Johnston, K., 1993, *Surviving the first year experience*, 2nd edn., Macmillan, Melbourne.
Several sources are cited at once	Bradford (1992), Curtis (1983), and Graham (1997) all agree ... *Or* Recent studies (Bradford 1992; Curtis 1983; Graham 1997) agree that ...	Bradford, C., 1992, *Genre in perspective: A whole language approach*, Bookshelf, Gosford. Curtis, A., 1983, *Practical math for business*, Houghton Mifflin, Boston. Graham, A., 1997, *Managing more postgraduate research students*, Oxford Centre for Staff Development, Oxford.

	Note: Paraphrasing is essential if you are going to cite the essence of what the authors all agree upon. **Alphabetise according to the name of the first author in each source. Separate entries by using semicolons.**	**Note: Each author will appear as a separate entry in the reference list.**
No date can be established	Bridging courses are studied by students who have not previously ... (Lansdown n.d.). *Or* Lansdown (n.d.:13) found that '...'	Lansdown, M. n.d., *Bridging courses*, Central Queensland University, Rockhampton.
The date can be established but only approximately	In a draft policy release, the Queensland Education Department (*c.* 1995) suggests ... *or* 'Disciplining a child should not invoke ...' (Queensland Education Department *c.*1995:xxii).	Queensland Education Department, *c.* 1995. *Draft policy on school discipline*, Author, Gladstone.
Journals	**In-Text Example**	**Reference List Example**
Single author	(Hammer 1990)	Hammer, M., 1990, 'Reengineering Work: Don't Automate, Obliterate', *Harvard Business Review*, July-August, 104-112. Kozulin, A., 1993, 'Literature as a psychological tool', *Educational Psychologist* 28(3), 253-265.
Two authors	(Lamb & Kling 2003)	Lamb, R. & Kling, R., 2003, 'Reconceptualizing users as social actors in information systems research', *MIS Quarterly* 27 (2), 197.
No volume or issue number	Sprague and Shameen (1999) indicate that alternatives to continual economic growth ... . *Or* It has been suggested that '[g]rowth at all cost is no longer aviable option' (Sprague & Shameen 1999: 50).	Sprague, J. & Shameen, A., 1999, 'Boosting growth, courting disasters?', *Asiaweek*, 31 July, 50–51.
Journal articles and book chapters from books of readings		Kuebler, S.A., 2004, 'OSHA's enforcement strategy', *Occupational Health & Safety* 73(12), 12-3, in I Eddington (ed.), *MGT 8015 Corporate occupational health and safety: Selected readings*, 2005, University of Southern Queensland, Toowoomba, Reading 4.1, pp. 71-72. Hancock, L., 2002, 'Australian federalism, politics and health', in H. Gardner & S. Barraclough (eds.), *Health policy in Australia*, 2nd edn., Oxford University Press, South Melbourne, in I. Eddington (ed.), *MGT 8015 Corporate occupational health and safety: Selected readings*, 2005, University of Southern Queensland, Toowoomba, Reading 1.2, pp. 28-35.

Non-English journal article		Give the original title, as well as an English translation in brackets. Ising, M., 2000, Intensitätsabhängigkeit evozierter Potenzial im EEG: Sind impulsive Personen Augmenter oder Reducer? [Intensity dependence in eventrelated EEG potentials: Are impulsive individuals augmenters or reducers?]. *Zeitschrift für differentielle und diagnostische Psychologie* 21, 208-217.
Back dating articles		**The volume number should be provided in Arabic numeral, without the preceding abbreviation "v", "vol." or "jrg.". Full page numbers must be given. If the date or place of publication is missing, the abbreviation "n.d." is used instead of referring to the date of publication and "s.l." instead of referring to the place of publication.** The date is placed in square brackets if the date of publication is known to the user but is not explicitly mentioned in the book or journal. Pont, A.D. [1978], Die herderlijke brief van die sinode van 1837. *HTS* 34(4), 91-105.
Supplement journal		Fisk, B.N., 2001, 'Do you not remember? Scripture, story and exegesis in the rewritten Bible of Pseudo-Philo', *Journal for the Study of the Pseudepigrapha*, suppl. ser. 37.
Proceedings	**In-Text Example**	**Reference List Example**
Published Conferences, seminars and meetings	(Eidenberger *et al.* 2002)	Eidenberger, H., Breiteneder, C. & Hitz, M., 2002, 'A Framework for Visual Information Retrieval', in S-K. Chang, Z. Chen & S-Y.Lee (eds.), *Recent advances in visual information systems: 5th International conference, VISUAL 2002 proceedings*, Hsin Chu, Taiwan, March 11-13, 2002, pp. 105-116.
Unpublished material	**In-Text Example**	**Reference List Example**
Unpublished conference paper	(Fitzsimmons 2005)	Fitzsimmons, D., 2005, 'Who chooses who belongs: Tactics and strategies and migrant literature', paper presented at the AULLA & FILLM conference, James Cook University, Cairns, 15-19th July.
Theses and Reports	(Rouse 2002)	Rouse, A.C., 2002, 'Information technology outsourcing revisited: success factors and risks', PhD thesis, Dept. of Information Systems, University of Melbourne. .
Encyclopedias and Dictionaries	**In-Text Example**	**Reference List Example**
Encyclopedias and Dictionaries	(Karlof 2002)	Karlof, B., 2002, 'Benchmarking', in H. Bidgoli (ed.), *Encyclopedia of information systems*, Academic Press, New York, vol. 1, pp. 65-80.
Newspaper	**In-Text Example**	**Reference List Example**
Print unattributed	(Sydney Morning Herald 7 March 1994:8)	'UNSW gains top ranking from quality team', Sydney Morning Herald, 30 February, 1994, p. 21.
Print attributed	(Barker 2004)	Barker, G., 2004, '$54m Deal To Heat Up Broadband War', *The Age*, Business, 24 February, p. 2. Donaghy, B., 1994, 'National meeting set to review tertiary admissions', Campus News, 3-9 March, p. 3.

Online	(Varghese 2004)	Varghese, S., 2004, 'The Linux desktop is here', The Age, viewed 1 March 2004, from http://www.theage.com.au/articles/2004/02/13/1076548215848.html.
Magazine	**In-Text Example**	**Reference List Example**
Single author	(Knight 2004)	Knight, W., 2004, 'How to second guess the next hack attack', *New Scientist*, 24 January, p. 19. **Note : Always evaluate information found in magazines for 'scholarliness'—including bias, validity, trustworthiness of the authors etc. Magazines are not generally considered scholarly pieces of work for research.**
Software		
Named author	(Rawson-Tetley 2005)	Rawson-Tetley, R., *Animal Shelter Manager*, computer software, viewed 11 January 2005 from http://sheltermanager.sourceforge.net.
No named author	(OpenOffice.org 2005)	*OpenOffice.org*, computer software, viewed 11 January 2005, from http://www.openoffice.org.
Corporate publisher	(MATLAB 2003)	*MATLAB* version 6.5.1, 2003, computer software, The MathWorks Inc., Natick, Massachusetts. 1. Title of software - in italics: *MATLAB* 2. Version of software: version 6.5.1, 3. Year of publication: 2003, 4. Identifier: computer software, 5. Publisher: The MathWorks Inc., 6. Place of publication: Natick, Massachusetts.
World Wide Web		
Document on the WWW (author/sponsor given but not dated)	According to Greenpeace (n.d.), genetically modified foods are ... *or* Greenpeace (n.d.:1 of 2) recommends that 'fewer genetically ...'.	Greenpeace n.d., *The future is GE free*, viewed 28 September 2005, from http://www.greenpeace.org.au/ge/farming/canola.html. **Note: The title of a webpage is treated like the title of a book. It is written in italics in the reference list.**
Identifiable, personal author	(Arch & Letourneau 2002)	Arch, A. & Letourneau, C., 2002, 'Auxiliary Benefits of Accessible Web Design', in *W3C Web Accessibility initiative*, viewed 26 February 2004, from http://www.w3.org/WAI/bcase/benefits.html.
E-book	(Eck 2002)	Eck, D.J., 2002, *Introduction To Programming Using Java*, 3rd edn., OOPWeb.com, viewed 26 February 2004, from http://www.oopweb.com/Java/Documents/IntroToProgrammingUsingJava/VolumeFrames.html.
E-journal: single author	(Lenoir 2003)	Lenoir, L., 2003, 'Response of the foraging behaviour of red wood ants (Formica rufa group) to exclusion from trees', *Agricultural and Forest Entomology* 5(3), 183-189, viewed 10 September 2003, from http://www.blackwell-synergy.com/links/doi/10.1046/j.1461-9563.2003.00176.x/full/.
E-journal: three author	(Mueller *et al.* 2003)	Mueller, J.K., Heckathorn, S.A. & Fernando, D., 2003, 'Identification of a chloroplast dehydrin in leaves of mature plants', *International Journal of Plant Sciences* 164(4), 535-542, viewed on 10 September 2003, from http://www.journals.uchicago.edu/IJPS/journal/no.s/v164n4/164053/164053.html.

E-journal: Abstract and more than 6 authors	(Wolter *et al.* 2003)	Wolter, B.F., Ellis, M., Corrigan, B.P., DeDecker, J.M., Curtis, S.E., Parr, E.N. *et al.*, 2003, 'Effect of restricted postweaning growth resulting from reduced floor and feeder-trough space on pig growth performance to slaughter weight in a wean-to-finish production system', *Journal of Animal Science*, (abstract), vol. 81, viewed 11 September 2003, from http://buffy.lib.unimelb.edu.au:2148/jas/abs/2003/a0340836.htm..
Other References		
CD-ROM	(World Atlas & Almanac 1995)	*World Atlas & Almanac*, 1995, CD-ROM, Mindscape Inc., Novato, California, USA.
Video & Audio Recordings: Named	(*Grumpy meets the orchestra* 1992)	*Grumpy meets the orchestra*, 1992, video recording, Australian Broadcasting Corporation, Sydney. Featuring the Sydney Symphony Orchestra.
Video & Audio Recordings: Named performer	(Sangare 1997)	Sangare, O., 1997, 'Dugu Kamalemba', in *The divas from Mali,* audio CD, Network Medien GmbH, D-60316 Frankfurt. Track #10. 1. Author (performer): Sangare, O., 2. Date (year): 1997, 3. Title (piece) - in single quotes: 'Dugu Kamalemba', 4. Title (collection) - in italics: in *The divas from Mali,* 5. Identifier: audio CD, 6. Publisher: Network Medien GmbH, 7. Place: D-60316 Frankfurt. 8. Qualifier: Track #10.
Personal Communication: Individual	• When interviewed on 15 May 2001, Mr R. Forbes stated... OR • Mr R. Forbes confirmed his statement by fax on 15 May 2003... OR • The statement claimed that Martians had landed in Moonee Ponds (R. Forbes [Australian UFO Society] pers. comm., 15 May 2003). Not included in the Reference list.	
Personal Communication: Email	(Milnthorpe 2002)	Milnthorpe, R.Q., 2002, e-mail, 26 November, milnthorpe@scraggemback.com.au 1. Author: Milnthorpe, RQ 2. Date (year): 2002, 3. Identifier: e-mail, 4. Date: 26 November, 5. Address: milnthorpe@scraggemback.com.au
Personal Communication: Lectures	• "There is no need to panic", stated Mr R. Forbes at his public lecture on 18 May 2003... OR • The Chair (Seminar on the Moonee Ponds Phenomena 11 June 2003) drew attention to the unexplained spontaneous combustion of Mr Ron Forbes...	

	Not included in the Reference list.	
Maps: Print	(Viking O'Neil 1991:32-33)	Viking O'Neil, 1991, *Australian Road Atlas*, 10th edn., Penguin Books Australia, Melbourne, pp. 32-33. 1. Author: Viking O'Neil 2. Date: 1991, 3. Title - in italics: *Australian Road Atlas*, 4. Edition: 10th edn, 5. Publisher: Penguin Books Australia, 6. City: Melbourne, 7. Pages: pp. 32-33.
Maps: Online	(maps.com 1999)	maps.com, 1999, *Bhutan*, viewed 11 September 2003, from http://www.maps.com/cgi-bin/search/hyperseek.cgi?search=CAT&Category=Asia%3ABhutanP&Qualifier= 1. Author: maps.com, 2. Date: 1999, 3. Title - in italics: *Bhutan*, 4. Viewed: viewed 11 September 2003, 5. URL: from http://www.maps.com/cgi-bin/search/hyperseek.cgi?search=CAT&Category=Asia%3ABhutanP&Qualifier=
Government		
Media Releases	(Alston 2003)	Alston, R., (Australian Minister for Communications, Information Technology) 2003, *Australian Government to ban spam*, media release 122/03, National Office for Information Economy, Canberra, viewed 23 July, from http://www.noie.gov.au/publications/media_releases/2003/Jul/spam.htm
Government media releases	According to the Commonwealth Scientific and Industrial Research Organisation (CSIRO) (1997–2004:5 of 12), 'the benefits of the new sheep weighing technology ...'.	Commonwealth Scientific and Industrial Research Organisation (CSIRO), 1997–2004, *Revolutionary sheep weigher on trial*, media release Ref PRO 4_168, 15 Sept 2004, viewed 16 September 2004, from http://www.csiro.au/index.asp?type=mediaRelease&id=sheepweigher&style=mediaRelease
Government publication and regulations	(Department of Education, Science & Training 2000) When citing government, legal or standards documents, it is recommended that for citing divisions of Acts and Ordinances, use s. or ss. for citing sections. For example:	Department of Education, Science & Training, 2000, *Annual Report 1999-2000*, AGPS, Canberra. Department of Immigration and Multicultural Affairs 2001, *Immigration: Federation to century's end 1901-2000*, Statistics Section, Business Branch, Department of Immigration and Multicultural Affairs, Canberra.

	• in ss. 4-7 of the *Copyright Act 1968* • the Copyright Act, ss. 4-7 • in s. 4 of the Casino Control Ordinance. When citing regulations, use r. and rr. For example: • the Copyright Regulations, rr. 18-19 • the Commonwealth's Copyright Regulations, r. 18 • in r. 4 of the Copyright Regulations. When citing legal authorities, the following details are necessary: • name of case • year or volume number or both • abbreviated name of the report series • the page on which the report of the case begins. For example: The State of New South Wales v. The Commonwealth (1915) 20 CLR 54	
Legislation	It must be realised that intent must be established before a prosecution can proceed concerning underage drinking (Queensland Government 1962, s. 12, ss. 5). Or Intent must be established before a prosecution can '...' (Queensland Government 1962, s. 12, ss. 5).	Queensland Government, 1962, *Queensland State Liquor Act*, Author, Brisbane. **Note: Author refers back to the sponsor who is also the publisher.**
Standards	According to the Standards Association of Australia (1997), ...	Standards Association of Australia, 1997, *Australian standard: Pressure equipment—manufacture*, (AS4458-1997), Standards Australia, North Sydney.
Patents	Tan and Arnold (1993) formalised and protected their ideas ... *Or* Tan and Arnold (1993, n.p.) protected their ideas by '...'	Tan, I.S. & Arnold, F.F., (US Air Force) 1993, *In situ molecular composites based on rigid-rod polyamides*, US patent 5 247 057.
Brochure	(New South Wales Dept of Primary Industries 2005)	New South Wales Dept of Primary Industries, 2005, *Saltwater recreational fishing in New South Wales: Rules & regulations summary*, brochure, NSWDPI, New South Wales. Include as much information as available. The publisher's name may be abbreviated if it is also the author.
To cite a work reproduced in a book (image, poem, painting etc)	De Kooning's 1952 painting 'Woman and Bicycle' (Hughes 1980:295) is an example of ...'	Hughes, R., 1980, *The shock of the new: Art and the century of change*, British Broadcasting Corporation, London.
Study Guide (author known)	Reports by Hallinan (2000) indicate that ...	Hallinan, P., 2000, *EDED48102 Development and disability: Study guide*, Central Queensland University, Rockhampton.

	Or Similarly, Hallinan (2000:66) reported that '…'.	
Study Guide (author unknown)	A recent report (Central Queensland University (CQU) 2000) has suggested that … *Or* Findings from a 1999 study indicate that '…' (Central Queensland University (CQU) 2000:5).	Central Queensland University (CQU), 2000, *EDE48201 Development and disability: Study guide*, Author, Rockhampton.
Tutorial/workshop handout (unpublished)	The importance of aerobic exercise … (The respiratory system 2000). *Or* Aerobic exercise is valuable because of its '…' (The respiratory system 2000:1).	The respiratory system, Tutorial handout distributed in the unit, HHM72160 Human anatomy, Central Queensland University, Gladstone on 2 March 2000. **Note: No italics nor quotation marks are shown because class handouts are unpublished sources.**
Lecture notes (unpublished)	Thompson (2001) found that the first teaching day may result in mixed emotions for many first year teachers. *Or* It has been found that beginner teachers, on their first day in the class room, will '… ' (Thompson 2001:1).	Thompson, R., 2001, The first day experience, Lecture notes distributed in the unit, EDED48314 Professional practice III, Central Queensland University, Bundaberg on 21 April 2001.
The Bible	These particular lines (Psalm 23:6–8) refer the reader to …	**Note: Bible references are not included in a reference list.**
Atlas (with an editor)	The position of the new city is to be in south-east Queensland (ed. Eales 2003, Map 34).	Eales, S. (ed.), 2003, *The Jacaranda atlas*, 3rd edn., John Wiley & Sons, Brisbane.
Atlas (with no editor)	The position of the new city is to be in south-east Queensland (*The Jacaranda atlas* 2003, Map 34).	*The Jacaranda atlas* 2003, 3rd edn., John Wiley & Sons, Brisbane.

Abbreviations:

Abbrev.	Meaning
art.	article
app.	appendix
c.	about, approximately (from Latin *circa*)
cf.	compare (from Latin *confer*)
ch.	chapter
col., cols.	column(s)
div.	division
ed., eds.	editor(s)
edn.	edition
et al.	and others (from Latin *et alii*)
fn., fnn.	footnote(s)
ill., ills.	illustrator(s)