

RESILIENCE IN PROFESSIONAL NURSES

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RESILIENCE IN PROFESSIONAL NURSES

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2 Corinthians 4:16: Therefore we do not lose heart. Even though our outward man is perishing, yet the inward man is being renewed day by day.

THIS STUDY IS DEDICATED TO MY PARENTS

MY FATHER, A RESILIENT MAN AND A LOVING FATHER, ALWAYS TRUE TO HIMSELF AND HIS FAITH, AN INSPIRATION, A TRUE MENTOR AND ROLE MODEL, HE LIVED HIS LIFE TO THE FULLEST.

MY MOTHER, AS SWEET AS SHE IS SHORT, ALWAYS ON THE GO, A TRUE EXAMPLE OF A LOVING, BELIEVING, CARING PERSON, QUICK TO LAUGH AND FORGIVE, CELEBRATING LIFE.

Proverbs 17:22 A merry heart doeth good like a medicine.

PREFACE AND DECLARATION

An article format was chosen for this study. The researcher, Prof MP Koen conducted the research and wrote the manuscripts. Prof C van Eeden (promoter) and Prof MP Wissing (co-promoter) acted as auditors. Three manuscripts have been written and will be submitted for publication in *Health SA Gesondheid*.

MANUSCRIPT ONE: “The prevalence of resilience in professional nurses”
(*Health SA Gesondheid*)

MANUSCRIPT TWO: “The stories of resilience in professional nurses”
(*Health SA Gesondheid*)

MANUSCRIPT THREE: “Guidelines with strategies for interventions to enhance resilience and psycho-social well-being in professional nurses”
(*Health SA Gesondheid*)

Consent to submit the above mentioned articles (manuscripts) for examination was obtained from Prof C van Eeden and Prof MP Wissing (co-authors).

I declare that RESILIENCE IN PROFESSIONAL NURSES is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

M.P. Koen (Student number: 10062211)

Date: 24th May 2010



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Letter of permission

Permission is hereby given that the following three manuscripts:

1. The prevalence of resilience in professional nurses
2. Stories of resilience in professional nurses
3. Guidelines with strategies for enhancement of resilience and psycho-social well-being in professional nurses

intended for publication in "Health SA Gesondheid", may be submitted by Daleen Koen for the purpose of obtaining a PhD-degree in Psychology.

Handwritten signature of C. van Eeden.

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DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrechia Terblanche, id nr 771105 0031 082, hereby declare that I have edited the PhD dissertation of MP Koen entitled *Resilience in Professional Nurses*.

Regards,
CME Terblanche

ABSTRACT

Research on human resilience has attempted to uncover how certain individuals, even when faced with adverse working conditions can bounce back without serious psychological harm and continue their development. There is a paucity of information on the concept resilience as it pertains to professional nurses. Relevant information in this regard can equip nurses who are fleeing the profession, or who are becoming physically or mentally ill because they are not coping. Information on the prevalence of resilience in professional nurses and a better understanding of the coping skills and resilient adaptations of identified resilient professional nurses can lead to the formulation of guidelines with strategies for interventions that can facilitate growth in professional nurses and be of benefit to the health care service.

This research investigated the prevalence of resilience in professional nurses and listened to the stories of identified resilient professional nurses in order to get a better understanding of their coping skills and resilient adaptations. The data was used to formulate broad guidelines with specific strategies that can be used by hospital managers for in-service training purposes and other programs to facilitate growth in professional nurses. The research was conducted in South Africa amongst nurses in private and public hospitals in the following suburban areas: Potchefstroom, Carletonville, Randfontein and Krugersdorp.

A sequential exploratory design was used where one phase is followed by another phase: the first phase was quantitative research conducted with validated psychometric instruments measuring aspects of resilience, namely: *The Mental Health Continuum*, *The Coping Self-efficacy Scale*, *Sense of Coherence Scale*, *The Adult Dispositional Hope Scale*, *The Life Orientation Test-Revised*, *The Resilience Scale*, and *The General Health Questionnaire*. The second phase was qualitative and explored the stories of the resilient professional nurses by requesting them to write their stories on how they manage to stay resilient and compassionate in the profession followed by focus group interviews also with resilient nurses.

The prevalence of resilience in the professional nurses in the first phase indicated the following: 10% with low resilience, 47% as moderate and 43 % with high resilience,

but with mostly negative feelings toward the profession and with many considering leaving their current job. The stories followed by focus group interviews with resilient professional nurses produced useful data that could be used to formulate guidelines with strategies for interventions to facilitate and enhance resilience and psycho-social well-being in professional nurses thereby improving the nursing profession and health care service overall.

Key words: Resilience, sense of coherence, coping self-efficacy, hope, optimism, mental health, well-being.

OPSOMMING

Navorsing oor veerkragtigheid in mense poog om te probeer verstaan hoe sommige mense daarin slaag om te herstel van werksplekdruk sonder om blywende psigiese skade te beleef en kan voortgaan met hulle ontwikkeling. Daar is min inligting beskikbaar oor die konsep veerkragtigheid soos van toepassing op professionele verpleegkundiges en sodanige inligting kan gebruik word om professionele verpleegkundiges wat swaar kry en die beroep verlaat of siek word omdat hulle dit nie kan hanteer nie, beter toe te rus. Inligting oor die voorkoms van veerkragtigheid in professionele verpleegkundiges en 'n beter begrip van die hanteringsvaardighede en aanpassingsvaardighede van geïdentifiseerde veerkragtige professionele verpleegkundiges kan daartoe aanleiding gee dat riglyne met strategieë vir intervensies geformuleer word gebaseer op hierdie inligting, en dit kan tot voordeel van die gesondheidsorgsisteem wees.

Hierdie navorsing het daarop gefokus om die voorkoms van veerkragtigheid onder professionele verpleegkundiges te ondersoek en na die stories van geïdentifiseerde veerkragtige professionele verpleegkundiges te luister om 'n beter begrip van hulle hanterings- en aanpassingsvaardighede te verkry. Die data is gebruik om breë riglyne met spesifieke strategieë te formuleer wat deur hospitaalbestuur gebruik kan word vir indiensopleiding en ander programme om so groei by die verpleegkundiges te bevorder. Die navorsing is gedoen in Suid-Afrika onder professionele verpleegkundiges in openbare en provinsiale hospitale in die Potchefstroom, Carletonville, Randfontein en Krugersdorp areas.

'n Opeenvolgende ondersoekende ontwerp is gebruik waar een fase opgevolg is deur die volgende fase: die eerste fase was kwantitatiewe navorsing gedoen met behulp van gevalideerde vraelyste wat aspekte van veerkragtigheid meet, naamlik: "*The Mental Health Continuum, The Coping Self-efficacy Scale, Sense of Coherence Scale, The Adult Dispositional Hope Scale, The Life Orientation Test-Revised, The Resilience Scale, en The General Health Questionnaire*". Die tweede fase was kwalitatief en het die stories van veerkragtige verpleegkundiges ondersoek deur hulle te versoek om hulle stories te skryf oor hoe hulle veerkragtig en toegewy kan bly oor die beroep, opgevolg met fokusgroeponderhoude ook met veerkragtige verpleegkundiges.

Die ondersoek na die voorkoms van veerkragtigheid in professionele verpleegkundiges in die eerste fase het die volgende aangedui: 10% met lae veerkragtigheid, 47% met matige veerkragtigheid en 43% met hoë veerkragtigheid, maar met hoofsaaklik negatiewe gevoelens teenoor die beroep en met baie wat voorneem om hulle huidige pos te verlaat. Die stories van die veerkragtige verpleegkundiges opgevolg met fokusgroeponderhoude het bruikbare data opgelewer wat gebruik kon word in die formulering van riglyne met strategieë vir intervensies om veerkragtigheid en psigo-sosiale welsyn in professionele verpleegkundiges te bevorder om sodoende die verpleegkundige professie en gesondheidsorgstelsel te verbeter.

Sleutelwoorde: Veerkragtigheid, kohesiesin, coping/hantering selfbevoegdheid, hoop, optimisme, geestegesondheid, welsyn.

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SECTION ONE

OVERVIEW OF THE STUDY

OVERVIEW OF THE STUDY

“Moreover let us exult and triumph in our troubles and rejoice in our sufferings, knowing that pressure and affliction and hardship produce patient and unswerving endurance. And endurance develops maturity of character. And character produces joyful and confident hope” Romans 5:3-4.

The background and rationale that inspired the study are discussed first, followed by the problem statement, paradigmatic perspective and the research methodology. The two phases of the study and the emerging guidelines with strategies for interventions for enhancement of resilience in nurses are presented in article format, according to the criteria of the journal of choice. The study is concluded with a reflection, evaluation, limitations, conclusions and recommendations.

1.1 Background and rationale for the study

The nursing profession is based on a philosophy of care and professional nurses are responsible to deliver this care to the sick, weak, traumatised, wounded and dying patients in their care, and to be an instrument of service to patients within the health care system (Kozier, Erb, Berman & Burbe, 2000). Professional nurses are considered the backbone of the health care system and they are the first point of contact for patients (Van Rensburg & Pelser, 2004). This entails catering to the individual, family and communities, physical, psychological, social, intellectual and spiritual needs as well as caring for the dying (Kozier et al., 2000). It can be said that nursing claims caring as the hallmark of the nursing profession. As such, all issues relating to caring are important to maintain the quality of care in the nursing profession (Muller, 2002).

The ethical foundation of nursing is vested in the Nurses’ Pledge (derived from the Nightingale Pledge) and has been in use since the onset of nurses training in South Africa (Muller, 2002). When taking the Pledge, the professional nurse enters into a verbal agreement with the community to always put the patient’s needs first. This is a

considerable promise to make and one that cannot be taken lightly. According to Vander Zyl (2002) for nurses to be successful caregivers they must be able to find a sense of purpose in caring for others, as their perceptions of personal and professional self-worth are dependent on emotional connection with their patients. Nurses enter the profession because they have a deep rooted desire and calling to care for people, it is therefore important for them to stay optimistic and keep the passion or the caring concern for patients to ensure high quality nursing care (Buchan, 2006; Talento, 1990; Watson, 1988).

When focusing on the well-being of South African professional nurses, the nature of the South African health care system and the effect it has on them should be taken into consideration. In the last 5-10 years there has been a shift from a fragmented, mainly curative, hospital-based service to an integrated, primary health care, community-based service (African National Congress, 1994; Geyer, Naude & Sithole, 2002). South Africa has a dual health care system consisting of both a private and a public sector. The private sector being profitable as clients have medical insurance paying for services while the public sector is a state system, publicly funded and free to unemployed citizens and available for a small fee to those able to pay (Geyer et al., 2002; Van Rensburg & Pelsler, 2004). The public sector is divided into the national, provincial and district system with professional nurses involved in all three levels and predominantly health care providers in the provincial and district levels (Dennill, King & Swanepoel, 2002).

The mentioned changes have had far reaching effects on professional nurses as the core or backbone of the health care system, as larger sections of the population are now able to afford or access services for free (Pelsler, Ngwene & Summerton, 2004). Accessibility to health care in the public domain and specifically for the vulnerable groups in the society, was ensured through clinic-building and free PHC (primary health care) programs that focus on the most acute needs and conditions (Van Rensburg & Pelsler, 2004). The introduction of free health care was, however, not adequately planned and budgeted for, resulting in overcrowding, poor staff morale, excessive use and abuse of scarce resources and an unfortunate deterioration in the quality of care. It is obvious that the overloaded,

impoverished health care system is not able to keep up with the demand (Ntuli & Day, 2004; Van Rensburg & Pelsler, 2004). Although several major milestones have been achieved with the transformation, many impediments, flaws and failures, which have not yet been mastered, are rampant in the system and dramatically affect the work environment of the professional nurse. In the rural areas, primary health care services are mainly provided by nurses, with professional nurses in overall charge of these services (African National Congress, 1994) having to cope with all the demands. Furthermore there are conflicting interests between the sectors and confusion between the national, provincial and local spheres of government resulting in unhappiness and uncertainty between these services (Van Rensburg & Pelsler, 2004).

The resultant increase in health care utilisation is placing a great burden on professional nurses, who had to bear the majority of consequences of the changes. They were demoted to primary health care services without the necessary preparation and support (Armstrong, Geyer, Mngomezulu, Potgieter & Subedar, 2008; Van Rensburg & Pelsler, 2004; Walker & Gilson, 2004). The vast financial and human resource disparities between the public and private health care sectors have adverse effects on health professionals and even more so on professional nurses (Day & Gray, 2005). These practitioners carry the burden of serving the majority of South Africa's population with minimal funds and insufficient personnel, 58.9% nurses in the public sector are serving 82% of the population and 41.1% in the private sector serving only 18% of the population (Van Rensburg, 2004). Only a limited number of South Africans have access to private health care, as only 18% can afford medical scheme coverage (Van Rensburg, 2004). The HIV and AIDS impact on health care needs increased the un-affordability of medical schemes as costs escalated in the private sector (Cornell, Goudge, McIntyre & Mbatasha, 2001). The ethics and ethos of nursing are based on the core value of caring and are in direct conflict with a profit-focused society, adding to the already challenged nursing profession (Hofmeyer, 2003).

Professional nurse staffing is another important factor to consider. There is an overall shortage of nursing professionals around the world, which is leaving in its wake a serious

crisis in terms of adverse impacts on the health and well-being of the population at large and also the professional nurse who have to counterbalance the shortage (Mitchell, 2003). In South Africa the shortages are acutely felt with an estimated nurse shortage of 32 000 (Oulton, 2006). What makes the situation worse in South Africa is the successful recruitment of its nursing staff by countries that offer more in terms of benefits and better working conditions (Xaba & Philips, 2001). Migration is taking place on three levels, from rural to urban areas, from the public to the private sector and out of the country to first-world, industrialised countries. At all these levels, professional nurses are moving from services where they are desperately needed as front-line care givers (Hospersa, 2002). With professional nurses at the core of health care provision the critical nurse shortage in South Africa is alarming. According to the South African Nursing Council a total of 47 390 800 patients were served by 101 295 registered nurses in 2006, that is a ratio of 468 patients for 1 registered nurse (SANC, 2006).

This shortage, partly due to nursing emigration, is further explained by reasons like low wages, heavy workloads, poor working and living conditions, lack of resources, limited career opportunities, poor management of health services, unstable work environments and economic instability, and the impact of HIV and AIDS (Bateman, 2005; Buchan, 2006). According to the Health Systems Trust (2005) an estimated 300 nurses are leaving South Africa every month. The financial cost to South Africa is estimated at 37 million U.S. dollars alone in 2005 (Lubanga, 2005). It was further estimated that 1640 nurses went to Britain alone in the same year. Overall nurse training from 1996 to 2004, produced a total of 34 364 professional nurses in South Africa but the South African Nursing Council showed a growth of only 10 707 nurses, representing 31.5% of those produced and further indicating an attrition rate of 68.5%. This was explained as a combination of reaching retirement age, morbidity and mortality, moving to other jobs and migration (Clarke & Aiken, 2003; SANC, 2006; Subedar, 2005). Another disturbing progression is the increasing ageing workforce. Of the 101 295 professional nurses registered at the South African Nursing Council, more than half (57 201) are over the age of 45 years, with a mere 12 451 under the age of 35 years (SANC, 2006). Ehlers (2003) reported that the significant impact will be between 2005 and 2020, as this is the period

when many of the current professional nurses will enter retirement age. This is also reported in the Lancet Reviews Healthcare in South Africa by Cullinan (2009) which is of the opinion that as many as 40% of professional nurses are due to retire in 5-10 years. These numbers don't seem likely to improve any time soon, as the intake of new students are declining and a number of nursing colleges were closed to save money during former President Thabo Mbeki's era. Cullinan (2006) suspected that health care institutions are run with half the staff needed and that one third of health posts are vacant countrywide.

According to Buchan (2006) the professional nurse who remains in the profession, suffer from a high workload and low morale that has lead to a compromise in the quality of care provided as hundreds of patients are often served by one practitioner and even providing the most basic care is sometimes impossible. In these circumstances the nursing personnel try only to survive as they work under high stress levels and unbearable work loads, affecting their physical health and emotional well-being (Levert, Lucas & Ortlepp, 2000). Not only is the professional nurses' level of job satisfaction diminishing, but the prevalence of compassion discomfort, stress and fatigue is increasing, which directly affects quality care, as professional nurses become increasingly despondent and unfeeling in a situation that shows no signs of a swift recovery. This all paints a very desperate picture of the professional nurses working environment and their battle to keep well and survive.

One cannot discuss the well-being of professional nurses and their environment without looking at the health of South Africans. With more money invested into health care and the changes in the health care system, the expectation would be an improved status but the present status reflects the opposite. Life expectancy has decreased from 57 years to 51.4 years between 1996 and 2004 (Day & Gray, 2005). The HIV and AIDS epidemic is a major concern if you consider that Sub-Saharan Africa carries 71.5% of the worlds HIV and AIDS infections (Ehlers, 2006; UNAIDS, 2006), add to this the TB epidemic which is in no way starting to level off, and a very gloom future unfolds. It can be said that South Africa is experiencing a triple burden of diseases, namely communicable diseases associated with poverty; non-communicable diseases associated with lifestyles; and

trauma and violence, most of these fuelling the HIV/AIDS epidemic. The situation is further complicated by the high unemployment rate, and the influx of people into metropolitan areas. This has created an explosion of people living in squatter areas in over-crowded dwellings and the lack of basic infrastructure increasing the potential for ill health (Armstrong, Geyer, Mngomezulu, Potgieter & Subedar, 2008).

The HIV and AIDS epidemic leaves South Africa with an estimated 5 500 000 adults and children living with HIV and AIDS in 2006, with 320 000 deaths in that same year, that is more than 800 deaths every day (UNAIDS, 2006). The AIDS death rate has increased from 26.4% in 2000 to 55.8% in 2004, doubling the amount of AIDS orphans from 338 932 in 2002 to 626 000 in 2004 (Day & Gray, 2005). Pelsler, Ngwena and Summerton (2004) claims that approximately 80% of the population is making use of the public health sector and the demands will increase, exceeding 5% a year from 2004 and rise to 11% a year from 2010 onwards as a direct result of HIV and AIDS. It is thus clear that the epidemic places a great burden on professional nurses as they not only deliver the biggest percentage of patient care, providing both physical and emotional support for people living with HIV and AIDS and their families, and caring for those dying of AIDS (Evian, 2003). Furthermore the incidence of TB has increased from 359.6 per 100 000 in 1999 to 550.1 per 100 000 in 2003 (Day & Gray, 2005). In a report of 2009 it was said that South Africa, with less than 1 percent of the world's population, now bears 17 percent of the world's burden of HIV and AIDS (Dugger, 2009) with more HIV infected people than any other nation.

Another emotionally taxing aspect is accidental exposure to the HI virus. It is estimated that on average, a nurse will sustain 3-4 sharp object injuries over 5 years (Aiken, Sloane & Klocinski, 1997). Contracting HIV is a frightening concern for nurses (Clarke, Rockett, Sloane & Aiken, 2002; Smit, 2004). A study done by Van Heerden (2007) reported the negative impact on nurse's emotions and their relationships. Emotions like anger, shock, anxiety, fear, panic, apathy and depression were present and relationships with family members and even God suffered, while they were waiting for results on their blood tests and even worse when they didn't report it and tried to handle it on their own.

Complicating the situation even more is the policy of most African countries, including South Africa, which protect the patients by withholding their HIV and AIDS status. This is forcing the professional nurse to treat every patient as being HIV positive, increasing their workload and zapping scarce resources and supplies (Ehlers, 2006).

Other aspects of the South African population that directly influence nursing, is the population growth and the ethnicity of the population. The mid-2005 population was estimated at approximately 46.9 million, compared to the census figure of October 2001, which was 44.8 million. Of this population the majority (72%) are Africans an estimated 37.2 million, the white population an estimated 4.1 million, the coloured population an estimated 4.1 million and the Indian/Asian population an estimated 1.1 million (Day & Gray, 2005). The population growth has the obvious impact of an increased workload for an already understaffed health care system, while the ethnic composition of South Africa presents professional nurses with a multi-cultural environment, which places its own demands on professional nurses regarding cultural competence. Cultural competence has been defined as a process of integrating knowledge, attitudes and skills that enhances cross-cultural communication and allows the professional nurse to function effectively in the context of cultural difference, or diversity (Andrews & Boyle, 1999; French, 2003). South Africa has a culturally diverse health sector and cultural differences create more barriers than any other in communication and collaboration in any organisation. Creating and communicating a shared vision and values is critical in a hospital where diverse individuals converge (Armstrong, Geyer, Mngomezulu, Potgieter & Subedar, 2008). Cultural competence requires professional nurses to be skilled and flexible in understanding their own and others' cultural values, beliefs, attitudes and practices that affect health, illness and health seeking behaviors, as well as to be able to accommodate different cultural needs and provide compassionate care. This presents as yet another encumbrance on already overburdened professional nurses.

Looking at the measures the government has thus far implemented to recruit and retain professional nurses their focus is solely monetary incentives, but this alone will not fulfill the needs that have been voiced. More positive approaches have been suggested to retain

and empower nurses such as strengthening work autonomy and providing a safe work environment (Adams & Kennedy, 2006; Connell, Zurn, Stilwell, Awases & Raichet, 2007). So far not enough has been done to alleviate the strain and distress of professional nurses currently in the profession, who seem to be disheartened and are losing their compassion for caring in a country where the population is becoming even more dependent on health care services. In a study done by Benner as early as 1984 nurses reported that they were forced to do only emergency nursing because of staff shortages, thus two important sources of satisfaction are missing: the human connection, and the sense of competency and accomplishment that comes from knowing you have offered your best (Benner, 1984). According to Flanagan (1991) nurses simply have to do more and are constantly being stretched further because today's adjustments require statistical proof of yesterday's unmet needs to compete for tomorrow's shrinking budget. Not being able to cope with the occupational stressors, the professional nurse will suffer as a whole, affecting every area of his/her life on a professional and personal level. Recent work in the caring professions are leaning towards an illness prevention and health promotion orientation, the focus being on the facilitation and enhancement of skills and competencies, with an emphasis on hope and optimism, rather than relying on survival and reactive treatment strategies (Cilliers, 2002; Collins & Long, 2003a; Fralic, 2008).

The current analysis of the environment of the professional nurse focusing on nursing as a career choice, the transformation of the health care system, the financial and human resource disparities between the public and private sector, the declining number of professional nurses in an already understaffed health care system, the health of the population with HIV and AIDS as a major problem, the growing population and the ever-increasing demands made on the professional nurse in a multi-cultural environment shows that this context is taking its toll on the well-being of professional nurses. This analysis shows that not enough is being done for professional nurses taking into account their high risk and stressful career.

1.2 Problem statement

The nursing profession and the stress commonly associated with it has been the subject of considerable research for decades. This is not surprising given that nursing is widely known for its high rates of staff turnover, absenteeism and burnout (Kirkcaldy & Martin, 2000). The most common sources of stress seem to be similar for all nurses imperative of type or ward or nursing specialty and appear to be inherent in the nursing role (Cross & Fallon, 1985). These factors include a high work load, poor collegial support, role conflict and role ambiguity. The perception of stress occurs when environmental demands exceed the individual's resources (Lambert & Lambert, 2001; Lazarus, 1990) leaving the nurse feeling hopeless and experiencing job dissatisfaction.

South African professional nurses find themselves daily in this high risk, stressful work environment affecting their physical health and emotional well-being (Levert, Lucas & Ortlepp, 2000; Van den Berg et al., 2006). Research findings and literature indicate that professional nurses feel emotionally overloaded, stressed, fatigued, helpless, hopeless, angry, shocked, grieved, irritated, fearful, unsettled, frustrated, experiencing job dissatisfaction, moral distress and lack of personal accomplishment and for these reasons often leave the profession (Aiken, Clarke, Sloane & Socchalski, 2001; Shisana, Hall, Maluleke, Chauveau & Schawbe, 2004; Smit, 2004; Van den Berg, Bester, Janse-van Rensburg-Bonthuysen, Engelbrecht, Hlophe, Summerton, Smit, Du Plooy & Van Rensburg, 2006). In the field of psychology, terms such as vicarious traumatisation, traumatic counter-transference, secondary traumatic stress, burnout, and compassion fatigue have emerged to explain these adverse emotional effects within the caring professions (Collins & Long, 2003b; Figley, 2002; Frederickson, 2001; Salston & Figley, 2003). Recently the positive psychology movement is building a science that aims at accumulating knowledge that will help individuals and organisations to promote personal satisfaction and resilience and high productivity and it is suggested that predictors of the positive end of the health continuum be explored (Keyes, 2007; Nelson & Simmons, 2003; Ryff & Singer, 2003; Seligman & Csikszentmihaly, 2000).

According to Vander Zyl (2002) professional nurses need to find meaning in their work to be successful caregivers and have a responsibility to model health care behaviors to assist patients to achieve healing. However with the workplace adversity of nursing associated with the excessive workloads, lack of autonomy, bullying and violence and organisational issues such as restructuring with its associated problems, retaining nurses in the workforce are becoming a challenge and posing dangers for the nursing profession and health care services. The professional nurse as a multi-dimensional being consisting of physical, emotional, intellectual and spiritual dimensions which are integrated and dependent on one another, not being able to cope with all the stressors, will suffer as a whole, affecting every area of his/her life on a professional and personal level (Cilliers, 2002). The professional nurse's equilibrium may be disturbed to such an extent that survival strategies are implemented to counteract the effects resulting in negative effects (Valent, 1995). It is a question what the level of psycho-social well-being of nurses as a group is, and how individuals themselves experience their situation, their strengths, their coping strategies, and their own resilience.

Research on human resilience has been done to try and understand how certain individuals, even when faced with challenges and risk factors or stressors are able to bounce back without lasting psychological damage and continue with their lives. Resilience has become an appealing concept because of its roots in a model of positive psychology. Rather than the traditional pathogenic model that focuses on factors which predispose individuals to adversity, resilience researchers seek to explore factors that allow individuals to successfully overcome adversity (Huber & Mathy, 2002; Joseph & Linley, 2005; Kaplan, 1999; Masten, 1999; Tedeschi & Calhoun, 2004). Resilience has proven itself to be a complex concept that is difficult to define and measure. A good amount of research has been undertaken since Garmezy and colleagues first began studying resilience in the early 1970's (Garmezy, 1971). Ryff and Singer (2003) identify three areas of resilience research, in high-risk children and adolescents, in the process of aging and, on individuals who have positively adapted despite severe trauma.

Three major aspects have been suggested as hindering the formal operationalisation of resilience: (a) a lack of consensus on the definition of resilience and related constructs, (b) differing conceptualisations of resilience as a personal trait versus an outcome or a process, and (c) a lack of consensus on the definition of central terms used within models of resilience (Kaplan, 1999; Luthar, Cicchetti & Becker, 2000). The second definitional issue regarding resilience is the various conceptualisations of the construct as a trait, an outcome, or a process. Kaplan (1999) identifies the two ways in which resilience has generally been conceptualised and studied. These are: (a) the achievement of positive outcomes in the face of adversity and, (b) the qualities or characteristics that allow individuals to achieve positive outcomes in the face of adversity. A third conceptualisation, was suggested by Luthar and Cicchetti (2000) namely resilience as a dynamic process encompassing positive adaptation within the context of significant adversity. The variation in definitions between resilience as a trait versus an outcome risks becoming a tautology that literally “explains itself” (Kaplan, 1999).

More recent conceptualisations of resilience see it as a dynamic process influenced by internal factors and environmental factors and leading to positive outcomes (Carver, 1998; Cicchetti & Garmezy, 1993; Kumpfer, 1999; Luthar & Zelazo, 2003; Richardson, 2002). Viewed in this light resilience is something that one “has” and “does”. It acknowledges personal, social, and environmental factors playing a part in the process. Most important being the interactions among these factors and the resulting adaptation that characterises what resilience is really all about (Luthar & Cicchetti, 2000). When understood in this way resilience is generally made up of four components, namely: (a) risk factors, (b) protective factors, (c) vulnerability factors, and (d) positive adaptation (Luthar & Zelazo, 2003).

For the purposes of this study applying resilience in the nursing profession and the world of the professional nurse the following components can be identified:

- Risk factors or stressors in the nursing work environment, like the high workload, the staff shortage, poor support and role conflict;

- Protective factors that have been identified in the literature as having protective influences, these factors may be internal or external, with internal referred to as psychological characteristics and external more to social support systems (Friborg, Hjembal, Rosenvinge & Martinussen, 2003). The characteristics include personality traits like, hope, optimism and sense of coherence. Kumpfer (1999) has identified five clusters of protective factors, which she termed internal resilience factors, being: (1) spiritual or motivational characteristics, (2) cognitive competencies, (3) behavioral/social competencies, (4) emotional stability and management and (5) physical well-being competencies;
- Vulnerability factors are the opposite of protective factors, and described by Luthar (1991) as attributes that make individuals more susceptible to deterioration in functioning due to high levels of stress and in this context implied the resulting fatigue, burnout and depression as was explained. The fourth and final component is
- Positive adaptation that can be defined as an outcome that is much better as would be expected given the presence of the risk factors (Luthar & Zelazo, 2003). Research by Richardson (2002) suggests that individuals have the potential to not only return to previous levels of functioning but experience gains in self-esteem, self-efficacy, self-reliance and a change in life perspective that serve to make them stronger than they were before. This gain has been termed thriving or flourishing (Carver, 1998; Keyes, 2006; Ryff & Singer, 2003).

There is a paucity of information about the concept resilience as it pertains to nurses in practice. Relevant information is needed to better equip professional nurses who are suffering and fleeing the profession or getting mentally or physically sick. Information and a better understanding of the prevalence of resilience in professional nurses and the coping skills and resilient adaptations of the resilient nurses can be of benefit to the health care service and provide hospital managers with useful guidelines for in service training that won't be threatening and can facilitate growth in professional nurses. The challenge is to identify resilient professional nurses (or the absence of resilience in nurses) and try to learn from their experiences and functioning, in order to fortify strengths and coping

skills in others. Identification of resilience can be affected with the aid of models and theories, like the resilience framework (Kumpfer, 1999) the resiliency process model (Richardson, Neiger, Jensen & Kumpfer, 1990), and validated instruments that measure aspects of resilience, such as: The Mental Health Continuum (Keyes, 2006); The Coping Self-efficacy Scale (Chesney, Neilands, Chambers, Taylor & Folkman., 2006), Sense of Coherence Scale (Antonovsky, 1987), The Adult Dispositional Hope Scale (Snyder, Harris, Anderson, Holleran, Irving, Stigman, Yoshinobu, Gibb, Langelle & Harney, 1991), The Life Orientation Test-Revised (Scheier, Carver & Bridges, 1994), The Resilience Scale (Wagnild & Young, 1993) and The General Health Questionnaire (Goldberg & Hillier, 1979).

Furthermore, extensive personal experience in the field of psychiatric nursing has proved that there are many nurses who choose to remain in nursing, and survive and even thrive despite a climate of workplace adversity. This awareness, in the context of the above analysis, has prompted the researcher to undertake this study to explore the prevalence of resilience in professional nurses and to identify the resilient professional nurses who had positively adapted to mostly adverse occupational circumstances. Their narratives of personal strengths and other protective factors that enabled them to cope and overcome and even thrive, can then be analysed. Information obtained could lead to the formulation of guidelines to facilitate and enhance resilience and psycho-social well-being of professional nurses. The socially relevant contribution of such a study could thus be to provide scientific information to be used as basis to improve the overall functioning of professional nurses, thereby improving the quality of nursing care and improving the health care service.

The following specific research questions are thus posed:

- What is the prevalence of resilience in a group of professional nurses?
- What can be learned from the analysis of stories (narratives) of identified resilient professional nurses about their coping, strengths, resilience and positive adaptation in

the nursing profession that may assist in an understanding of resilience as an enabling factor for psycho-social well-being in a difficult professional context?

- What guidelines with strategies for training and other programs to facilitate and enhance professional nurse's resilience and psycho-social well-being can be extracted from the results obtained from answers to the above questions?

1.3 Research objectives

- To investigate the prevalence of resilience in a group of professional nurses and to identify resilient professional nurses with the help of selected psychometric instruments.
- To identify resilient characteristics, strengths and other protective factors by employing qualitative research methods with identified resilient professional nurses in order to obtain a thorough understanding of resilience as an enabling factor for psycho-social well-being in the nursing profession.
- To formulate guidelines with strategies for interventions or training, based on the results obtained from findings of studies relating to the above two objectives, in order to facilitate and enhance resilience and psycho-social well-being of professional nurses.

1.4 Central theoretical argument

The investigation of the prevalence of resilience in professional nurses will lead to the identification of resilient professional nurses and by analysing the stories of resilient nurses, characteristics, strengths and other protective factors can be identified to facilitate a thorough understanding of the nature of resilience in nurses. From these findings guidelines with strategies for interventions can be deduced to facilitate and enhance resilience and psycho-social well-being of professional nurses.

1.5 Philosophical positioning/paradigmatic perspective

The researcher agrees that no research is free of values and therefore views a proclaimed philosophical position as important, which implies that the researcher's beliefs and assumptions influence the research (Burns & Grove, 2005). A paradigm is a worldview, a general perspective on reality and all its complexities (Polit & Beck, 2006). In the practice of science, it refers to belief systems or philosophical position and helps us to interpret our world. The researcher focuses on the dynamic, holistic and individual aspects of phenomena (Polit & Beck, 2006) and agrees that in mixed methods research, the choice for this study, different philosophical paradigms and methods are compatible (Tashakkori & Teddlie, 2003) and that the paradigm is determined by the researcher and the research problem rather than the method. The paradigmatic perspective of this study includes the meta-theoretical assumptions (ontological and epistemological dimensions), theoretical statements and methodological statements (methodological dimension).

1.5.1 Meta-theoretical assumptions: Ontological and epistemological dimensions

Ontology refers to the study of being, reality or existence and its basic categories and relationships. The ontological dimension in the context of this research refers to the researcher's beliefs about the nature, form, structure and status of phenomena, as well as the reality which is being investigated (Denzin & Lincoln, 1994; Mouton & Marais, 1996). The researcher aims to understand and create knowledge through individual or group re-constructions centered on consensus (Guba & Lincoln, 2005). The researcher supports critical realism in the ontological dimension, believing that a real external objective world exists, which functions independently from our knowledge, understanding, beliefs, theories and descriptions of it, people are active participants in this reality and are constantly in mutual interaction with it. Mutually interacting with one another, they effect change in each other. In our daily interaction with reality we come into contact with different experiences and phenomena of the external world that we try to understand by developing the best informed construction for which there is consensus

at a given time, which we call knowledge, but which may change as man and the external objective world continually effect change on each other.

Epistemology refers to the quest for truth and knowledge, the researcher strives to produce research results that approximate the true reality as far as possible. According to Mouton and Marais (1994:15) it is important to remember the complexity of the research domain of the social sciences and the inherent inaccuracy and fallibility of research and it is necessary to accept that complete certainty is unattainable. To the researcher this implies that a continuous awareness and strive to obtain the “truth” and to be critical, interpretive and inquisitive to learn as much as possible is essential in this research. The ontological perspective of the researcher informs the epistemological perspective of the researcher and in this study the researcher sees the participants as the experts of the phenomenon under investigation, namely resilience.

Within these dimensions the meta-theoretical assumptions are grounded on my own philosophy. As a Christian I respect the uniqueness of every person including their beliefs and value systems which influence their manner of dealing with their environment which includes their working environment or career, and believing that resilience is important for living life to the fullest. The way people perceive life is revealed in their values and the choices they make, reflecting attitudes toward life and work. The meta-theoretical assumptions comprise assumptions on the person, environment, mental health or well-being, as follows.

1.5.1.1 The person

I believe that a person is made in the image of God, unique and holistic with interacting biological, psychological, social and cognitive subsystems. A person as a whole being is in constant interaction with the internal and external environment. Every person is unique in the manner that they react to stimuli and stressors in their environment and it is often based on previous experience. As a person and the environment interact with one another, they effect change in each other forming constructions to explain and address these

changes. Some people seem to be able to thrive in spite of adversity and seem to be more resilient. In this study a person refers to the professional nurse who has to deal with a high risk, stressful work environment.

Assumptions on the nature of humans/persons refer in this study on the empirical level to professional nurses as individuals who have undergone training and who are qualified and registered with the South African Nursing Council for the purposes of practicing the nursing profession. Nurse practitioners are classified in either professional or sub-professional categories based on the training received. The professional category includes professional nurses who have undergone a comprehensive four year diploma or degree in general health nursing, community health nursing, psychiatric health nursing and or psychiatric professional nursing. Sub-professional categories include enrolled nurses who have undergone a two-year certificate program and enrolled auxiliary nurses who have undergone a one-year certificate program (Van Rensburg, 2004). For the purposes of this study professional nurses from these two categories were included as they carry the most responsibilities in the profession according to their scope of practice and licensed as a professional nurse under the Nursing Act (no 33 of 2005) and assumes responsibility and accountability for independent decision making, and is educated and competent to practice comprehensive nursing (SANC, 2006).

1.5.1.2 Environment

The environment is internal and external and comprises all those forces that influence a person at any given time of a lifetime. The internal environment refers to the physical, social, spiritual and psychological subsystems, including values and beliefs of a person. The external environment refers to external forces namely, physical, social, psychological and spiritual and includes a person's career or working environment. The environment and a person are in constant mutual interaction, effecting change on each other, and a person constantly assesses this change and creates mental constructions to explain and address these changes. These forces and changes influence the person positively or negatively.

In this study the external environment refers on an empirical level to the working environment of the professional nurse, namely the nursing profession which is mostly a high risk, stressful working environment. This includes public hospitals, private hospitals and primary health care clinics.

1.5.1.3 Mental health or well-being

Mental health or well-being refers to more than the absence of disease and illness, it is a state of wholeness where a person can deal with stressors in an effective way, or shows resilience in the face of adversity. A person's well-being can be displayed on a continuum, from pathology on the one end, through incomplete mental health or languishing with low well-being, to flourishing on the other end of the continuum. Optimal well-being or flourishing consists of positive feelings and positive functioning in personal and social spheres of life. Wholeness is maintained when a person interacts with his/her environment in a positive or resilient way. When a person fails to maintain his or her mental health, he or she can't cope with stressors and may need interventions from health professionals.

In the context of this study it is assumed that the stressful working environment can negatively affect the mental health or well-being of the professional nurse, but also that internal and external resources may maintain well-being despite the stressful context.

1.5.2 Theoretical statements

Theories are a systematic way of looking at the world and describing the events explored in this study. Various models and theories are investigated and used in this study, like Kumpfer's resilience model (Kumpfer, 1990) and the resiliency process model (Richardson et al., 1990). Kumpfer's resilience model is helpful as it serves as a framework that includes both process and outcome constructs and provides a means of integrating findings on risk and protective factors in individuals and environments and focuses attention on processes of adaptation. The environmental context in this study

comprises of the nursing working environment that are the stressors or challenges that activate the resilience process and create a disequilibrium or disruption in the professional nurse. The transactional processes include transactional processes between the professional nurse and his/her environment either passively or actively attempting to perceive, interpret and surmount threats, challenges or difficult environments to construct more protective factors. Internal or resiliency self characteristics include internal individual spiritual, cognitive, social/behavioral, physical and emotional/affective competencies or strengths.

Resilience processes include stress/coping processes learned by the individual through gradual exposure to the increasing challenges and stressors that help the individual to bounce back with resilient integration. A positive outcome or successful adaptation suggests the protective factors that the professional nurses use to thrive making the professional nurse a resilient nurse (Glantz & Johnson, 1999). Richardson and his associates' (1990) process model of resilience focuses on the processes of coping with disruptions that are seen as opportunities for growth, development, and skill building. The products of the resiliency enhancing process are increased protective skills as well as skills that facilitate the coping process. After disruptive experiences (in this study the stressors in the nursing working environment) the resilient individual (the resilient professional nurse) can withstand disintegration following disruption and if over taxed recovers in a shorter time. This study focus mainly on the resilient individual (professional nurse), that adapts competently to disruptive events (stressors in the nursing working environment), and develops new skills in the process, using the events as a challenge to become a better person. The theoretical statements comprise the core concepts or conceptual definitions. Because concepts tend to have different meanings and interpretations, the applicable concepts used in this study, with resilience as the overarching concept, are defined.

1.5.2.1 Nursing

Nursing, according to the researcher's belief is a unique profession involved with caring for people who, due to ill-health, cannot take care of themselves, as well as those who due to stressful life situations, need professional guidance and advice. It is both an art and a science dependent on resilient professional nurses to care compassionately for those in need of caring. It has developed and exists as a comprehensive clinical healthcare response to the basic life needs of an individual, group or community.

The Nursing Act, 2005 (Act No. 33 of 2005) defines nursing as a caring profession and makes provision in sections 30 (1) and 31(1) of the Act for the prescribing of a scope of practice for professional nurses, who is qualified and competent to independently practice nursing and are registered at the South African Nursing Council.

1.5.2.2 Resilience

Understanding the nature of resilience requires conceptual and definitional clarity.

1.5.2.2.1 Conceptualising resilience

Before resilience can be conceptualised, a brief look at the history may be of value. At first resilience was nothing more than an interesting side-finding in many studies. Richardson (2002) stated that from a historical view, the first wave of resilience inquiry focused on the paradigm shift from looking at the risk factors that led to psycho-social problems to the identification of strengths of an individual. In the course of conducting research an awareness of these protective factors for children at risk of developing schizophrenia and yet despite the risk adapted favorably, became evident (Garmezy & Streitman, 1974). Resilience research since then has varied greatly in terms of how the components of resilience have been defined and subsequently measured (Luthar & Cushing, 1999; Tedeschi & Calhoun, 1996). A good amount of research has been undertaken since Garmezy and colleagues began studying resilience in the early 1970's.

Ryff and Singer (2003) identify three primary areas of resilience research: research focusing on resilience in high-risk children and adolescents and this lead to by far the most abundant research activities with the most important findings regarding resilience; secondly research on resilience in the aging process; and thirdly research on individuals who have positively adapted despite severe trauma. Ryff and Singer (2003) have followed a line of research devoted to resilience in response to life challenges. Unlike earlier researchers that defined resilience as merely the absence of disease in the face of adversity, these researchers have defined resilience in adults as recovery or improvement following life challenges (Ryff & Singer, 2003). Further studies related to trauma suggest that individuals have the potential to not only return to previous levels of functioning but experience gains that serve to make them stronger than they were before and is termed thriving which is similar to the idea of resilient re-integration (Carver, 1998; Ryff & Singer, 2003). Resilience has been conceptually linked with curiosity and intellectual mastery as well as the ability to detach and conceptualise problems (Block & Kremen, 1996) and the capacity to mobilise resources (Wilson & Drozdek, 2004).

1.5.2.2.2 Defining resilience

Defining the concept is challenging, however, the potential gains in further understanding the construct can be of theoretical and practical importance and resilience is therefore the choice as overarching concept for the study (Glantz & Johnson, 1999; Patterson, 2002). The Oxford dictionary (Hornby, 2000: 1000) defines resilience as “the activity of rebounding or springing back; to rebound; to recoil.” It further defines resilience as “elasticity; the power of resuming the original shape or position after compression”. It is the ability “to return to the original position.” The lexical analysis also includes the adjectives “cheerful, buoyant, and exuberant” (Hornby, 2000: 1000). The property of resilience, then, would apply to behavioral phenomena, and human behavior in a variety of environmental contexts. Resiliency however, is generally viewed as a quality of character, personality, and coping ability or a personality trait (Benard, 1999). That is why it is so important to specify at the outset that in this research the concept resilience is used referring to a process or phenomenon of positive adaptation despite adversity

(Egeland, Luthar & Sroufe, 1993; Masten, 1997; Rutter, 1999). Resilience is defined by many as an individual's ability to recover successfully from psychological trauma and various life stressors without any adverse side effects or great harm (Gordon, 1996; Gordon & Wang, 1994; Howard & Johnson, 2000; Hunter & Chandler, 1999; Kaplan, 1999; Masten, 1997; Muller & Louw, 2004).

Resilience connotes strength, flexibility, a capacity for mastery, and resumption of normal functioning after excessive stress that challenges individual coping skills (Lazarus & Folkman, 1984; Richardson, 2002). The task is to distill the many characteristics that are called protective factors, and the risk factors into their essential elements which can lead to skills and desirable adaptations (Kaplan, 1999). These protective factors could be intrinsic (intrapersonal) or extrinsic (interpersonal). Intrinsic protective factors include self-efficacy, autonomy, social competence, and problem solving skills (Hunter & Chandler, 1999; Wissing & Van Eeden, 2002). Extrinsic protective factors include good family support, community support and peer support (Oswald, Johnson & Howard, 2004). The use of resilience in this study is to learn from the professional nurses (a specialty area) about their own resilience which can lead to a stronger empirical basis for targeted prevention and promotion guidelines in the nursing profession and be of benefit for the health care system. In research where the concept of resilience has been invoked, the process implies good outcome despite the presence of the stressors.

As explained the definitions of resilience have varied, but two central constructs are subsumed in every definition and acknowledged in this study, that is, the presence of risk and adversity (the nursing workplace), and positive adaptation or skills and competencies (as used by the resilient professional nurses') which is what the researcher wants to learn more about. There are many constructs related to resilience that are also implying stress-resistance and protective factors and a few will be used in this study as determinants to identify the resilient professional nurses, namely: sense of coherence, coping self-efficacy, hope, optimism, general health and mental health. These traits have been used synonymously to characterise individuals who have this abstruse attribute of withstanding stress without permanent damage and are able to bounce back. Resilience is the construct

or trait that is proposed in this study to explain the development of a positive outcome despite the presence of adversities, or the ability to tolerate, to adapt to, or to overcome. One can conclude that resilience is complex to define and in many instances difficult to determine if one is referring to resilience as an outcome versus resilience as an influential quality or resilience as a process. As noted previously, the two main definitions refer to the fact of having achieved desirable outcomes in the face of adversity or to the qualities that facilitate achievement of the desirable qualities under adverse conditions. This study subscribes to these facets as important components of resilience. These link to Garnezy's (1991:416) view that described resilience as: "the capacity for recovery and maintained adaptive behavior that may follow initial retreat or incapacity upon initiating a stressful event" or the ability to bounce back. In the most basic sense one can say resilience is a good outcome regardless of high demands, stress or risk, it refers to healthy recovery and the capacity to mobilise resources (Block & Kremen, 1996) and is described as a two-dimensional or multi-dimensional construct (Masten, 1999; Rutter, 1999).

1.5.2.2.3 Measuring resilience

Various research designs have been used to study the occurrence of resilience. Windle (1999) suggests that resilience is never directly measured but inferred on the basis of significant interactions between risk and protective factors associated with healthy adaptation. A common feature of all designs is an inference of resilience based on the presence of significant adversity and positive adaptation. The key to understanding resilience is analysing risk and vulnerability, protective factors, coping, competence, personality factors, and the capacity to effectively use resources (Caffo & Belaise, 2003). It is a multi-dimensional construct that is defined by performance outcome, the adequacy of responses to normal and severe stressors, and how cognitive processes and the ability to modulate emotions influence the ability to utilise personal and social resources (Block & Kremen, 1996). It therefore seems clear that the best approach is a mixed method or multi method where both qualitative and quantitative methods are used to gain the best understanding of the concept/phenomenon. A variety of scales have been used to measure the presence or absence of resilient traits in individuals, most of these measures attempt

to assess qualities or innate protective factors shown to be indicative of resilience, or which are measures of psycho-social well-being. In this study these qualities include hope, optimism, coping self-efficacy, sense of coherence, mental health and general health. Given the complexity of resilience, it is important to acknowledge the multi-dimensionality of the construct. The overarching concept resilience with the relating concepts operationalised to measure aspects of resilience can be illustrated as follows:

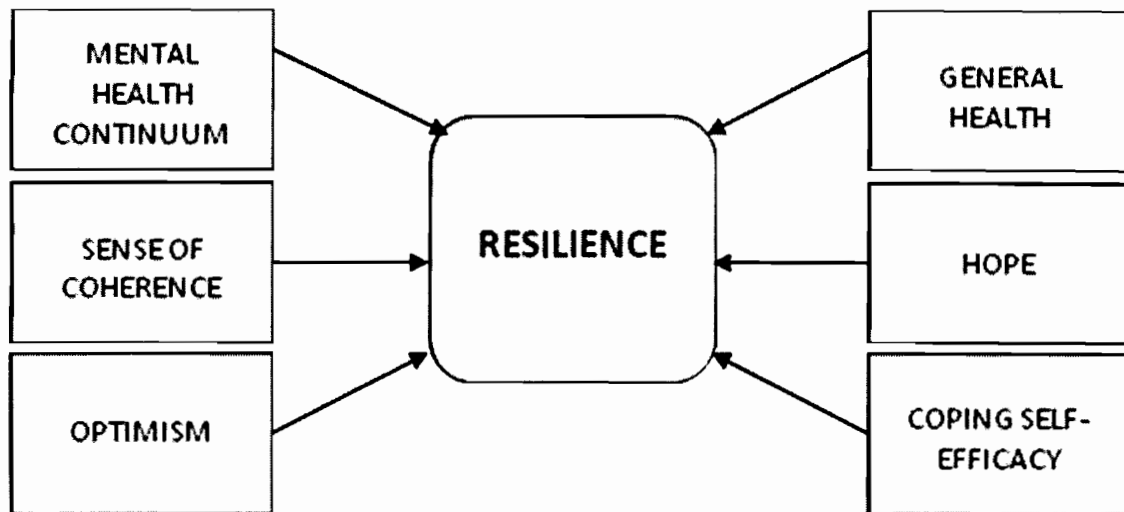


Figure 1.1: Resilience as the overarching concept

1.5.2.3 Coping self-efficacy

Coping refers to the efforts made to handle something difficult and these efforts may be cognitive, behavioral or psychosocial strategies that an individual uses to alleviate stress when events challenge the routine predictions of the world (Kleinke, 1998). Coping is the effort made by an individual to manage situations that he/she appraises as potentially harmful or stressful (Kleinke, 1991; Lazarus & Folkman, 1984; Zeidner & Endler, 1996). Coping strategies may be constructive or destructive, and coping efforts may be effective or in-effective. On the other hand self-efficacy refers to beliefs about having the capabilities to organise and perform tasks successfully within a specific domain and thereby influencing the outcome of circumstances (Bandura, 1997). Bandura also

indicated that self-efficacy convictions influence resilience to adversity (1997. Chesney et al., (2006) combined the coping and self-efficacy concepts and introduced the coping self-efficacy construct (and measuring instrument) referring to confidence in performing coping behaviors when faced with difficulties or challenges in life. Like Bandura, Chesney et al., (2006) indicates that beliefs about one's ability to perform specific coping behaviors or coping self-efficacy, would influence the outcomes of adverse situations.

In this study coping self-efficacy refers to the belief of the professional nurses that they could perform coping behavior that would succeed in dealing with the work stress they encounter and is for purposes of this study also part of the overarching concept resilience.

1.5.2.4 Sense of coherence

Antonovsky (1984; 1987) defined sense of coherence as a global orientation that expresses the extent to which the individual has a pervasive, enduring, though dynamic feeling of coherence, that the stimuli deriving from his or her internal and external environments in the course of living are structured, predictable and explicable, that the resources are available to meet the demands posed by these stimuli, and that these demands are challenges worthy of investment and engagement (Antonovsky, 1987: 19). A strong sense of coherence leads to a way of seeing the world which facilitates successful coping with the innumerable, complex stressors confronting people in the course of living (Antonovsky, 1987, 1993). The sense of coherence is believed to be a construct that is universally meaningful, cutting across lines of gender, social class, region and culture. It does not refer to a specific type of coping strategy, but to factors which are the basis for successful coping with stress in all cultures and times (Strümpfer, 1990). It consists of three core characteristics, namely comprehensibility (making sense of the stimuli in the environment), meaningfulness (an appreciative experience that challenges are worthy of emotional and energy investment in the environment) and, manageability (coping with the stimuli is possible by using internal or external available resources). The strength of the sense of coherence is linked to a variety of coping mechanisms, called generalised resistance resources (GRRs), which Antonovsky (1979)

defined as any characteristic of the person, the group, or the environment that can facilitate effective tension management.

In this study a high sense of coherence will be typical of the professional nurse that views the demands in her career as challenges worthy of investment, making sense of the stimuli in the working environment, finding meaning in it and coping with the stimuli with available resources. A sense of coherence fits with the overarching concept resilience.

1.5.2.5 Optimism

Optimism has been conceptualised as a broad personality trait characterised by general optimistic expectations (Scheier & Carver, 1985), and as an explanatory style for understanding life issues (Seligman, 1998). In this study it refers to a trait of dispositional optimism – a global expectation that more good things than bad will happen in the future (Carr, 2004). Studies have shown that optimistic individuals are less likely to develop physical ill-health, depression or suicide tendencies when they face major stressful life events (Richardson, 2002). It is associated with better achievement, performance, occupational adjustment and family life. Optimistic individuals, in the face of difficulties, will continue to pursue their valued goals and regulate themselves and their personal states using effective coping strategies, so that they are likely to still achieve their goals. These individuals experience fewer and less intense negative emotions when they encounter obstacles to valued goals (Scheier, Carver & Bridges, 1994).

High levels of optimism refer in this study to the lasting expectations of the professional nurse that what she/he does will turn out well and make a positive difference. Optimism links to the overarching concept resilience and is associated with good health and the ability to cope with the stressors in the nursing profession.

1.5.2.6 Hope

Hope is closely related to optimism, and has been conceptualised by Snyder (2000) as involving two main components, the ability to plan pathways to desired goals and agency or motivation to use these pathways despite obstacles. Hope is the sum of these two components. Individuals with high levels of hope also experience setbacks but have developed beliefs that they have pathways to deal with challenges and are motivated to deal with adversity. They maintain an ongoing positive internal dialogue, such as “I can do it, I will find a way, I will not give up.” They focus on success rather than failure, and when faced with large vague problems they break it up into small clearly understood and manageable parts. In this study high levels of hope will be typical of professional nurses who perform their duties with knowledge and skill (pathways) and are able to reach their goals effectively in their challenging work context. Hope is part of the overarching concept resilience.

In figure 1.2 a theoretical framework is suggested developed from Kumpfer’s resilience model and Richardson’s process model (Glantz & Johnson, 1999) and serves to anchor research in the literature and facilitates the dialogue between the literature and the empirical study, it is an alignment of the key concepts of the study (Henning, Van Rensburg & Smit, 2004).

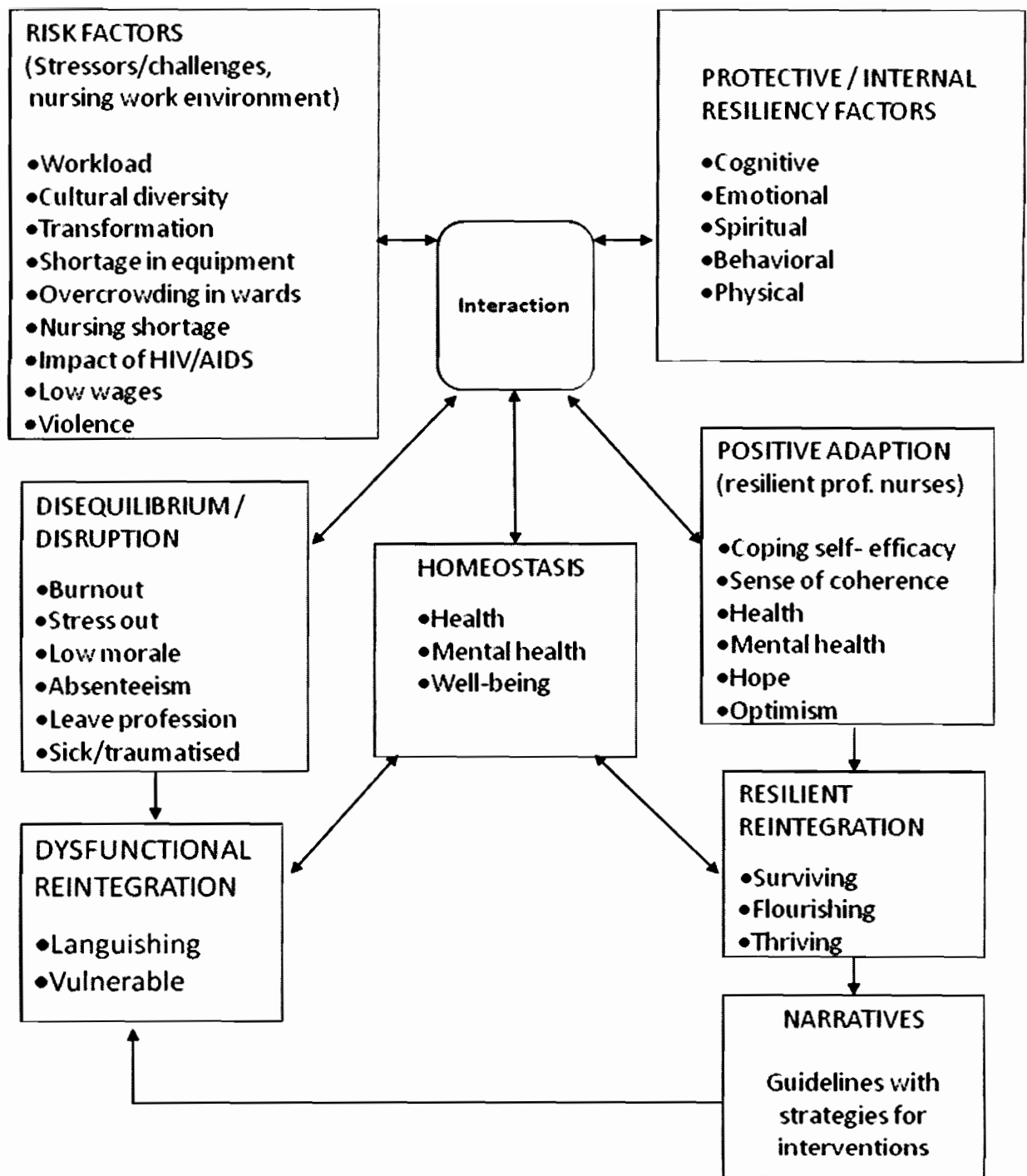


Figure 1.2: Theoretical framework

1.5.3 Methodological dimension

This dimension includes the assumptions as stated above and the methodology of this research. How we learn about the reality as stated in the ontological and epistemological dimensions are reflected in the methodological dimension. Methodology is the study of how we know the world or gain knowledge of it through the research process. It refers to logically planning, ordering and conducting research using scientific decision making and deciding on methods which will result in the most valid findings (Denzin & Lincoln, 1994; Mouton & Marais, 1996). The researcher believes that the research process is influenced by practice, theory and philosophy which are interdependent and interconnected and will direct the way in which the researcher can gain knowledge of the phenomenon under investigation. Pragmatism draws on many ideas including using “what works”, diverse approaches and valuing both objective and subjective knowledge (Tashakkori & Teddlie, 2003). The pragmatist believes that, regardless of circumstances, both quantitative and qualitative methods may be used in a single study (Tashakkori & Teddlie, 2003). This means obtaining statistical, quantitative data from a sample of a population and using it to identify individuals, who may further add to the results through qualitative data and information. The practice of nursing has to continually adapt to a transforming health care environment, which makes demands to identify needs and opportunities and to generate, and validate knowledge for the nursing practice. The knowledge sourced must be fully functional for the improvement of practice. These solutions are sought through mixed method research. The problem or challenge in this research was to identify resilient professional nurses quantitatively and by exploring and analysing their shared experiences (stories) of resilience qualitatively, to identify strengths and protective factors. Thereafter, based on these findings, to formulate guidelines and strategies for interventions and training, by which resilience and psycho-social well-being of professional nurses could be facilitated and enhanced.

1.6 Research methodology

Keeping in mind the complexity of the concept and the debate on the empirical study of resilience, the importance of validity of measurement and of personal experiences of participants have become clear and therefore the study used both approaches: the validated instruments (quantitative) and the writing of stories and focus group interviews (qualitative). A mixed method was used as both quantitative and qualitative data were gathered and used sequentially (one after the other) in order to identify resilient nurses, analyse their shared experiences, and use the findings to formulate guidelines and strategies that may be used to enhance resilience and psycho-social well-being in professional nurses. Using both quantitative and qualitative data in the research process in a single study has the purpose of gaining a better understanding of the researched phenomenon (Creswell, 2003) and the researcher can draw on the strengths of each and allow for a more robust analysis (Tashakkori & Teddlie, 2003). It is like including a quantitative mini-study and a qualitative mini-study in one overall research study (Tashakkori & Teddlie, 2003).

1.6.1 Research design

A sequential exploratory design was implemented (Creswell, 2009). The first phase was quantitative research and done in public and private hospitals including the latter's primary health care clinics, using validated psychometric instruments that could be useful for an investigation into the prevalence of resilience in professional nurses and identification of the resilient nurses. Selecting an instrument that measures resilience is no simple task and after studying a large body of literature, looking at the nursing population and discussing this with experts in Psychology, a selection of useful validated instruments was made. The instruments were the following: The Mental Health Continuum (Keyes, 2006), The Coping Self-efficacy Scale (Chesney et al., 2006), Sense of Coherence Scale (Antonovsky, 1987), The Adult Dispositional Hope Scale (Snyder et al., 1991), The Life Orientation Test-Revised (Scheier et al., 1994), The Resilience Scale (Wagnild & Young, 1993) and The General Health Questionnaire (Goldberg & Hillier,

1979). These questionnaires all cover important aspects of resilience (or the absence thereof) and were used to determine the level of resilience in the professional nurses.

The second phase was qualitative and explored and analysed the storied (narrated) experiences of resilient professional nurses who have been identified in the first phase of the study (Creswell, 1998; 2003). The analysis of the narratives followed by focus group interviews also with resilient professional nurses enabled the researcher to explore and analyse the phenomena of resilience that enables professional nurses to cope with their stressful work environment and maintain their caring concern for their patients. The information obtained assisted the researcher in formulating guidelines with strategies for interventions and training that may be used to enhance resilience and psycho-social well-being of professional nurses, thereby improving quality care in the nursing profession and the quality of the health care service.

The research was conducted in private and public hospitals as well as primary health care clinics in the Potchefstroom, Carletonville, Randfontein and Krugersdorp areas. The resilient professional nurses were identified as those scoring in the upper third of the scales when the measuring instruments that measure aspects of resilience are combined, each carrying the same weight (< 0.4 = low resilience, > 0.4 and < 0.6 = moderate resilience, > 0.6 = high resilience). Thereafter the researcher contacted 39 professional nurses with high resilience from all the hospitals and primary health care clinics involved and 35 stories were received back from the nurses. The stories allowed the participants to tell their stories in their own words and create a partnership with the researcher (Piercy & Thomas, 1998). A focus group interview can be defined as a carefully planned discussion designed to obtain information in a non-threatening environment from a group of participants sharing and responding to similar views, experiences, ideas, feelings and perceptions (Krueger, 1994). The group typically consists of four to twelve participants, using a number of interventions in the form of open ended questions. The role of the researcher requires planning, management, and interpersonal skills (Morgan, 1998). The assumptions underlying the data gathering are that focus group data reflect collective notions of understanding of the topic. With well designed questions guiding focus group

interviews, 3 to 5 interviews can provide honest in-depth information (Creswell, 2003). A less structured approach was used to elicit flexible responding (Morgan, 1998) with the help of an interview schedule consisting of relevant questions. A visual picture or design map of the research is illustrated in Figure 1.3.

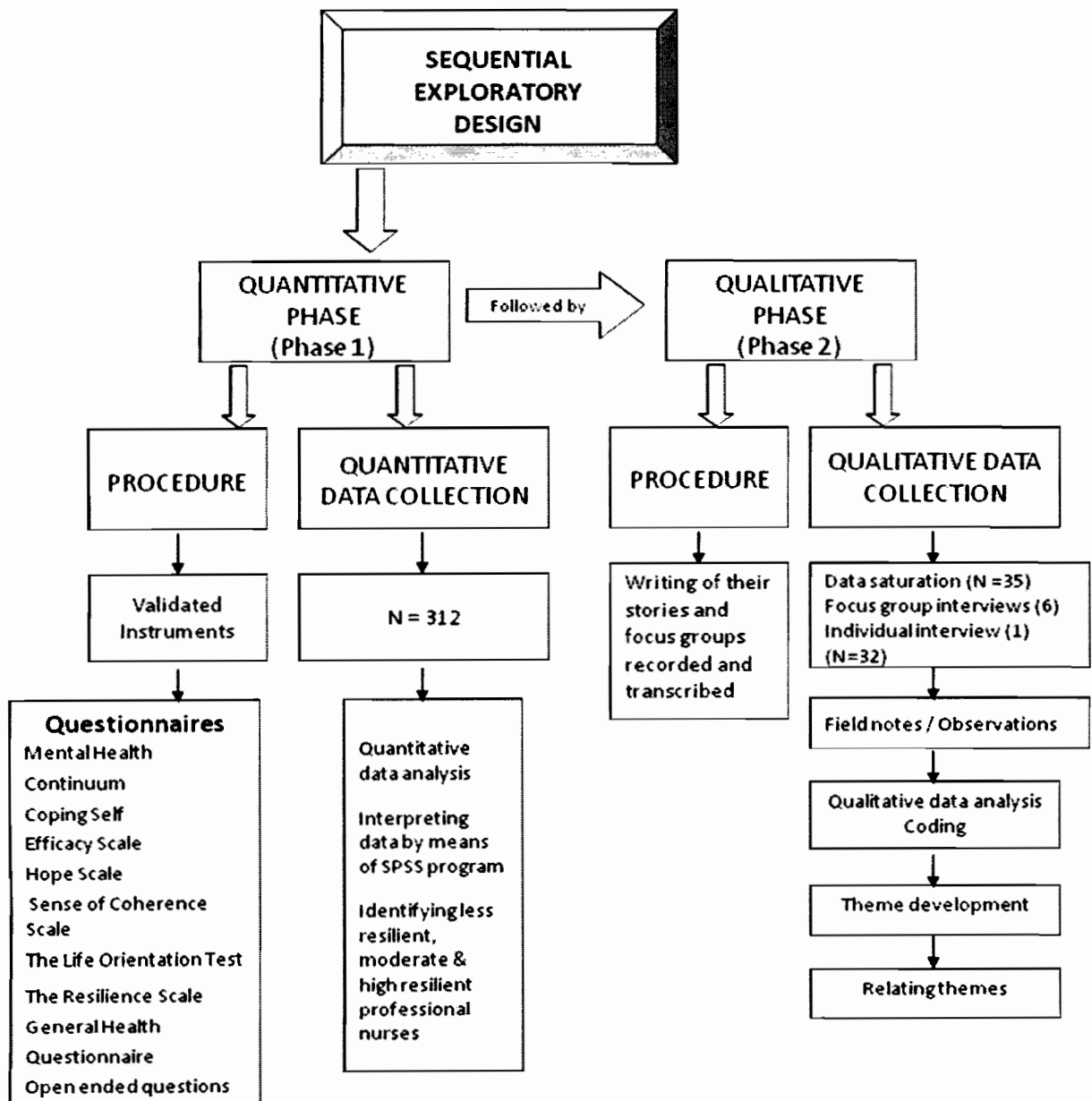


Figure 1.3: Design Map

1.6.2 Research methods

The research methods included sampling, data-collection and data-analysis and the role of the researcher was also discussed.

1.6.2.1 Sampling

a) Population and setting

The population in the first phase included professional nurses that were willing to participate voluntarily, working in private or public hospitals and primary health care clinics in South Africa. The following towns were included due to practical reasons as the researcher is residing in Randfontein: Potchefstroom, Carletonville, Randfontein and Krugersdorp. The participants of the second phase were identified from the first phase and were the professional nurses manifesting high resilience.

Participants had to meet the following criteria for the first phase:

- Were professional nurses practicing for at least six months
- Were willing to participate voluntarily
- Were able to communicate in English or Afrikaans

Participants had to meet the following criteria for the second phase:

- Were the professional nurses who scored in the upper third of the measuring instruments
- Were willing to participate voluntarily in the second phase and share in writing their stories/narratives for the researcher
- Were comfortable in partaking in focus group interviews that were recorded.

b) Sampling method

Voluntary, all inclusive non-discriminatory sampling of professional nurses in both private and public hospitals and primary health care clinics were used. Approximately 300 participants would ensure validity in the first phase. In the second phase purposive sampling was used to select participants who were identified from the first phase as resilient and were willing to share their stories until data saturation was obtained (Woods & Catanzaro, 1988). The researcher asked for permission to conduct the research at eight hospitals, four public hospitals and four private hospitals and the primary health care clinics affiliated with the latter. Approximately 650 professional nurses were working in these hospitals and clinics according to the information given to the researcher by the nursing management. (See letters Appendix A – C).

c) Sample size

To ensure validity, sample size in the first phase of the study was estimated at 300 professional nurses to be included (according to the statistical consultant), who were willing to participate voluntarily and complete the questionnaires.

The sample size of the second phase was determined by data saturation, i.e. when recurrent themes evolve from the data and additional sampling provide no new information (Burns & Grove, 2005; Woods & Catanzaro, 1988). Data saturation was obvious after 20 stories were analysed, but as 35 stories were written all the data was analysed. Data saturation was reached after 5 focus group interviews were conducted and analysed, however the researcher held two more to include all the facilities. At the one clinic, due to unforeseen circumstances, only one professional nurse was available and an individual interview was held.

1.6.2.2 Data collection and operational context

The data was collected by means of validated psychological instruments, namely: The Mental Health Continuum (Keyes, 2006), The Coping Self-efficacy Scale (Chesney et al., 2006), Sense of Coherence Scale (Antonovsky, 1987), The Adult Dispositional Hope Scale (Snyder et al., 1991), The Life Orientation Test-Revised (Scheier et al., 1994), The Resilience Scale (Wagnild & Young, 1993) and The General Health Questionnaire (Goldberg & Hillier, 1979). A biographical questionnaire was included for socio-demographic information on the participants and further included three open ended questions (to which the answers were transformed to quantitative data) to establish nurses' view or feelings about the nursing profession; whether they consider leaving their job and why, and whether they consider themselves as resilient and why. A pilot study was done with 15 professional nurses at a school of nursing science, who completed the questionnaires. They reported the scales as being user friendly and that it took approximately 15-30 minutes to complete, which is acceptable according to Brink (2006). In the facilities, the chief professional nurses were asked to act as mediators, distributing and collecting the compiled booklet containing the questionnaires on behalf of the researcher, which however proved to be a problem due to busy work schedules of these nurses and in some facilities the researcher had to do this herself. Finally 328 questionnaires were received back with 312 completed from the 650 that were distributed.

In the second phase data was collected by means of the stories of identified resilient professional nurses, written in their own words about how they manage to stay resilient and compassionate in the nursing profession. The researcher contacted 39 nurses who manifested high resilience, 35 written stories were received from them. This was followed by focus group interviews on the same topic also with resilient professional nurses at all the facilities. Discussions were recorded on an audio-tape and voice recorder. The initial focus group interview served as a trial run and could be included for data analysis. The participants' thoughts were probed by a list of open ended questions, which wasn't followed strictly but served as a point of departure in the discussions. These

questions were formulated based on the results of the first phase and the stories of the resilient nurses, and included the following themes:

- What does resilience mean to you?
- How does resilience manifest in the work of a nurse?
- What would you say is hindering you in maintaining resilience?
- What is your opinion on the importance of resilience in professional nurses?
- What do you think guidelines for training resilience in nurses should include?
- How do you think such guidelines on resilience for professional nurses should be used?

The focus group interviews were conducted by the researcher who has proven skills and experience in conducting interviews. Communication techniques such as clarifying, summarising and reflection, as described by Kneisl, Wilson and Trigoboff (2004) were used to facilitate the group discussions. The researcher made field notes during and after each interview containing descriptive notes, reflective notes and demographic information (Creswell, 1994). Voluntary, written consent was obtained from each participant before both phases of the study (Appendix D).

By using multiple data collection methods as in this study, data is triangulated as the topic is analysed from multiple angles, sources, and varieties of expression (Guba & Lincoln, 1985; Patton, 1990). This also increased the trustworthiness of the data and the findings (Guba & Lincoln, 1985). In this qualitative phase the researcher was looking at ways to engage the participants so that the multi-dimensionality of the human experience could be encapsulated (Goldman, 1992).

1.6.2.3 Data analysis

Data of the first phase was captured and statistically analysed by a statistical consultant using the SPSS computer program. Descriptive statistics as well as cut-off points for resilience were determined. The researcher interpreted the statistical results derived from

the data. The biographical information was also analysed and the answers to the open ended questions transformed to quantitative data regarding nurses' feelings about the profession and about their own resilience, providing a profile of the participating professional nurses.

The analysis of data in the second phase involved the examination of words with the researcher becoming immersed in the data, reflecting on possible meanings and relationships in the data (Brink, 2006). Data was analysed simultaneously with data collection, -interpretation and narrative report writing (Creswell, 1994). It also implied that the researcher filters the data through a personal lens that is situated in a specific sociopolitical and historical moment. The researcher thus systematically reflects on who she is in the inquiry and is sensitive to her personal biography and how it shapes the study. This introspection and acknowledgement of biases, values, and interests (or reflexivity) is an important part of the qualitative phase (Mertens, 2003). Data analysis took place by means of open coding (Babbie, Mouton, Vorster & Prozesky, 2004) and inductive analysis, constructing understanding and meaning from data, where prior theory could be set apart in an attempt to open new aspects of the phenomena under investigation (Gilgun 2006). Inductive analysis involves reflection on data records and discovering patterns, themes and categories (Camozzi & Marthie, 2005; Patton, 2002). The interviews were transcribed verbatim and field notes were compiled directly after each focus group (Creswell, 1994). The raw data was reduced to themes or categories and interpreted by the researcher and an experienced co-coder working independently on the data. The co-coder was an advanced psychiatric nursing specialist and the researcher involved her from the start of the study, the hospital settings are known to her and she could emerge herself in the data. The researcher and the co-coder reached consensus on the themes for the final narrative using a protocol compiled with the help of Tesch's steps of analysing textual data (Appendix H). Several sessions were held to reach consensus on the main and sub-themes/categories. These themes or categories were reduced to "families" of themes that consisted of a small, manageable set of themes to write the final narrative.

With completion of data collection and data analysis in the second phase, the research findings were compared or related to the existing body of knowledge of resilience in professional nurses. In a qualitative study a literature control is necessary (investigation, interpretation and integration of literature) so that the findings can be discussed within the context of what is already known about resilience in nurses (Streubert & Carpenter, 1999). The literature serve the purpose of validating the data, identifying data that confirm findings, identifying what is in literature but not evident in the study, or the findings that are unique in the study and not found in literature (Burns & Grove, 2005).

1.6.2.4 The role of the researcher

Written, informed consent was obtained from all the role players and the participants, as well as from the mediators. The researcher first contacted the Departments of Health and the management of the different hospitals to establish their willingness to give permission and allow staff to participate in the study, as well as to explain the objectives of the research. The researcher followed this up by personally visiting the management of the hospitals with letters to explain the study and request for the research to be conducted in the facility and again followed this up by presenting the study to the nursing personnel. Appointments were confirmed at least a day before an appointment and again with the follow up for the second phase of the study for the interviews. The questionnaires were delivered and collected by the researcher together with the consent forms to serve as records of proof that participation was voluntary. The focus group interviews were conducted at the place of choice of the participants and care was taken to assure a peaceful and quiet setting for discussion. The researcher was the primary instrument for data collection and analysis in the second phase of the research, although a co-coder was used for analysis. The presence of the researcher during the research activities was brief but personal, as requests were made for the narratives of and focus group interviews with participants (Marshall & Rossman, 1995), (Examples of field notes, part of a transcription and written stories, Appendix I, J & K).

1.7 Rigor

To describe rigor in this study the framework of Guba and Lincoln (2005), (also supported by Krefting, 1991; Morse, Barrett, Mayan, Olson & Spiers, 2002 and Botes, 1995), was used. The product or knowledge of a research process should be valid and therefore accountable to the truth (Botes, 2003). The researcher questioned herself with regard to the following basic standards and measures:

- Is the research well defined to ensure theoretical validity?
- Can the research findings be trusted, was credibility assured when the population was chosen, data collected and analysed, what is the authority of the researcher?
- Can the research findings be applied elsewhere, are the findings transferable?
- How consistent are the research findings, how dense was the description of the research methodology?
- Are the research findings neutral, was the research done without prejudice and can it be said that it has operational value?
- Is inferential validity clear throughout the research process, are the arguments logical and can the researcher justify the research decisions and findings?

Rigorous research is ensured by the methods to collect data in both phases of the study, namely the 7 validated psychological instruments and the open ended questions in the first quantitative phase to determine resilience in professional nurses. Thereafter to explore the narratives in the second phase, by requesting participants to write their stories, followed by focus group interviews in order to understand resilience in the difficult nursing context.

1.8 Ethical considerations

In order to conduct the research in an ethical manner, the researcher was guided by various international ethical principles such as the Helsinki declaration (DENOSA, 1998), Burns and Grove (2005) and Brink (2006). Ethical issues may manifest in the study and the researcher should be sensitive and aware of what is right and wrong in any given situation (Babbie, Mouton, Vorster & Prozesky, 2004). Special care should be given to confidentiality and cognisance should be taken of organisations and stakeholders involved in the study, like the management of the different hospitals. Permission for the study was obtained from the Department of Health in the provinces where the study was conducted and the management of the private and public hospitals used in the study. Informed voluntary consent was obtained from the participants and protection from discomfort and harm were ensured (Appendix A-D). The three fundamental ethical principles defined by Brink (2006), are respect for persons, beneficence and justice and human rights to be protected such as: the right to self-determination, the right to privacy, the right to anonymity and confidentiality and the right to fair treatment and protection from discomfort and harm. Apart from the ethical guidelines stated above, this research was part of a larger project of the NWU (NWU-00002-07-A2) under the supervision of Prof. MP Wissing and met all the ethical requirements. It was approved by the Ethical Committee of the North-West University (Appendix F). The following ethical aspects were observed throughout this study:

- **Quality of research**

The researcher maintained the highest standard of research through the accredited methodologies as recommended by the promoters, as well as literature. All procedures were carried out with integrity as described below:

- The questionnaires used in the quantitative phase were all validated and analysed according to recommendations
- The focus group interview questions were assessed by experts for validity.

- Focus group interviews were transcribed verbatim and an independent co-coder did independent co-coding of transcriptions.

- **Confidentiality and anonymity**

Participants' identities were not disclosed throughout the research procedures. The privacy, personal worth and the dignity of the participants were maintained. The researcher made sure that there was no linking of any participant's identity or organisation with the research data (Burns & Grove, 2005; DENOSA, 1998).

- **Consent**

Permission to conduct research was obtained from the Ethics Committee of the North-West University and the Department of Health from North West province (Appendix E & F). Letters to request participation, obtain consent and explain the research objectives and expectations, were given to prospective participants. The chief professional nurses acting as mediators provided the researcher with lists of names. The participants were informed about their voluntary participation as well as their right to withdraw at any stage of the process. The use of audio-tapes and the voice recorder during the second stage of the research as well as the fact that confidentiality, anonymity and privacy would be maintained throughout the process, were explained (Appendix A – D).

- **Benefits and risks**

The researcher ensured that participants were protected from discomfort and harm by informing and debriefing them. The researcher is an advanced senior psychiatric nurse and capable of handling the situation and ensuring that focus groups were conducted in a professional manner to cause no or minimal discomfort. The participants were free to withdraw at any time in the process (Burns & Grove, 2005).

All these ethical measures as well as the principles of human dignity, were observed throughout the study. The researcher conducted the research with integrity and in a scientifically honest manner. She would have preferred more participants for the first phase, however it proved to be an impossible task whilst simultaneously keeping to the ethical principles.

The researcher also utilised the North-West University's principles on the prevention of plagiarism.

1.9 Report outline

The report was written according to the article model Rule A.7.5.7 of the NWU. The PhD candidate, Prof MP Koen, conducted the research and wrote the manuscripts. Prof C van Eeden and Prof MP Wissing acted as promoters and auditors by providing valuable guidance during the research process and critically evaluating research report writing, thereby adding expertise and enhancing the quality of the research. Three manuscripts have been written and are submitted according to criteria for the "Health SA Gesondheid". The references and appendixes are at the end of the report. This research report is structured as follows:

Section 1:

- Overview of the study

Section 2:

- Manuscript 1: The prevalence of resilience in professional nurses, submitted to "Health SA Gesondheid"
- Manuscript 2: Stories of resilience in professional nurses, submitted to "Health SA Gesondheid"

- Manuscript 3: Guidelines with strategies for enhancement of resilience and psycho-social well-being in professional nurses, submitted to “Health SA Gesundheit”

Section 3:

- Conclusions and recommendations of the study

SECTION TWO

MANUSCRIPTS

MANUSCRIPT ONE

THE PREVALENCE OF RESILIENCE IN PROFESSIONAL NURSES

Submitted to “Health SA Gesondheid”

Guidelines for authors: Health SA Gesondheid

Author Guidelines – Quantitative Research

How to submit your paper online:

1. Registered authors must login to submit a paper
 - REGISTER HERE if you do not have a username and password
 - LOGIN HERE if you have already registered with Health SA Gesondheid.
2. Select Author
3. Click on **CLICK HERE TO FOLLOW THE FIVE STEPS TO SUBMIT YOUR MANUSCRIPT**
4. Follow the five steps to submit your paper
5. To view a video on how to submit a paper online **CLICK HERE**
6. To visit the instructions to authors **CLICK HERE**

Review policy and timelines

1. Immediate notification if submitted successfully
2. Notification within 3 weeks if not accepted for further review
3. Notification within 3 months if accepted for publication, if revisions are required or if rejected by both reviewers.
4. Publication within 6 months after submission.

Aims, scope and review policy

Health SA Gesondheid is an interdisciplinary research journal in which only select articles of the highest scientific standard with human health as the main theme are published. The journal also aims to facilitate the gathering and critical testing of insights and viewpoints on knowledge from different disciplines involved in health service delivery. Articles on research work or review articles with the same theme shall also be considered for publication. Papers are peer reviewed to ensure that the contents are understandable, valid, important, interesting and enjoyed. All manuscripts must be submitted online. All articles in Health SA Gesondheid will undergo a double-blinded peer review.

The following contributions are accepted (word counts exclude abstracts, tables and references):

1. Original research (Between 3500 – 7000 words)
 2. Book Reviews (Between 700-900 words)
- Please see the journal's section policies for further details.

Manuscript Specifications:

Font Type: Times New Roman

Font Size: 12

Line Spacing: 1.5

Page Margins: Bottom & Top = 2.5cm

Left & Right = 2 cm

Length of Manuscript:

About 25 pages text only (maximum), excluding tables, figures and the list of references.

Manuscript Guidelines

Title: Informative but concise, In small capital letters, centered and in bold, font size 14, eg.: Names of questionnaires, countries, and or authors start with capital letters.

Author: Name(s), include full first name, e.g. Gert P. Roux, not G.P. Roux. Include the name of the department and the University of each author. The e-mail address, postal and phone number of the corresponding author should be included.

Abstract: Not more than 200 words, and should state concisely the scope of the work and the principal findings:

- the objective of the study
- the population size, sampling strategy, sample size and response rate
- main statistical procedures used for analyzing the data
- most significant results of the study.

Opsomming: Always include an Afrikaans abstract of the article, please follow the same format and structure as indicate within the heading 'abstract'.

Key words: Use five [5] words not already included in the title, separated by a semi-colon.

Synopsis: Afrikaans articles (or articles in any other official SA language) must also have a synopsis of the article of between 500-600 words in English (the entire synopsis appears in italics).

We also ask that you upload a brief biographical note (entered into the 'Bio statement' box during the submission process). This note will appear online in our 'About the Author' section should your article be published with us.

Manuscript Contents

The manuscript contains five sections, namely the introduction, research design, results, discussion and the references. All these first-level headings (except 'introduction') appear in bold capital letters and are centered.

INTRODUCTION:

The introductory section normally contains the following seven elements; headings are indicated in [brackets]:

- (1) [**Key focus of the study**] A thought-provoking introductory statement on the broad theme or topic of the research (why should I even bother to read further?);
- (2) [**Background to the study**] Providing the background or the context to the study (explaining the role of other relevant key variables in this study);
- (3) [**Trends from the research literature**] 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);
- (4) [**Research Objectives**] Indicate the most important controversies, gaps and inconsistencies in the literature that will be addressed by this study;
- (5) In view of the above (in 4) state the core research problem and specific research objectives that will be addressed in this study;
- (6) [**The potential value-add of the study**] Explanation of the study's academic (theoretical & methodological) or practical merit and/or importance (provide the value-add and/or rationale for the study); and
- (7) [**What will follow**] Provide the reader with an outline of what to expect in the rest of the article.

Tips on Introduction Section:

The first-level heading, **INTRODUCTION**, is **not** used. However, second-level headings may be used in this introductory section. These subheadings are flush with the margin, and are typed in lower case; bold starting with a capital letter.

If lists of bullet points are presented, they should be in the following format:

Longevity. How long individuals live.

Prognosis. How well an individual responds to challenges of disease or trauma.

Mental health. General level of mental functioning

Avoid using lists that contain more than 10 bullet points.

Synthesis and Critical evaluation of the literature – Still apart of Introduction

A synthesis and critical evaluation of the literature (not a compilation of citations and references) should at least include or address the following aspects:

- (1) Conceptual (theoretical) definitions of all key concepts;
- (2) A critical review and summary of the themes emerging from previous research findings (constructs, research participants, research designs, objectives, etc.) on the topic;
- (3) Including a review of existing approaches towards the measurement of relevant constructs; and
- (4) A clearly defined link should be established between formulated hypotheses and objectives. The stated objectives follow directly on the section where the literature was reported.

RESEARCH DESIGN

The first-level heading **RESEARCH DESIGN** is typed in capital letters, centered and in bold. Only **two** secondlevel headings follow on the research design and they appear in lower case, bold and are flush with the margin.

Research approach

A brief description of the research approach followed in the study should be included. It should for instance state that the study follows the quantitative tradition and further explain whether it is a cross-sectional field survey, an experiment or a factorial design and why this design was chosen. Furthermore, it should explain what type of data (primary or secondary) was used and which approach (e.g. correlational) was followed in the data analyses. This section is not similar to the description of the research procedure.

Research methods

Normally, at least the following four third-level headings are used to explain the research method followed in the study, namely research participants; measuring instruments; research procedure; and statistical analyses.

Third-level headings are flush against the margin, are in italics and not bold.

Research population & sampling

A description of the target population, sampling frame and the sampling procedure are provided here. The obtained sample size and response rate are reported. This section normally provides a summary table and a discussion of the research participants in terms of their biographical details such as age, gender, home language, highest academic qualification, etc.

Research measuring instrument(s)

This section describes the measuring instrument(s) used in the study or the way in which constructs were operationalised. Fourth-level headings are in italics, underlined, and end with a full-stop. These types of headings are directly followed (in the same line) by a sentence. Besides clearly referencing the origin of the scale this section should also clearly explain the basic scale design, the number of dimensions covered by the scale, exemplary examples of items (not the ones used in the scale) in each dimension as well as an example of the response rating scale. It should also be indicated which items are reverse scored or reflected and how total scores are calculated. This section should also report on the reliability and validity of the scale (as reported in other studies) as well as the rationale for using this scale in the study.

Research procedure

This section sets out the procedure used for the collection of the data for the study, specific reference to the validity and reliability of the method. Specific attention should be given to the clarity of the research procedure for possible replication purposes.

Data collection & Statistical analysis

Normally, only a brief mentioning of the statistical procedures employed in the analyses of the data is provided. See the opposite example. In the event of unusual or new statistical techniques a brief description of each is then also provided under this heading. The description of familiar statistical procedures is otherwise incorporated into the presentation of the results.

RESULTS

The next first-level heading is **RESULTS**, which appears in capital letters, in bold and is centered.

The results section can be divided broadly into two sections:

Firstly, an overview of the descriptive statistics of each scale (if space permits), as well as the reliability statistics for each scale is provided.

Secondly, an overview of the inferential statistics according to all stated hypotheses is provided.

Keep the following guidelines in mind when presenting the results of your study:

- present your results as concisely as possible;
- use tables and figures selectively, by not cluttering the article with tables and figures;
- cro

ss-references to relevant tables or figures should precede the mentioned table or figure;

- interpret the contents of a table or a figure for the reader;

- follow established conventions when reporting statistical data; and

- report the statistical hypotheses (both the null and the alternative hypotheses) when reporting the results.

Tables and Figures are each presented on a separate page after the section **REFERENCES** and appear in the same numerical order as they appear in the text. The positions of tables or figures are indicated in the text in the following way: <include Table 1 about here>

Therefore, no tables or figures appear in the text of an article, but are each displayed on a separate page for the type setter to see as a whole. If the sizes of the table or figure are too large it can be uploaded as supplementary files in Step 4 of the submission process. It is essential that all table and figures are clearly labelled.

DISCUSSION

The next heading is **DISCUSSION**, which appears in capital letters, in bold and centred.

This section normally contains the following eight elements:

- restate the main objective of the study;

- 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;

- provide the conclusion and recommendations (implications for practice);

- point out the possible limitations of the study; and

- provide suggestions for future research.

Second and third-level headings may be used.

REFERENCES

References begin on a separate page. References cited in the text should all be included in the list at the end of the paper. Full references at the end of the paper, arranged alphabetically by surname, chronologically within each name, with suffixes a, b, c, etc. to the year for more than one per year by the same author. Note that the second and subsequent lines are indented.

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The prevalence of resilience in professional nurses

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ABSTRACT

The literature and practice show that many professional nurses feel emotionally overloaded and are experiencing job dissatisfaction, often leaving the profession. Some nurses choose to remain in nursing and survive and even thrive despite the workplace adversity. It is, however, not known what the prevalence of resilience in nurses is, and what the roles of private versus public contexts are. The aim of this study was to determine the prevalence of resilience in a group of professional nurses and whether private versus public contexts play a role, and to obtain an indication of participants' view of their profession and resilience there-in. Professional nurses (N=312) working in public or private hospitals in South Africa voluntarily completed measures of psychosocial well-being as indicators of the degree of resilience, in a cross-sectional survey design and answered three open ended questions on the profession. Results showed moderate to high correlations among scales indicating conceptual coherence as indicators of resilience. Prevalence of resilience was determined by normalising the mean scores of the measuring instruments and expressing the total value of the normalised mean scores as a fraction (0-1), representing a level of resilience manifested by the participants across all scales which indicated three levels of resilience; 10% of participants manifested low resilience, 47 % moderate and 43% high resilience. Nurses in private health care had significantly (small practical effect) higher levels of resilience. Information on the prevalence of resilience in professional nurses can be used to improve the well-being of nurses and the quality of nursing care and the health care service.

Key words: Sense of coherence, coping self-efficacy, hope, optimism, mental health, well-being.

OPSOMMING

Die literatuur en praktyk dui daarop dat baie professionele verpleegkundiges emosioneel uitgeput is, werksontevredenheid ervaar en dikwels die beroep verlaat. Sommige verpleegkundiges kies om in die beroep te bly, en floreer selfs ten spyte van negatiewe werksomstandighede. Dit is egter nie bekend wat die voorkoms van veerkragtigheid in verpleegkundiges is nie, of wat die rol van privaat versus die openbare omgewing is nie. Die doelwit van die studie was om die voorkoms van veerkragtigheid in 'n groep professionele verpleegkundiges te bepaal, of privaat versus openbare omgewing 'n rol speel en om 'n indikasie van deelnemers se siening oor hul professie en veerkragtigheid daarin te bekom. In 'n eenmalige dwarsdeursnit ontwerp het professionele verpleegkundiges (N=312) werksaam in openbare of privaat hospitale in Suid-Afrika vrywillig vraelyste oor psigososiale welstand as aanduiders van die vlak van veerkragtigheid voltooi, asook drie oop-einde vrae oor hul beroep beantwoord. Bevindinge het op matige tot hoë korrelasies tussen skale gewys wat dui op konseptuele samehorigheid tussen die indikatore van veerkragtigheid. Veerkragtigheid is bereken deur normalisering van die gemiddelde tellings van al die skale en deur die totale waarde van genormaliseerde gemiddeldes uit te druk as 'n gedeelte (0-1), verteenwoordigend van 3 vlakke van veerkragtigheid gemanifesteer deur die deelnemers: 10% van die deelnemers het met lae veerkragtigheid gemanifesteer, 47% matige en 43% hoë veerkragtigheid. Verpleegkundiges in privaat gesondheidsorg het beduidende (klein praktiese waarde) hoër vlakke van veerkragtigheid getoon. Inligting oor die voorkoms van veerkragtigheid in professionele verpleegkundiges kan gebruik word om die welsyn van verpleegkundiges en die kwaliteit van verpleegsorg in die gesondheidsorgstelsel te verbeter.

Sleutelwoorde: Kohesiesin, coping/hantering selfbevoegdheid, hoop, optimisme, geestesgesondheid en welsyn.

Focus and background of the study

Research and practice indicate that many professional nurses feel emotionally overloaded and are experiencing job dissatisfaction, especially in the public sector (Ehlers, 2006). However, although many nurses consider leaving the profession, some resiliently survive and even thrive despite the experienced workplace adversity. It is, however, not known what the prevalence of resilience in nurses is, what the role of private versus public contexts are, and what the implications thereof are for the health care system.

Professional nurses are considered the backbone of the health care system and are often the first point of contact for patients in the health care system (Van Rensburg & Pelser, 2004:109). In the last 5-10 years there has been a shift in health care from a fragmented, mainly curative, hospital based service to an integrated, primary health care, community-based service in South Africa (African National Congress, 1994; Geyer, Naude & Sithole, 2002: 11-15). The health care system currently consists of both a private and public sector with the private sector being profitable as clients have medical insurance paying for services while the public sector is a state owned system, publicly funded and free to unemployed citizens or available for a small fee to those able to pay (Geyer *et al.* 2002: 11-15; Van Rensburg & Pelser, 2004: 109-170). The public sector is divided into the national, provincial and district system with professional nurses involved at all three levels and predominantly health care providers at the provincial and district levels (Dennill, King & Swanepoel, 2002: 207).

These changes had far reaching effects on the work context of professional nurses as larger sections of the population have now become able to afford or get services for free (Pelser, Ngwena & Summerton, 2004: 109-170). The resultant increase in health care utilisation placed a great burden on nurses, especially those in the public sector, with vast financial and human resource disparities between the public and private health care sectors having adverse effects on the working conditions of these professionals (Day & Gray, 2005: 248-255). The public sector nurses carry the burden of serving the majority of South Africa's population with minimal funds and insufficient personnel, 58.9% nurses in the public sector are serving 82% of the population resulting in an increase in

workload, a shortage of equipment and supplies, overcrowding in clinics, poor working conditions, poor staff morale, deterioration in quality care and abuse of scarce resources (Van Rensburg & Pelsler, 2004: 109-170; Walker & Gilson, 2004: 1251).

Furthermore the critical nurse shortage in South Africa with an estimated shortage of 32 000 (Oulton, 2006: 34-39) has become alarming with a total of 47 390 800 patients served by 101 295 professional nurses in 2006, that is a ratio of 468 patients for 1 nurse according to the South African Nursing Council (SANC, 2006). This shortage is partly due to nursing emigration but also the result of low wages, heavy workloads, poor working and living conditions, lack of resources, limited career opportunities, poor management of health services, unstable work environments and economic instability, and the impact of HIV and AIDS (Bateman, 2005: 905-907; Buchan, 2006: 16-25). South African professional nurses find themselves daily in this high risk, stressful work environment affecting their physical health and emotional well-being (Levert, Lucas & Ortlepp, 2000: 36-43; Van den Berg *et al.* 2006: 35). Previous research reported that professional nurses feel emotionally overloaded, stressed, fatigued, helpless, hopeless, angry, shocked, grieved, irritated, fearful, unsettled, frustrated, experiencing job dissatisfaction, moral distress and lack of personal accomplishment and for these reasons often leave the profession (Aiken, Clarke & Sloane, 2001: 255-263; Shisana *et al.* 2004: 846-850; Smit, 2004: 22-29; Van den Berg *et al.* 2006: 35).

South Africa's health care is dependent on caring compassionate professional nurses as the backbone of the health care system, being the first point of contact for patients and with primary health care services mainly provided by these nurses (Ntuli & Day, 2004; Van Rensburg & Pelsler, 2004). These practitioners carry the burden of serving the majority of South Africa's population with minimal funds and insufficient personnel especially in the public sector. Professional nurses need to find satisfaction and meaning in their work in order to be successful caregivers, able to care for patients and model health care behaviors (Vander Zyl, 2002). It is therefore necessary to accumulate knowledge that will help these nurses and the organisations they serve to promote personal satisfaction and resilience and enhance productivity. It is suggested that

predictors of the positive end of the health continuum be explored (Keyes, 2007; Nelson & Simmons, 2002; Ryff & Singer, 2003; Seligman & Csikszentmihalyi, 2000). Information about the prevalence of resilience and positive psycho-social functioning in professional nurses could indicate the nature and magnitude of the problem and the need for interventions. Such knowledge could also reveal what enables resilient nurses to cope with and thrive in a difficult context in order to base interventions on sound evidence.

Since 2000 the positive psychology movement has been building a science that aims to help individuals and organisations to promote strengths, personal fulfillment, resilience and optimal productivity (Seligman & Csikszentmihalyi, 2000). Research on human resilience has been done in order to understand how certain individuals, when faced with challenges and risk factors or stressors are able to bounce back without psychological harm and develop into confident, competent, caring adults (Huber & Mathy, 2002: 214-224). Resilience has become an appealing concept because of its roots in theoretical models of positive psychology that seek to explore factors that enable individuals to successfully overcome adversity (Kaplan, 1999: 17-83).

Just as there are multiple risk factors or stressors in given situations there are multiple indicators of positive adaptation. Research done by Richardson (2002: 307-321) indicates that resilient individuals have the potential to not only return to previous levels of functioning after experiencing adversity but manifest gains in self-esteem, self-efficacy, autonomy and a change in life perspective that serve to make them stronger than they were before, this gain has been termed thriving or flourishing (Carver, 1998: 245-266; Keyes, 2006: 1-10; Ryff & Singer, 2003: 181-205). Garmezy (1991: 416) defined resilience as: “the capacity for recovery and maintained adaptive behavior that may follow initial threat or incapacity upon initiating a stressful event” in other words the ability to bounce back after adversity. In research where the concept of resilience has been invoked, the process implied good outcome despite the presence of the stressor, or healthy recovery and the ability to bounce back or resile and the capacity to mobilise resources for positive adjustment despite the adverse experiences (Block & Kremen, 1996: 349-361).

Resilience is a multi-dimensional construct and is used in this study as an overarching umbrella term operationalised by measures of specific facets of psycho-social well-being. These facets were identified from literature and previous research. For purposes of this study resilience is conceptualised in terms of high levels of hope, optimism, coping self-efficacy, sense of coherence and flourishing mental health - all described in the literature to be characteristics of resilient people (Kaplan, 1999: 17-83; Lifton, 1993: 190-214; London, 1993: 55; Risher & Stopper, 1999: 8-10; Seligman, 1998: 5). These constructs can be described in short as follows:

Coping self-efficacy: Coping refers to efforts to deal with something difficult and these efforts may be cognitive, behavioral or psychosocial strategies that an individual uses to alleviate stress when events challenge the routine predictions of the world (Kleinke, 1998). Constructive coping is seen as a characteristic of resilient people when making the effort to manage situations that they appraise as potentially stressful or harmful (Kleinke, 1998; Lazarus & Folkman, 1984; Zeidner & Endler, 1996). Self-efficacy refers to beliefs about having the capabilities to organise and perform tasks successfully within a specific domain and thereby influencing the outcome of circumstances (Bandura, 1997). Bandura also indicated that self-efficacy convictions influence resilience to adversity (1997). Chesney *et al.* (2006) combined the coping and self-efficacy concepts and introduced the coping self-efficacy construct (and measuring instrument). Coping self-efficacy refers to a person's perceived ability to cope effectively with life challenges or threats. Like Bandura, Chesney *et al.* (2006) indicates that beliefs about one's ability to perform specific coping behaviors or coping self-efficacy, would influence the outcomes of adverse situations. In this study coping self-efficacy refers to the belief of the professional nurses that they could perform coping behavior that would succeed in dealing with the work stress they encounter.

Sense of coherence: Sense of coherence refers to the extent to which individuals see life issues as manageable, understandable, and meaningful, and therefore expectations that things will mostly work out well. Antonovsky (1987) defined it as a global orientation that expresses the extent to which an individual has a pervasive, enduring, though

dynamic, conviction, that the stimuli deriving from his or her internal and external environments in the course of living are structured, predictable and explicable, that the resources are available to meet the demands posed by these stimuli, and that these demands are challenges worthy of investment and engagement. The sense of coherence is linked to a variety of coping mechanisms and/or characteristics of a person that can facilitate effective tension management and can thus be associated with the construct resilience (Erikson & Lindström, 2006; Kinman, 2008). In this study it refers to the ability to view the demands in the nursing workplace as challenges, finding meaning in it and coping with the stressors with the help of available resources.

Optimism: Optimism refers to a global expectation that things will turn out well. According to Scheier, Carver and Bridges (1994) optimistic individuals are able to pursue their valued goals in the face of difficulties, using effective coping skills and experiencing less intense negative emotions when they encounter obstacles. Optimism is associated with good health, active coping styles and good occupational adjustment which are characteristics of resilient people (Carr, 2004). In this study it refers to the ability to maintain an optimistic explanatory style regarding the difficulties in the nursing profession and be able to positively adjust.

Hope: Hope refers to the ability to plan pathways to reach desired goals despite obstacles and the motivation to use these pathways. Hope is closely related to optimism and conceptualized by Snyder (2000) as involving two main components: pathway thoughts that formulate positive goal outcomes and agency thoughts that create efficacy expectations to reach the goals, a characteristic of resilient individuals that can apply hope features to adapt to change, accept challenges and cope with adversity. In this study hope refers to professional nurses being able to set realistic goals in the nursing profession and to find the ways and will to achieve these goals despite difficulties they may encounter.

Flourishing mental health: Mental health can be described on a continuum with optimal mental health characterised as flourishing with high levels of well-being on one end and

with mental ill health with low levels of well-being or languishing on the other end and moderate mental health in between. Keyes (2002) indicated that flourishing individuals have enthusiasm for life and they are actively and productively engaged with others and in social institutions. Flourishing is a state of wholeness where a person can deal with stressors in an effective way and maintain wholeness when interacting with his/her environment in a positive way (Keyes, 2002). Resilient professional nurses would need mental and physical health when interacting with the demanding nursing workplace in a positive way (Keyes, 2002: 207-222). Resilient nurses would be closer to the flourishing end than to moderate or low mental health.

The overarching concept of resilience used in this study with the relating concepts and measurement of aspects of resilience in professional nurses can be illustrated as follows in Figure 1.

> include Figure 1 about here <

Many nurses choose to remain in nursing, and some even thrive despite a climate of that only 18% of the adults in the USA are flourishing as measured with the Mental Health Continuum – Short Form. The current study will explore the prevalence of resilience in professional nurses in South Africa. There is a paucity of information on resilience as it pertains to nurses and information on the prevalence of resilience in professional nurses is lacking. A better understanding of resilience can be of theoretical and practical importance (Glantz & Johnson, 1999: 120-188; Patterson, 2002: 233-246). Information obtained could lead to a better understanding of the quality of life and well-being of professional nurses and could be used to develop specifically targeted interventions as well as improvement of the quality of the overall functioning of professional nurses, thereby improving the quality of nursing care and improving the health care service overall.

Research objectives

The aims of this study were to determine the prevalence of resilience in a group of professional nurses, to determine whether there are significant differences in levels of psycho-social well-being and resilience between participants working in private and public health care facilities, and to obtain an indication of participants' view of their profession and resilience there-in.

RESEARCH DESIGN

Research approach

This was primarily a quantitative investigation in which a cross-sectional survey design was used. In such a design the interrelationships among variables are assessed without experimental variation. The cross-sectional design is well-suited for descriptive purposes in an investigation (Shaughnessy & Zechmeister, 1997).

Research methods

Research population and sampling

The participants were 312 South African professional nurses, willing to participate in the study and working in public and private hospitals and primary health care clinics affiliated with the latter. For practical reasons the suburban areas of Krugersdorp, Randfontein, Carletonville and Potchefstroom were used for the research. This was a convenience sample based on voluntary, all inclusive and non-discriminatory inclusion. Participants were professional nurses practicing for at least six months and able to communicate in English or Afrikaans. The socio-demographic data of the participants are illustrated in Table 1.

> include Table 1 about here <

Measuring instruments

A booklet was compiled starting with a biographical questionnaire to gather socio-demographic information from the participants including three open ended questions on their feelings about the profession and resilience, followed by the seven measuring

instruments. The booklet also contained instructions for completion of questionnaires and information about the confidential handling of personal data, information explaining the objectives of the study and a consent form for voluntary participation that was to be signed by all the participants. Six hundred and fifty questionnaires were distributed, 330 were received back, 18 were discarded because participants did not complete all the questionnaires, thus 312 (48%) were completed and analysed. Szelényi, Bryant and Lindholm (2005) suggest that a response rate of 32% is acceptable in self-report surveys such as the present one.

Resiliency Scale (RS) (Wagnild & Young, 1993: 165-178): The RS is a 25-item scale that measures the degree of individual resilience, which is considered a positive personality characteristic that enhances individual adaptation. All items are scored on a 7-point scale from 1 = disagree, to 7 = agree. All items are worded positively and reflect accurately the verbatim statements made by participants in the initial study on resilience conducted by Wagnild and Young. Possible scores range from 25–175, with higher scores reflecting higher resilience. The authors reported good internal consistency with a 0.80 Cronbach alpha and the test-retest reliability showed coefficients between 0.5-0.98. No previous studies could be found in South Africa using this scale. In a study done by Meredith (2005) among 105 students at Oxford University, a reliability index of 0.89 was reported. In the current study a Cronbach alpha of 0.95 was obtained.

Mental Health Continuum – Short Form (MHC-SF) (Keyes, 2005: 3-11): The MHC-SF consists of 14 items. The items represent three sub-scales, namely Emotional Well-Being (MHC-EWB), Psychological/Personal Well-Being (MHC-PWB) and Social Well-Being (MHC-SWB). To be flourishing, individuals must experience “every day” or “almost every day” at least one of the three signs of hedonic well-being and at least six of the eleven signs of positive functioning during the past two weeks. Individuals who exhibit low levels (never, or once or twice during the past two weeks) on at least one measure of hedonic well-being and low levels on at least six measures of positive functioning are languishing. Individuals who are neither flourishing nor languishing have moderate mental health. The short form has shown excellent internal consistency (Cronbach alpha

0.80) and discriminatory validity. The test-retest reliability estimates range from 0.57 – 0.82 for the total scale (Keyes, 2007: 95-108). The three factor structure of the short form—emotional, psychological, and social well-being - has been confirmed in American representative samples (Keyes, 2005: 1-10 & 2009: 3-29). In a study done in South Africa using the MHC-SF in Setswana-speaking Africans a Cronbach alpha of 0.74 was reported (Keyes, *et al.* 2008). In the current study Cronbach alpha indices of 0.84, 0.77 and 0.88 were obtained for the subscales and a total scale alpha of 0.83.

The Coping Self-efficacy Scale (CSE) (Chesney *et al.* 2006): The CSE is a 13-item measure of one's confidence in coping behaviors when faced with life challenges. The scale is the short form of the original 26-item CSE measuring coping self-efficacy. The scale has three sub-scales with 6 items on Problem-Focused Coping (CSE-PFC), 4 items on Stopping Unpleasant Emotions and Thoughts (CSE-SUE) and 3 items on getting Support from Friends and Family (CSE-SFF). Internal consistency and test-retest analyses showed these factors assess self-efficacy for different types of coping. Predictive validity analyses showed that residualised change scores in using problem- and emotion-focused coping skills were predictive of reduced psychological distress and increased psychological well-being over time (Chesney *et al.* 2006: 421-437). In research done in the UK by Chesney *et al.* (2006) reliability indices of 0.40-0.80 were reported for the CSE with the sub-scales almost identical to this. In a South African study by Wissing *et al.* (2008) reliability indices of 0.86 and 0.87 for the 26-item version were reported. In the current study Cronbach alpha coefficients of 0.87, 0.89 and 0.79 were found for the subscales and a total scale alpha of 0.85.

The Sense of Coherence Scale (SOC) (Antonovsky, 1987: 30-37): The SOC is a 29-item questionnaire that measures the three dimensions of the sense of coherence construct viz. comprehensibility, manageability and meaningfulness. According to Antonovsky these should not be seen as sub-scales, as the SOC was developed to be a uni-dimensional instrument with three interrelated components. The items are answered on a seven-point Likert scale with two anchoring phases. Antonovsky (1993: 725-733) reported Cronbach alpha coefficients in 29 research studies varying between 0.85 and 0.91. Test-retest

reliability studies have found coefficients ranging between 0.41 and 0.97. Studies done in South Africa reported reliability indices of 0.88 (Walker, 1999) and 0.85 (Wissing & Van Eeden, 2002). In the current study a Cronbach alpha of 0.64 was obtained.

The Adult Dispositional Hope Scale (HS) (Snyder, Irving & Anderson, 1991: 285-305): The HS consists of 12 items, measuring the self-reported hopefulness trait of an individual, to which participants indicate their responses on a 4-point Likert scale ranging from 1 (definitely false) to 4 (definitely true) measuring aspects of hope. Four items of the scale reflect agency (HS-A) (e.g. I energetically pursue my goals), four items reflect pathways (HS-P) (e.g. even when others get discouraged I can find a way to solve the problem), and four items are unrelated distracters. Cronbach alphas coefficients for the total score range from 0.74 to 0.84 and test-retest correlations have been 0.80 or above over periods exceeding 10 weeks (Snyder *et al.* 1991). A study conducted with nurses in Philadelphia reported a reliability index of 0.61 (Feudner et al. 2007: 119). Wissing *et al.* (2008) found reliability coefficients ranging from 0.67 to 0.79 for the HS total and the subscales in a South African study. The current study showed Cronbach alpha indices of 0.58 for the HS-P and 0.64 for the HS-A with an alpha of 0.64 for the HS-Total.

Life Orientation Test-Revised (LOT-R) (Scheier & Carver, 1985: 219-247): The LOT-R was developed to assess individual differences in generalised optimism versus pessimism. This measure has been used in a good deal of research on the behavioral, affective, and health consequences of this personality variable. It is a very brief measure, with 10 items, that is easy to use (items 2, 5, 6 and 8 are fillers). Responses to scored items are coded and high values imply optimism. Half the items are framed in an optimistic manner and half in a pessimistic manner, and respondents indicate their extent of agreement or disagreement on a multi-point scale. Scheier and Carver (1985) have reported a high level of reliability (Cronbach alpha of 0.79) and a South African study by Dreyer (2003) reported indices ranging between 0.60 and 0.70. In the current study a Cronbach alpha of 0.59 was obtained for the LOT-R.

The General Health Questionnaire (GHQ) (Goldberg & Hillier 1979: 139-145): The GHQ-12 measures aspects of mental health by assessing symptoms and signs of non-pathological mental ill-being or lack of mental well-being. It consists of 4 subscales: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. According to Goldberg and Hillier (1979) a Cronbach's alpha coefficient of 0.79 was found for the GHQ-12 in the population studied. A study done in Iran with 714 young people showed a Cronbach alpha coefficient of 0.87 (Montazeri *et al.* 2003: 66) and a study done in South Africa by Bosman (1990) found a reliability coefficient of 0.91. The current study showed a Cronbach alpha of 0.84 for the total scale.

Open ended questions: Three open ended questions were included to establish nurses' view on how they feel about the nursing profession, if they consider to leave their job and why, and if they think they are resilient and why. Answers were quantified.

Research procedure

Data was gathered by means of a compiled booklet containing the measuring instruments as discussed above. A pilot study was done and 10 participants reported the questionnaires to be clear, user friendly and that it took about 30 minutes to complete. The Ethics Committee of the North-West University approved this study (reference no.NWU-00002-07-A2, Wissing, 2008). Permission and written consent was also obtained from all the stakeholders, namely: the Department of Health, the managements of all the partaking facilities and research participants. The first author presented the intended research project at all the facilities to the management of the hospitals with chief professional nurses present, explaining the objectives and giving them an opportunity to ask questions and to establish trust relationships. She followed up on her initial contact by phoning and confirming appointments. Chief professional nurses that were present at the initial presentations acted as facilitators and distributed and collected the questionnaires in some facilities, and in others they introduced the first author to the participants who then distributed and collected the questionnaires herself.

Statistical analysis

The data obtained in this study was analysed by the statistical consultation service of the North-West University in Potchefstroom, by means of the SPSS program. Descriptive statistics and Cronbach alpha reliability coefficients were determined for all scales and sub-scales used. Confirmatory factor analysis was conducted to determine the validity of the scales. Correlations among scales were determined by means of Pearson-R scores and significant differences between subgroups were calculated with t-tests and MANOVA analysis. Prevalence of resilience was determined across measures by normalising the mean scores of the measuring instruments and expressing the total value of the normalised mean scores as a fraction (0-1), representing a level of resilience manifested by the participants across all scales. Indices thus obtained were categorised as follows:

Low resilience = < 0.4

Moderate resilience = > 0.4 and < 0.6

High resilience = > 0.6

Flourishing as measured with the MHC-SF, was determined according to the criteria described by Keyes (2006a).

Answers to open-ended questions were analysed and quantified according to the following:

Question 1: Positive and negative feelings

Question 2: Yes/No answers and the alternatives given

Question 3: Resilient or not and alternatives as well as reasons/explanations given.

RESULTS

The results are discussed with reference to descriptive statistics, reliability and validity of the measuring instruments, correlations between measuring instruments, the prevalence of resilience in the professional nurses, significance of differences between the participants of private and public health facilities, and findings from the open-ended questions.

Descriptive statistics, reliability and validity of instruments

The descriptive statistics and Cronbach alpha reliability indices for all scales are presented in Table 2.

> include Table 2 about here <

The mean scores and standard deviations found in this study mostly correspond with those found in literature. The Cronbach alpha reliability indices of all the measuring instruments as presented in Table 2 are acceptable to good except for the SOC, HS and LOT-R. Construct validity of the measuring instruments was determined by confirmatory factor analyses which indicated that all scales were valid in this regard and could be used in this research group.

Correlations among measures

The correlations shown in Table 3 between scales and sub-scales used to measure aspects of resilience in this study, range from moderate to high.

> include Table 3 about here <

The significant positive correlations between the scales and sub-scales (RS, MHC-SF, CSE, SOC, HS, GHQ-12 and LOT-R) indicate that the underlying constructs have features in common on an empirical level which is, for the purposes of this study, conceptualised as resilience. The significant negative correlations of the GHQ-12 with all the other scales and subscales support what is theoretically expected, namely that resilient professional nurses would have low levels of mental ill-being and dysphoria.

Prevalence of levels of resilience across measures

Using the statistical categories described above the following was found:

The prevalence of resilience in the total group of professional nurses (N=312): 30 participants (10%) seemed less resilient, 149 participants (47%) seemed moderate, and 133 participants (43%) seemed to be highly resilient.

Public sector (N=124), 14 participants (11%) manifested low resilience, 68 participants (55%) manifested moderate resilience, and 42 participants (34%) manifested high resilience in this group of professional nurses.

Private sector and primary health care clinics (N=188), 15 participants (8%) manifested low resilience, 88 participants (47%) manifested moderate resilience and 85 participants (45%) manifested high resilience in this group of professional nurses.

These findings are illustrated in Figure 2.

> include Figure 2 about here <

Levels of mental health (with flourishing as an index of resilience), according to the criteria for a categorical diagnosis specified by Keyes (2002) for the MHC-SF, were as follows:

Total group: Languishing: 4% (N=12); Moderate mental health: 51% (N=158); Flourishing: 45% (N=142).

Public sector: Languishing: 5% (N=6); Moderate mental health: 56% (N=69); Flourishing: 40% (N=49)

Private sector: Languishing: 3% (N=6); Moderate mental health: 47% (N=89); Flourishing: 50% (N=93).

Differences in resilience between nurses in the public and private hospitals

Significance of differences in resilience (across measures) between participants from the private and public sectors is shown in Table 4.

> include Table 4 about here <

Results show that participants working in private facilities score significantly higher on resilience (RS) and emotional well-being (MHC-EWB) than those nurses working in public hospitals.

Results from open ended questions

Three questions were asked to the participants as part of the biographical questionnaire:

- *How do you feel about the nursing profession at the moment?*

The positive feelings reported by participants focused mostly on the satisfaction or reward they experience in caring for the patients (11%), being good at it (9%), that it is a passion or calling (7%), feeling comfortable or secure (5%), and feeling as being part of a family (3%). The negative feelings reported by participants was poor remuneration (24%) followed by staff shortages (18%) and working conditions (17%) (mostly from the public sector) the poor professional image (13%), the managerial problems (12%), low morale (11%), lack of recognition (11%), the high stress and responsibilities (11%) and abusive patients (5%).

- *Are you considering leaving the profession, if yes to do what?* See Table 5 for the results.

> include Table 5 about here <

Alternatives considered were: Own business (28); Emigrate (12); Not sure (15); Early retirement (6), the rest didn't say where they want to go. A cause for concern is that these findings show that 116 (37%) of the nurses want to leave, while 53 (17%) are considering it, which is more than half of these nurses (54%).

- *Do you consider yourself as resilient, and why?* See Table 6 for the results.

> include Table 6 about here <

Reasons or explanations given were: Learned to cope (N=10); Support (N=15); Religion (N=8); Nursing is a calling (N=7); Balanced lifestyle (N=8); Positive mindset (N=8); It's a choice (N=5). These self-reported findings on resilience fairly correspond with the results of the measuring instruments on resilience finding that 43% are resilient, while

129 (41%) self reported that they are resilient. Seventy (22%) reported sometimes. The 48 (15%) reporting themselves as not resilient correspond with the 10% indicated before, while the rest (22%) reported that they did not know.

A further refinement of these results indicated that: In public hospitals 60% of the nurses who saw themselves as resilient indicated that they would remain in the profession while 40% of the non-resilient participants would stay. In the private facilities 66% of self-reported resilient nurses would stay in the profession while 35% of the non-resilient nurses indicated that they would stay.

DISCUSSION

The aims of this investigation were to determine the prevalence of resilience in this group of professional nurses, to determine whether there are significant differences in levels of psycho-social well-being and resilience between participants working in private and public health care facilities, and to obtain an indication of participants' view of their profession and resilience there-in. The main finding was that 43% - 45% of the participants in the total group could be described as resilient or flourishing.

Descriptive statistical findings indicate that the mean scores and standard deviations are mostly similar to those reported in literature – which suggests that this group of participants is not very different from the general population in their mental health. The reliability coefficients of the measuring instruments used were acceptable except for the SOC, HS and LOT-R. However, these scales also presented with relatively lower reliability indices for African groups in other South African studies (Wissing & Van Eeden, 2002; Wissing *et al.* 2008). Confirmatory factor analysis indicated acceptable validity of the measuring instruments for use in this research group. Moderate to high positive correlations among the scales measuring aspects of resilience indicated that the underlying constructs have features in common on an empirical level which, for purposes of this study, was conceptualised as resilience. This findings links to that of Gillespie (2007) who found that self-efficacy, hope, coping and stress management were good

predictors of resilience in a group of nurses. The significant negative correlations found between the scales measuring aspects of resilience and the GHQ-12 measuring aspects of pathology (non-resilience) was theoretically expected and support criterion related validity.

The findings about the fairly high prevalence of resilience in this group of professional nurses were surprising as studies done on burnout reported high levels of burnout and stress in nursing staff. Research done by Ehlers (2003: 63-69) on why nurses decide to de-register, found that more than 60% of these nurses suffer from burnout and that in primary health care settings more than 80% of nurses were experiencing exhaustion or compassion fatigue (Ehlers, 2006). The prevalence of flourishing in the total group of nurses (45%) as found on the Mental Health Continuum – Short Form, which is similar to the percentage of resilient nurses as determined across all measures (43%), is much higher than the 18% of adults flourishing in the USA as reported by Keyes (2007), or as the 20% of an adult African community sample as reported by Keyes *et al.* (2008). This finding may suggest two important matters or hypotheses: Firstly, people who enter the nursing profession, or who have survived the difficult nursing context thus far, are generally more resilient than people in the general population. The strengths of nurses in general to function in such a way need to be explored further, especially in a qualitative approach. Secondly, the current finding of a relatively high percentage of nurses who are flourishing together with findings from previous studies that indicated high levels of burnout in nurses, may provide support for the hypothesised two dimension nature of psychological health (Keyes, 2005; 2006a): pathology and wellbeing are two separate although correlated dimensions of human functioning, which may overlap to some extent. Thus, to some extent symptoms of burnout and symptoms of flourishing may co-exist in some instances in the nursing profession. Although a surprising high number of nurses were flourishing, it should be remembered that 55% are not flourishing (57 % not resilient as measured across measures) and may need support and interventions in order to develop higher levels of psycho-social well-being and work satisfaction. The fact that 650 questionnaires were distributed and only 312, less than 50% were completed, may also indicate the despondence or burn-out experienced by many of these nurses.

As far as the private versus public contexts are concerned, participants in private hospitals manifested higher levels of psychosocial well-being than nurses in public hospitals on some of the measuring instruments. However, these differences were, although statistically significant, too small to have an impact in practice as the effect sizes are small. Of importance is the fact that forty five percent of professional nurses in private hospitals manifested high levels of resilience and flourishing (50%) compared to the 34% resilience and 40% flourishing of professional nurses working in public institutions. The private health care facilities clearly seem to be more conducive to resilience and maintaining mental health and well-being in the demanding nursing profession.

A quantification of answers to three questions posed to the participants indicated that 41% saw themselves as resilient in their profession which is remarkably close to the 43% found in the quantitative data across measures. However, the majority (54%) were considering leaving the nursing profession. Further refinement of the answers indicated that the majority of the nurses who planned to leave the profession were those who self-reported moderate to low resilience. Of the self-reported resilient participants in both public and private hospitals, 60% to 63% indicated their commitment to the nursing profession and their willingness to stay. It could be speculated that their resilience enable these nurses to cope with the difficulties posed by the nursing context and to even attempt to improve the situation from within (to make a difference).

Findings also showed an aging workforce, with only 22 participants younger than 30 years (7%), and 230 (72%) older than 40 years. Furthermore many of these participants want to leave the profession with 96 (31%) or 63 (20%) considering leaving the profession, 7 ready for retirement, and 6 thinking about early retirement. This is alarming considering the shortage the nursing profession is already facing. Ehlers (2003: 65) indicates that the South African nurse shortage could be exacerbated by the retirement of baby boomers, people born between 1946 and 1964, which constitute more than half of professional nurses currently registered at the South African Nursing Council.

The hindering or negative aspects identified in the nursing context, outweighed the positive aspects (which were mostly about a love for nursing), namely: poor salaries, staff shortages, poor working conditions, the bad professional image, low morale, the stressors and responsibilities, managerial problems, lack of recognition and abusive patients. Although all the participants alluded to these problems in the professional context, nurses working in the public hospitals expressed less positive feelings and noticeably more negative feelings about the profession. Various authors (Basson & Van der Merwe, 1994: 35-43; Buchan, 2006: 16-23; Cavanagh, 1997: 128-134; Jackson, Clare & Mannix, 2007: 1-7; Mitchell, 2003: 219-224; Oulton, 2006: 34-39; Tusaie & Dyer, 2004: 3-10) reported on these and similar problems while an emphasis seems to be on the financial and managerial problems and lack of recognition or autonomy, a high workload and low morale (Buchan, 2006: 16-23). Fletcher (2001: 324) found in a study with professional nurses that they love the work they do but hate their job, mainly because of adverse working conditions. If this current situation continues, where entry into nursing seem outweighed by exit with nurses either emigrating or discontinuing practice, the crisis will deepen unless strategies are developed not only to retain nurses but to empower them and to attract new recruits into nursing and entice nurses who left to return to the profession. The current findings on levels of psychosocial wellbeing and prevalence of resilience in nurses indicate the preciousness of nurses who could have stayed resilient for the profession, but also the need to facilitate psychosocial wellbeing of the majority of nurses who are not resilient or flourishing.

A limitation of the study, namely the relative small number of participants (N=312) was partly caused by the delay in obtaining permission from the Department of Health which led to two public hospitals not being included in the study. Another limitation is that the southern provinces in South Africa were not included. There is, however, no reason to assume that findings will be very different as the health care system is nationally under pressure, but still the findings cannot be generalised.

It is recommended that all the measuring instruments used should be further validated for specific contexts. A new measure of resilience may also be developed through factor

analyses on findings from all scales, similar to the general well-being component identified across measures by Wissing and Van Eeden (2002). In this study resilient professional nurses were identified. Further qualitative in-depth analyses of the experience and functioning of these nurses may provide a thorough understanding of resilience in the nursing profession and may help to identify guidelines on which programs for training and/or interventions for the empowerment of nurses can be based.

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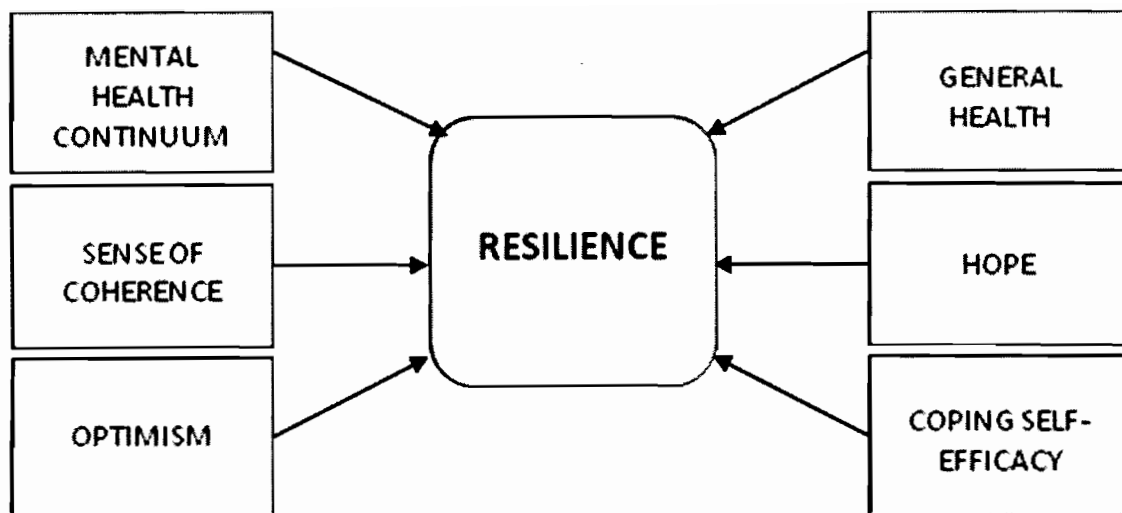


Figure 1: Resilience as the overarching concept

Table 1: The socio-demographic data of professional nurses in this study (N = 312)

| Hospital | N | % |
|--------------------------------------|----------|----------|
| Public | 124 | 39.7 |
| Private | 158 | 50.7 |
| Primary health care clinic | 30 | 9.6 |
| Position | | |
| Chief professional nurse | 269 | 86.2 |
| Professional nurse | 43 | 13.8 |
| Gender | | |
| Males | 50 | 16 |
| Females | 262 | 84 |
| Age | | |
| 20-30 years | 22 | 7 |
| 31-40 years | 60 | 19.2 |
| 41-50 | 114 | 36.5 |
| 51-60 | 97 | 31.2 |
| 61 plus | 19 | 6.1 |
| Race/Ethnicity | | |
| African | 230 | 73.7 |
| White | 60 | 19.2 |
| Coloured | 7 | 2.2 |
| South African (as indicated by some) | 39 | 12.5 |

Table 2: Descriptive statistics and internal consistency indices of the measuring instruments for the total group (N=312)

| Variable | Mean | Std Dev | Min | Max | Cronbach alpha |
|------------------|-------------|----------------|------------|------------|-----------------------|
| RS | 137.2 | 25.65 | 62 | 175 | 0.95 |
| MHCSF-EWB | 10.3 | 2.83 | 0 | 15 | 0.84 |
| MHCSF-SWB | 13.7 | 4.88 | 2 | 25 | 0.77 |
| MHCSF-PWB | 22.6 | 5.21 | 6 | 30 | 0.88 |
| CSE-PFC | 41.2 | 10.85 | 16 | 60 | 0.87 |
| CSE-SUE | 25.9 | 9.10 | 0 | 40 | 0.89 |
| CSE-SFF | 20.5 | 6.88 | 1 | 30 | 0.79 |
| CSE-Total | 87.5 | 22.73 | 33.6 | 130 | - |
| SOC | 120.0 | 14.44 | 71 | 157 | 0.64 |
| HS-P | 9.7 | 1.49 | 6 | 12 | 0.58 |
| HS-A | 9.5 | 1.40 | 5 | 12 | 0.61 |
| HS-Total | 19.1 | 2.50 | 12 | 24 | - |
| LOT-R | 14.9 | 3.43 | 7 | 24 | 0.59 |
| GHQ-12 | 0.80 | 0.25 | 0 | 12 | 0.84 |

Note: RS = Resiliency Scale; MHCSF = Mental Health Continuum – Short Form, EWB = Emotional Well-being, SWB = Social Well-being, PWB = Psychological Well-being; CSE = Coping Self-efficacy Scale, PFC = Problem Focused Coping, SUE = Stopping Unpleasant Emotions and Thoughts, SFF = Support from Friends and Family; SOC = Sense of Coherence Scale; HS = Hope Scale, P = Pathways, A = Agency; LOT-R = Life Orientation Test-Revised; GHQ = General Health Questionnaire.

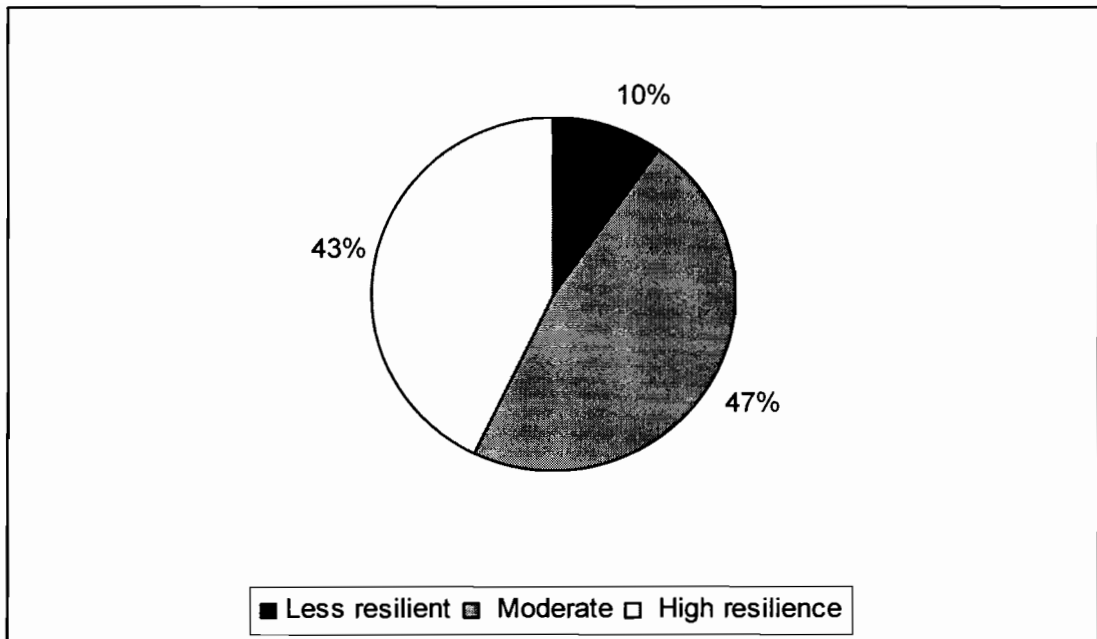


Figure 2: Prevalence of resilience in professional nurses (N=312)

Table 3: Correlations between all the measuring instruments for the total group (N=312)

| | RS | MHCSF -EWB | MHCSF -SWB | MHCSF -PWB | CSE- Total | SOC | HS- Total | LOT-R | GHQ-12 |
|-----------------------|--------|---------------|---------------|---------------|---------------|--------|--------------|--------|--------|
| RS | 1 | | | | | | | | |
| MHCSF- EWB | 0.470 | 1 | | | | | | | |
| MHCSF- SWB | 0.251 | 0.423 | 1 | | | | | | |
| MHCSF- PWB | 0.558 | 0.620 | 0.450 | 1 | | | | | |
| CSE-Total | 0.643 | 0.363 | 0.311 | 0.593 | 1 | | | | |
| SOC | 0.319 | 0.467 | 0.390 | 0.430 | 0.332 | 1 | | | |
| HS-Total | 0.721 | 0.483 | 0.415 | 0.618 | 0.638 | 0.311 | 1 | | |
| LOT-R | 0.416 | 0.376 | 0.175 | 0.334 | 0.381 | 0.339 | 0.326 | 1 | |
| GHQ-12 | -0.491 | -0.467 | -0.226 | -0.362 | -0.373 | -0.423 | -0.342 | -0.338 | 1 |

Note: All values quoted are significant at $p < 0.05$.

Table 4: Significant differences on the measuring instruments between respondents in public and private hospitals (N=312)

| Variable | Means | | Means Diff. | Df | T | P | d |
|-------------------|----------------|-----------------|--------------|------------|--------------|--------------|-------------|
| | Public (N=124) | Private (N=188) | | | | | |
| RS | 134.0 | 140.3 | -6.34 | 309 | -2.19 | 0.029 | 0.28 |
| MHCSF-EWB | 9.9 | 10.6 | -0.76 | 303 | -2.35 | 0.019 | 0.27 |
| MHCSF-SWB | 13.4 | 14.1 | -0.67 | 303 | -1.21 | 0.226 | - |
| MHCSF-PWB | 22.1 | 23.0 | -0.95 | 303 | -1.59 | 0.114 | - |
| CSE-PFC | 40.2 | 42.1 | -1.88 | 309 | -1.53 | 0.127 | - |
| CSE-SUE | 25.7 | 26.0 | -0.23 | 309 | -0.23 | 0.821 | - |
| CSE-SFF | 20.4 | 20.5 | -0.09 | 309 | -0.11 | 0.910 | - |
| CSES-Total | 86.4 | 88.6 | -2.22 | 309 | -0.86 | 0.390 | - |
| SOC | 119.6 | 120.4 | -0.730 | 309 | -0.45 | 0.653 | - |
| HS-P | 9.5 | 9.8 | -0.29 | 309 | -1.70 | 0.090 | - |
| HS-A | 9.4 | 9.5 | -0.15 | 309 | -1.01 | 0.315 | - |
| HS-Total | 18.9 | 19.3 | -0.45 | 309 | -1.61 | 0.108 | - |
| LOT-R | 14.8 | 14.9 | -0.120 | 306 | -0.30 | 0.763 | - |
| GHQ-12 | 0.80 | 0.80 | -0.04 | 310 | -1.41 | 0.161 | - |

Note: Significant differences given in bold print. Practical effect (Cohen, 1977) indicated as follows: Small effect: $D < 0.30$; Medium effect: $0.30 < D < 0.50$; Large effect: $D > 0.50$

Table 5: Participants considering leaving the profession

| | Yes | No | Maybe | Retiring |
|---------------|-----|----|-------|----------|
| Public n=124 | 48 | 48 | 24 | 4 |
| Private n=158 | 60 | 74 | 21 | 3 |
| Clinics n=30 | 8 | 14 | 8 | 0 |

Table 6: Participants' views on own resilience

| Resilient | Yes | No | Sometimes | Do not know |
|---------------|-----|----|-----------|-------------|
| Public n=124 | 55 | 29 | 20 | 20 |
| Private n=158 | 64 | 16 | 40 | 38 |
| Clinics n=30 | 10 | 3 | 10 | 7 |

MANUSCRIPT TWO

THE STORIES OF RESILIENCE IN PROFESSIONAL NURSES

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Title: Informative but concise, In small capital letters, centered and in bold, font size 14, eg.: Names of questionnaires, countries, and or authors start with capital letters.

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Abstract: Not more than 200 words, and should state concisely the scope of the work and the principal findings:

- the objective of the study
- the population size, sampling strategy, sample size and response rate
- main statistical procedures used for analyzing the data
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Opsomming: Always include an Afrikaans abstract of the article, please follow the same format and structure as indicate within the heading 'abstract'.

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Manuscript Contents

The manuscript contains five sections, namely the introduction, research design, results, discussion and the references. All these first-level headings (except 'introduction') appear in bold capital letters and are centered.

INTRODUCTION:

The introductory section normally contains the following eight elements; headings are indicated in [brackets]:

- (1) [**Key focus of the study**] A thought-provoking introductory statement on the broad theme or topic of the research (why should I even bother to read further?);
- (2) [**Background to the study**] Providing the background or the context to the study (explaining the role of other relevant key variables in this study);
- (3) [**Trends from the research literature**] 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);
- (4) [**Research Objectives**] Indicate the most important controversies, gaps and inconsistencies in the literature that will be addressed by this study;
- (5) In view of the above (in 4) state the core research problem and specific research objectives that will be addressed in this study;
- (6) [**Ethical Considerations**]
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Tips on Introduction Section:

The first-level heading, **INTRODUCTION**, is **not** used. However, second-level headings may be used in this introductory section. These subheadings are flush with the margin, and are typed in lower case; bold starting with a capital letter.

If lists of bullet points are presented, they should be in the following format:

Longevity. How long individuals live.

Prognosis. How well an individual responds to challenges of disease or trauma.

Mental health. General level of mental functioning

Avoid using lists that contain more than 10 bullet points.

Synthesis and Critical evaluation of the literature – Still apart of Introduction

A synthesis and critical evaluation of the literature (not a compilation of citations and references) should at least include or address the following aspects:

- (1) Conceptual (theoretical) definitions of all key concepts;
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- (3) Including a review of existing approaches towards the measurement of relevant constructs; and
- (4) A clearly defined link should be established between formulated hypotheses and objectives. The stated objectives follow directly on the section where the literature was reported. .

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Research approach

A brief description of the research approach followed in the study should be included. It should, for instance, explain from which qualitative tradition the study is and also motivate why this approach is specifically required. The author(s) may state their scientific beliefs (ontology and epistemology) if these have an effect on the choice of the research approach.

Research methods

Under the research method the author(s) provide at least descriptions on the following third-level headings, namely: research context (setting), entrée and ethical considerations, data collection methods, recording of the data, data analyses, strategies employed to ensure data quality and reporting.

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The qualitative sampling procedures used in the study, such as cueing, purposive sampling or snow-balling are described and motivated in this section.

Data collection methods

In this section the author(s) explain where the data was sourced and which data collection methods (e.g. semistructured or unstructured interviews, focus-groups) were applied. In some instances solicited documents are also used.

Data analyses

In this case the author(s) explain which methods of data analyses were applied. Different data analyses techniques result in different variations of qualitative research.

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Tables and Figures are each presented on a separate page after the section **REFERENCES** and appear in the same numerical order as they appear in the text. The positions of tables or figures are indicated in the text in the following way: <include Table 1 about here>

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CONCLUSION & RECOMMENDATION

The next heading is **CONCLUSION & RECOMMENDATION**, which appears in capital letters, in bold and centred.

This section normally contains the following eight elements:

- restate the main objective of the study;
- 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;
- provide the conclusion and recommendations (implications for practice);
- point out the possible limitations of the study; and
- provide suggestions for future research.

Second and third-level headings may be used.

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References begin on a separate page. References cited in the text should all be included in the list at the end of the paper. Full references at the end of the paper, arranged alphabetically by surname, chronologically within each name, with suffixes a, b, c, etc. to the year for more than one per year by the same author. Note that the second and subsequent lines are indented.

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The stories of resilience in professional nurses

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ABSTRACT

Nurses enter the profession because they have a deep rooted desire to care for people, and it is important for them to stay optimistic and keep the passion to ensure high quality nursing care. We can learn from resilient professional nurses who are compassionate, to better equip nurses who are suffering, getting physically or mentally unwell, or want to enhance the quality of their lives. The objective of this study was to identify resilient characteristics, strengths and other protective factors through in-depth qualitative methods from professional nurses, identified quantitatively as resilient. Thirty five (35) resilient professional nurses participated voluntarily and wrote their stories on how they manage to stay resilient and compassionate in the profession. Six focus group interviews and one individual interview were also conducted with nurses at public and private facilities. Rich data on resilience in professional nurses was obtained and their resilience as an enabling factor emerged and is conceptualised as a self-sustaining strength. Resilience in attitude and ability is reinforced by their resilient behavior and the latter by positive outcomes such as being able to overcome difficulties, to adapt, to become stronger and more committed to a profession that they value. These findings add to the knowledge base of quality nursing care in the nursing profession and can be applied to improve resilience in professional nurses thereby enhancing the health care system.

Key words: Sense of coherence, coping self-efficacy, hope, optimism, mental health, well-being.

OPSOMMING

Verpleegkundiges betree die beroep omdat hulle 'n begeerte het om vir mense te sorg en dit is belangrik dat hulle positief bly om sodoende hoë kwaliteit verpleegsorg te verseker. Ons kan by veerkragtige verpleegkundiges wat daarin slaag om passievol en toegewyd te bly, leer hoe om verpleegkundiges toe te rus wat swaar kry, psigies en fisies onwel raak, of wat die kwaliteit van hul lewens wil verbeter. Die doelwit van die studie was om kenmerke van veerkragtigheid, sterktes en ander beskermende faktore te identifiseer deur middel van in-diepte kwalitatiewe metodes met professionele verpleegkundiges wat kwantitatief geïdentifiseer is as veerkragtig. Vyf en dertig (35) veerkragtige professionele verpleegkundiges wat ingestem het om vrywillig deel te neem het stories geskryf oor hoe hulle daarin slaag om veerkragtig en passievol in die beroep te bly. Ses fokusgroeponderhoude en een individuele onderhoud is met veerkragtige professionele verpleegkundiges by openbare en privaat fasiliteite gehou. Ryk data oor veerkragtigheid in professionele verpleegkundiges is verkry. Veerkragtigheid as 'n bemagtigingsfaktor blyk 'n self onderhoudende sterkte te wees. Veerkragtigheid in houding en vermoë word versterk deur veerkragtige optrede en laasgenoemde deur positiewe uitkomst, soos om probleme te kan oorkom, aan te pas, sterker te word en meer toegewyd te word aan 'n professie waarvoor hulle waardering het. Hierdie bevindinge dra by tot die kennisbasis van kwaliteitsversorging in die verpleegkunde professie, en kan gebruik word om veerkragtigheid in professionele verpleegkundiges te bevorder en sodoende die gesondheidsorgstelsel te verbeter.

Slutelwoorde: Kohesiesin, coping/hantering selfbevoegdheid, hoop, optimisme, geestesgesondheid, welsyn.

Focus and background of the study

The nursing profession is based on a philosophy of care and professional nurses are responsible to deliver this care to the sick, weak, traumatised, wounded and dying patients entrusted to them, and to be an instrument of service to patients within the health care system (Kozier *et al.* 2000: 1479) thereby also enhancing their quality of life. It can be said that nursing claims caring as the hallmark of the nursing profession. As such, all aspects relating to caring are important to maintain the quality of care in the nursing profession (Muller, 2002: 316). For nurses to be successful caregivers they must be able to continuously find a sense of purpose in caring for others, to be optimistic, and to have compassion and a caring concern for their patients in order to achieve this goal (Talento, 1990: 293-310; Watson, 2003: 197-202). Therefore they need to be psychologically well, resilient and flourishing.

When focusing on the well-being of South African professional nurses, the nature of the South African health care system and the effect it has on them should be taken into consideration. In the last 5-10 years there has been a shift from a fragmented, mainly curative, hospital based service to an integrated, primary health care, community-based service (African National Congress, 1994; Geyer, Naude & Sithole, 2002: 11-15). This leads to larger sections of the population now being able to afford or get services for free, which was not adequately planned and budgeted for, resulting in overcrowding, poor staff morale, excessive use and abuse of scarce resources and deterioration in the quality of care (Van Rensburg & Pelser, 2004: 109-170).

The South African health care system is dual, consisting of both a private and public sector, the private sector being profitable and catering for clients who have medical insurance and the public sector, publicly funded and free to unemployed citizens or available for a small fee to those who are able to pay (Geyer *et al.* 2002: 11-15; Van Rensburg & Pelser, 2004: 109-170). This placed a great burden on professional nurses who had to bear with the consequences due to the changes and without the necessary preparation and support (Armstrong, Daellenbach & Dixon, 2008: 22-69; Van Rensburg & Pelser, 2004: 109-170; Walker & Gilson, 2004: 1251). The vast financial disparities

between the private and public health care sectors also had adverse effects on health professionals and even more so on professional nurses (Day & Gray, 2005: 248-366), of whom 58.9% in the public sector are serving 82% of the population and 41.1% in the private sector are serving 18% of the population (Van Rensburg, 2004: 109-170).

The ethics and ethos of nursing with the core value of caring are in direct conflict with a profit-focused society adding to the already challenged nursing profession (Hofmeyer, 2003: 9-19). There is an overall shortage of nursing professionals around the world and in South Africa the shortages are acutely felt with a nurse shortage of 32 000 (Oulton, 2006: 34-39). According to the South African Nursing Council a total of 47 390 000 patients were served by 101 295 registered nurses in 2006, that is a ratio of 468 patients for 1 registered nurse (SANC, 2006). These numbers are not likely to improve any time soon, as the intake of new nurses is declining. Furthermore an ageing workforce, of which more than half currently registered at the Nursing Council over the age of 45 years, and many starting to retire between 2005-2020, will have a significant impact (Ehlers, 2003: 63-69).

According to Buchan (2006: 16-25), the nursing professional who remains in the profession suffer from a high workload and low morale that has lead to a compromise in the quality of care provided as hundreds of patients are often served by one practitioner and even providing the most basic care is sometimes impossible. Under these circumstances the professional nurses try only to survive as they work under high stress levels and unbearable work loads, affecting their physical health and emotional well-being (Levert, Lucas & Ortlepp, 2000: 36-43). Cullinan (2006: 25) reported that health care facilities are run with half the staff needed and that one third of posts are vacant countrywide.

Looking at the measures that government has thus far implemented to recruit and retain professional nurses their focus is solely monetary incentives, but this alone will not fulfill the needs that have been voiced. More positive approaches have been suggested to retain and empower nurses such as strengthening work autonomy and providing a safe work environment (Adams & Kennedy, 2006: 68; Connell *et al.* 2007: 1876-1891). Recent

research in the caring professions are indicating an illness prevention and health promotion orientation, the focus being on the facilitation and enhancement of skills and competencies in care givers with an emphasis on hope and optimism, rather than relying on survival and reactive strategies (Collins & Long, 2003: 17-27; Delle Fave, 2006; Fralic, 2008: 1-18; Joseph & Linley, 2006). Ryff and Singer (2003) have followed a line of research devoted to resilience in response to life challenges. Unlike earlier researchers that defined resilience as merely the absence of disease in the face of adversity, these researchers have defined resilience in adults as recovery or improvement following life challenges (Garmezy, 1991; Ryff & Singer, 2003). Further, studies related to post traumatic growth suggest that individuals have the potential to not only return to previous levels of functioning but to experience gains that serve to make them stronger than they were before (Tedeschi & Calhoun, 1995). Such acquired strengths after adversity are termed thriving which seems similar to the idea of resilient re-integration after disruption or stress (Carver, 1999; Kumpfer, 1999; Ryff & Singer, 2003). Resilience has been conceptually linked with curiosity and intellectual mastery as well as the ability to detach from and conceptualise problems (Block & Kremen, 1996) and the capacity to mobilise resources during stressful circumstances (Wilson & Drozdek, 2004).

More recent conceptualisations of resilience describe it as a dynamic process influenced by internal factors and environmental factors and leading to positive outcomes (Carver, 1999; Kumpfer, 1999; Richardson, 2002; Tugade & Fredrickson, 2006). When understood in this way resilience is a multi-dimensional construct generally made up of four components, namely: (a) risk factors, (b) protective factors, (c) vulnerability factors, and (d) positive adaptation (Luthar & Zelazo, 2003). Applying these factors to the world of the professional nurse, the following components can be identified:

- Risk factors or stressors in the nursing work environment, such as the high work load, the shortage of staff, poor support and role conflict (Ehlers, 2006);
- Protective factors, identified in literature as having protective influences also implying stress-resistance such as external factors and internal resiliency factors including cognitive, emotional, spiritual, behavioral and physical factors, for

example personality traits identified to enhance resilience, hope, optimism, sense of coherence, mental health, and coping self-efficacy (Kumpfer, 1999: 5-14; Richardson, 2002: 307-312);

- Vulnerability factors are the opposite of the protective factors, and described by Luthar (1991) as attributes that make individuals more susceptible to deterioration in functioning due to high levels of stress and in this context would refer to the resulting fatigue, burnout and depression that cause many nurses to leave the profession, and
- Positive adaptation that can be defined as an outcome that is much better than would be expected given the presence of the risk factors, referring to the resilient professional nurses who cope with the demands and even thrive in the face of the adverse nursing workplace (Luthar & Zelazo, 2003; Richardson, 2002).

Resilience has become an appealing concept because of its roots in the field of positive psychology where resilience researchers seek to explore factors that allow individuals to successfully overcome adversity and even thrive while doing so (Huber & Mathy, 2002: 214-224; Kaplan, 1999: 70-83; Masten, 1999; Tedeschi & Calhoun, 2004). Many nurses currently still choose to remain in the nursing profession despite the demanding circumstances described before. They survive and even thrive while providing high quality care to patients in need. There is a paucity of information about the concept resilience and/or the strengths, abilities, assets and competencies that enable nurses as those mentioned above, to remain committed to their profession.

Various research designs have been used to study the occurrence of resilience. Windle (1999) suggests that resilience is never directly measured but inferred on the basis of significant interactions between risk and protective factors associated with healthy adaptation. A common feature of all designs is an inference of resilience based on the presence of significant adversity and positive adaptation. The key to understanding resilience is analysing risk and vulnerability, protective factors, coping, competence, personality factors, and the capacity to effectively use resources (Caffo & Belaise, 2003). Resilience is a multi-dimensional construct that is defined by performance outcome, the

adequacy of responses to normal and severe stressors, and how cognitive processes and the ability to modulate emotions influence the ability to utilise personal and social resources (Block & Kremen, 1996). It therefore seems clear that the best approach is a mixed method or multi method where both qualitative and quantitative methods are used to gain the best understanding of the phenomenon. In a quantitative first phase of this research, professional nurses manifesting high in resilience were identified with validated psychological instruments measuring aspects of resilience. These nurses manifest theoretically conceptualised characteristics of resilience as operationalised with measures of hope, optimism, coping self-efficacy, sense of coherence, mental health and well-being. These constructs correspond with other resilience related concepts identified in literature which can be intrinsic (intrapersonal) abilities or extrinsic (interpersonal) assets. Intrinsic protective or resilience resources include self-efficacy, autonomy, a flexible self concept, adaptational abilities, self direction and internal mastery and competent coping abilities (Baumgardner & Crothers, 2009; Bonanno, 2004; Compton, 2005; Ungar, 2005). Extrinsic protective or resilience assets include quality inter-personal relationships, environmental mastery skills and communal competence (Oswald, Johnson & Howard, 2004). These characteristics of resilience are however (1) theoretical in nature, and (2) not specific to nurses and especially not to South African professional nurses who come from a multi-cultural context. It could thus be valuable to ask a group of South African nurses manifesting some of the theoretical characteristics of resilience, to share their experience and awareness of their own resilience within the context of their adverse working conditions by sharing their stories/narratives. This exploration of stories/narratives is an effort to identify unique characteristics that may correspond with or differ from the theoretically hypothesised characteristics measured by the questionnaires and found in resilience theory. Resilience will be conceptualised as pertaining to the South African nursing profession and will have practical application value for dealing with the adverse working conditions specific to this profession. The socially relevant contribution of this study could thus be that its findings can be used to develop strengths-enhancing interventions for nurses to improve their psycho-social well-being and overall functioning, with outcomes that will contribute to a higher quality of nursing care, and thereby improving the overall health care service.

Research objective

This study aims to identify resilient characteristics, strengths and other protective factors, specific and possibly unique to a group of South African professional nurses by employing qualitative research methods with participants who were previously quantitatively identified as resilient with measures developed in a western context, in order to obtain a thorough understanding of resilience as an enabling factor for professional nurses in the multi-cultural South African context.

RESEARCH DESIGN

Research approach

An explorative and descriptive qualitative design was followed, as an understanding of resilience in professional nurses was sought in this study. Resilient professional nurses were identified in a previous phase of this research (cf. Koen, Van Eeden & Wissing, submitted) with the following validated instruments that showed good psychometric properties in this sample: **The Mental Health Continuum –Short Form** (Keyes, 2006) that measures emotional, psychological, personal and social wellbeing; **The Coping Self-efficacy Scale** (Chesney *et al.* 2006) that measures confidence in the efficacy of own coping behaviors such as use of problem-focused coping strategies, stopping unpleasant emotions and thoughts, and getting support from friends and family. **Sense of Coherence Scale** (Antonovsky, 1987, 1993) that measures an individual's way of experiencing the world and his/her life in it with core facets such as comprehensibility, manageability and meaningfulness; **The Adult Dispositional Hope Scale** (Snyder *et al.* 1991), which measures the motivation to reach goals and obtain pathways to them; **The Life Orientation Test-Revised** (Scheier *et al.* 1994) measuring the degrees of optimism and pessimism; **The Resilience Scale** (Wagnild & Young, 1993) that measures the degree of individual resilience, which is considered a positive personality characteristic that enhances individual adaptation; and the **The General Health Questionnaire** (Goldberg & Hillier, 1979) that measures symptoms of mental ill-health.

Research methods

Population, sampling and research setting

The participants were professional nurses, all registered at the South African Nursing Council to practice nursing, working in health facilities and hundred and thirty three (N=133) were previously identified as high on aspects of resilience as quantitatively measured. The context within which the research took place was public and private hospitals as well as primary health care clinics in the following sub-urban areas: Krugersdorp, Randfontein, Carletonville and Potchefstroom, as this was convenient for the researcher residing in the area. Included were a psychiatric and general hospital from the public sector and four private hospitals, three of them under management of the mining industry, as the area is mainly a mining community. The three primary health care clinics are affiliated with one of the private hospitals under mining management catering for primary health care needs of the mining industry. The first author telephonically contacted the participants who scored high in resilience, six from each facility (N=42) that provided a contact number, requesting them to write their stories to describe how they manage to stay resilient and compassionate in the nursing profession. In this way thirty nine nurses initially agreed and the thirty five who eventually wrote their stories were: 2 (14%) Males and 33 (86%) Females, 27 (77%) African, 7 (20%) White and 1 (3%) Coloured. This was followed by randomly selecting, from the remaining resilient nurses as identified quantitatively, participants for focus group interviews. The first author phoned those that provided contact numbers and so resulted in seven nurses from each facility who were requested them to take part in the interviews. Before each focus group interview the researcher followed the request up by again contacting each participant to remind them of the date and time. Six focus group interviews and one individual interview were conducted. The individual interview, although not arranged, was the only option at one of the primary health care clinics because four of the nurses had resigned and only one professional nurse was available and she wanted to make use of the opportunity to tell her story. Thirty two participants took part voluntary in the focus group interviews (N=32): 5 (16%) Males and 27 (84%) Females; African 22 (69%) and Whites 10 (31%). Data saturation was clear when the data was analysed. Participants had to meet the following criteria:

- They were previously identified measuring high in aspects of resilience
- They were willing to participate
- They were able to communicate in Afrikaans or English

Data collection and recording methods

Detailed data was gathered by means of the narratives (N=35) followed by six focus group interviews and one individual interview (N=32). One of the benefits of written narratives is that the participants give the researcher their experiences and words in an exact form, the words are their words and reflect their stories (Gilbert, 1993: 139-145). The focus group interviews were planned group discussions with 4-6 participants in a group to obtain the group's opinion on a specific topic (Kingry, Tiedje & Friedman, 1990:124) and took approximately 45 minutes each. By using such multiple data collection methods, data are triangulated, as the topic is analysed from more than one angle, which also increases the trustworthiness of the data and findings (Guba & Lincoln, 2005: 1212; Patton, 1990: 25).

In the focus group interviews the participants' thoughts were probed by a list of open ended questions, which wasn't followed strictly but served as a point of departure in the discussions. These questions were formulated based on analysis of the stories of the resilient nurses who wrote narratives, and included the following themes:

- What does resilience mean to you?
- How does resilience manifest in the work of a nurse?
- What would you say is hindering you in maintaining resilience?
- What is your opinion on the importance of resilience in professional nurses?
- What do you think guidelines for training resilience in nurses should include?
- How do you think such guidelines on resilience for professional nurses should be used?

The first author initially conducted a pilot focus group interview to assess the interview schedule using co-workers who were also trained nurses, and the feedback from them was positive. Interviews were facilitated by the first author, who has proven skills and

experience in conducting qualitative research interviews. Communication techniques such as clarifying, summarising and reflection, as described by Kneisl, Wilson and Tringoboff (2004: 154-155), were used to steer the discussions. The focus group interviews were conducted at the various workplaces convenient to the participants and were audio-taped with permission of participants. A MP3 voice recorder and tape recorder as back-up were used to make sure that no data was lost, and the recordings transcribed for the purpose of data analysis. Field notes were taken by the first author and were used in conjunction with transcriptions during data analysis (Creswell, 2003).

Data analysis

Data analysis took place by means of open coding and inductive analysis to build an understanding and meaning from data where prior theory can be set apart in an attempt to open new aspects of the phenomena under investigation (Babbie *et al.* 2004: 499; Gilgun, 2006). Categories of results were created by coding words and themes – as units of analysis – and grouping these codes together in logical themes. An independent co-coder who assisted in data-analysis followed the same procedure, by following the steps in the protocol compiled and provided by the first author as a framework for data-analysis, which entailed assisting guidelines for coding. A consensus meeting was held to verify the themes for the final narrative with the help of Tesch's steps of analysing textual data (Creswell, 2003: 73-84). The analysis of the written stories of the professional nurses was done first, followed by the analysis of the data from the focus group interviews. In both cases the same procedure was followed.

Ethical considerations

Ethical permission was obtained from the Ethics Committee of the North-West University (reference no. NWU-00002-07-A2, Wissing, 2008). The first author ensured that she was equipped to conduct the research and experienced promoters guided the research process and viewed the participants as autonomous and provided adequate information regarding the objectives and anticipated benefits. Participants participated voluntarily and could withdraw at any time without reprisal as explained in a letter accompanied by a consent form that had to be signed as proof of voluntary participation.

Written consent was again obtained from all the participants. Confidentiality was ensured therefore the voice recordings and audio-taped recordings of the interviews and transcripts thereof were marked by means of codes, and securely stored after completion of the analysis.

Trustworthiness

Guba's model of trustworthiness was followed (Krefting, 1991: 215). The following strategies were employed: Prolonged engagement, meaning that adequate time was spent with the participants, allowing time for the establishment of trust so that participants could feel comfortable and safe enough to share opinions even on sensitive issues. Questions were rephrased and/or repeated as applicable and facilitative communication techniques were used to ensure adequate exploration of the topic. A further strategy, reflexivity, was used, namely that the first author wrote field notes directly after each focus group interview. This enabled the author to maintain a critical, questioning thought process throughout the data gathering process, thereby limiting the threat of becoming over-involved. The first author's trustworthiness as a human research instrument was proven through her experience and skills in research interviewing and scientific writing, gained through basic and advanced studies and practicing as a psychiatric nurse, research supervisor and research lecturer. A dense description of the research process and characteristics of participants were provided, ensuring that the research is auditable. The involvement of a co-coder in the data analysis and consensus discussions enhanced the consistency of the results. The use of story writing and the focus group interviewing added to triangulation and trustworthiness of the study.

Literature control

A literature control was conducted (an investigation, interpretation and integration of literature) in order to ground findings in literature, as well as to identify similarities, differences, and what is unique in the findings as explained by Burns and Grove (2005).

FINDINGS & DISCUSSION

Written stories

Data saturation was clear after analysing 20 of the written stories of the resilient professional nurses, but as 35 were received and because they were in the words of the participants, they were all analysed. After consensus was reached between the first author and the independent co-coder the following final version was written and discussed under themes and sub-themes as identified. They are presented using the exact words of the participants. The number of the story from which the quote came is in brackets after the quote. The authors support the later trend in qualitative research to report the richness of the data and in this case to give these nurses a voice, by telling their story and to rather report too much of the data than too little (Chenail, 1995). The goal is to make the data as public and the process as replicable as possible (Anfara, Brown & Mangione, 2002; Constas, 1992). It is suggested in literature that results be reported by building a narrative or a story (Denzin & Lincoln, 2005) therefore a concluding essential narrative is also build from the stories of the participants in this study. The request to participants was that they write their story on: **How I manage to stay resilient and compassionate in the nursing profession.**

Theme 1: Belief system/foundation/roots

Under this theme, four sub-themes emerged.

Sub-theme 1: Spiritual dimension: Most of the participants referred to a strong belief system or spiritual philosophy that they are depending on for strength and direction (22 stories had this theme). They say: *“God is on my side, therefore I can do anything (1); I start every day in the name of Jesus, and live as if it is my last day (3); I believe God put me in the profession, to serve others (27); Nursing is a calling and I will keep going with the help of God (28); I tap into and harness my spiritual dimension (35)”*.

Literature that refers to the importance of a strong belief system, although not in reference to nurses, includes Garbarino, Kostelny and Dubrow (1993) and Wicks (2005: 197), who discussed the importance of inner-strength and spiritual wisdom to overcome stress and improve well-being, and Milne (2007: 5) who stressed the importance of developing a personal moral compass or shatterproof set of beliefs to increase resilience. Seligman (2002: 130) identified spirituality and transcendence as an important virtue in authentic happiness, while Polk (1997: 1-13), Deveson (2003: 192) and Prevatt (2003:469-480) also addressed philosophical issues, including personal beliefs and

principles and a moral-religious orientation. Faith as a protective factor have also been indicated by other authors (Killian, 2004: 46; Myers, 2000: 56; Schlessinger, 2006: 38; Williams, 2002: 205).

Sub-theme 2: Personal dimension

Most of the participants wrote about their upbringing by strict, loving parents that provided them with discipline, or values for life, the support and correction by friends that help them in managing their life, or providing direction in life (23 stories had this theme): They say: *“My family support me, specially my children and I try to spend time with them I want to make them proud, it gives me direction in life (2); Support from friends and family, keep me going (8); My upbringing, my parents taught me and disciplined me, they taught me values and are my role models (6); Advice and corrections from family and friends help me to stay on the right track (13); I was taught to stick to things and do my best (17)”*.

Literature that refers to friends or parents as important in resilience include: Milne (2007: 5) referred to victims of Hurricane Katrina who attributed their survival to faith, and referring to the supportive prayers of friends and family, while Wolin and Wolin (1993: 100), Grove (2002) and Reed-Victor (2003:2) discussed the importance of trusting relationships with parents or significant others as a protective factor in resilience. Literature refers to the importance of a good relationship with parents or other people and the importance of a thorough upbringing to instill values and discipline which will add to building character, a sense of responsibility, good habits and the ability to cope with difficulties (Ganiere, Howell & Osguthorpe, 2007; Grotberg, 1997).

Sub-theme 3: Value driven

What became clear from reading the stories, was the fact that many of the participating nurses are value-driven (17 stories carried this theme).

They say: *“I am committed to make a success and live with integrity and dignity giving my best for my patients (2); I am proud of my achievements and don't focus on money and material things (9); I stick with my principles, that makes me feel good about myself (10); I want to be of value and make a difference, being loyal to my patients (13); I must be committed and loyal to management and my co-workers (25); I want to do my work justice, and be fair towards my patients, giving them my best and value them (29)”*.

The importance of values are mentioned in literature by Pawelski (2008: 16-22) who referred to the importance of acting just and being fair, and according to Seligman (2002: 140-158), justice is a virtue on which character strengths such as loyalty, duty and fairness is based. A study among nurses about burnout also found that nurses coping better referred to their commitment, feeling that nursing was a calling and that they had to be loyal, it seemed as if they found meaning in the belief that there was a larger purpose behind their work (Cilliers, 2002: 61-85).

Sub-theme 4: Professional dimension

Many of the participants wrote about the importance of good training and ongoing training that have equipped them with knowledge and skills to cope with the many demands and stressors in the profession. The importance of good role-models also stood out (19 stories carried this theme).

They say: *“My good training has equipped me and consultation with co-workers is a good source of support (1); I thirst for knowledge and I want to become the best setting goals and challenges for myself (6); Good training, specially Psychiatry has taught me a lot and equipped me with skills (22); The role models and good nurses, have taught me a lot a good tutor has inspired me (26); I learn from my experiences and don't make the same mistakes, reflecting a lot and trying to stay abreast by continuous development (32); I feel I have to be a role model for juniors, I try to teach and empower them (33)”*.

Literature mentions the importance of training, ongoing training and role-models (Waterman, Waterman & Collard 1994, 87-96). Gaba (2003: 130-134) and Kakabadse (1999: 9-11) discussed the importance of further training and formal educational processes to strengthen characteristics of resilient individuals. A study among nurses found that the nurses who were coping reported that they made a deliberate effort to learn more about nursing and to improve themselves (Cilliers, 2002: 61-84). Authors that expressed the importance of role-models as a protective factor in resilience are amongst others Black (2007), Charney (2005), Killian (2004: 43) and Milne (2007: 5). What couldn't be found in literature and seems to be a unique finding is the fact that professional nurses feel responsible to equip the junior personnel, be role models and empower the nurses who are still learning.

Theme 2: Support systems related to work

The support of friends and co-workers seem to help most of them as they can debrief and ventilate. Many mentioned the importance of positive friends (26 stories had this theme).

They say: *“I respect the rest of the team and learn from them we support each other(1); I listen to advice of co-workers they are like my family (7); I get help from others and share time with positive people who makes me feel better (10);; I have support systems among nurses and also at home and at church (16); Positive relationships with colleagues help me a lot and motivate me to keep going (17); I debrief after death of a patient, by talking to friends or family (19)”*.

According to Milne (2007: 5) a supportive social network must be established and nurtured for sustained resilience and according to Loesel (1992: 299) resilience is reinforced by emotional support outside the family. Morano (1993: 395-402) referred to the importance of using a social support system as part of interpersonal coping strategies and connecting with other people can enhance hope and positive adjustment (Niederholfer & Pennebaker, 2005; Snyder, Rand & Sigman, 2005; Williams, 2002: 200).

Theme 3: Healthy lifestyle

Many of the participants mentioned the importance of a balanced, healthy lifestyle that helps them to stay healthy and give their best (this theme was found in 16 stories).

They say: *“I take care of myself, and do nice things (5); I rest and get enough sleep (7); I eat healthy and stay fit (9); I make time for fun (11); I have hobbies and live a balanced lifestyle (16); I spend time doing gardening (20); I go for regular check ups and I treat myself to something special regularly (23); I have to rest enough and do things like going to the gym, to stay healthy (33).”*

The importance of a healthy life style is mentioned in literature: Milne (2007: 5) mentioned the importance of keeping fit as part of resilience, saying that exercise for physical well-being will also enhance brain health. A study among nurses found that those with a healthy lifestyle could cope better with burnout (Cilliers, 2002: 61-85).

Theme 4: Positive mindset and characteristics of resilience

Most of them wrote about the fact that they have a positive mindset or attitude towards life, making the best of every day. They see problems as challenges, which by overcoming, strengthen them (27 stories contained this theme).

They say: *“I appreciate life and people and see things as challenges trying to make a difference (6); I don’t see myself as a victim and focus on the positive things in life and can cope with the demands (20); I have a positive attitude, thankful for every day (22); I feel privileged for all the blessings in my life and am thankful (23); Dealing with difficult situations have made me stronger (29); I mourn failures and rejoice in successes (32); Life is a journey and I believe I can make a difference (33); I focus on the good things, I make a choice every day to be joyful and hopeful, never giving up (34)”*.

Literature mention the importance of a positive outlook or mindset: A study among nurses about burnout found that the coping nurses find meaning in small things (Cilliers, 2002: 61-85) and humour as being a part of resilience was mentioned by Holmes and Marra (2002: 1683-1710). The theme of the importance of a positive mindset is also found in the work of Seligman (2002: 130), and Risher and Stopper (1999: 8-10) about being positive and optimistic and other authors referring to the importance of staying positive by cultivating a positive frame of mind (Block, 1996: 349-361; Bonanno, G.A, 2004:20-28; Tugade & Fredrickson, 2004: 320-333; Tusaie & Dyer, 2004: 3-10; Wolkow & Ferguson, 2001: 489-498). There seems to be a growing awareness that positive perceptions and attitudes are necessary for effective functioning in the face of adversity (Boss, 1992; Lazarus & Folkman, 1984; Potgieter & Heyns, 2006). Seligman and his colleagues showed the difference between optimism and pessimism as a state where the former lead to better health, better performance at work, and ability to age well (Seligman, 1990: 5).

Theme 5: The uniqueness of the nursing profession

The nursing profession has provided many of them with opportunities and some of them feel it is a satisfying and interesting job (23 stories carried this theme).

They say: *“I care for my patients and they need me therefore I will keep going (1); Being there for my patients, they are like my family (2); Patients appreciation is my reward and encouragement (9); There are many opportunities in Nursing (15); I think about my patients who need me when I want to quit (16); It is fulfilling to care for patients (19); I have a passion for nursing and care for my patients (20); I seize the opportunities in the profession (28); It is rewarding when patients get better (30)”*.

Literature refers to the importance of resilient people to stick to their jobs and manage the demands in their workplace: It has been suggested that resilient careerists will exhibit a greater tendency to persevere in their occupations, with weaker intentions to withdraw (London, 1993: 21-30). Charney (2005) referred to altruism as a therapeutic tool and asserted that stress is often made easier by helping others (Milne, 2007: 42). Schaufeli *et al.* (2002: 71-92) referred to the positive side of nursing, namely engagement. Engaged nurses see themselves as competent in dealing with the demands of their job, and have a sense of effective connection with their work activities. Though there is mention of the reward of the profession in literature, this was not found to be a prominent theme. The uniqueness of this study is that it reveals aspects of resilience in professional nurses and a strong factor seems to be the fact that many of them feel the profession is a calling and that the patients need them. They also learn a lot from patients who have to endure pain and suffering, thereby becoming stronger in themselves and their resolve to manage the stressors or obstacles in the profession.

Essential narrative built from the stories of the nurses

We are proud to be professional nurses. We get up in the morning thankful for a new day, to perform our duties. We are strengthened by a strong belief system or spiritual philosophy, are value-driven and make a choice to make the best of every day, and to take care of our patients to the best of our ability. Being equipped with knowledge and skills from our basic training and keeping updated with new trends make us competent nursing practitioners who can provide high quality nursing care. Meeting regularly in our tearoom where we can share our experiences serve as support and we can learn from each other, providing us with the opportunity to be role models to junior nurses and mentors to each other. Being available to each other and having trust-based relationships with management make it possible to debrief and re-load when necessary. Regular in-service training programs will enable us in our striving for excellence. After work we are able to exercise, relax, keep fit and get rid of stress and frustrations. A flexible working schedule will make it possible to spend time with family and friends and to do fun things whilst maintaining a balanced lifestyle. We value our own well-being that enables us to take care of others. We find meaning in our service to the patients, nursing is a calling and we choose to do what we do to the best of our ability.

In reflecting on the stories the uniqueness of each story on resilience should be recognised, how each of these professional nurses are managing in their own way to keep going and do the best they can for their patients, making a real difference. Much of resilience seems to lie in simplicity, getting up every day, fulfilling their tasks of caring to the best of their ability, finding joy and happiness in the small things of life, simply being optimally functional in their caring context. This reminds of the “ordinary magic” coined by Masten (2001) and the view of Ryff and Singer (2003) that resilience is often based on people’s normal and everyday activities in which they find meaning. Although the stories were on resilience most of the nurses wrote about the fact that the journey, or profession wasn’t always easy and yet in spite of the difficulties or obstacles, stressors and hardships they still manage to go on and find meaning in what they do.

From the stories it can be concluded that resilience is more than just a list of adjectives but rather a dynamic and evolving developmental process which in this case enables professional nurses to remain committed in the face of career adversity. The stories reveal how they are choosing to interact with their environment, realising that people are complex with the potential for enormous adaptability and flexibility (Siebert, 2002). Resilience is not only what you are faced with, but what you do, or can do about the reality, it is not a static state, but can be enhanced and learned in some manner, it is an active and enabling process that contributes to well-being. Viktor Frankl’s final conclusion about the inner processes that enabled people to overcome unthinkable conditions was that, “the last of the human freedoms - to choose one’s attitude in any given set of circumstances, to choose one’s own way” (Frankl, 1963: 104), would determine the ability to survive. The resilient nurses’ stories attest to their chosen ownership of their attitude toward and behavior in the nursing profession and how this empowered them to stay and serve. Also noteworthy in the final analysis is the work of Coutu researching resilience over a period of forty years, referring to the overlapping of theories on resilience and concluding that there are three characteristics that resilient people possess: a clear acceptance of reality, a deep belief that life is meaningful, and the ability to improvise (Coutu, 2002: 48). These three characteristics were found in the resilience stories of nurses regarding their efforts to live what they believed was the

essence of their profession. It is thus clear that resilience in professional nurses are what they have (referring to their characteristics), what they are (referring to their belief systems), and what they can (referring to their skills and knowledge) as viewed in Grotberg's (1997) model of resilience. However, resilience is also what nurses can become (referring to their ongoing strive towards excellence to be the best for their patients), and what they can give to others (patients and being a role model for younger nurses). In Figure 1 a synopsis is given of essential features of the resilience of professional nurses in this exploration as extracted from their narratives.

> include Figure 1 about here <

Focus group interviews

Data saturation was obtained with the six focus group interviews and one individual interview. The details of the results are discussed in themes and sub-themes as analysed by the first author and co-coder from the transcribed interviews and agreed upon in a consensus discussion following a protocol drawn up by the researcher from Tesch's guidelines (Creswell, 2003: 73-84). The data is discussed according to the interview schedule, which had 6 questions.

Question 1: What does resilience mean to you?

Theme 1: The ability to get up and carry on no matter what

In all the focus group interviews this came up, that even if there are struggles they get up and carry on. They say: *"To me it means that I get up and carry on with what I have to do even if it is a struggle; Even if I am overloaded I persevere; I force myself to do my work well no matter what; It can be a real struggle, some days worse than others but I get up and do it all over again (F1). It is the ability to carry on and deal with any situation (F2). It is a commitment to do my best, even if I don't feel like it; It is an ongoing desire to do my best; It is a choice to be resilient and not to give up (F3).* Literature refers to the ability to bounce back as part of or a short definition of resilience (Kaplan, 1999: 17-83; Lazarus & Folkman, 1984: 162; Richardson, 2002: 307-321). Block and Kremer (1996: 349-361) discussed the possibility of a good outcome regardless of high demands. The high achievement and positive work performance in relation with resilience were also

evident in literature (Bandura & Locke, 2003: 87-99; Payne, Youngcourt & Beaubien, 2007: 128-155).

Theme 2: Giving your best/striving for excellence

In all the groups the importance of doing your best, making a difference was mentioned in some way. They say: *“Nursing is what I do well no matter what; It is an ongoing desire to do my best for my patients; It’s the ambition to get even better (F3). It means to constantly strive for excellence, trying to be a better person; To me it is about the value for life, trying to make a difference every day (F4). It is a calling to care for my patients to the best of my ability; To me it means to be a good nurse, all the time and to be there for my patients (F5)”*. Literature that refers to the importance of trying and striving for the best is by Cilliers (2002: 61-84) and Maddi (2002: 175-185) and also refers to nursing as a calling with a desire to do the best for patients. Strong goal orientation and job good performance have been mentioned by Bandura and Locke (2003: 87-99).

Theme 3: To view problems as challenges

In some of the groups the importance of seeing problems as challenges were mentioned. They say: *“I see all the changes as challenges, and I keep on developing to keep up; I would say the cornerstone of resilience in nursing is to see things as challenges (F3). It must be a calling, striving for excellence; I must always study wanting to be a role model for others; It is the ability to overcome obstacles (F4). It’s the human capacity to have the resolve to come back (F6)”*. Literature reported the importance of viewing problems as challenges (Cilliers, 2002: 61-85; Grotberg, 1997: 50-85). Fredrickson and Branigan (2005: 172-175) have shown that positive emotions are linked to problem solving and flexibility in thinking and handling problems.

Theme 4: Strong character/inner strength

Some of the group members mentioned the importance of character, or personality. They say *“It has a lot to do with how you were raised it taught me to choose between what is right and wrong; It is about being balanced, well in body, mind and spirit; It has a lot to do with personality traits like curiosity, it is a choice to be resilient, the ambition to get better (F3). It is because of your personality, your whole being, making the best of what you have (F4); It is about character, you can’t explain it is an inner strength, a choice to be the best and do your best (Int.1)”*. Literature links resilience to the importance of

certain characteristics and inner strength (Kinder & Robertson, 1994: 3-13; Risher & Stopper, 1995: 8-10; Seligman: 2002: 130; Tusaie & Dyer, 2004: 3-10; Werner, 1993: 81-84).

Question 2: How does resilience manifest in the work of a nurse?

Theme 1: It is all about caring and quality nursing care

Only one theme really stood out and it is all about caring with passion for patients. All of the group members mentioned the importance of caring passionately for the patients, that it is different than any other job and very demanding. They say: *“A nurse is somebody who gives, people need us and we care for them; It is about caring for the patients, providing for the needs of the patients; It is all about the patients, it is not just a job, it must be a calling (F1). As nurses we deal with patients in need, their most basic state, depending on you to care for them; Caring for the patients and the family, it is very scary for them; It is a commitment, it is in the passion for people, caring for your patient (F2). It is not like any other job, you can’t leave your patients for another day, it lies in the responsibility the nurse has to carry, you are accountable to your patients, to the society and the Council; It is huge, it is a very demanding work (F6)”*. Literature refers to nursing as a calling, the importance of caring for patients and values (Cilliers, 2002: 61-85; Giordano, 1997: 1032-1036; Schaufeli *et al.* 2002: 71-92).

Question 3: What would you say is hindering you in maintaining resilience?

Theme 1: Lack of recognition

Sub-theme 1: The profession isn’t respected

Many of the participants lamented that the nursing profession is not being recognised or respected. They say: *“I would say we are not respected as a profession and therefore we are not appreciated for the work we do (F1). There is no recognition for nurses, not money, not respect, not being seen as important within the health care system (F3). It is the lack of recognition, from management, from doctors, and even from the clients and the unions (F4). Even the politicians don’t recognize the importance of nurses (F6)”*. The lack of autonomy or not feeling respected that nurses experience have been reported in literature by Basson and Van der Merwe (1994: 35-430) and by Parse (1998: 212).

Sub-theme 2: Remuneration

All the groups mentioned the problem with remuneration. They say: *“They don’t even appreciate us enough to pay us properly; It is managerial and financial, at least if you work so hard you must get paid for it; If you have to worry at the end of the month of how you are going to make ends meet it is harder to stay resilient (F1).. We also don’t get paid for what we do, working short-staffed under difficult circumstances (F5).”* Many studies that have been done in nursing, reported dissatisfaction of the nurses with their salaries (Cavanagh & Snape, 1997: 128-134; Cline, Reilly & Moore, 2003: 10-53; Jackson, Clare & Mannix, 2002: 13-20; Strachota *et al.* 2003: 111-117).

Theme 2: Managerial problems/lack of information

Most of the groups indicated this as a hindering aspect. They say: *“Management don’t seem to care, they should at least meet us half-way; We need management to do something, provide people to do the work, and equipment; Even if we complain it doesn’t look as if management hear us (F1). We don’t get any feedback about the fact that we are doing our work well, no recognition from them (F4). The uncertainty, not being informed what’s going on, like new policies being introduced (F6)”*. The managerial problems and lack of information has been reported in literature (Cavanagh, 1997: 128-134; Cline *et al.* 2003: 10-53; Jackson *et al.* 2002: 13-20; Schaufeli & Enzman, 1998: 100-122; Strachota *et al.* 2003: 111-117).

Theme 3: Infrastructure/working conditions

All the groups mentioned problems with facilities, equipment or working conditions, like being under-staffed. They say: *“Often there are not enough hands on the floor, and it is a struggle to get things done; Quality can be compromised if there is a constant shortage The long working hours, people are getting tired and can make mistakes (F4). And we are short-staffed you always have to hurry to get everything done, we are only a few who have to do all the work we don’t have human resources (F5). I would say the environment, the infra-structure, things are not maintained, like now we are sitting without water, the circumstances are just impossible, frustrations are running high (F6).”* The problems concerning poor working conditions have been discussed in literature (Cavanagh, 1997: 128-134; Cline *et al.* 2003: 10-53; Jackson *et al.* 2002: 13-20; Schaufeli & Enzman, 1998: 100-122; Strachota *et al.* 2003: 111-117). In an international

study done by Mitchell (2003: 219-224) among nurses the main reason for leaving the profession was reported as poor working conditions.

Question 4: What is your opinion on the importance of resilience in professional nurses?

Only one theme really emerged, namely that if a professional nurse is not resilient he/she won't make it, will leave, get sick or stay away from work.

Theme 1: It is important to survive and cope

The feedback from all the groups were that resilience is important for professional nurses to survive and do their best. They say: *"If it is not a calling and you are not passionate and resilient, you won't be able to keep up with the hardships and the demands, only a resilient nurse are really value-driven and care for the patients (F1). Without resilience you won't survive as a nurse, it is then that you will get sick and depressed and leave, that is why we are losing so many nurses (F2). We really need resilient nurses, without it you will run away from nursing; the job is just too hard (F4)..* Literature refers to the importance of resilience to survive in the face of adversity and manage stress (Giordano, 1997: 1032-1036; Grotberg, 1997: 50-85 Masten, 2001: 227-234; Richardson, 2002: 307-321; Seligman, 2002: 125).

Question 5: What do you think guidelines for training resilience in nurses should include?

Theme 1: The importance of values, compassion and caring

In most of the groups the importance of these aspects was mentioned. They say: *"I think we need to look at values again, it should be re-addressed, the new nurses must realize the importance of the caring aspect, and the passion for nursing must be realized (F1). Also you know where we all started, the importance of values the ethos of nursing, knowing the importance of the caring philosophy that is carrying us (F4). The new generation must be drawn in to get the feel for nursing, the importance of caring for your patients (F6)".*The importance of values and the caring aspect of nursing have been reported in literature by Cilliers (2002: 61-85) and Pawelski (2008: 16-22).

Theme 2: Hindering aspects should be addressed

It was clear that the hindering aspects and specially recognition should be addressed in the guidelines. They say: *"Management should be made aware of all the problems we*

have mentioned, like the constant shortage of staff (F2). Recognition for the work we do, better conditions overall; More flexibility, like with the working hours and uniforms (F3). Better communication, it is all about communication, if you know what is expected from you, you can do it; We must give nursing a voice, so that we get the image right (F4)”. Literature was referred to in the discussion above under each aspect.

Theme 3: Skills training and further development

Most of the group members mentioned the importance of skills training to improve resilience. They say: *“And maybe some skills training, we also battle to cope and I think continuous development is needed for all of us; Specially the new nurses are struggling and need to develop skills; Like coping skills and maybe communication, and problem solving, or how to manage stress (F1). Teambuilding activities will help us so that we can get to know each other and be supportive. We need somebody in a post that is responsible for continuous development and maybe giving support, so that staff can de-brief (F2)”. Literature that refers to the importance of life long training and evidence that life long learning improve resilience was found in Hammond (2004: 551-568) and Hartog and Oosterbeek (1998: 245-256).*

Question 6: How do you think such guidelines on resilience for professional nurses should be used?

Theme 1: All the stakeholders should become involved

All the groups mentioned the importance of important stakeholders and specially management to take note of and act on the guidelines. They say: *“All the stakeholders, like management need to buy into it, they must be part of it, so that they support it (F1). The management will have to take note, they and other important stakeholders, even the politicians must be made aware (F4). People who make the decisions must be made aware, like the nursing forums, and the nursing managers’ forum; Labour organizations, organized labour can take it further, like DENOSA; The training professional departments, and the management of the hospital (F6)”. Literature that refers to the involvement of the different stakeholders couldn’t be found, and this seems to be a unique finding.*

Theme 2: In-service training and regular meetings

Group members *mentioned* the importance of introducing the guidelines by way of ongoing development. They say: *“Maybe regular meetings to discuss things in a more informal way, supporting and motivating each other; Maybe it can come back as a program, or in-service training, like once a month, but it must be ongoing (F1). Maybe like a skills course, but it should become an ongoing thing to better equip nurses (F3). We need sessions on skills and even like de-briefing to cope better (F5)”*. Literature refers to the importance of education and training (Hammond, 2004: 551-568; Hartog & Oosterbeek, 1998: 245-265; Seligman, 1992; Snyder *et al.* 2005).

Essential narrative built from focus group interviews

We are able to carry on and provide high quality care to our patients despite the adverse working conditions. We see problems as challenges and rather than giving up we are getting stronger, determined to go the extra mile for our patients. A conducive environment with the necessary equipment and enough personnel will enhance our efforts and patient care won't be compromised. It will motivate us if we know that management support and respect us and by working in a multi disciplinary team where we are acknowledged for our contributions and in turn we compliment the work of other health care professionals. Meeting regularly in our private tearoom where we can share our experiences will be inspirational and we will be able to learn from each other. We wish to be paid for what we do and not have to worry about making ends meet, even considering leaving the profession. We need to have opportunities to enhance our resilience and equip us to deal with the adverse working conditions. Despite everything we rise above ourselves and our circumstances, focusing on the needs of the patients. Our professional image needs to be restored by ourselves and be acknowledged by management and fellow professionals and the value that we bring to the health care context must be recognised.

In Figure 2 the resilience concepts obtained from and representing the participants' conceptualisation of their resilience (question 1,2 and 4) building on the information from the written stories (Figure 1) as well as the hindering aspects (question 3) are given.

> include Figure 2 about here <

Reflecting on the focus group interviews it is clear from question 1, 2 and 4 (namely: what does resilience mean to you, how does resilience manifest in the work of a nurse, and what is your opinion on the importance of resilience in professional nurses), that the findings correspond with those from the written stories on how the professional nurses manage to stay resilient and compassionate in the nursing profession. It stood out from the first question that resilience is the ability to overcome obstacles and stay committed, and that in the face of adversity they can carry on, managing to give their best for the patients. From question two on how resilience manifest in the work of a nurse, the feedback focused on the quality of caring, rising above yourself and meeting the needs of the patients. The fourth question on the importance of resilience for professional nurses, was responded to by indicating the motivational energy that resilience entails and that without resilience a nurse won't be able to carry on and provide high quality care to her patients, they would more likely get sick or depressed or stay away from work, not being able to cope and leaving the profession.

Question 3 focusing on the hindering aspects emphasised the importance of recognising managerial problems, poor remuneration, lack of autonomy and recognition, lack of opportunities for development, and poor working conditions with shortages of staff. The last two questions exploring their thoughts on guidelines for resilience emphasise the importance of addressing the hindering aspects and that obstacles to optimal performance of nurses should be brought under the attention of important stakeholders. The enhancing aspects that improve resilience are the factors at the core of the profession that they felt should be brought back and introduced in the form of skills training or in-service training and discussed regularly in meetings to facilitate resilience in professional nurses.

The objective of this investigation was to identify resilient characteristics, strengths and other protective factors specific and possibly unique to this group of professional nurses by employing qualitative research methods with quantitatively identified resilient participants in order to obtain a thorough in-depth understanding of resilience as an enabling factor for psycho-social well-being in the nursing profession. This objective has been reached and resilient characteristics of professional nurses have been identified from

their stories and the focus group interviews which were illustrated in figures 1 and 2. Many of the characteristics relate with the concepts identified in literature to measure aspects of resilience, namely: hope, optimism, coping self-efficacy, sense of coherence, mental health and well-being. The data from the narratives also revealed other important characteristics such as: joyfulness, having dreams, making a choice to be happy, appreciation of life, being thankful, forgiving, self-respect, perseverance, overcoming obstacles, curious, rejoicing in success, self-reflection, self-control, vigilant, constructive, self-disciplined, efficient, committed, taking responsibility, passionate, flexible, able to adapt, open minded, handling emotions, striving to improve, confident and mature with inner strength and proudly professional.

The strengths identified from the findings are discussed using the Resilience model of Grotberg (1997), namely the, I have, I am and I can components. I HAVE implying the external factors of support and resources, the stories revealed the importance of a strong foundation, spiritual, personal and professional. A strong belief system or spiritual philosophy was identified with strong values and principles under the spiritual dimension which serve as guidance and drive them. The importance of a good basic education, ongoing education and role models and mentors were identified to equip the nurses as part of the professional dimension. With the personal dimension the importance of good support from family and friends were evident. I AM means having inner personal strengths, the participants revealed their values, their strive for excellence, are self-disciplined, taking control, making choices to be committed and provide quality care to the patients in the face of adverse working conditions. I CAN indicate social and interpersonal skills and they referred to their perseverance, working hard and tolerating bad attitudes toward them, to using laughter and humor, seeing problems as challenges, coping with adverse working conditions, communicating and sharing with others, being mentors and role models to junior nurses and serving the patients. Another dimension identified was evident namely: I BECOME referring to the nurses' strive to improve their skills and knowledge and be role models to patients and young nurses.

From all the stories and discussions with resilient professional nurses presented in detail above, their resilience emerged as an enabling factor, and it can be conceptualised as a self-sustaining strength. Resilience in attitude and ability is reinforced by resilient behavior and the latter by positive outcomes such as being able to overcome difficulties, to adapt, to become stronger and more committed to a profession that they value.

CONCLUSIONS & RECOMMENDATIONS

This study aimed to identify specific and unique resilient characteristics, strengths and other protective factors by employing qualitative research methods with previously quantitatively identified resilient professional nurses in order to obtain a thorough in-depth understanding of resilience as an enabling factor in the nursing profession. After a thorough literature control was conducted unique features or strengths that emerged in this group of participants were: The desire of the nurses to be an inspiration to junior nurses by being mentors and role models, the unique nature of the nursing profession experienced and valued by all the participants and the reward of being a nurse and nursing being a calling. The unique nature of nursing and the deep philosophical value of their calling that these nurses cherish, though mentioned in literature, were strong themes in this study and seem to be important factors that need attention to restore the status of the profession. The fact that the nurses feel all stakeholders should be involved in solving the hindering aspects of the nursing profession could also not be found in literature and seem to be another unique finding.

A strong message that seems to have emerged from engaging with the professional nurses in their own context is that by understanding the qualities and skills that promote resilience amongst themselves, the nurses will be able to develop protective factors that will strengthen their resistance to the risks posed by their demanding profession. Self-awareness, empathy for each other and their shared compassion for the patients seem to be career assets that they wish to strengthen. Personal traits that enhance their psychosocial well-being seem to include self-esteem and competence (self-efficacy); self-respect and the appropriate use of their caring power; introspection (personal and professional),

acceptance of reality and an open-mindedness; respect for others, empathy and tolerance of ambiguity; cognitive development and flexibility; a keen sense of ethics and professionalism; appreciation of personal style with respect for boundaries. Added strengths seem to flow from assertiveness, an attitude of hope and commitment, being able to manage disappointment, stress and change, maintaining a strong spiritual value base, motivation, quality support networks and having a sense of humour.

The professional nurses ascribed their strengths to personal and training sources. They noted the importance of goal setting and a sense of purpose, as well as a commitment to self care, supporting one another and giving optimal care to the patients in their charge. They clearly stated that having inner strength to cope with challenges and adversity was linked to their resilience. All the participants expressed the essence that adequate attention should be given to issues of resilience and coping during training and that this should be an ongoing process throughout the career of a professional nurse.

The professional nurses participating in this qualitative study were able to succinctly articulate their perceptions of resilience, coping, strengths and enabling factors and these views were mostly in keeping with relevant theory and research findings (e.g. Smith & Drower, 2008). It is recommended that the unique strengths evident in the professional nurses enabling them to be resilient, be used to develop guidelines for in-service training and other programs to enhance resilience and psycho-social well-being in all nurses, for example:

- The importance of a solid foundation (spiritual, personal and professional) that seem to be a driving force in their lives should be recognised and opportunities should be made available to uphold and enhance this in their lives;
- Good knowledge and skills (good basic education and ongoing training) supported by good role models and mentors in practice should be in place and opportunities for further development must be available to manage the ever changing demands and to enable them to provide quality care;

- A healthy lifestyle, supportive networks and relationships (a conducive environment or work place is seen as part of this) should be encouraged by giving attention to the importance of reasonable working hours;
- The unique nature of the nursing profession which can be equally challenging, rewarding and satisfactory can be used positively, and if the work they do is being acknowledged and they get professional recognition, the career image and morale may improve resulting in a positive outcome, namely quality nursing care thereby improving the health care service overall.
- The professional nurses (or their representatives) should be empowered to contribute to the solution of their workplace problems that were described in the beginning of this paper.

It is further recommended that strengths specific to the various cultures from which the nursing population is made up of, be further explored. Although the authors recognise the significance and inter-relativeness of culture in resilience and were respectful and mindful of culture differences, it was not explored. The nursing profession as having a culture of its own was clearly recognised in the similarities of the findings from the stories/narratives of the participants from the different South African cultural groups taking part in this multi-cultural study.

It must be remembered that in qualitative research, the design that was followed to explore the stories of the nurses, it cannot be assumed that the findings can be generalised for other settings or participants. Further research is recommended to add to the knowledge gained.

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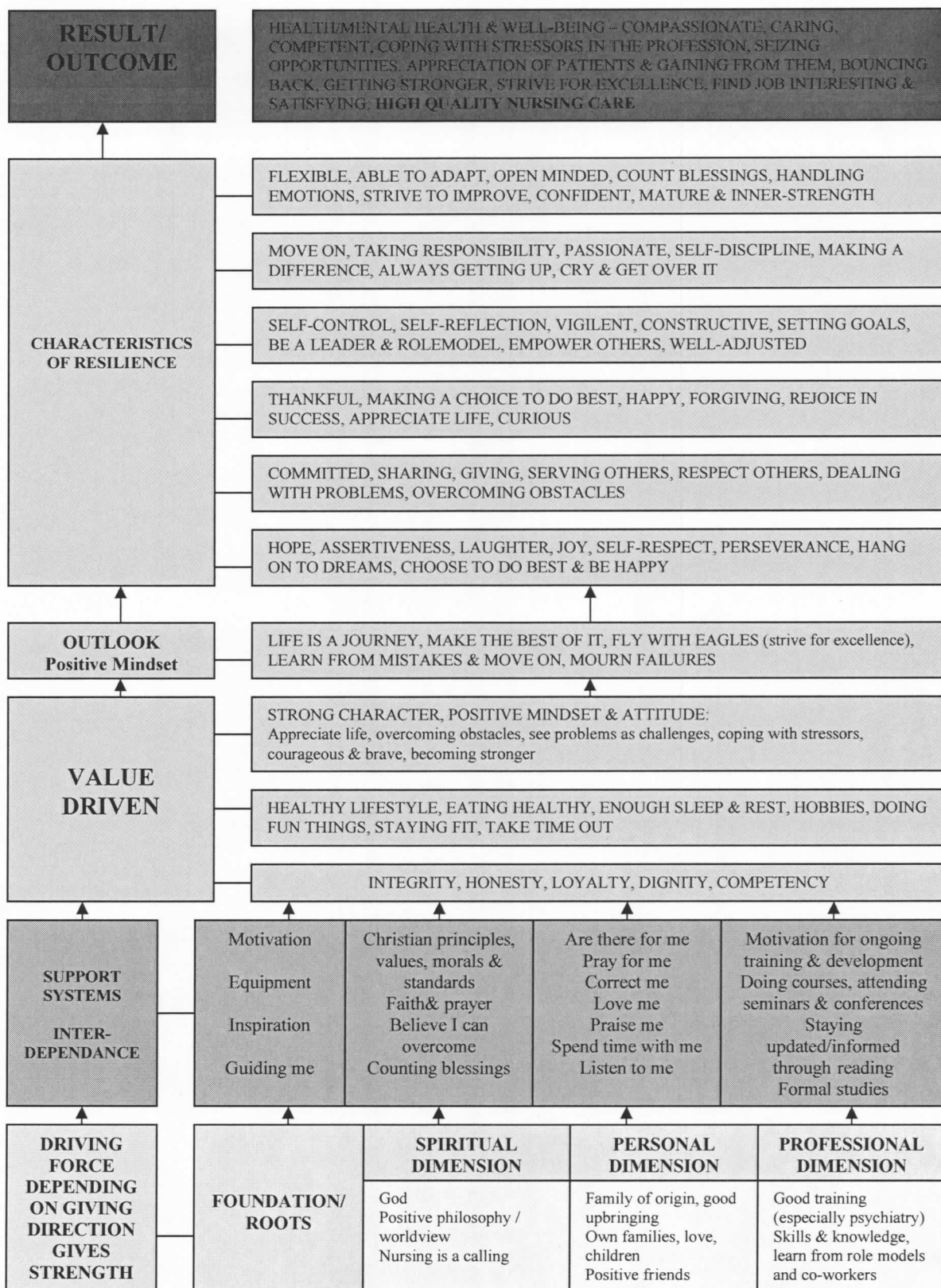


Figure 1 Essential features of resilience in professional nurses

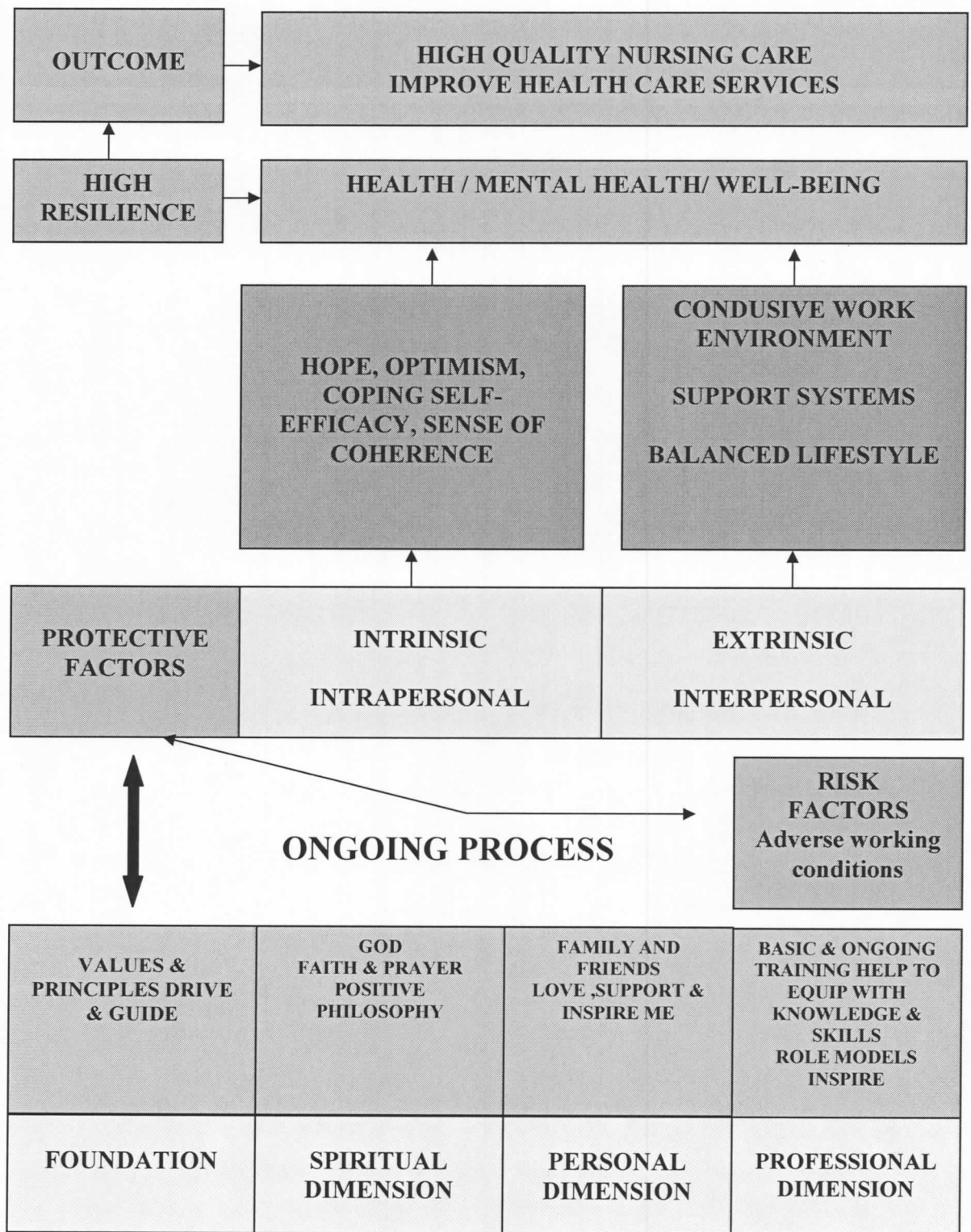


Figure 2: Conceptualisation of resilience in professional nurses



MANUSCRIPT THREE

**GUIDELINES WITH STRATEGIES FOR ENHANCEMENT OF RESILIENCE
AND PSYCHO-SOCIAL WELL-BEING IN PROFESSIONAL NURSES**

Submitted to “Health SA Gesondheid”

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Title: Informative but concise, In small capital letters, centered and in bold, font size 14, eg.: Names of questionnaires, countries, and or authors start with capital letters.

Author: Name(s), include full first name, e.g. Gert P. Roux, not G.P. Roux. Include the name of the department and the University of each author. The e-mail address, postal and phone number of the corresponding author should be included.

Abstract: Not more than 200 words, and should state concisely the scope of the work and the principal findings:

- the objective of the study
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The manuscript contains five sections, namely the introduction, research design, results, discussion and the references. All these first-level headings (except 'introduction') appear in bold capital letters and are centered.

INTRODUCTION:

The introductory section normally contains the following eight elements; headings are indicated in [brackets]:

- (1) [**Key focus of the study**] A thought-provoking introductory statement on the broad theme or topic of the research (why should I even bother to read further?);
- (2) [**Background to the study**] Providing the background or the context to the study (explaining the role of other relevant key variables in this study);
- (3) [**Trends from the research literature**] 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);
- (4) [**Research Objectives**] Indicate the most important controversies, gaps and inconsistencies in the literature that will be addressed by this study;
- (5) In view of the above (in 4) state the core research problem and specific research objectives that will be addressed in this study;
- (6) [**Ethical Considerations**]
- (7) [**The potential value-add of the study**] Explanation of the study's academic (theoretical & methodological) or practical merit and/or importance (provide the value-add and/or rationale for the study); and
- (8) [**What will follow**] Provide the reader with an outline of what to expect in the rest of the article.

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The first-level heading, **INTRODUCTION**, is **not** used. However, second-level headings may be used in this introductory section. These subheadings are flush with the margin, and are typed in lower case; bold starting with a capital letter.

If lists of bullet points are presented, they should be in the following format:

Longevity. How long individuals live.

Prognosis. How well an individual responds to challenges of disease or trauma.

Mental health. General level of mental functioning

Avoid using lists that contain more than 10 bullet points.

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A synthesis and critical evaluation of the literature (not a compilation of citations and references) should at least include or address the following aspects:

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- (2) A critical review and summary of the themes emerging from previous research findings (constructs, research participants, research designs, objectives, etc.) on the topic;
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RESEARCH DESIGN

The first-level heading **RESEARCH DESIGN** is typed in capital letters, centered and in bold. Only **three** secondlevel headings follow on the research design and they appear in lower case, bold and are flush with the margin.

Research approach

A brief description of the research approach followed in the study should be included. It should, for instance, explain from which qualitative tradition the study is and also motivate why this approach is specifically required. The author(s) may state their scientific beliefs (ontology and epistemology) if these have an effect on the choice of the research approach.

Research methods

Under the research method the author(s) provide at least descriptions on the following third-level headings, namely: research context (setting), entrée and ethical considerations, data collection methods, recording of the data, data analyses, strategies employed to ensure data quality and reporting.

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Population Sampling

The qualitative sampling procedures used in the study, such as cueing, purposive sampling or snow-balling are described and motivated in this section.

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In this section the author(s) explain where the data was sourced and which data collection methods (e.g. semistructured or unstructured interviews, focus-groups) were applied. In some instances solicited documents are also used.

Data analyses

In this case the author(s) explain which methods of data analyses were applied. Different data analyses techniques result in different variations of qualitative research.

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The next heading is **FINDINGS & DISCUSSIONS**, which appears in capital letters, bold and is centered. This section presents the results of the investigation in the sequence of the formulated objectives or formulated postulates/propositions (if applicable).

Tables and Figures are each presented on a separate page after the section **REFERENCES** and appear in the same numerical order as they appear in the text. The positions of tables or figures are indicated in the text in the following way: <include Table 1 about here>

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CONCLUSION & RECOMMENDATION

The next heading is **CONCLUSION & RECOMMENDATION**, which appears in capital letters, in bold and centred.

This section normally contains the following eight elements:

- restate the main objective of the study;
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- 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;
- provide the conclusion and recommendations (implications for practice);
- point out the possible limitations of the study; and
- provide suggestions for future research.

Second and third-level headings may be used.

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References begin on a separate page. References cited in the text should all be included in the list at the end of the paper. Full references at the end of the paper, arranged alphabetically by surname, chronologically within each name, with suffixes a, b, c, etc. to the year for more than one per year by the same author. Note that the second and subsequent lines are indented.

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Guidelines with strategies for enhancement of resilience and psychosocial well-being in professional nurses

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ABSTRACT

There are currently no programs available for enhancement of resilience in professional nurses and therefore this study aims to provide broad guidelines with specific strategies for interventions that may enhance resilience and psycho-social well-being in professional nurses. These guidelines are based on findings from previous quantitative and qualitative research on resilience in professional nurses in the public and private sector in South Africa, and focus against the backdrop of Kumpfer's (1999) theoretical model of resilience on the building of strengths and protective factors as well as dealing with risk or hindering factors identified in the nursing profession. The complex interaction between context specific risk and protective processes is acknowledged, and resilience is considered to be a complex phenomenon and process, that may vary in manifestation and developmental needs according to specific contexts as in the case of the difficult working conditions of the professional nurse for whom these guidelines and suggested strategies for enhancement of resilience and psycho-social well-being are intended.

Key words: Resilience, psycho-social well-being, job satisfaction, guidelines, strategies, interventions.

OPSOMMING

Daar is tans geen programme beskikbaar vir versterking van veerkragtigheid in professionele verpleegkundiges nie. Hierdie studie het daarom ten doel om breë riglyne met spesifieke strategieë vir intervensies te verskaf wat veerkragtigheid en psigo-sosiale welstand in professionele verpleegkundiges kan bevorder. Hierdie riglyne is gebaseer op bevindinge van vorige kwantitatiewe en kwalitatiewe navorsing wat veerkragtigheid onder professionele verpleegkundiges in die openbare en privaat sektor in Suid-Afrika ondersoek het. Die riglyne fokus teen die agtergrond van Kumpfer (1999) se teoretiese model van veerkragtigheid op die bou van sterktes en beskermende faktore asook die hantering van risiko faktore soos geïdentifiseer in die verpleegkunde professie. Die komplekse interaksie tussen konteks spesifieke risiko faktore en beskermende faktore word in ag geneem en daarom word veerkragtigheid gesien as 'n komplekse verskynsel en proses wat mag verskil in manifestasie en volgens behoefte in spesifieke kontekste, soos in die geval van die veeleisende werksomstandighede van professionele verpleegkundiges vir wie hierdie riglyne en voorgestelde strategieë om veerkragtigheid en psigososiale welstand te bevorder, bedoel is.

Sleutelwoorde: Veerkragtigheid, psigo-sosiale welsyn, werkstevredenheid, riglyne, strategieë, intervensies.

Introduction

The nursing profession and the stress commonly associated with it has been the subject of considerable research for decades. This is not surprising given that nursing is widely known for its high rates of staff turnover, absenteeism and burnout (Kirkcaldy & Martin, 2000). The most common sources of stress seem to be similar for all nurses regardless of type or ward or nursing specialty and appear to be inherent to the nursing role (Cross & Fallon, 1985). These factors include a high work load, poor collegial support, role conflict and role ambiguity (Ehlers, 2006; Mitchell, 2003). The perception of stress occurs when environmental demands exceed the individual's resources (Lambert & Lambert, 2001; Lazarus, 1990) leaving the nurse feeling hopeless and experiencing job dissatisfaction.

Looking at the current health care system in South Africa with the primary health care focus and the burden that free health care has placed on professional nurses adding to the stressful working environment of these nurses, there is cause for concern (Geyer, Naude & Sithole, 2002). Factors such as the declining number of professional nurses in an already understaffed health care system, the ageing workforce, the health of the population with HIV and AIDS as a major problem, the growing population and the ever-increasing demands made on the professional nurse in a multi-cultural environment, are taking their toll on the well-being of these nurses (Armstrong *et al.* 2008; Van Rensburg & Pelser, 2004; Walker & Gilson, 2004). Under such circumstances nurses often try only to survive as they work under high stress levels and unbearable work loads, affecting their physical health and emotional well-being (Levert, Lucas & Ortlepp, 2000). Not only is the professional nurses' level of job satisfaction diminishing, but the prevalence of compassion discomfort, stress and fatigue is increasing, which directly affects quality care, as professional nurses become increasingly despondent and unfeeling in a situation that shows no signs of a swift recovery. This all paints a bleak picture of the professional nurses' working environment and their battle to keep well and survive, however despite the adverse working conditions many nurses still choose to stay in the nursing profession and even seem to thrive.

Koen, Van Eeden and Wissing (2010a, submitted) explored resilience using a mixed method study design in professional nurses from public and private hospitals as well as primary health care clinics in South Africa in the Krugersdorp, Randfontein, Carletonville and Potchefstroom areas. In the quantitative cross-sectional component of this study a group of 312 professional nurses completed various measures of psycho-social well-being as indicators of the degree of resilience. Tertiles of normalised scores indicated three levels of resilience: 43% manifested high in resilience, 47% manifested with moderate resilience and 10% measured on the vulnerable or languishing side. The demographic data showed an aging workforce with only 22 participants younger than 30, and 230 (72%) older than 40, while many of them indicated that they want to leave the profession (86), with 44 seriously considering leaving, and 5 ready for retirement. The cultures represented were African 230 (73.7%), White 60 (19.2%), Coloured 7 (2.2%) and some indicated South African, 39 (12.5%). Most of the feelings reported in response to an open ended question on how they feel about the profession, were negative. This presented a concerning picture considering the shortage the nursing profession is already facing.

In the qualitative component of the above mentioned study Koen *et al.* (2010b, submitted) explored how professional nurses manage to stay resilient and compassionate in the profession. Thirty five (N=35) identified resilient professional nurses wrote their stories on resilience and in 6 focus group interviews and 1 individual interview (N=32) also with resilient professional nurses it became clear that these nurses are of the opinion that without resilience a professional nurse will not survive and will often get sick or despondent and eventually leave the profession. The need for facilitating and enhancing the resilience and psycho-social well-being in professional nurses was evident. The findings also showed that quality nursing care depends on resilient nurses, as they are the caring ones who will stay committed and serve their patients. The main themes identified from the stories and focus group interviews with participants were: Theme 1: Belief system/roots/foundation with sub-themes: spiritual dimension; personal dimension, value dimension and professional dimension. Theme 2: Support systems. Theme 3: Healthy life style. Theme 4: Positive mindset and characteristics/aspects of resilience. Theme 5: The

uniqueness of the nursing profession. These themes will be translated into guidelines for interventions. Furthermore, findings obtained from open ended questions, stories and interviews, on what are hindering nurses to stay resilient, indicated financial and managerial deficiencies, lack of autonomy and recognition, lack of opportunities for development and poor working conditions with shortage of staff topping the list. The urgency for all involved to seek solutions for these problems was expressed by the participants in order for the nursing profession to survive. They call for investigations to expose and understand the nature and causes of these problems, starting with the reasons nurses plan to leave the profession. The solution of their current workplace adversity or stressful nursing conditions requires a dynamic and balanced interaction of all factors, and not only focusing on one source e.g. remuneration, as that will not be sufficient to resolve the complexity of the problem saturating the health care environment. These findings are taken into consideration in the hereafter suggested guidelines for interventions and the strategies to enhance resilience in professional nurses.

From the above findings it is clear that guidelines for interventions to promote resilience should focus on solutions for the hindering aspects, as well as enhancing the factors that help current professional nurses to stay resilient and compassionate in the face of the stressors they have to face on a daily basis. Research done on improving resilience in other groups found that interventions are often more effective when they focus on enhancing the positive behavior than on eliminating the negative (Cordery, 2007). The successful management of risk is a powerful resilience-promoting factor in itself, and the promotion of resilience may be an important strategy to reverse the preoccupation with risk factors (Newman & Blackburn, 2002).

One of the most significant areas of most people's lives is the world of work (Compton, 2005) and the importance of job satisfaction is thus clear. Job satisfaction can be defined as an emotional reaction that "results from perceptions that one's job fulfills or allows the fulfillment of one's important job values" (Locke, 1976). Organisational interventions to enhance job satisfaction and well-being at work at the individual level are attempts to enrich job experience by offering feedback, improve and align motivation, increase

responsibility and to focus on development. Improving working conditions and job satisfaction indirectly improve work performance (Hackham & Oldham, 1980; Boehm & Lyubomirsky, 2008). Organisational motivation can be external rewards ranging from recognition for good work such as an award or a bonus but also intrinsic such as being satisfied and proud on work well done (Nayak & Ketteringham, 1991): The importance of one's work is clear and therefore everyone strives for work satisfaction. The main problem identified in the above mentioned research is the adverse working conditions of professional nurses', therefore it will be beneficial to help create a healthy work environment that will improve well-being and resilience in the workplace. In the positive psychology movement various authors have identified qualities or elements promoting healthy work environment, that add to job satisfaction and well-being (Boehm & Lyubomirsky, 2008; Yates & Masten, 2004). The centrality of work to personal well-being and resilience is not surprising when one thinks of the benefits it offers such as an identity, opportunities for social interaction and support, purpose, time filling, engaging challenges, possibilities for status and an income (Judge & Watanabe, 1993). Well-being or resilience in work is known to interrelate with general life satisfaction, which is linked with a conducive work environment that is tied to a person's values and needs (Warr, 1999) like the importance of positive emotions of the person; that it must not only be a job but a calling; being in flow at the work, when high skills are matched with high challenges; emotional intelligence at work; recognising a person's strengths and development of strengths; opportunities for personal control and skill use; reasonable externally generated goals; variety; environmental clarity; availability of money; physical security; supportive supervision and a valued social position (Csikszentmihalyi, 1990; Haworth, 1997; Warr, 1999). It is evident that work experiences translate directly into other psychological well-being outcomes such as the life satisfaction of employees (Turner, Barling & Zacharatos, 2002).

According to the Job Demand-Control model (JD-C) - one of the most influential models in research on occupational health, there are two important dimensions in the work environment namely, job demands and job control. It postulates that high demands in combination with a lack of control in the workplace are associated with negative health

related outcomes (Bakker *et al.* 2007; Demerouti *et al.* 2001). More recently researchers extended the model to the Job Demand-Resource model (JD-R). It is a heuristic model that specifies how employee well-being and satisfaction may be produced by two sets of working conditions. The first set concerns the demands that are physical, social and organisational aspects of the job that require sustained physical and psychological effort and costs on the part of the employee (Bakker *et al.* 2007). The second set concerns the extent to which resources are available to the individual, including physical, psychological, social or organisational aspects that will reduce job demands and the associated costs, are functional in achieving work goals, stimulate personal growth, learning, and development (Bakker *et al.* 2007; Demereouti *et al.* 2001). Boehm and Lyubomirsky (2008) also explain the relationship between happiness and workplace success and indicate that a job with resources to support an employee is likely to enhance success because this makes the job more pleasant.

In spite of evidence of the importance of well-being at work, in terms of day-to-day practice many organisations still seem to operate from a negative orientation with hierarchical structures, a problem solving orientation and a competency framework for development (Haworth, 1997; Henry, 1994; Turner *et al.* 2002; Warr, 1999). Participatory organisational practices can help, such as moving to more open cultures, emphasis on personal development and multidisciplinary team work (Csikszentmihalyi, 1990; Henry, 1994, Turner *et al.* 2002). Bakker and Schaufeli (2008) indicated that organisations are in need of engaged employees, firstly with motivational resources such as support and recognition from colleagues and supervisors and opportunities for learning and development, secondly that they should experience personal satisfaction and affirmation that they are being part of the organisation, and thirdly that the work is a commitment, a dedication referring to work-related well-being.

As resilience research has evolved, several scholars have appraised appropriate directions for interventions targeting different at-risk groups (Cowen, 1999; Luthar, 1999; Luthar & Suchman, 2000; Rutter, 1999; Werner, 2000). Luthar and Suchman (2000) summarised a series of guiding principles for resilience related interventions, namely: Interventions

must have a strong base in theory, and previous research on the group being targeted; efforts should be directed not only towards the reduction of negative outcomes or maladjustments but also toward the promotion of positive adaptation or competence; therefore, interventions must be designed not only to reduce negative influences (vulnerability factors) but also to capitalise on specific resources within particular populations; interventions should target salient vulnerability and protective processes that operate across multiple levels of influence (influences from individual, family and community); interventions must have a strong developmental focus; similarly, the contextual relevance of the overall interventions aims, as well as of the specific strategies, must be ensured (this is often achieved via collaborative participation involving the leaders or management and the people for whom the interventions are intended); and that intervention efforts should aim at fostering strengths that eventually can become self-sustaining, such as creativity in harnessing existing resources.

The context of the proposed guidelines here after is the work environment of the professional nurse which is a significant source of stress and the response to the stress that impacts on the nurse's well-being and resilience. The professional nurse is seen as a whole being in constant interaction with the internal and external environment and every nurse is unique in the manner that they react to stimuli and stressors in their environment. As the nurse and the environment interact with one another, they affect change in each other forming constructions to explain and address these changes. A comprehensive multi-faceted approach or process is therefore necessary (Grotberg, 1997; Kumpfer, 1999) to enhance resilience and psycho-social well-being in professional nurses.

Purpose of the research

The purpose of this article is to formulate broad guidelines with specific strategies for interventions, based on previous research findings and recent literature with a view to the later development of programs to facilitate and enhance resilience and psycho-social well-being in professional nurses, thereby contributing to improvement of health care services overall.

Guidelines and strategies

Guidelines (mostly developed in medical clinical practice) are described as a set of recommendations or statements aimed at the development of appropriate care processes, the enhancement of health care practices and to improve the outcomes of interventions (Shekell *et al.* 1999). These authors also mention that guidelines can be implemented in enhancing and/or conserving resources in providing care, such as the professional nursing service of this study. Strategies refer to specific actions or intentions to reach aims, or deal with a specific situation in a specific context (Van Dyck, 1998). In this study the guidelines with strategies for interventions are based on the insights gained from the contributions of professional nurses (empirical data) and theoretical knowledge that already exists regarding indicators for the development of resilience (Grotberg, 1997; Kumpfer, 1999; Luthar, 1999; Fredrickson, 2001, 2008) as well as qualities or elements of healthy work environments and models as discussed above (Compton, 2005; Cooley, 2006; Cordery, 2007; Demereouti, 2001 *et al.*; Yates & Masten, 2004), linked with positive organisational practices and elements identified for well-being at work (Bakker *et al.* 2007; Cherniss, 2001; Haworth, 1997; Turner *et al.* 2002; Warr 1999). Earlier assumptions were that resilience is dependent on protective individual traits, while more recent research has moved beyond this and currently, the complex interaction between context specific risk and protective processes is emphasised (Fredrickson, 2001, 2008; Kumpfer, 1999; Schoon, 2006) acknowledging the fact that resilience is a multi-factor process. The Job Demand-Resource model (JD-R) links the demands of the job (the adverse working conditions of the nurse) to the resources that is supposed to be offered, referring to physical, psychological, social or organisational aspects reducing the demands and providing support to the nurse who is an important resource in the health care service (Bakker *et al.* 2007; Demereouti *et al.* 2001), and to the enhancing features identified in the discussion before on well-being in the workplace (resources).

Although the factors that promote resilience are widely understood, there is less known on how we can move from theory to practice or to formulate guidelines and strategies that can be used in real life settings (Newman & Blackburn, 2002). Programs for enhancement of resilience in professional nurses could not be found. This study therefore

sought to formulate guidelines with strategies for interventions which have promise for practical application in the nursing profession and are mainly based on protective factors and resilient processes identified from the stories and focus group interviews shared by resilient nurses, as well as current literature that serve as evidence for the guidelines. Guidelines and strategies that are proposed for meaningful interventions need to be positioned within a framework of a resilience theory, and Kumpfer's (1999) resilience framework is utilized for this purpose in the current study. Guidelines or statements, based on previous findings in the target group and recent literature, are structured in line with the six major components of Kumpfer's (1999) model and further elaborated with the aid of Fredrickson's (2001, 2008) "Broaden-and-Build" model of positive emotion. The components of Kumpfer's model are: the perception of stressors and challenges, protective and risk factors in the external environment, person-environment transactions, internal resiliency components (spiritual, cognitive, emotional, physical, social/behavioural), resilience processes (stress and coping processes) and positive outcomes – which feed back into component 1 of the model as also illustrated in Fredrickson's model where it is indicated that positive emotions broaden cognitive processes which build personal strengths, interpersonal relations, work performance and community involvement, that in turn feed back into more positive emotions. Broad guidelines are followed by some specific recommended strategies that can be used in health care facilities to facilitate and enhance resilience and psycho-social well-being in professional nurses, and although the Kumpfer framework is used it must be remembered that the six major components are interrelated and internal resiliency factors are linked with interactional processes.

Kumpfer model: The perception of stressors and challenges

The stressors or demands in the nursing profession have the potential to threaten the well-being of the professional nurse. The degree of stress perceived by the nurse depends on perception, cognitive appraisal and interpretation of the stressor as threatening or manageable, disruptive or challenging. The nurses identified as resilient in the target population by Koen *et al.* (2010a & b, submitted) managed to demonstrate resilience therein that they grew from the stressful experience while learning valuable lessons in coping with their adverse working conditions. This means the stressors became

challenges that they met, thus strengthening them to face new stressors. Kumpfer (1999) calls this the essence of resilience. A self regulatory process (Boekaerts & Niemivirta, 2005) seems to be functioning here, in which case positive appraisal (stressors seen as challenges) led to growth enhancing self regulation experiences that protected these nurses from negative appraisals that may have threatened their resilient abilities to adapt to a difficult context. The resilience process begins with a demanding initiating event and ends with an adaptive outcome, in this case the resilience of professional nurses.

Kumpfer model: External environment (protective and risk factors)

The stressor is found within a context and the external environmental context contains the balance and interaction of salient risk and protective factors and processes in the person's life (Kumpfer, 1999). Resilience is cultivated through risk and protective factors, which are variables that shift developmental pathways (Reis, Colbert & Hebert, 2005), risk factors are those that increase vulnerability toward negative outcomes and protective factors are those that increase the chance of positive outcomes. As risk and protective factors differ for each field or context, the empirical data from previous studies (Koen *et al.* 2010a & b, submitted) provided valuable information on the risk factors (hindering aspects) and protective factors (supportive factors) in the nursing field.

Protective factors: The uniqueness of the nursing profession and social support systems (personal and professional)

Uniqueness of the nursing profession

The uniqueness and the benefit of caring for others in the nursing profession that characterise it as a meaningful career, was stated by the identified resilient nurses (Koen *et al.* 2010b, submitted). They saw this as a strength in the profession that can be used to improve the image of nursing and promote respect for and recognition of their work as a value to society, thereby enhancing their professional pride, resilience and well-being as nurses.

Guidelines based on the uniqueness of the nursing profession

The nursing profession needs to be re-invented, for the sake of nurses and for the public, so that everybody can start believing in its value again and so that young people will be attracted to it and nurses will feel proud of the profession. Attempts should be made to

change the current tainted culture of nursing, involving consumers and creating partnerships with communities.

Discussion of evidence

Literature that refers to the uniqueness of the nursing profession, for example London (1993) and Schaufeli *et al.* (2002), discussed the positive side of nursing. The benefit of caring for others, or being altruistic and help oriented, are explained by authors and that by helping others personal stress is relieved (Cilliers, 2002; Milne, 2007).

Strategy: We Commit to Care

Aim: To use the uniqueness of the nursing profession to create a sense of pride and professional integrity in nurses

Actions:

- 1) Re-affirm the Florence Nightingale ethos and to strengthen the traditional values of respect, service, care and compassion.
- 2) Encourage principled behavior and decision making by nurses to restore pride in their work and the profession, adding to quality nursing care. Nurses should stand for what is important and leadership- and assertiveness training could equip them for this.
- 3) Nurses could share their experiences in pleasurable and helpful activities, making them aware of philanthropic values and the “feel good” value to serve others.
- 4) Nurses can use symbolic gestures like lighting the “candle of care” at the beginning of every shift and announcing the commitment to care aloud – this could create an awareness of the purpose and meaning of nursing (the calling).
- 5) Positive and worthwhile events in the health care facilities can be published in a monthly newsletter adding to nurses’ sense of being part of a meaningful context.

Outcome: Nurses would have a deeper sense of their own value and the meaning of their profession, in relieving other people’s pain and suffering.

Support systems

The second strong indication from the nurses’ stories is the importance of support systems whether coming from family, friends, co-workers, supportive supervision, physical security and/or somebody assigned in a post to be available for debriefing, guidance and motivation. Support served as a strong protective factor in promoting resilient adaptation of the identified nurses to stressful working conditions.

Guidelines aimed at strengthening support systems (personal and professional)

Strengthening their resources of personal support

According to the participants, nurses need to have enough time to spend with their families and friends in order to maintain good relationships and to be nurtured by them. The on-duty schedule should be drawn up in a flexible, responsible and fair way taking

the importance of enough free time into consideration and this would make nurses feel considered and make it possible to strengthen and utilise their resources.

Fulfilling the need for interpersonal contact and support at work (professional)

The participants advised that teambuilding activities could be created that can improve interaction and help the personnel to work as a team supporting each other, or to work and operate like a family, as it will help them to keep going and feel supported and safe. The sharing of ideas and perspectives in the workplace can establish supportive and motivational networks and nurses should make an effort to make connections, accepting help and support from others who care, as this strengthens resilience. Nurses should value colleagues through seeking ways to support them, this can range from helping with a complex task or working together to maintain a safe, high quality working environment. Functioning comfortable in the team could develop a positive view about themselves and their professional contribution, and add to them feeling confident about their own strengths and abilities in the profession. Management can promote organisational commitment by implementing two-way communication processes and a participatory style of management characterised by transparency, respect and trust, thereby building a healthy and safe work environment where people can work as a team, where the employees will feel committed and supported and where there is a willingness to share knowledge and information.

Discussion of evidence

The importance of good emotional support and social supportive networks for people to function with resilience are indicated by various authors (Baumann & Blythe, 2003; Cherniss, 2001; Loesel, 1992; Morano, 1993). The presence of a good infrastructure rendering support and support services as a necessary component of resilience have been found in research (Sirgy & Cornwell, 2002). Such support is essential because emotionally nurses go through periods of great emotional stress as they watch varying degrees of illness and death, sometimes feeling frustrated and inadequate as they battle with an increased work load while and at the same time try to fulfill patient's needs (Vogt, Cox, Velthouse & Thames, 1993). The importance of providing a worthwhile workplace is discussed by various authors (Brown & Ryan, 2003; Compton, 2005; Cordery, 2007; Diener & Seligman, 2002; Locke, 1976; Seligman & Csikszentmihalyi,

2000; Warr, 1999). Resilient people have social skills and people abilities that reduce inter-personal stress and help them to maintain positive relationships with others (Ford, 1994; Kumpfer, 1999).

Strategy: Care for the Caregivers

Aim: To build and maintain positive support systems in the personal and professional environment in order to enable nurses to function resiliently.

Actions:

- 1) Cherish and nurture contact with positive friends and families and to seek marital and family guidance and/or enrichment experiences if necessary.
- 2) Network with other nurses and multi-disciplinary team members to establish a reciprocal support system and clarify their caregiving roles in the team.
- 3) Develop collaborative partnerships within a professional context to inspire each other, engaging in kindness activities thereby maintaining and establishing supportive relationships.
- 4) Social events to build relationships can be arranged on a regular basis.
- 5) Team-building exercises can be done yearly off-site involving leisure, which can add to building trust and support networks.
- 6) Share ideas and brainstorm on a regular basis to improve patient care and employ peer-teaching methods.
- 7) Bond with significant others and professionally with patients, to establish trust relationships with colleagues, can add to a sense of hope and optimism and meaningfulness.
- 8) Replace learned powerlessness in nurses with a sense of learned empowerment, by amongst other things instilling a sense of collective efficacy in their midst, which refers to a sense of agency or willingness to assist one another (see Compton, 2006 & Sampson, 2001).
- 9) Appoint a workplace councilor or advisor with whom the nurses can build a trust relationship and who is available when they need to debrief and discuss their fears, for example when they were exposed to or had a needle prick or witnessed a patient's tragedy. This will reduce situational stress and promote coping, thereby maintaining mental health, well-being and resilience in these nurses and help to prevent burnout.

Outcome: These actions will lead to stress reduction and less compassion fatigue due to a sense of collective belonging, involvement, support and protection developed from receiving and giving support.

Risk factors

It is recognised that the identified hindering aspects or stressors that nurses' experience need attention and the following were mentioned by identified nurses as risk factors – poor remuneration, lack of recognition, lack of autonomy and managerial problems, poor working conditions, lack of staff and opportunities for development. Stakeholders from government to management need to attend to the problems and these issues solved in mutually satisfactory ways in order to retain nursing professionals. The aspects mentioned by the professional nurses as hindering are each presented and guidelines

followed by strategies are proposed to resolve these problems thereby building nurses' resilience and strengthening their commitment to the nursing profession.

Guidelines aimed at resolving hindering aspects (risk factors)

Recognition and remuneration

Nurses feel that the work they do is not recognised as important. Improving the image of nursing and equipping the nurses with problem solving and assertiveness skills to act responsibly and gain respect, can resolve the problem. The importance of respect between the nurses and other medical personnel like the doctors and efforts to establish better working relationships and role clarification to establish mutual respect, were emphasised by participating nurses. Part of recognition has to do with how people compare their income to the income of people doing the same job. In the focus group interviews it was expressed that nurses are often doing the work of the doctors who are seldom there, or that they are not paid for the kind of work or responsibilities that they have to deal with. Reasonable remuneration and recognition for their services would contribute to their job satisfaction.

Opportunity for autonomy and improving working conditions

The participating nurses indicated that the decentralisation of power to allow professional nurses greater professional autonomy will reduce powerlessness and promote discipline. Managerial problems and a lack of information and open communication can be overcome by having regular meetings with staff where they get the opportunity to talk about their uncertainties and where they can be informed of new developments. Infrastructure and working conditions are less than conducive. (In some of the facilities where the research was done the most basic requirements were not in place. In one hospital the wards was out of water for days and nurses had to do their work under these circumstances). This factor contributes gravely to feelings of disrespect towards them and their patients.

Staff shortage and physical unsafe conditions

The focus group interviews emphasised that the working environment should not pose discomfort and physical safety must include things like location, clean surroundings, adequate equipment and tools, as well as safe buildings. Nurses should not be expected to perform roles and duties that fall outside their scope of practice as this causes uncertainty

and isn't safe practice. At the individual level physical work demand factors, like the workload and exposure to hazardous and infectious substances and threats to personal safety are high-risk factors. The nursing shortage is serious and needs urgent attention as the extra workload deprives nurses of work satisfaction, patient care is suffering and mistakes are made.

Managerial problems and lack of opportunities for development

Focus group interviews indicated that opportunities to openly share with the management and identify the obstacles can make a difference and help to motivate the nurses. The organisational climate is important and if goals are clarified and nurses can share their feelings and perceptions the climate will improve. Organisational processes that do not support quality patient care must be challenged. The nurse managers' leadership styles must be evaluated and the adoption of transformational leadership styles considered, where nurses will be empowered and inspired by the manager's vision, goals, world view and values. Management can benefit from training in emotional intelligence as this will help to engage in healthy and supportive relationships with the nurses, leading to successful service delivery. Being happy at work is considered a fundamental element of a person's life satisfaction and management of health facilities should cultivate this by improving the management styles, communication methods and working conditions.

Discussion of evidence

The importance of attending to the stumbling blocks or hindering aspects in nursing has been emphasised in literature (Dunleavy, Sharman & Thomson, 2003; Person *et al.* 2004; Shindui-Rothchild, 1994). An abundance of research (Acker, 1999; Prosser, Johnson & Kuipers, 1996) has been conducted investigating the relationship between job satisfaction and burnout in health care workers, and stressing the importance of taking steps to improve the working conditions of these people. Kane (1999) identified job-sharing as a strategy that could be adopted, where two people jointly do one job, relieving the burden. Happiness as being an important part of job satisfaction is discussed in literature (Boehm & Lyubomirsky, 2008). According to literature employees value working surroundings that do not pose discomfort or physical harm and Snow (2002) refers to organisational issues that need to be attended to, namely: flexibility, responsibility, standards, rewards, clarity and team commitment. Organisational improvement interventions are most

effective when they resolve the negative aspects and enhance the positive aspects (Cordery, 2007) and a study done on job satisfaction stressed the importance of building hope, optimism, confidence and resilience in organisations which will in turn enhance job satisfaction and psychological health, resulting in personnel that will not easily quit their work (Cordery, 2007). Fabre (2002) and Sochalski (2002) suggested that short term or band-aid solutions be replaced with responsible long-term solutions that include factors such as building relationships and effective communication strategies. Warr (1999) and Peterson (2006) also refer to the importance of a good salary, physical security, opportunities for ongoing development and support from management.

Strategy: Work Well-being

Aim: To reduce risks or hindering aspects and minimise and buffer negative effects.

Actions by management:

- 1) Create a healthy working environment characterised by safety, cleanliness, functional working equipment and employer-employee trust.
- 2) Hold regular staff meetings to inform staff of new developments and give them a voice for example a choice in the uniforms they wear thus creating a healthy organisational culture/climate
- 3) Delegate tasks and responsibility to nurses with the authority to take decisions in this regard, adding to nurses' autonomy and self respect.
- 4) Acknowledge work well done, using sound performance appraisal methods, incentives and excellence awards.
- 5) Appoint sufficient well-trained staff and provide equal opportunities to all staff for further development based on individual needs.
- 6) Provide access to functioning lifting equipment, occupational health and safety policies, as well as security personnel to ensure the safety of the nursing personnel.
- 7) Ensure good risk assessment is in place to provide a safe environment with clear lines of communication so that nurses know whom one reports to when facing difficulties.
- 8) Do surveys on a regular basis in order to determine the level of job satisfaction and job commitment. Conducting exit interviews can help with identifying problems and giving attention on a continuous basis can be beneficial.
- 9) Employ a public relations officer to promote the professional profile of nursing in the media and retired professional nurses who played an important part in the profession can be approached to become champions for the profession thereby improving the image of the profession and promote nurses' sense of worth.

Outcome: Increased job satisfaction with reduced job strain and burnout experiences in nurses, would build their coping skills and workplace resilience.

Kumpfer model: Person-environment interactional processes

The person-environment interactional processes include transactional processes between the nurse and the environment enabling the nurse to either passively or actively attempt to perceive, interpret and surmount threats, challenges or difficulties in the working

environment to construct more protective environments (Kumpfer, 1999). The work of a nurse can be defined as “high-risk” and interactional processes that can help the nurses to transform the high risk environment into a more protective environment seem necessary - it was clear from the findings from nurses’ narratives when they were asked how they manage to stay resilient and compassionate in the nursing profession (Koen *et al.* 2010 b, submitted) that they could not resist reporting the stressors or challenges that they have to deal with. If nurses can learn to understand and manage their environment by modifying it consciously or unconsciously, or selectively perceive meaningful aspects of it, they will improve their well-being and overall functioning and environmental mastery of the difficult nursing context will develop (Kumpfer, 1999; Rashid, 2008).

Guidelines aimed at enhancing nurses’ positive appraisals and transforming their environment into a more protective context

The participating nurses felt the nurses need to learn that certain things can be changed in their interaction with the nursing profession, like how they re-frame negative events and create more positive experiences versus the fact that nursing remains a stressful occupation. How nurses plan their work and the choice to associate with positive people and role models, learning and taking advice from them and benefiting from positive feedback and discipline will contribute to them being meaningfully involved in their work. Nurses need to be active in taking control of their lives, make positive choices and have reasonable expectations and goals, actively pursuing these and seeking support if needed to achieve them, thereby building autonomy and giving them a sense of control. Environmental mastery involves engendering co-operation and support from the environment.

Discussion of evidence

Potentially useful resiliency building processes including selective perception, cognitive re-framing, active coping, role modeling, effective supervision, advice giving and teaching are discussed in literature (Kumpfer, 1999; Kumpfer & Bluth, 2004; Reis, Colbert & Hebert, 2005), with the potential to improve the interaction between the person and the environment, for environmental mastery and to forge a pathway to success (Compton, 2005; Doll & Lyon, 1998; Frey, Jonas & Greitemeyer, 2003; Rashid, 2008; Spence-Laschinger, 2001).

Strategy: Environmental Mastery

Aim: To enhance positive appraisals and engendering environmental support, thereby improving the nurse-work interaction

Actions:

- 1) Identify and express three positive aspects about their work each day and share this with each other, e.g. that it is an interesting job and that there is joy in caring for others, that there is always something funny to laugh about.
- 2) Realise and learn to cope with the fact that nursing is a stressful occupation and rather focus on the positive side like the reward in caring for others, thus increasing a sense of meaning and purpose.
- 3) Re-frame and realise they can choose how they view adversities in their work, that they can change the meaning ascribed to a painful event, re-define the events around strengths and talents and turn it into something meaningful.
- 4) Identify their strengths in their work by narrating or reframing their professional story from a strengths perspective, seeing themselves as capable agents of care rather than as victims and to be reasonable in their expectations.
- 5) Identify with good role-models who can teach and advise them from their experience, thereby inspiring them. To develop mentoring programs where the more seasoned nurses can provide support to new nurses can motivate, support and inspire inexperienced nurses. Excellence (high level competence) is also transmitted through mentorship.
- 6) Plan their work and actively be involved with caring for their patients, keep an interest in their work and use opportunities to do new things or move to a different ward, keeping the work a novelty and a challenge, seek positive emotions which go hand-in-hand with positive actions.
- 7) Discipline themselves and act responsibly under the provided supervision, adding to a sense of self-respect and competence.

Outcome: Nurses would have an increased sense of empowerment characterised by feelings of competence, purpose, self efficacy and contribution (see Spenc-Laschinger 2001).

Kumpfer model: Internal self characteristics (spiritual, cognitive, emotional, social/behavioral, physical competencies or strengths)

Spiritual competencies

Having a purpose in life or “spirituality” is seen as a major predictor of resilience and will help nurses to achieve their dreams and goals (Kumpfer, 1999; Masten, 1997). The importance of having a good personal basis or foundation was evident from previous research by Koen, Van Eeden and Wissing (2010b, submitted), namely: the belief in a higher power and the belief of nursing to be a calling, serving a higher purpose. Values about, and a philosophy of caring for patients should exist, and must be instilled in nurses to strengthen their personal foundation.

Guidelines aimed at deepening spiritual competencies (personal and professional - nursing to be a calling)

The identified nurses recommended that the nursing pledge and the philosophy of care need to be carried forward in a responsible way and nursing tutors should look at ways to incorporate ethical conduct in the basic education of the nurses. It could be presented under professionalism which should be a central part of the curriculum. Identifying with a shared philosophy and believing that they are part of something meaningful will add to quality care and their self respect. This link of practice with spirituality or the positive philosophy mentioned by participating nurses, having a strong belief system and believing in a higher power, can provide comfort and give a sense of belonging, value and purpose. Cultural values and awareness need to be acknowledged and respected, inter-cultural social cohesion will add to sound interaction and positive working relationships.

Discussion of evidence

The importance of spirituality and the philosophical basis of work and that it must be a calling is discussed in literature (Kumpfer, 1999; Turner *et al.* 2002). Many authors mentioned virtues or traits of resilience and the importance of a meaningful personal foundation (Brown & Ryan, 2003; King, 2001; Kumpfer, 1999; Peterson, 2006). Rashid (2008) also talks about the positive effect of experiencing a career as more than just a job. Feeling that you are part of something bigger than yourself is mentioned by Seligman (2002).

Strategy: A Personal Ethos

Aim: To improve and deepen a solid foundation: personal and professional groundedness

Actions:

- 1) Encourage nurses to regularly reflect on the value of the pledge they have taken and re-commit to nursing as a calling.
- 2) Build professionalism, nurses can reflect and think about their own practice and performance in relation to their values and discuss this in growth meetings.
- 3) Identify with the vision and mission of the institution thereby taking ownership and reflecting on their personal vision and mission.
- 4) Share and discuss ethical issues and dilemmas in staff meetings.
- 5) Embrace the cultural diversity among them and develop cultural sensitivity and competence.
- 6) Engage in community and/or church life, giving the gift of their time, value their spiritual development, value contemplation and appreciation, to meditate and pray, to enjoy the sunset, and to pay attention to what is good and be grateful.
- 7) Count their blessings, cultivate feelings of gratitude, savour good experiences and special moments.

Outcome: A deeper sense of self-worth, awareness of life's gifts and compassion for patients will deepen nurses' personal foundation.

Cognitive competencies

Cognitive competencies such as being able to apply knowledge and skills will help nurses to achieve their goals (Kumpfer, 1999; Masten, 1997). The importance of having a good knowledge base to build on was evident from previous research by Koen, Van Eeden and Wissing (2010b, submitted). Good foundational training and ongoing competence building training to equip professional nurses with refined knowledge and skills and keep them updated with new trends and developments must be guaranteed.

Guidelines for continuous development of cognitive competencies (knowledge and skills)

The focus group participants stressed that the importance of good basic education at nursing schools and colleges must be valued and implemented by nursing tutors, as well as them being good role models and mentors to inspire the students and set an example for life long learning and commitment to care. Good basic training that produce professional nurses that can handle the demands and are fully prepared for practice, should be recognised and provided to ensure that nurses feel equipped to use their skills with confidence. Ongoing training and development opportunities both formal and informal must be provided and should be used by nurses. They must also seek other ways to improve their skills and knowledge, act in responsible and accountable ways and seek to accomplish their goals even in the face of opposition and be assertive for good practice. In this way nurses can take responsibility for their development and for the quality of care for their patients.

Discussion of evidence

The importance of knowledge and skills are discussed in literature and having opportunities to use skills and competencies add to feeling worthwhile in the workplace (Haworth, 1997; Warr, 1999) as well as the importance for variety and setting reasonable goals (Turnet *et al.* 2002; Warr, 1999). The importance of a good training, ongoing training and good role-models or mentors, abound in literature (Baumann & Blythe, 2003; Seligman, 1992; Snyder, Rand & Sigman, 2005). Hammond (2004) found that participation in lifelong learning adds to well-being and the capacity to cope with potentially stress-inducing situations. Findings from longitudinal data sets also suggest that education has positive effects upon an array of health outcomes (Ross & Mirowsky, 1999). Yates and Masten (2004) discussed the importance of wisdom and knowledge,

creativity, curiosity and courage to be brave and stand up for yourself and others as important traits of resilience. Many authors mentioned virtues or traits of resilience and the importance of a sound knowledge base (Brown & Ryan, 2003; King, 2001; Kumpfer, 1999; Peterson, 2006).

Strategy: I Know therefore I Can

Aim: To improve knowledge and cognitive skills of professional nurses to empower them with competence

Actions:

- 1) Provide opportunities to nurses for knowledge and skill development e.g. coping skills, problem-solving skills, autonomy, a sense of purpose and a future orientation and communication skills, thus empowering themselves.
- 2) Use legislation and standards of practice to clarify scope of practice thereby clarifying uncertainty and grey areas and act with competence and the necessary "know how".
- 3) Identify own growth areas and set goals to meet their needs, critical thinking and a love of learning will help them to master new skills and bodies of knowledge helping them to think and talk things through, weighing evidence, being open-minded and act with confidence.
- 4) Think of ways of how they can do things more productively, maintain an interest in the experiences in the wards and clinics where they work and to seek tasks that correspond with their strengths.

Outcome: Increased self confidence in tasks, feelings of self-efficacy and courage to apply skills in new areas of practice and cope with changing demands.

Emotional competencies

Resilient people have emotional stability (Kumpfer, 1999), mostly an internal locus of control, a positive sense of self and feelings of empowerment (Ford, 1994). A positive mindset characterised by positive emotions will minimise stress and negative affect and help them to maintain a healthy self-concept and gain access to opportunities (Masten, 1997). These competencies can be improved or acquired by focusing on life skills, problem solving and communication skills, thus adding to emotional well-being of nurses in their basic and ongoing training. The nurses who participated mentioned the importance of being in control of their emotions and to have the opportunity to express their feelings after traumatic events. The in-house counsellor can be of value in developing these skills.

Guidelines aimed at building and enhancing emotional competencies

Resilience-building that focus on emotional competencies should be incorporated into nursing education, focusing on building personal strengths in nurses through strategies such as: enhancing emotional intelligence; re-framing experiences, savouring positive

events and experiences, harnessing opportunities to experience positive emotions and learning to cope with negative feelings.

Discussion of evidence

The importance of a positive mindset and positive emotions resulting in making the best of every day are evident in literature (Bandura & Locke, 2003; Block, 1996; Cilliers, 2002; Liebenberg & Ungar, 2008; Risher & Stopper, 1999; Seligman, 2002). A positive outlook encapsulates a range of interrelated innate or learned positive psychological characteristics related to resilience and studies have shown that positive emotions in general have enduring effects on individual functioning by promoting coping abilities and flexibility in thinking and enhancing general well-being (Bandura & Locke, 2003; Bonanno, 2004; Diener & Seligman, 2002; McMahon, 2008; Peterson, 2006).

Strategy: Emotional Wellness

Aim: Cultivating positive emotions in nurses to optimise positive outcomes and resilient well-being.

Actions:

- 1) Teach nurses how to identify and express positive emotions in their work and find positive meaning in adverse working conditions – this can enhance positive awareness and emotions and have the potential to undo negative emotions.
- 2) Apply relaxation and behavioral techniques aimed at increasing rates of pleasant activities, use cognitive coaching aimed at teaching hope and optimism and develop coping strategies aimed at finding positive meaning, e.g. meditation or yoga, progressive muscle relaxation and biofeedback.
- 3) Focus on or recall a positive emotion which can initiate or jumpstart other positive feelings, thereby counteracting negative emotions. To tap into their positive emotions effectively will have a positive effect on their relationship with their environment.
- 4) Offer personal enrichment/growth interventions to nurses (e.g. Fordyce's Happiness Training Program; or programmes to foster reflection on meaningful things and enhance meaning-making processes) aimed at increasing their subjective well-being, of which positive emotion is a strong feature (See Compton, 2006).
- 5) Believe in themselves, follow their heart and focus on the journey, congratulate themselves and take pride in achievements would add to their emotional well-being.

Outcome: Experience of positive emotions, meaning in life and the emotional skill to deal with negative affect. A deepened sense of compassion is also an outcome of emotional health.

Behavioral/social competencies

In Kumpfer's model (1999) behavioral and social competencies are combined. Since social support systems (relationships with others) were discussed under protective factors above (see p.152), the discussion of this component will focus on a few interpersonal behavioral competencies and more specifically on self-related or intrapersonal strengths

as identified by the participating nurses. Interpersonal behavioral competencies can be improved or acquired by focusing on life skills, problem solving and communication skills and conflict resolution skills of nurses in their basic and ongoing training. However intrapersonal competencies that serve as a premise for effective behavior, are based on self-related competencies of nurses. Self-esteem and a sense of self-efficacy, self-regulation and -control and personal or signature strengths of character, are the building blocks of behavioral mastery and success.

Guidelines aimed at building behavioral competencies

Resilience-building during ongoing nursing education could focus on self-esteem, self-efficacy and ego resilience abilities, strengths awareness and building life skills which will give a sense of personal control to nurses. These self-related strengths will lead to improved interpersonal skills and behaviour, enhancing the confidence of nurses, believing in themselves and enabling them to act with conviction, adding to constructive behavior and positive intentions in difficult working circumstances.

Discussion of evidence

The importance of a positive self-esteem, acting with confidence, enjoying life and making the best of every day (having good intentions) is evident in literature (Bandura & Locke, 2003; Block, 1996; Liebenberg & Ungar, 2008; Risher & Stopper, 1999; Seligman, 2002). A positive outlook and self-esteem involve a range of interrelated innate or learned positive psychological characteristics and have enduring effects on enhancing general well-being and the importance of an engaged life (Bonanno, 2004; Diener & Seligman, 2002; Fredrickson & Branigan, 2005; Mruk, 1999; Peterson, 2006; Rashid, 2008; Seligman, 2002).

Strategy: Build Well-being Strengths

Aim: To improve intra- and interpersonal strengths and resilient characteristics to enhance constructive behavior

Actions:

- 1) Discover their unique signature strengths by doing assessments available on the positive psychology website and work on ways in which to optimally use these strengths in practice. In-service training or brown bag sessions where they can discuss their strengths and provide examples thereby inspiring each other can be useful.
- 2) Start a gratitude journal documenting daily at least 3 good things that happened and to maintain this long term to manually override the fundamental negative bias, adding to a positive outlook and enhancing general well-being.
- 3) Instill hope and optimism as positive life skills in in-service training, as well as cultivating positive emotions, as evidence suggest that it broadens their scope of attention, cognition, action and build physical, social and intellectual resources.
- 4) Complete measures of resilience on a yearly basis to identify strengths and vulnerability and continue practicing strategies to enhance positive affect and attend courses on building strengths or resilience that include important virtues like wisdom, courage, love, justice, temperance and transcendence, that can help them becoming more appreciative and joyful adding to their quality of life.
- 5) Attend empowerment and leadership training aimed at environmental mastery, instilling a sense of efficacy, competence and self-determination and this can be done in their basic training and enhanced in in-service training courses or workshops.
- 6) Build and refine social skills leading to interpersonal competence such as effective communication, conflict resolution, empathy and compassionate listening skills etc., as these would further improve and deepen the nurse's cooperation and caring abilities.
- 7) Be thankful for what they have and what they are capable of by recognising and acknowledging it, savouring joy's, paying attention to and taking delight in small pleasures that are plentiful in the nursing profession, providing, a "lightness of being".

Outcome: An enhanced awareness of personal ability in signature strengths, autonomy and self-regulation capabilities, will manifest in behavioral competence and responsible life management.

Physical competencies

Good physical status, strength and well-being are predictive of resilience (Kumpfer, 1999; Masten, 1997). The nurses' stories indicated the importance of a healthy lifestyle including good eating and sleeping habits as well as staying fit or having hobbies and spending time with valued others. Many of the nurses mentioned gardening, reading and other activities as being important in keeping a balance. A healthy life style seems to help them to cope, while staying fit and energetic help them to manage with the workload and the long hours. The maintenance of personal well-being can further be promoted by an in-house counsellor as suggested before.

Guidelines to enhance physical resilience components

The participating nurses advised that hospitals can re-organise their infra-structure and provide places where the personnel can have privacy and relax or destress e.g. a gym or

tea garden may be a good idea. Nurses should look after themselves – health, fitness and need for restoration of energy and peace should be a personal priority to ensure strength and balance to deal with difficult situations.

Discussion of evidence

Having a healthy lifestyle is emphasised by numerous authors (Cilliers, 2002; Milne, 2007; Needleman & Buerhaus, 2003). Research supports the contention that a healthy lifestyle, with good habits, like staying fit and having a sense of humour has been shown to be an effective buffer to stress (Tusaie & Patterson, 2006). Strategies to enhance resilience include ways to ensure physical health, taking care of oneself and improving relationships (Coutu, 2002). Lyubomirsky (2007) stressed the importance of intentional activities claiming that as much as 40% of happiness comprises intentional activities and strategies. Healthy self care plays an important role in avoiding the negative consequences of job-related stress (Cheng *et al.* 2005).

Strategy: Restorative Self-care

Aim: To improve and maintain a healthy lifestyle based on sound self care principles.

Actions:

- 1) Invest in self care, savoring and enhancing positive emotions in the present by partaking in pleasurable activities and finding activities that they fully can engage in and practice like reading a good book, listening to calming music, gardening, cooking, etc.
- 2) The off duty roster must be flexible and make provision for enough free time in order for nurses to take time out and do fun things, a healthy work-life balance is necessary.
- 3) Provide a quiet room, a gym or even a small chapel, as well as health services and healthy food for staff at their working place and a day care centre can be considered.
- 4) Engage in self care strategies like calming breathing, taking a mental health day or hour, keeping a well-being diary can be helpful for nurses.
- 5) Attend self-enrichment and -maintenance courses like the constructive use of time, creative skill development, meditation, choir singing etc.
- 6) Develop a positive self-esteem, constructive self dialogue, self assertive skills etc. could be promoted in regular workshops.
- 7) Occupational health, safety and wellness policies should be put into place and practiced by nurses to feel safe and keep safe.
- 8) Learn new skills, be creative and do fun things (play) and identify their strengths, talents or goals and actively pursue them can add to self-esteem and self-appreciation.

Outcome: Restoration and rekindling of personal enthusiasm, energy and zest, motivation for work and caring compassion for patients. Increased endurance- and tolerance ability are also results of being physically and mentally rested.

Kumpfer model: Resilience processes (stress/coping processes)

Resilience processes include short-term or long-term processes learned by the individual through gradual exposure to challenges and stressors that help the individual to bounce back with resilient re-integration (Kumpfer, 1999). Nurses have to cope with their stressful working environment on a continuous and ongoing basis and although they learn from it, it is also important that they have constructive coping skills in order to survive and thrive in their difficult work context and know the difference between constructive and destructive coping in order to practice strategies that will enable them to manage stress.

Guidelines aimed at developing constructive coping skills

The stories of identified nurses indicated that nurses should learn and practice constructive but applicable coping strategies for example, the emotion-focused coping strategies like maintaining a sense of humour for relieving emotional stress and cultivating optimism, debriefing after an upsetting event, to see stressors as a challenge instead of a threat and to use solution-focused strategies where sometimes a small change can lead to other changes that can result in a chain of reactions and a positive result. Nurses must realise that taking action can give them a sense of control and active coping strategies and problem solving methods could serve this purpose, while realising that different situations call for different actions and often they need to be brave and optimistic to find unique solutions in situation where they often have to think on their feet. Self control and self regulation, being disciplined and to practice modesty can be helpful, nurses need to take personal control, being careful of choices they make for themselves regarding their own lives and the lives of those in their care.

Discussion of evidence

Coping refers to efforts to deal with something difficult and these efforts may be cognitive, behavioral or psychosocial strategies that an individual uses to alleviate stress when events challenge the routine predictions of the world (Kleinke, 1998). Constructive coping is seen as a characteristic of resilient people when making the effort to manage situations that they appraise as potentially stressful or harmful (Lazarus & Folkman, 1984; Rashid, 2008; Scott, 2009; Zeidner & Endler, 1996).

Strategy: I Bounce Back

Aim: To build constructive coping strategies and a growth enhancing orientation in nurses

Actions:

- 1) Provide opportunities to master constructive coping strategies such as problem solving strategies and seeking social support.
- 2) Share in group discussions what strategies are helpful and in this way they learn from each other and enhance positive mastery. A “you at your best” exercise of writing about a difficult task at work that brought out the best in them can strengthen the “I can” resilience component.
- 3) Share and discuss the negative effects that destructive coping strategies can have on them and their patients, like smoking, drinking, over eating and discuss ways or alternatives to manage their stress.
- 4) Coach them to develop an awareness that problems do not reside in them, see change as a process, view mistakes as opportunities for learning, to utilise strengths like using a calming strategy and focus so that they choose the most beneficial course of action, or distancing and taking time out if they need to recover or re-gather self worth.
- 5) Allow themselves to acknowledge and experience the strong emotions they are confronted with in the caring of their patients, and also realise when they need to use avoidance or emotion focused strategies at times to continue functioning. They need to sometimes step back to rest and re-energise, nurturing themselves.
- 6) Acknowledge the connection between utilising strengths and experiencing positive emotions, learn to consider alternative explanations for adverse events and to choose the one that is most helpful to focus on the positives that actually exist, exercising and realising that one door closes another door opens (like recalling 3 times when things turned out well in spite of bad expectations).
- 7) Seek counselling or therapy if personal resources to cope are dysfunctional or depleted.

Outcome: To manifest resilience through positive re-integration after coping effectively with stress during adverse experiences and thereby further building their effective coping strategies and capacity to handle stressors as challenges from which they can grow.

Kumpfer model: Positive outcomes (links with how nurses’ perceive stressors)

Positive outcomes and adaptation in specific tasks are supportive of later positive adaptation in specific new tasks (Kumpfer, 1999). The implementation of the above strategies will result in positive outcomes for the nurses as illustrated in Fredrickson’s model (2001) where it is indicated that positive emotions broaden cognitive processes which build personal strengths, interpersonal relations, work performance and community involvement, feeding back into more positive emotions and by continuing practicing positive emotion-boosting strategies will result in better personal outcomes and resilience. Kumpfer’s (1999) model of resilience referring to the fact that individuals possess internal factors that buffer them against risk, that protective factors form part of the process and that individuals learn coping processes over time enabling them to bounce back could be achieved by the guidelines and specific strategies for interventions,

given above. The process begins with an initiating event and ends with an outcome, in this case resilience and psycho-social well-being in professional nurses.

DISCUSSION

The purpose of this article was to formulate broad guidelines with specific strategies for interventions based on previous research findings and recent literature with a view to the later development of programs to facilitate and enhance resilience and psycho-social well-being in professional nurses, and thereby contributing to improvement of health care service overall. Specific guidelines and strategies were formulated taking previous findings on resilience in the target group into account, as well as other findings on psychosocial health and building of resilience. The guidelines focused on: The external environment with protective factors such as the uniqueness of the nursing profession and social support systems; risk factors such as lack of recognition and poor remuneration, lack of autonomy and poor working conditions, staff shortages and physical unsafe conditions, managerial problems and lack of opportunities for development; Person-environment interactional processes such as enhancing nurses' working conditions; Internal self characteristics (spiritual, cognitive, emotional, behavioral/social and physical competencies or strengths); Resilience processes (stress/coping processes); Developing constructive coping skills. Although an effort was made to organise the guidelines according to the six components of Kumpfer's (1999) model it was difficult to do so without some duplication and overlapping, illustrating the complexity of resilience as a multi-dimensional construct and the interrelativeness of the components, as well as the fact that internal resiliency factors are linked with interactional processes.

It seems clear that just as each nurse had an own unique story of resilience and well-being in the profession, each individual will also have his/her journey of development and resilience in the face of difficulty and the path may be paved by fairly simple steps. It could be the importance of positive feedback for work well done, or the opportunity to share their stories/experiences in the nursing profession which can be both healing and inspiring. However, without a healthy workplace culture and climate that creates an

environment in which the caring ethos of the nursing profession can be manifested, the job satisfaction and the well-being and resilience at work which flows from job satisfaction will always be compromised. Although the guidelines with strategies for interventions presented here, were intended for the development of resilience and psycho-social well-being of professional nurses, it became evident that there is much correspondence between these guidelines and strategies for interventions to foster healthy work environments (Bakker *et al.* 2007; Fredrickson, 2008; Turner *et al.* 2002, Warr, 1999). These guidelines with strategies for interventions could thus serve the purpose of developing resilience and psycho-social well-being in nurses as well as improving the overall organisational well-being of the health care facilities in which nursing care takes place.

Professional nurses working in an environment where they are caring for people in need, can themselves benefit from the reward and satisfaction they feel when providing quality care. The authors believe that although much can be done and should be done to enhance resilience in professional nurses, the nurses will however have to realise that although they are focusing on the needs of their patients, it is also important to focus on their own needs or well-being. They should treasure their own journey of happiness and resilience in the nursing profession, not passively reacting to negative circumstances, but actively engaging with people that are positive and supportive, they should utilise opportunities to improve self-efficacy and autonomy, cultivating positive emotions thereby achieving psychological growth and building their resilience. The health care system needs resilient professional nurses who are able to provide and maintain quality care to patients thereby improving the quality of the nursing profession and the health care services overall.

Programs based on the guidelines and strategies for interventions aimed at building resilience in the nursing profession, can be context specifically developed and implemented in various health care facilities to maintain, facilitate and enhance resilience and psycho-social well-being of professional nurses. Evaluation of the effectiveness of such programs will then be the next step, after which further adaptations can be made to enhance target specific effectiveness. Various strategies can be implemented on an as-

needed-basis in specific contexts without necessarily being part of a complete program. The implementation of the strategies does not have to be inordinately expensive as costs can be substantially curtailed with creative and careful use of existing resources.

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SECTION THREE

CONCLUSIONS AND RECOMMENDATIONS OF THE RESEARCH

CONCLUSIONS AND RECOMMENDATIONS OF THE RESEARCH

1 Introduction

In the preceding manuscripts the realisation of each phase of the research, research results, conclusions and guidelines with strategies were described. These results, conclusions, guidelines and strategies were synthesised, and are presented as the conclusions and recommendations derived from this research project. It is a retrospective evaluation of the research. Limitations of the research are also discussed.

2 Evaluation of the study

The evaluation of this research is divided into a critical reflection of the central theoretical argument followed by a personal narrative of the researcher.

As a point of departure the research questions for this research were:

- What is the prevalence of resilience in a group of professional nurses?
- What can be learned from the analyses of stories (narratives) of identified resilient professional nurses about their coping, strengths, resilience and positive adaptation in the nursing profession that may assist in an understanding of resilience as an enabling factor for psycho-social well-being in a difficult professional context?
- What guidelines and strategies for training and other programs to facilitate and enhance the professional nurse's resilience and psycho-social well-being can be extracted from the results obtained from answers to the above questions?

Thereafter the researcher formulated the following argument: The investigation of the prevalence of resilience in professional nurses will lead to the identification of professional nurses and by analysing the stories of resilient nurses, characteristics, strengths and other protective factors can be identified to facilitate a thorough

understanding of the nature of resilience in nurses. From these findings guidelines with strategies for interventions can be deduced to facilitate and enhance resilience and psycho-social well-being in professional nurses.

Data was collected and analysed using a mixed research method. The investigation and interpretation of the prevalence of resilience in the first quantitative phase provided useful information. The main finding was that aspects of resilience could be reliably and validly measured by the measuring instruments used for the purpose and that 43% of the participants emerged as manifesting high levels of resilience. The results of these findings made it possible to identify resilient professional nurses. In the second qualitative phase of the study the stories of some of these resilient nurses about their resilience in the profession were explored. Thirty five of these nurses wrote their stories on how they manage to stay resilient and compassionate in the demanding profession (N=35) and a further number of resilient professional nurses (N=32) shared in six focus group interviews and one individual interview their experiences of and views on resilience, leading to rich findings. These findings were used in the formulation of broad guidelines with specific strategies for interventions that can be used to develop formal and informal training programs to enhance resilience and psycho-social well-being in professional nurses in order to enrich the nursing profession, thereby improving the health care service overall.

2.1 Personal narrative

The journey I undertook with this research led to the reflection on my own journey in nursing and the struggles I had to face, realising that I shared most of the struggles and triumphs these professional nurses referred to. In my training I realised my interest in the Psychiatric field where I found I had a lot to offer and where I worked for seven years. However, due to all the responsibilities of being in charge of Psychiatric Community Services, working for long hours as well as having to cope with the needs of my own family, I decided to further my studies. In the end I never returned to practice to implement the obtained knowledge and skills. I came to realise that I was escaping from

the responsibilities a nurse has to carry in practice, the very demanding role that was described by nurses in the focus group interviews was too much for me and I opted for something I could manage and combine with my personal life more effectively. This research was inspired by my respect and admiration of the nurses who have chosen to remain in practice and are giving their best for their patients despite all the hardships they have to endure.

Spending time in the clinical settings and hearing the stories of the professional nurses made the awareness grow of how important it is to understand their experiential world and to care for these caregivers. We need these committed nurses to stay in the nursing profession and especially in the practice to care for people when they get sick and are at their most vulnerable. Their stories of personal struggles and triumphs, and the compassion and care many of them expressed for their patients made the researcher even more determined to research this field and to present useful guidelines and strategies. Such guidelines and strategies are aimed at empowering these professionals in their personal journeys, making sure they stay in the profession and use their knowledge and skills to care for the many patients who are so dependent on them and add quality and value to the nursing profession and health care service.

I enjoyed the research process and learned a lot even though it was tough at times. The article model that was chosen for reporting the research proved challenging, as the restriction in words for the articles were difficult to adhere to (a maximum of 7000 words, excluding, abstract, references, tables and figures). The researcher had a struggle to let go of some of the information. My passion for the professional nurses deepened and I hope that this research proves to be useful and makes a difference in the lives of some of these outstanding people.

3 Limitations of the research

This research was limited by the following factors:

- The sequential exploratory design was demanding and expensive, both energy and time consuming. The first quantitative phase was the most difficult as the researcher had to obtain at least 300 completed questionnaires for the study to be valid, 650 questionnaires were made available to professional nurses and less than half completed the questionnaires, namely 312. Permission from the different stakeholders and the Department of Health was problematic. Although it was communicated from the Department that the proposal was approved the letter of approval hadn't been signed and the researcher could not distribute questionnaires in some hospitals, which resulted in 2 public hospitals not being included in the study. At some hospitals management showed a negative attitude about research and did not want the nurses to partake. It seemed that researchers didn't report their findings in the past, which made the management feel that it isn't worthwhile to partake. This should serve as a reminder to future researchers to make the results available and go the extra mile to present the findings to the stakeholders involved.
- A similar negativity also came from some of the nurses, which may be a symptom of the current adverse situation in the profession. It was difficult for the researcher who struggled to get questionnaires back from the participants, resulting in a relatively small amount of participants (N=312) in the first phase.
- The delay in getting permission from the Department of Health and the fact that only 2 public hospitals, and 4 private hospitals with affiliated primary health care clinics formed part of the study may also be a limitation, as more participants from public hospitals would be preferable to generalise the findings.
- It must be remembered that in qualitative research, the design that was followed in the second phase of the study, it cannot be assumed that the findings can be generalised for other settings or participants. Further research is recommended to add to the knowledge gained.

- The constantly changing context and the differences between and within people make it difficult to measure resilience. The researcher realised this and used a mixed method in an effort to provide new and useful information about resilience pertaining to professional nurses.

4 Conclusions

The findings together with conclusions and the guidelines with strategies for interventions developed from the data, are all considered in order to reach the overall conclusions and these are related to the objectives of the research.

4.1 Literature conclusions

Based on literature explored, interpreted and integrated for the purpose of this study, it was clear that resilience is a challenging concept and not easy to define or measure. The multi-dimensionality of the construct was evident, but the potential gains of understanding the construct and the theoretical and practical importance thereof made it a worthwhile choice for the research. Literature drawn from the field of Psychology could offer information relating to the theoretical underpinnings of resilience and aspects or factors of resilience. A great deal has been written about resilience in children and young people, much less about resilience in adults and hardly anything on resilience in professional nurses. Most of the research into resilience focused on unfavorable circumstances or traumatic events or risk factors, while more recent research shifted focus onto more positive aspects or protective factors. The studies varied in the way resilience was measured and it was challenging to find a suitable method to operationalise resilience to be reliable and valid for this study, specially in relation to the nursing profession.

Although a wealth of information is available on the theoretical aspects of resilience, not much could be found on how to move from theory to practice and practical and functional guidelines to improve resilience are scarce. However, in the literature control

(exploration, interpretation and integration of literature) performed by the researcher useful information could be found about spirituality, morality, values, supportive relationships, the importance of training and establishment of a positive mindset, positive emotions and living a full life. The positive psychology movement's focus on positive institutions with an emphasis on job satisfaction and well-being and the JD-R model proved to be useful in the formulation of the guidelines with strategies for interventions. The qualities identified by authors in the positive psychology movement regarding healthy working environments and organisations together with the themes identified from the stories and focus group interviews were used and Kumpfer's resilience model (1999) together with Fredrickson's (2001) "Build-and-Broaden" positive emotions model were useful in the development of constructive broad guidelines with specific strategies for interventions for facilitating resilience and psycho-social well-being in professional nurses.

As far as resilience in the nursing profession is concerned it was easy to find literature and trace studies that focused on the adverse working environment, the stressors and high burnout among nurses. Some studies done in nursing referred to positive aspects like coping and problem solving skills, but there is a paucity of information on resilience as it pertains to the nursing profession, emphasising the importance and value of this study.

The literature review aimed at understanding the nature of resilience led to the researcher conceptualising and defining resilience in the overview of the study. This provided clarity on the multi-dimensionality of the construct and theoretically related concepts could be identified to measure aspects of resilience, namely: hope, optimism, sense of coherence, coping self-efficacy, health and mental health. Resilience, the umbrella concept of the research could thus be clarified and explained as illustrated in Figure 1.1 in the overview of the study.

4.2 Empirical conclusions

The mixed method that was chosen for this study, with both quantitative and qualitative methods that followed sequentially in two phases of the study, proved to be successful as the objectives stated to guide the research were achieved. The questionnaires used to measure aspects of resilience in the first quantitative phase were found to be reliable and valid measuring instruments for use in this research group. Further research will be necessary to investigate which of the questionnaires (RS, MHC-SF, CSE, SOC, HS, LOT-R and GHQ-12) are the best predictors of resilience in professional nurses and whether a resilience construct can be identified through factor analyses of these results. It is clear from this study that a qualitative design, which was used in the second phase, could meaningfully explore resilience and the manifestation thereof by the participants. The written stories provided useful and recurrent themes that were trustworthy as they are in the nurses' own words. The qualitative analysis of 35 stories was quite taxing. The focus group interviews added information and corresponded well with findings in the stories, which added to the reliability of the study. The mixed method, using both quantitative and qualitative methods can be recommended for further research on resilience.

4.2.1 Conclusions from the first article of the study

- The aims of this investigation were to determine the prevalence of resilience in this group of professional nurses, to determine whether there are significant differences in levels of psycho-social well-being and resilience between participants working in private and public health care facilities, and to obtain an indication of participants' view of their profession and resilience there-in. The main finding was that 43% - 45% of the participants in the total group could be described as resilient or flourishing.
- Descriptive statistical findings indicated that the mean scores and standard deviations are mostly similar to those reported in literature. The psychometric properties of the measuring instruments used were mostly acceptable. Moderate to high positive correlations between the scales measuring aspects of resilience supported the theoretical assumption that the underlying theoretical base of the scales has features in common that could represent the multi-dimensional

construct of resilience. The scales were thus successful in measuring and indicating aspects of resilience in this research group. Significant differences in resilience and emotional well-being was found with higher levels manifested by nurses in private hospitals. However, only the trend could be observed since the practical effect was small.

- The quantification of answers in three open ended questions posed to the participants indicated that although 41% saw themselves as resilient in their profession (43% according to the scales used), the majority (54%) were considering leaving the nursing profession. A question that comes to mind is whether the 43% resilient nurses are included in the 46% planning to stay in the profession, perhaps because their resilience enable them to adjust to adverse working conditions and they even attempt to improve the situation from within, or are they part of the 54% who plan to leave because their resilience enables them to seek other options and to have the courage to act in their own interest. Although resilience manifested by nurses was surprisingly high, the feelings about the profession are mostly negative, especially in the public sector, resulting in many of these nurses wanting to leave or considering leaving the profession, showing the urgency of action to be taken. There is a need for enhancing resilience and psychological well-being in these nurses to maintain the high level of resilience in some and to empower the rest, with more than half of them manifesting with moderate to low resilience (57%). The fact that 650 questionnaires were distributed and only 312, less than 50%, were completed may indicate that some of the professional nurses couldn't bother or were so demotivated that they did not want to complete the questionnaires. The findings of prevalence of resilience in this group of professional nurses may thus not present the true picture. Findings also showed an aging workforce, with only 22 younger than 30 (7%), and 230 (72%) older than 40. Furthermore, many of them want to leave the profession 96 (31%) or 63 (20%) consider leaving the profession, 7 are ready for retirement, and 6 thinking about early retirement. This is alarming considering the shortage the nursing profession is already facing.

- The hindering or negative aspects identified in the nursing context outweighed the positive aspects (which were mostly about a love for nursing), namely: poor salaries, staff shortages, poor working conditions, the bad professional image, low morale, the stressors and responsibilities, managerial problems, lack of recognition and abusive patients. If this current situation continues, where entry into nursing seem outweighed by exit with nurses either emigrating or discontinuing practice, the crisis will deepen unless strategies are developed not only to retain nurses but to empower them, to attract new recruits into nursing and entice nurses who left to return to the profession.
- There was no difference as far as the researcher could observe or that could be derived from the results shown between the cultures, which proves that the nursing profession has a culture of its own. Language barriers weren't mentioned and all the partaking respondents were comfortable in English, which was encouraging and showed their eagerness to partake.
- The results of the first phase (article 1) made it possible for the researcher to identify resilient professional nurses in order to move to the second phase, where the stories of some of these nurses about their own resilience in the profession could be qualitatively obtained and analysed in an attempt to develop a thorough understanding of resilience in the nursing profession (article 2) and to develop guidelines with strategies for interventions on which training and programs for the empowerment of nurses can be based (article 3).

4.2.2 Conclusions drawn from the second article of the study

- The objective of this investigation was to identify resilient characteristics, strengths and other protective factors by employing qualitative research methods with quantitatively identified resilient professional nurses in order to obtain a thorough understanding of resilience as an enabling factor for psycho-social well-being in the nursing profession. This objective has been reached and resilient characteristics of professional nurses have been identified from their stories and the focus group interviews. The characteristics correspond with the concepts

identified in literature to measure aspects of resilience, namely: hope, optimism, coping self-efficacy, sense of coherence, health, mental health and well-being. However, the data from the narratives revealed other important characteristics that are also closely related to resilience, such as joyfulness, having dreams, making a choice to be happy, appreciative of life, being thankful, forgiving, self-respect, perseverance, overcoming obstacles, curious, rejoicing in success, self-reflection, self-control, vigilant, constructive, self-disciplined, efficient, committed, taking responsibility, passionate, flexible, able to adapt, open-minded, handling emotions, striving to improve, confident and mature with inner strength and being proudly professional.

- The strengths identified from the findings were discussed using the Resilience model of Grotberg (1997), namely the, I have, I am and I can components. I HAVE implying external factors of support and resources, the stories revealed the importance of a strong foundation for spiritual, personal and professional resilience and strength. A strong belief system or spiritual philosophy was identified with strong values and principles under the spiritual dimension which serve as guidance, gives meaning and drive them. The importance of a good basic education, ongoing education and role models and mentors were identified to motivate and equip the nurses as part of the professional dimension. With the personal dimension the importance of good support from family and friends were evident. I AM means having inner personal strengths and the participants revealed their values, their strive for excellence, having self-efficacy, being self-disciplined, taking control and coping with difficulties, making choices to be committed and providing compassionate quality care to the patients in the face of adverse working conditions. I CAN indicates social and interpersonal skills and they referred to their perseverance, working hard and tolerating bad attitudes toward them, to using laughter and humour, seeing problems as challenges, stress management within adverse working conditions, communicating and sharing with others, being mentors and role models to junior nurses and serving the patients. Another dimension that emerged was the I BECOME, referring to the nurses'

strive to improve their skills and knowledge, in order to provide quality care and be role models for patients and young nurses.

- From all the stories and discussions with resilient professional nurses presented in detail, their resilience as an enabling factor emerged and is conceptualised as a self-sustaining strength. Resilience in attitude and ability is reinforced by resilient behavior and the latter by positive outcomes such as being able to overcome difficulties, to adapt, to become stronger and more committed to a profession that they value. A circular self-sustaining process is concluded as illustrated in Figure 4.1.

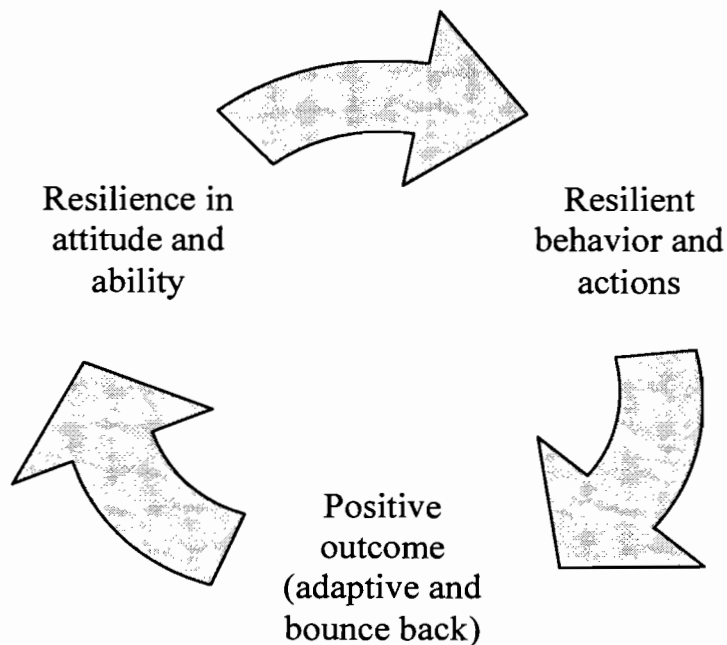


Figure 4.1: Self-sustaining cycle of resilience

- From the contributions of both resilient and less resilient nurses it became clear that the staff shortage and working conditions must receive urgent attention as patient care is being compromised. A serious attempt should be made to fill posts and attract suitable young people to the nursing profession. A lasting impression left with the researcher is the outcry of the nurses to be acknowledged and recognised for their professional integrity and value as well as their concern for

the profession and their plea that the caring concern which lie at the heart of nursing must be re-discovered. The professional image of nursing needs to be improved in order for the morale, pride and motivation of these nurses to be restored.

4.2.3 Conclusions drawn from the third article of the study

- The purpose of this article was to formulate guidelines and strategies based on the previous research findings and relevant literature with a view to later development of programs to facilitate and enhance resilience and psycho-social well-being in professional nurses, and thereby contributing to improvement of health care services overall. In the first phases of the study the prevalence of resilience in professional nurses was investigated with the help of validated measuring instruments, and resilient professional nurses were identified. Thereafter their stories were obtained and analysed and the data gained was used in the formulation of the guidelines with strategies for interventions. The aim has been met in that guidelines with specific strategies for interventions were formulated based on the findings (evidence) from the narratives of the resilient professional nurses (empirical data) and evidence from literature (theoretical data) that can be used for training purposes and other programs to facilitate resilience and psycho-social well-being in nurses.
- Guidelines with specific strategies were formulated taking previous findings on resilience in the target group into account, as well as other findings on psycho-social health and building of resilience. The guidelines focused on; The external environment (risk and protective factors), with protective factors including the uniqueness of the nursing profession and social support systems and risk factors including lack of recognition and poor remuneration, lack of autonomy and poor working conditions, staff shortages and physical unsafe conditions, managerial problems and lack of opportunities for development; Person-environment interactional processes, enhancing nurses' working conditions; Internal self characteristics (spiritual, cognitive, emotional, behavioral/social and physical

competencies or strengths); Resilience processes (stress/coping processes) and Developing constructive coping skills. Although an effort was made to organise the guidelines according to the six components of Kumpfer's (1999) model it was difficult to do so without some duplication and overlapping, illustrating the complexity of resilience as a multi-dimensional construct and the interrelativeness of the components, as well as the fact that internal factors are linked with interactional processes. The development and formulation of the guidelines with strategies for interventions are practical and the implementation thereof may improve resilience, strengths and psycho-social well-being of professional nurses, thereby improving the quality of nursing care and the health care service in general. Kumpfer's model of resilience was useful and could be used with the rich results obtained from the two phases of the study (empirical data) and relevant literature (theoretical data). The implementation of the strategies do not have to be inordinately expensive as costs can be substantially curtailed with creative and careful use of existing resources.

- This research may provide evidence about resilience as a strategy to facilitate and enhance nurses ability to survive and thrive in the difficult nursing profession and managing the rapid health and organisational changes. The study provide information about the value of initiating sustainable strategies that can support nurses and can assist health organisations to develop resilience in nurses and may prevent staff turnover. A theoretical framework demonstrating resilience in professional nurses can be concluded, see Figure 4.2.

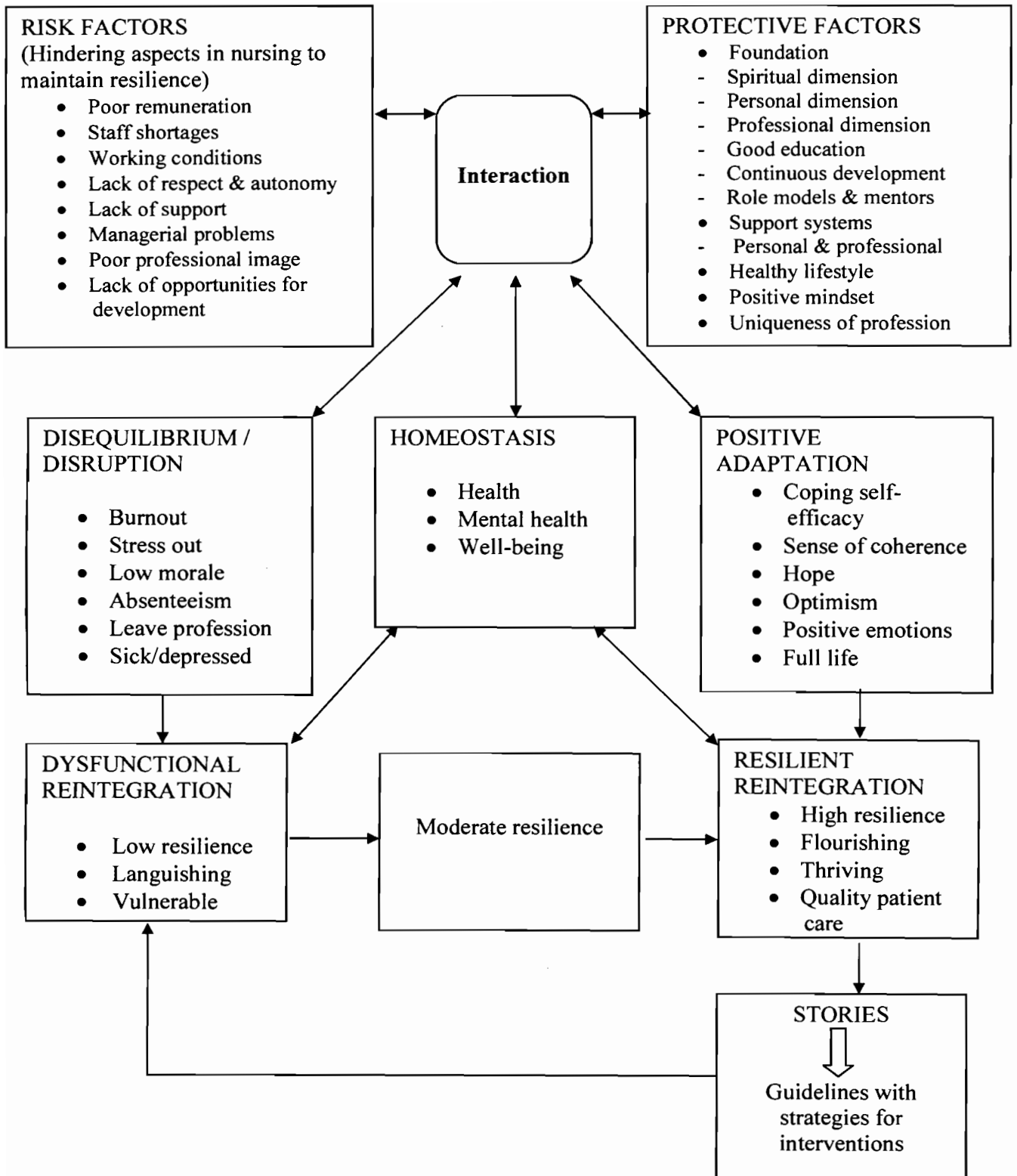


Figure 4.2: Theoretical framework

In Figures 4.3 and 4.4 frameworks to facilitate and enhance resilience and psycho-social well-being in professional nurses are suggested. Figure 4.3 is an attempt to illustrate the process to enhance resilience keeping in mind individual characteristics, strengths or needs of each nurse.



Figure 4.3: Facilitating and enhancing resilience keeping individualism in mind

Figure 4.4 illustrates the importance of a solid foundation (spiritual, personal and professional), good knowledge and skills (good basic education and ongoing training), a healthy lifestyle, supportive networks and relationships (a conducive environment or work place is seen as part of this). It also shows the ongoing interaction that exists between protective and risk factors and if positive adaption and resilient integration take place, which can be promoted by the suggested guidelines for interventions, resilient professional nurses can be the result. These nurses are working in a unique profession which can be rewarding and satisfactory and if the work they do are being acknowledged and they get recognition, their professional image and morale may improve and this will lead to a positive outcome, namely quality nursing care.

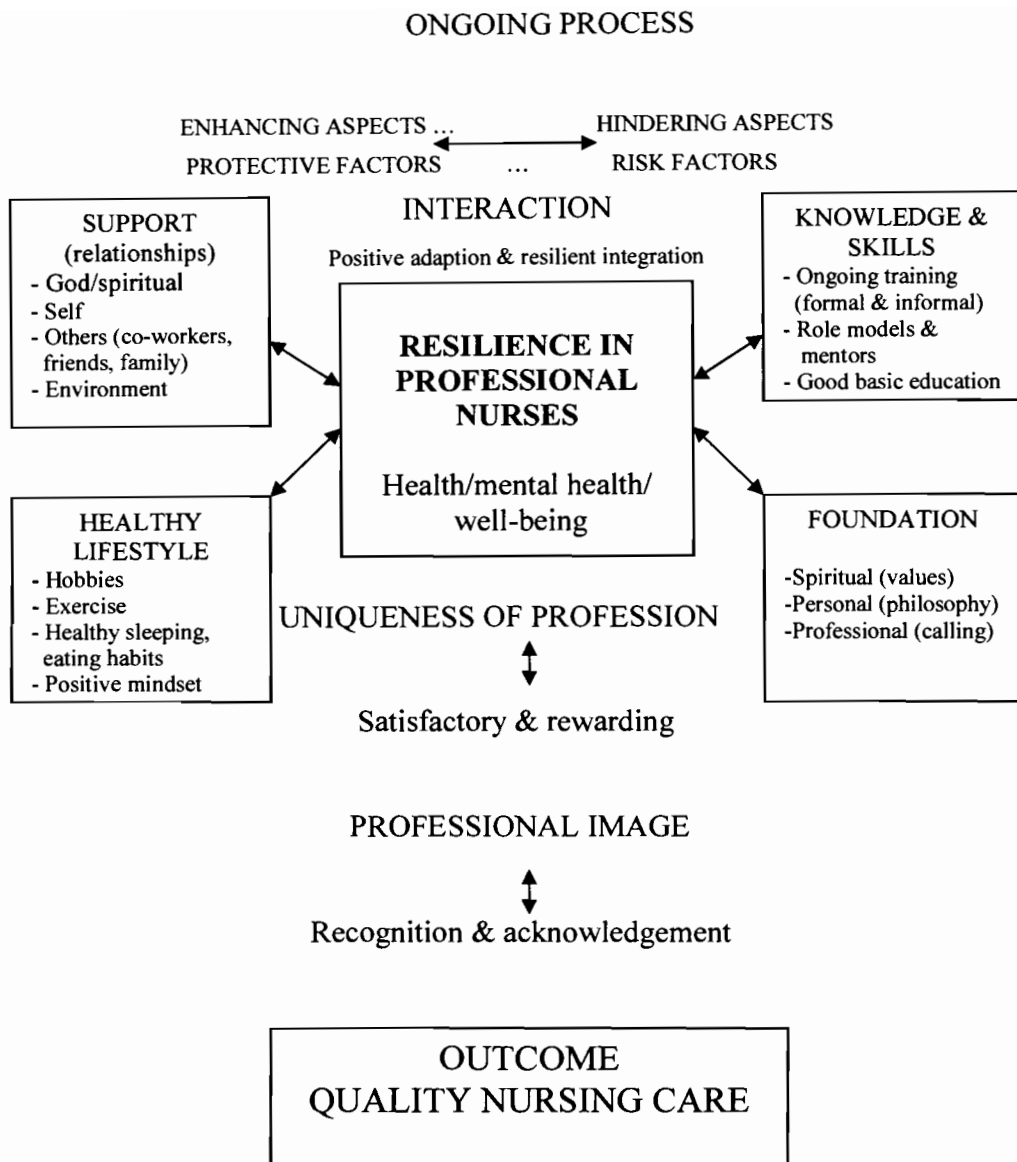


Figure 4.4: Framework for facilitating and enhancing resilience and psycho-social well-being in professional nurses

4.3 Recommendations

The research was undertaken to improve resilience in the nursing profession, thereby improving the health care services. The proposed guidelines and strategies for interventions are used as a framework. Topics for further research are suggested.

4.3.1 Recommendations for the health care service/sector

- The activation of a “Heart of Nursing” program that is focused on establishing and restoring passion for nursing as a care giving profession, should be considered. The uniqueness of the nursing profession and the deep personal reward of being a nurse and of nursing being a calling was a strong theme in this study and seem to be an important factor that needs to be emphasised to restore the status of the profession. The ethical foundation of the nursing profession is vested in the Nurses’ Pledge (derived from the Nightingale Pledge) and has been in use since the institution of nurse training in South Africa. The professional nurse enters into a verbal agreement with the community, promising to always put the patients’ needs first – even above his/her own interests – through the provision of the best service-directed compassionate care. The meaning of the lamp in the pledge of service is a symbol of the philosophy of the nursing profession, that those who nurse should be a light unto others and it confirms that nurses are prepared to carry out professional acts in accordance with the legal and ethical codes of the profession and are prepared to care for the patients’ in their uniqueness, with knowledge and compassion. The lighting of the lamp at the beginning of a shift and the renewal of this pledge on a yearly basis (as suggested in a strategy) by all the professional nurses at health facilities, can serve as a reminder of the considerable promise and commitment they made. The South African Nurses’ Pledge reads as follows:

I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity.

I will maintain by all the means in my power the honour and the noble traditions of my profession.

The total health of my patients will be my first consideration.

I will hold in confidence all personal matters coming to my knowledge.

I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life.

I make these promises solemnly, freely and upon my honor.

- The maintenance and improvement of the empowering enhancing aspects of resilience are factors at the core of the profession that should be brought back and introduced in the form of skills training or in-service training and regular discussions in meetings to facilitate resilience in professional nurses.
- It is recommended that the hindering aspects that compromise resilience of professional nurses, like the working conditions, managerial and financial aspects, receive urgent attention by management, government and the professional body for nurses. Good basic training is essentially supported by good role models and mentors in practice, as well as opportunities for lifelong learning to equip the nurses with skills and knowledge to manage ever changing demands and provide quality care. The importance of good support systems and a healthy lifestyle need to be realised by all the professional nurses in their personal lives and working hours should be reasonable and flexible enough to provide them with time to be able to establish this. In order to uphold the quality of nursing care and health care, these nurses must be recognised for their value and acknowledged for their essential skills and competencies without which the health care system will grind to a halt.

- It is recommended that relationships between the private and public sector be improved. Furthermore, quarterly meetings can be held between the personnel and management to share ideas and get a better understanding and appreciation of the problems and ideas that can improve the current situation.
- The importance of the multi-disciplinary team working as a curative unit has been identified and health facilities should look at opportunities to improve the situation. Sharing their experiences and roles in meetings is recommended since it can lead to a better understanding and establish trust relationships. Workshops and in-service training focusing on teamwork and appreciation of the multi-disciplinary team to ensure quality nursing care can be held and form part of the training program at health facilities.
- A program based on the guidelines with strategies for resilience in the nursing profession as suggested in article 3 can be further developed and implemented in health care facilities to maintain, facilitate and enhance resilience and psychosocial well-being of professional nurses. Evaluation of the guidelines, strategies and program is recommended to assess and to improve the program on a continuous basis as the interventions are by no means exhausted and further research and literature reviews can result in more guidelines for interventions.

4.3.2 Recommendations for future research

- Trust levels among the different health care workers in health facilities; among personnel working in public and private hospitals and between management and nursing personnel, should be investigated.
- An investigation under professional nurses who left the profession to determine reasons for leaving can be beneficial.
- An investigation into healthy work environments for health care professionals is recommended.
- Support systems for health care professionals should be investigated.
- Nurse educators' role should be investigated as it can help to better prepare nurses for sustained professional resilience.

- The place of psychiatric nursing and the role it plays within the nursing profession should be investigated as these nurses voiced the fact that they feel left out.
- Further research to investigate predictors for resilience in professional nurses and to explore resilience in professional nurses in other settings can be meaningful.
- It is recommended that all the measuring instruments used should be further validated for specific contexts. A new measure of resilience may also be developed through factor analyses on findings from all scales.
- It is further recommended that strengths specific to the various cultures from which the nursing population is made up of, be further explored. Although the authors recognise the significance and inter-relativeness of culture in resilience and were respectful and mindful of culture differences, it was not explored. The nursing profession as having a culture of its own was clearly recognised in the similarities of the findings from the stories/narratives of the participants from the different South African cultural groups taking part in this multi-cultural study.
- The constructs used to represent resilience in this study should not be seen as exclusive and it is recommended that as many descriptives of resilience as possible in various combinations should be researched to eventually be able to come to a description of resilience as a construct. Factor analysis and structural equation analysis could be used for such research.

The social relevance and contribution of this study has already become evident. The researcher has been invited by all the partaking health facilities to present the research results. Furthermore, one of the Nursing Council's members approached the researcher and requested her to present the results of the research in May 2010 at the SANC. It seems a wonderful coincidence that 6-12 May 2010 is the International Nurses Week with the logo "Be Inspired. Be Motivated. Be Renewed", and the International Nurses Day is 12 May where nurses are reminded of the commitment they made and to mark the 100 year memorial of Florence Nightingale (1910 – 2010).

This study contributes to the knowledge base of psychology and more specifically positive psychology therein that resilience has been indicated as an enabling factor in

professional nurses as important health care providers in the health care service. Although resilience has proven itself to be a complex concept that is difficult to define and measure, the potential gains in further understanding of the construct as explained in the study could be of theoretical and practical importance as resilience has become an appealing concept because of its roots in positive psychology. The acceptable psychometric properties of the scales measuring aspects of resilience supported the theoretical assumption that the underlying theoretical base of the scales has features in common that could represent the multi-dimensional construct of resilience. The scales were thus successful in measuring and indicating aspects of resilience in this research group and can be used in other studies investigating resilience. The professional nurses participating in this qualitative study were able to articulate their perceptions of resilience, coping, strengths and enabling factors and these views were mostly in keeping with relevant theory and research findings. The unique strengths evident in the professional nurses enabling them to be resilient were used to develop guidelines with strategies for in-service training and other programs to enhance resilience and psycho-social well-being. Although the guidelines and strategies were mainly aimed at nurses in their professional context, these strategies could be adapted for use in interventions in other contexts to promote resilience and psycho-social well-being.

5 Final conclusion

It can be concluded that the objectives that was set for this research have been reached. By investigating the prevalence of resilience in a group of professional nurses resilient professional nurses were identified. Thereafter the stories (narratives) of resilient professional nurses presented resilient characteristics, strengths and other protective factors and a thorough understanding of resilience as an enabling human phenomenon was obtained. Guidelines with strategies could be deducted that can be used for training and other programs to facilitate and enhance resilience and psycho-social well-being in professional nurses. The outcome thereof can promote the quality of nursing care thereby improving the health care service overall.

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APPENDIX A: LETTER TO REQUEST PERMISSION TO CONDUCT RESEARCH

I am a student registered for a PhD in Psychology at the North-West University, Vaal Triangle Campus. The title of the research is: **RESILIENCE IN PROFESSIONAL NURSES**. The research is conducted at private and public hospitals in the areas, including: Potchefstroom, Carletonville, Randfontein, and Krugersdorp.

I am also a registered nurse and working as an associate professor in the School of Nursing Science at the North-West University.

The objectives of the research are to:

- Investigate the prevalence of resilience in professional nurses and identify resilient professional nurses with the help of psychometric instruments (questionnaires)
- Identify strengths and other protective factors from the stories of resilient professional nurses employing qualitative research methods (writing of their stories and focus group interviews)
- Formulate guidelines with strategies for interventions to facilitate and enhance resilience and psycho-social well-being of professional nurses

Permission is, therefore, requested to undertake this project, this will entail the help of chief professional nurses at the hospitals to act as mediators to identify the professional nurses, distribute the consent forms and then the questionnaires to those willing to participate and hand it with the list of their names and telephone numbers to the researcher after completion, the questionnaire take about 30 minutes to complete. The researcher will then contact the resilient professional nurses after the questionnaires have been analyzed to participate in the second part of the research. This will be done by requesting them to write their stories or to partake in a focus group interview at the hospital, clinic or a venue of their choice and will take approximately one hour. Questionnaires will be distributed between September and April 2009, and the second part of the research from April to June 2009. Participation will be voluntary and the research proceedings will be treated confidentially, the names of the hospitals and the participants will not appear anywhere on the recordings or the report. The benefits of participation will be that guidelines will be formulated to facilitate and enhance resilience and psycho-social well-being of professional nurses which will be made available to the hospital management and can assist the hospital in programs and in-service training of the nurses and serve to improve the quality of nursing care.

Ethical permission for this research has been obtained from the North-West University under the provision of Professor M.P. Wissing (NWU-00002-07-A2). A letter has also been send to the Department of Health, requesting permission.

Your prompt response in this regard will be appreciated so that the researcher can be able to make further arrangements.

For more information please contact the researcher at the following number:
073 207 2324.

Thanking you in anticipation.

Prof. M.P. Koen (researcher)

Prof. C. van Eeden (promoter)

Prof. M.P. Wissing (co-promoter)

APPENDIX B: LETTER TO REQUEST CHIEF PROFESSIONAL NURSES TO ACT AS MEDIATORS

I am a student registered for a PhD degree in Psychology at the North-West University, Vaal Triangle Campus. I am conducting research on resilience in professional nurses. The title is: **RESILIENCE IN PROFESSIONAL NURSES**. The research will be conducted in private and public hospitals in the areas, including: Potchefstroom, Carletonville, Randfontein and Krugersdorp.

The objectives of the research are to:

- Investigate the prevalence of resilience in professional nurses and identify resilient professional nurses, with the help of psychometric instruments (questionnaires)
- Identify strengths and other protective factors from the stories of resilient professional nurses employing qualitative research methods (writing of their stories and focus group interviews)
- Formulate guidelines with strategies for interventions to facilitate and enhance resilience and psycho-social well-being of professional nurses

In order for the objectives to be realised questionnaires need to be completed by at least 300 professional nurses in order to identify resilient professional nurses to request their stories in writing or conduct focus group interviews with them and formulate guidelines from the findings from the stories and the focus group interviews.

The criteria for inclusion are the following:

- Must be working as a professional nurse for at least six months
- Must be able to communicate in Afrikaans or English
- Must be willing to participate willingly and give consent to the research

As a mediator, you are requested to distribute the consent forms and then the questionnaires to the professional nurses who are willing to participate with the list of their names and telephone numbers to the researcher to follow through with the second phase of the research. The focus group interviews will be conducted on request with the identified resilient professional nurses at the hospital or a facility, by choice to ensure

convenience and comfort. All the names of participants will be treated confidentially and will not appear anywhere on the questionnaires, tapes or research report. Participation will be voluntary and they will have the right to withdraw at any stage of the research if they wish to do so.

Your prompt response in this regard will be appreciated so that further arrangements can be made.

For more information please contact me at the following number: 073 207 2324.

Thanking you in anticipation.

Prof. M.P. Koen (researcher)

Prof. C. van Eeden (promoter)

Prof. M.P. Wissing (co-promoter)

APPENDIX C: LETTER TO REQUEST PARTICIPANTS TO PARTICIPATE IN THE RESEARCH

I am a student registered for a PhD in Psychology at the North-West University, Vaal Triangle Campus. I am conducting research on resilience in professional nurses, the title is: RESILIENCE IN PROFESSIONAL NURSES. I will appreciate your participation as a professional nurse.

The objectives of the research are to:

- Investigate the prevalence of resilience in professional nurses and identify resilient professional nurses with the help of psychometric instruments (questionnaires)
- Identify strengths and other protective factors from the stories of resilient professional nurses employing qualitative research methods (writing of stories and focus group interviews)
- To formulate guidelines with strategies for interventions to facilitate and enhance resilience and psycho-social well-being of professional nurses

Should you consent to participate in the study the benefits for the profession will be that the findings from the stories and focus group interviews of the resilient professional nurses will lead to the formulation of guidelines which will also be made available to the hospital where you work for possible in service training purposes. Apart from the feedback on request regarding the guidelines there will be no advantages or disadvantages partaking in the study.

A chief professional nurse at your hospital will act as mediator and give you a questionnaire, which takes about 30 minutes to complete. After the questionnaires have been analysed, and the resilient nurses identified, you may be requested to take part in the second phase and will be requested to write your story or partake in a focus group interview at the hospital or clinic, or a convenient facility of your choice to share your narrative of resilience with the researcher and this will take approximately one hour. The focus group will be recorded on a tape recorder and voice recorder and will be confidential between the researcher and her promoters. Your participation is voluntary and you have the right to withdraw at any stage if you wish to do so. The recordings will be erased after data-analysis. Your name will not be disclosed during the research or publication of the results.

Should you experience any mental discomfort or distress as a result of your participation, emotional support will be provided by the researcher who is an advanced psychiatric nurse.

You are kindly requested to complete the attached consent form to indicate that you are willing to participate in this research.

Thanking you in anticipation.

Prof. M.P. Koen

Prof. C. van Eeden

Prof. M.P. Wissing

APPENDIX D: CONSENT TO PARTICIPATE IN THE RESEARCH

RESEARCH TOPIC: RESILIENCE IN PROFESSIONAL NURSES

I, _____ hereby consent to participate voluntary in the above research project. The objectives, benefits, risks and obligations of the research are clear and I understand the implications of participation. I am willing to complete the questionnaire and understand that I may be contacted to write my story or to partake in a focus group interview that will be recorded by a voice recorder and a tape recorder.

Participant: _____

Date: _____

APPENDIX E: LETTER OF APPROVAL FROM DEPARTMENT OF HEALTH



HEALTH
DEPARTMENT:
HEALTH
NORTH WEST PROVINCE



2nd Floor Tiroto Building
Dr Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068

Directorate: Policy,
Planning & Research

Eng. R. Moseane
Tel: (018) 587 5780
Fax: (018) 387 5817
E-mail: moseaner@nwpp.gov.za

TO : The Office of Superintendent- General
North West Department of Health

FROM : Mr K Rabanye
Director: Policy, Planning and Research

DATE : 22 May 2009

SUBJECT : Resilience in Professional Nurses

The above subject matter refers

1. Purpose

To appeal for the final approval of a research study to be undertaken in the North West Province, Department of Health.

2. Background

The Principal Investigator Prof M.P. Koen of the above mentioned research study has requested permission to undertake the study in the North West Province.

The researcher has submitted all the necessary required documents and her protocol was reviewed by members of Provincial Health Research Committee. The reviewers recommended that the investigator be granted approval to continue with the study on condition ethics approval is submitted.

This project is a sub-study in the overarching FORT 3 project; therefore it is covered on with an ethics clearance number NWU (NWU- 00002-07-A2) under the leadership of Prof M P Wissing.

3. Aim and Objective

The objective of the study is to investigate the prevalence of resilience in professional nurses and identify these resilient nurses with the help of psychometric instruments.

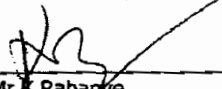
4. Financial Implications

There are no financial implications to the North West Department of Health.

4.1 Specific Action

4.1.1 The Chief Director to further recommend for final approval by the Superintendent General, Dr. L. K. Sebegu.

4.1.2 The Superintendent General to grant approval.



Mr K Rabanye
Director: Policy, Planning and Research

Recommended for approval/~~Not recommended~~

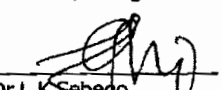


Mr Y.W. Mbulawa: Chief Director: Corporate Service
Final approval

Recommended for approval/Not recommended

Notes :

.....
~~Granted / Not granted~~



Dr L.K. Sebegu
Superintendent -General
North West Department of Health

APPENDIX F: ETHICAL APPROVAL FOR THE STUDY UNDER THE PROJECT OF PROFESSOR M.P. WISSING



NORTH-WEST UNIVERSITY
YUNIBESITHA YA BOKONE BOPHIRIMA
INDORWES UNIVERSITEIT

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Ethics Committee
Tel +27 18 299 1366
Fax +27 18 297 5308
Email Ethics@nwu.ac.za

28 August 2007

Dear Prof M P Wissing (*project leader*)

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC 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: The prevalence of levels of psychosocial health; dynamics and relationships with biomarkers of (ill)health in South African social contexts (FORT3). | | | | | | | | | | | | | | | |
| Ethics number: <table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>-</td><td>0</td><td>7</td><td>-</td><td>A</td><td>2</td></tr></table> | N | W | U | - | 0 | 0 | 0 | 0 | 2 | - | 0 | 7 | - | A | 2 |
| N | W | U | - | 0 | 0 | 0 | 0 | 2 | - | 0 | 7 | - | A | 2 | |
| Approval date: 3 August 2007 | Expiry date: 3 August 2012 | | | | | | | | | | | | | | |

Special conditions of the approval (if any):

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-EC:
 - 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-EC. Would there be deviation 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-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC 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-EC 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

A handwritten signature in black ink, appearing to read 'M Lowes', with a stylized, cursive script.

Prof M Lowes
(chair NWU Ethics Committee)

APPENDIX G: APPROVAL FROM THE AUTHORITIES OF DIFFERENT HEALTH FACILITIES (pages with signatures)

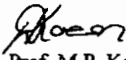
guidelines will be formulated to facilitate and enhance resilience and psycho-social well-being of professional nurses which will be made available to the hospital and college management and can assist in programs and in-service training of the nurses and serve to improve the quality of nursing care.

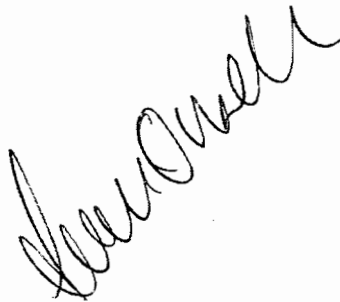
Ethical permission for this research has been obtained from the North-West University under the provision of professor M.P. Wissing (NWU-00002-07-A2).

Your prompt response in this regard will be appreciated so that the researcher can be able to make further arrangements.

For more information please contact the researcher at the following number: 073 207 2324.

Thanking you in anticipation.


Prof. M.P. Koen (researcher)



hospitals and the participants will not appear anywhere on the recordings or the report. The benefits of participation will be that guidelines will be formulated to facilitate and enhance resilience and psycho-social well-being of professional nurses which will be made available to the hospital management and can assist the hospital in programmes and in service training of the nurses and serve to improve the quality of nursing care.

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further arrangements.

For more information please contact the researcher at the following number: 073 207 2324.

Thanking you in anticipation.


Prof. M.P. Koen (researcher)

Permission granted.

*(Cambrecht)
Nursing manager.*

names of the hospitals and the participants will not appear anywhere on the recordings or the report. The benefits of participation will be that guidelines will be formulated to facilitate and enhance resilience and psycho-social well-being of professional nurses which will be made available to the hospital management and can assist the hospital in programmes and in-service training of the nurses and serve to improve the quality of nursing care.

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Your prompt response in this regard will be appreciated so that the researcher can be able to make further arrangements.

For more information please contact the researcher at the following number: 073 207 2324.

Thanking you in anticipation.



Prof. M.P. Koen (researcher)

approved 25.8.18


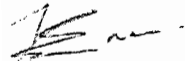
WEST WITS

12 May 2009

To whom it may concern:

I Felicity Geraldine Erasmus, Nursing Manager at AngloGold Ashanti Health (Pty) hereby grant permission to Prof. Koen to conduct her survey at our Hospital.

Yours faithfully



Mrs. FG Erasmus
Nursing Manager – Hospital and Periphery
AngloGold Ashanti Health (Pty) Ltd
Tel: (018) 788 8210
Fax: (018) 788 8301
Email: ferasmus@anglogoldashanti.com


names of the hospitals and the participants will not appear anywhere on the recordings or the report. The benefits of participation will be that guidelines will be formulated to facilitate and enhance resilience and psycho-social well-being of professional nurses which will be made available to the hospital management and can assist the hospital in programmes and in-service training of the nurses and serve to improve the quality of nursing care.


Ethical permission for this research has been obtained from the North-West University under the provision of professor M.P. Wissing (NWU-00002-07-A2). A letter has also been send to the Department of Health in Gauteng and North-West, requesting permission.

Your prompt response in this regard will be appreciated so that the researcher can be able to make further arrangements.

For more information please contact the researcher at the following number: 073 207 2324.

Thanking you in anticipation.


Prof. M.P. Koen (researcher)

Non Clinical
Approved
AT
EXCO


APPENDIX H: WORK PROTOCOL FOR DATA ANALYSIS (stories and focus group interviews)

Dear co-coder

Work protocol for analysis (open-coding) for the stories and focus group interviews

Please follow the following guidelines when analysing the stories and the transcriptions of the focus group interviews.

Important notes: The opinions of participants (words and themes) are the units of analysis. Look for statements/judgements that can be linked to the words: I/we feel, I/we believe, I/we think, I/we know, I/we agree, I/we recommend.

The level of analysis: focus on proximity analysis (recurrent opinions (concepts), and when affect is apparent (e.g. descriptive words, punctuation marks, metaphors) note these as well.

Guidelines:

1. Get sense of the whole by browsing through transcriptions/stories, asking: what is it about?
2. Keep the research objectives in mind, which are:
 - To explore the meaning of resilience for the participants, the request in the writing of the story being: How do you manage to stay resilient and compassionate in the nursing profession.
 - The interview schedule for the focus group interviews are attached
3. Read through the stories/transcripts, carefully identifying opinions by underlying/highlighting relevant phases.
4. Note opinions in the left margin, note own thoughts (relating to underlying meaning), affect as identified appropriateness of responses in right margin
5. Cluster similar opinions together to form columns.
6. Give descriptive names to columns to form categories and sub-categories.
7. Identify similarities in categories and sub-categories and re-group or reduce if necessary.
8. Write summary of own thoughts/impressions.

Please contact me if you need more information.

Regards

Prof M P Koen

APPENDIX I: EXAMPLES OF FIELD NOTES

FIELD NOTES FOR FOCUS GROUP INTERVIEW (primary health care clinic)

- All interviews held in language (English or Afrikaans) as preferred by group members.
- Interview schedule was available in both English and Afrikaans.
- Informed consent was obtained from all participants.

Descriptive notes

- 4 participants, all professional nurses, 3 English, 1 Afrikaans
- The setting was comfortable and private, and no disturbances during the interview
- 3 Black, 1 White
- 1 Male, 3 female

Reflective notes

- Relaxed atmosphere, all members eager to participate
- All the participants on time
- I started by giving them feedback on the progress of the study and they all showed interest on the prevalence of resilience in professional nurses
- I had to probe quite a lot at the start to get them to participate freely
- One member was very quiet but kept eye contact and was non-verbally nodding her head showing when she agreed
- Question 2 and 4 were very similar to them, however they did add new ideas
- I talked to much at the start of the interview to get them all involved, and will keep this in mind with the next interview
- They were very anxious that something useful must come from the guidelines from the study and expressed this during the questions on the guidelines
- It seems that it is important that hope is instilled
- They all mentioned that it was healing to voice their opinions
- It should be mentioned in the guidelines that it is healing to share their stories

Demographic notes

- Interview one at primary health care clinic
- The interview lasted 45 minutes
- The atmosphere was warm and nice for participation
- The setting was an office at the clinic at the mine at Driefontein.

FIELD NOTES FOR FOCUS GROUP INTERVIEW (private hospital)

Descriptive notes

- 6 participants, all professional nurses, all English speaking ladies
- The setting was comfortable, only one cell phone rang during interview
- All black
- All English speaking
- 6 Female

Reflective notes

- Atmosphere a bit tense at the start, as if they were a bit surprised about being in the interview, but after introduction and explanation everybody seemed happy and more relaxed.
- I gave them feedback on the progress of the study which served as a ice breaker
- I talked to much maybe to eager to get them all involved it didn't seem to be a problem, they all gave their inputs
- Giving them feedback on the progress of the study also proved useful and got them really focused and interested
- I had to probe a bit to get inputs from everybody
- All eager to partake and active in interview
- They said that they found it healing to partake in the group at the end of the group
- They all expressed the hope that something positive will come from the research
- They expressed their concern about the nursing profession.
- The healing aspect of sharing came up and should be included in the guidelines
- Hope was again expressed that shows the importance of instilling hope

Demographic notes

- Interview four at a private hospital
- The interview lasted 55 minutes
- The atmosphere was warm and relaxing
- The setting was a tearoom at the private hospital but proved to be very convenient.

FIELD NOTES FOR INDIVIDUAL INTERVIEW (primary health care clinic)

Descriptive notes

- Although I made arrangements for the interview, circumstances were very bad when I got there, 6 of the personnel gave notice, and the 24 hour clinic were left with 4 professional nurses, who were very upset and discouraged
- It was agreed that I have an individual interview with one of them so that the rest could carry on with the work
- I decided to stay because they were eager to tell me what happened and I carried on with the individual interview
- Things were so bad that when I phoned to confirm the appointment nobody answered the phone, and I tried over and over again
- Apparently there is a possibility of the clinic going to be moved or even closed which is causing uncertainty among the personnel
- I held the interview in Afrikaans on request of the professional nurse who is Afrikaans speaking

Reflective notes

- The atmosphere was tense and a bit sad because of what happened at the clinic
- The professional nurse who volunteered to participate found it hard at the beginning of the interview to express herself
- I had to probe quite a bit and repeat questions to get her attention
- At the end of the interview she said she felt better being able to talk about it
- The fact that it helped to share came out and will be included in the guidelines.

Demographic notes

- This was suppose to be a focus group interview with 4 professional nurses, however as explained the researcher had a individual interview with only one that was available
- The atmosphere relaxed a lot towards the end of the interview
- The interview was held in an empty office which was convenient and the only disturbance was somebody who came in to make photocopies.
- The interview lasted 30 minutes.

APPENDIX J: FOCUS GROUP INTERVIEW (part of transcription)

Interview 1: 45 minutes, 4 participants

Introduction was done

Informed consent was obtained

Interview schedule made available

R = researcher

P = participant (1,2,3,4)

R: Greeting and thanking everybody for willingness to partake and inviting them to share freely or ask if anything is unclear, clarify time available, started by introducing the first question: What does resilience mean to you?

P1: According to my understanding it means I get up and carry on with what I have to do even if it is a struggle, even if I am overloaded and the patients are so many to attend to, I persevere, mmm, like sometimes when it is hard, I force myself to do my work well. It is the will to carry on even when the work is hard. It means that I give everything of myself no matter what.

P2: Yes, it means I go out there and I give everything to my patients because they need me, I care for them and I have to be there for them, it is for them, it drives me.

R: So you are saying that the patients are your inspiration.

P2: Yes, yes, precisely, they keep me going.

P3: I pray to keep going and the going is sometimes very tough, and as they say because the clients need me, I will keep doing my best to meet their needs. You know it is not always easy, it can become a real struggle, and some days are worse than others, but I just get up and do it all over again.

R: Look at P4, nods and says she agrees.

P1: Yes it is about caring for the patients, being there for them and doing your best in the face of all the adversities, going out there with everything you've got and caring for them, not thinking of yourself. You know it gets very hard, we are only a few who have to keep up and some days it gets very busy we are running and we get so tired but you just keep going no matter what.

R: It seems that it boils down to caring for your patients, everybody agreed, anything else that you would like to add?

Everybody indicated no

R: Let's move on to the next question and you can add if you like when you think about something, how does resilience manifest in the work of a nurse?

P2: A nurse is somebody who gives, these people need us, and we have to care for them, and if we do that, I mean provide for those needs it also helps you, they feel good and happy and are thankful, which make you feel good. Like sometimes I feel so tired and one smile can energize me, to keep going.

R: So you feel appreciated, like you benefit from that.

P1: Yes in our work it is not about us, mmm, it is not what we need, it is all about the patients, it means now, no matter what you are going to meet the needs of the patients.

P3: A nurse need to be resilient in order to be there for the patients, you can't give up, you must be there for them, it isn't just a job, it is an important work, caring for your patients. I would say it is a very unique work, focusing on people.

P3: Yes, though it is hard, you do it.

P4: A nurse must be there for her patients, no matter what, a nurse must give to them, it is about taking care for people in need. Sometimes I ask myself why I am still doing it, why all of us (looking at others) are still doing it, it is just for the patients we care for them they need us.

R: It seems to focus on the care for the patients, anything that you like to add?

Everybody indicated no.

R: The next question is what would you say are hindering you in maintaining resilience?

Laughter

P2: It is managerial and financial, laughing, you are giving yourself totally, trying your best nobody even see it or thanking you, that's why we are losing so many good nurses, you know we all need money and everything is to expensive, at least if you work so hard you must get paid for it. It can't be a one way street all the time, they must give us recognition for all we are doing, all the hard work under difficult circumstances.

P1: You know even if you are resilient you need some driving force or motivation, if you have to worry at the end of the day or the month how you are going to make ends meet it is to costly, you can just lose it, so now this financial connotation is important, I have to live.

P3: I would say we are not recognized as a profession and they don't even appreciate us enough to pay us or recognize our inputs. What is expected from us to do on a daily basis and what we are paid isn't in line.

P4: Yes you work so hard and nobody cares and that is why so many nurses are leaving and we are sitting with all the shortages.

R: It seems that recognition is a great concern, whether it is from management, or financially.

Everybody agreed.

P1: I just want to add if you work so hard the task of management is to meet us halfway, provide people for the work and equipment that we need to do our work well, otherwise even the best of us can lose it and the patients can suffer, we are also human and must be able to stay resilient. You know I also have a family that I must be able to provide for, and life is getting more and more expensive.

P2: Yes, we need to survive, and staffing is a big problem, and nobody seems to care even if we complain, nothing changes, I don't know if they don't hear us or if they just don't care. There are not enough of us to do the work good all the time.

R: You are concerned about the quality of care that can suffer.

Everybody agreed.

R: Anything you want to add?

Everybody indicated no.

R: The next question is what is your opinion on the importance of resilience in professional nurses?

P1: It is because it is a calling, if it is not a call you won't be able to keep up with all the hardships, you really need to be passionate and show compassion for your patients, again I can say it is not just a job.

P2: Yes we need those values and remember the pledge to care for all the patients.

R: It seems as if you are referring to having a philosophy, or are value driven.

P3: Yes it is like we said if you don't really care for the patients you mustn't be a nurse, so a resilient nurse is a caring, compassionate nurse, doing the best for her patients, being there when they need you.

P4: Yes it is similar it boils down to taking care of the patients no matter what, you carry on and you do your best for them. It is what help me to get out of bed every day and come back to this place.

R: I will ask the next question and you can always come back and add, what do you think guidelines on resilience should include?

P1: I think it is like we said that we need to look at values again, the new nurses must realize the importance of caring for the patients, somehow the passion for nursing must be realized. The recognition that nurses deserve should also get attention and the management must realize the importance of it, like the money.

P2: Yes, all the stakeholders, like management must take note, and also maybe some skills training, sometimes we also battle to cope and I think continuous development is needed for all of us, and you know the new nurses are struggling and need to develop skills.

R: If you say skills what are you referring to?

P3: Like coping skills and maybe communication, and problem solving, or to manage stress, then they will maybe stay and not get so burnt out.

R: Any other ideas, they all indicated no.

R: Let's move to the last question, how, do you think guidelines on resilience should be introduced to the nurses or facilities:

P1: I think now that we have re-addressed resilience and the important issues we will have to be reinforced on everything, mmm, like in service training, but it won't help if all the stakeholders like management don't buy into it. If we revive the people the management must also be part of it, they must know about all the difficulties and take note so that they support it.

R: So you are saying they must be involved.

P2: Maybe it must come back as a program, or in service training, but like once a month, it must become an ongoing thing where ideas and thoughts can be shared, and concerns can be voiced, and things like team building can be done.

P3: That will also help because we can ventilate and support each other.

P4: We must maybe also not always do it in a formal way but in a fun way over lunch we can discuss, even if can be like a meeting where we can talk and be heard.

R: Support and motivating each other in this seem to stand out.

P1: Something will also have to be introduced to the patients they have a bad attitude, how can I say they don't even respect us and if we can make them aware of the impact their attitude have on us it will be good and add.

APPENDIX K (EXAMPLES OF WRITTEN STORIES)

RESILIENCE

How do I manage to stay resilience in the nursing profession?

Life is a dynamic process, not one day is the same as the previous day. We must be willing to change and except change or disappointment, it does not mean that we must not stand up for our selves or our principals. You must stand up for what you believe in and for that what is rite.

When growing up we learn from our parents and the examples they set for us. Pears also influence us and our Christian upbringing is a good foundation, it is easier for us to cope with life's challenges and disappointments when we are well adjusted.

It does not mean that you will always be treated fairly or that everything will always go your way. We will more often be disappointed or treated unfairly than what we would expect.

We are all disappointed in the attitudes of the newly qualified Professional Nurses, it appears as if they are there because it is a job that pays but they do not care or have any compassion for the patients. Essential services that have the right to strike, something is wrong in our contrary.

All this is enough to make you feel like throwing in the towel. This is where your inner strength must come out and you need to grab the bull by the horns. In your working environment do what you think will make a difference. What you do, do it to the best of your abilities.

At the end of the day you must answer to your conscious and if you can do that you have contributed something to someone. I believe we must also have trust and believe in God. He will undertake in his own way and work miracles where we cannot see thing happening.

With a positive attitude everyday you will get more done and with a smile you will get more out of others. We must be thanking God for every day that he has given to us and make the most if.

HOW DO I MANAGE TO BE RESILIENT AND PASSIONATE

Above all, through the Grace of God. I pray every day and at all times when faced by problems asking God to give me the strength and peace and to guide me as I go through doing my job.

My passion for nursing started when I doing matric. We had a reading book that talked about a doctor and a nurse who was very passionate about their job. I could then visualize myself as this nurse and I would go about calling myself by her name. After matric I wanted to do medicine but could not due to financial constraints, my next best option was then nursing.

I came into nursing because I've always had a passion to help others, and as I did my training as a nurse I found that I enjoyed talking to patients and found fulfillment when patients got healed and were discharged. I consider myself as a very caring person though at times "too caring for comfort" so, I enjoy assisting and helping others and I get satisfaction and gratification from seeing others being happy that I could help. Training as a nurse then equipped me with the necessary skills

At times it is very hard and frustrating, one feels like "throwing in the towel" but when one thinks about the helpless patients that depend on us to facilitate their healing process, one just continue for their benefit.

Psychiatric training really empowered me and made me a better person than I was. Learning about human behaviour strengthened my passion for caring and equipped me with the necessary skills to endure most hardships. I'm able to look at problems as challenges and face them head-on. I was able to learn to listen and assess the whole problem in an objective manner.

My philosophy in life is to treat others as I would like to be treated, thus when I am confronted by a problem, I ask myself as to how would I have liked to be treated, and this enables me to be compassionate and understanding.

My love for nursing is not primarily about money but the love and the sense of being of value to others and to be able to make a difference.

HOW DO I MANAGE TO STAY RESILIENT AND COMPASSIONATE IN THE NURSING PROFESSION

I believe happiness and thankfulness is a choice, I strive to make the best of everything I do. The profession hasn't always been good for me, there is so much unfairness and it hasn't been a well paid job. I have studied many years to get my qualifications and am carrying many responsibilities often doing the job of unthankful doctors who are getting paid and are hardly never available for patients.

Management hasn't been supportive and professional nurses are having a hard time coping with the ever increasing demands. It seems as if patients are getting sicker and the nurses to do the work in a caring way are getting less. It is also a problem to do the work in the current environment as it isn't always clean and not all the resources are available leading to many frustrations and unhappiness.

The work I have been doing for my patients however have been rewarding and makes it worthwhile even when I am tired and trying to manage with all the roles I have to play, one smile a day from a thankful patient or family member make it worth my while. The nursing environment has change a lot and keeping going takes a lot, I have learned to cope with difficulties, I don't give up and set short term and long term goals that helps me to focus.

God has been my strength and power and by His grace I manage to do my work in a compassionate and resilient way. I also learn from my mistakes and struggles and I believe I am getting stronger. I also live a balanced lifestyle doing a lot with a loving supportive family which means a lot to me. I believe in continuous development and believe this is also helping me to focus.

I try to do other things that is important to me, I read a lot, spend time with my dogs, I also try to keep fit only if I can manage to build in a walk with the dogs.

I am concerned about the nursing profession and believe that it is important that I play my small but I believe important part not giving up and fighting for my patients. I think the fact that I have been raised by loving parents providing me with principles and guidelines for my life has contributed a lot so that I do things in a disciplined way.

I have learned a lot from other nurses who were real role models who never seemed to waver and kept going and I hope this study will help to provide guidelines to other struggling nurses. I have also learned and gained much from patients who in the face of terminal sickness and death could manage to laugh and spread happiness fearless and loving.

The journey isn't always easy but it is worthwhile and I am on my way.

Thank you.

How I manage to stay resilient and compassionate in the profession

I believe it is because I never give up, I had a lot of heartache in the profession and not everything was good and uplifting, but I am prepared to learn from my mistakes and I always try to do things better, reflecting back and trying to answer this question made me realise that most people and specially nurses probably have a story to tell and don't even know it. If I have to try and share my story it will be mostly about my patients and their heartache or thankfulness when they get better that is making me strong and thankful to be blessed and healthy in a position to care for others.

I still believe that the nursing profession is a calling and it can be so rewarding to be in a position to help and care for others even if it is only to listen to their stories when hope is gone, being there when it is dark and the pain is getting too much. Praying for or with a patient or family member for a dear one, trying to be strong if I also feel as if there is no more hope.

Laughing and crying with fellow nurses when we are tired or disillusioned, or when a patient who we thought will never make it gets better. The fact that I often have to be strong for others have made me strong, coping with difficult situations and often feeling that I can't put one foot in front of the other, yet still walking and being there for my patients.

The disappointments ate hard to deal with and I only pray that those who are caring will stay and make a difference standing for what we believe in and be responsible professional nurses, being role models to new nurses and sharing our experiences and stories with them, hoping that they can benefit from it.

I also believe that I learn everyday as I have to deal with a lot every day getting stronger and more skilful, planning better and

learning to avoid stumbling blocks, setting goals and staying hopeful and optimistic believing in the fact that I am making a difference in my patients life.

I also try to live a good life, making time for my family and friends, and doing other things to keep my mind positive and healthy.

Be a blessing and be blessed.

How you manage to stay resilient and compassionate in the profession.

- To stay resilient and compassionate is a **choice** that I make on a daily basis, especially in an environment where most of the nurses suffer from burn-out syndrome or compassion fatigue.
- Try not to get isolated from peers, classmates (with whom you had wonderful times) and other positive individuals in the profession. Reach out to other resilient and compassionate nurses. Share ideas, discuss trends, brainstorm problems to find solutions.
- Stay updated on important developments in the nursing profession. Attend congresses, workshops, etc.
- Don't get isolated from the clinical field. Stay updated on issues in your field of expertise.
- Keep on growing in the profession by developing yourself. Do not wait for others to initiate your development. Look out for new opportunities- sometimes they come in the form of retrenchment or disappointments
- Identify your sources of psychosocial support at work and use them whenever you feel discouraged. We as nurses need a lot of debriefing after the death of a patient to combat feelings of guilt or a sense of failure.
- Read biographies of great nursing leaders to stay inspired to make a difference.
- Create opportunities to have fun at work. Organise special awareness campaigns, competitions. Try to involve other nursing leaders and experts to add glamour and value to these events.
- Always have a challenge that keeps you motivated. Nothing breaks you down like routine and averageness. Strive for excellence and it will lift you to a next level of motivation.
- Always have a vision on how to motivate others at work to also stay positive. Never underestimate the power of positive thinking.
- Empower nurses in daily contact with you.
- View problems as challenges, not as obstacles.
- Celebrate your victories and mourn your failures.
- Have a dream. Be a trendsetter. Be creative at work..
- Set **reachable** objectives on a monthly/ weekly/ daily basis. Nothing kills compassion more than feeling of being a failure.

- Say “no” when overburdened. We as nurses should not allow other members of the medical team to abuse us as that will make us negative and kill our compassion.
- Be **visible** as a nurse in your area of responsibility. Don’t get intimidated by members of other professions. Don’t view being a nurse as inferior. Be proud of your nursing background., as it taught you a lot of problem-solving, leadership, resilience.
- Reflect! Reflect!

How do I manage to stay resilient/cope in nursing profession.

The workplace can be a difficult place for both very experienced and less experienced nurses regardless of the environment. Nurses navigate their way in the workplace through a series of complex negotiations with each other and deal assess the potential success of an interaction before approaching another. I also developed resilient to conflict workplace, accepting it as part of work life.

Creation of a more positive work environment requires increase understanding of the way nurses relate to each, appreciation of the factors in the environment that contribute to conflict and negative atmosphere. This appreciation is an appreciation to developing a more satisfying and productive workplace.

- I have to identify a sense of meaning and purpose
- Analyse my skills, values and career motivators
- Re-claim skills and interest that have been neglected.
- To look at my life and career in a holistic and integrated manner.
- To identify and deal to blocks and barriers getting in the way.
- Live a balance and quality life.
- Appreciate my life journey right now.
- To tap into and harness my spiritual intelligence.

Resilience in the Nursing Profession. Why I stay in the Nursing Profession.

I often ask myself this question. The answer is that nursing is what I want to do. It is what I am trained to do, and it is what I do best. It has shaped who I am and opened many doors for me. I can't visualise myself doing anything else, especially not at my age (fifty two years old). I also get a tremendous amount of job satisfaction. Nursing is a meaningful profession. Helping people and making a difference in their lives is so rewarding. I am not as resilient as you may think, and I am feeling the pressures this profession is facing in South Africa. I am also not happy with the crime rate, politics, work load and much more. No matter how hard some of us work, and try and remain positive and find ways to cope, I feel we are on a downward slide. If I am honest with myself the only thing that motivates me is money.

At this stage of my life I need to earn as much as I can, so that I can save, rather to stop working as a registered nurse in South Africa or to immigrate to another country and to work there in the Nursing Profession.

How Do I STAY RESILIENT IN NURSING PROFESSION?

My everyday philosophy is that I believe that I'm here on earth for a purpose. My purpose in the nursing profession is to help those who are unable to help themselves in the best possible way that I can. That is one reason I use as a coping mechanism.

The second coping mechanism that I apply and have maintained for years is that nursing to me is a calling. Even in the most adverse conditions, this rule has been upheld and maintained.

Spiritually and emotionally is the third ~~main~~ factor that has given me the resilience to keep on working as a nurse. One becomes spiritually fulfilled when I manage to see a patient who is critically ill, recover and come back to say "thank you" to the health team.

Although it is difficult to at times to cope with an adverse situation like for example poor resources, shortage of human resources, positive comes out of such situation like gaining knowledge, experience and encouraging other nurses to be resilient.