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## NURSE LEADERS' EMOTIONAL RESPONSE AND COPING MECHANISMS WHILE CARING FOR YOUTH VICTIMS OF VIOLENCE AT A COMMUNITY HEALTH CENTRE

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### **ABSTRACT**

*Violence continues to take its toll on post-apartheid South Africa and the youth remain the most affected group of many communities. Youth, more and more, visit community health centres to seek health care with a subsequent increase in workload for nurse leaders at these facilities. It was unclear how nurse leaders experience caring for youth victims of violence at a community health centre. A qualitative, descriptive and contextual design was used. A purposive and snowball sampling led to nine nurse leaders, working at a community health centre, being interviewed. Teschs' descriptive method of open coding was used for data analysis. The findings revealed challenges faced by the youths, however, also rewarding experiences. Nurses revealed some emotive responses and different coping mechanisms to deal with these emotions. Understanding these emotive responses and coping mechanisms used will help develop guidelines to support nurse leaders in community settings.*

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**Keywords:** emotional response, coping mechanisms, youth, victims, nurse leaders, community health centres

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## **INTRODUCTION AND RATIONALE**

Violence is a leading cause of death in South Africa. Every year, an estimated 3,5 million people seek health care for non-fatal injuries, of which half are caused by violence (Seedat, Van Niekerk, Jewkes, Suffla and Ratele, 2009). Physical injury and violence also have an increased risk of psychological and behavioural problems. Decades of violence during the apartheid era have normalised the use of violence as a first line strategy in resolving conflicts, with youth violence being particularly high in South Africa (Norman, Schneider, Bradshaw, Jewkes, Abrahams, Matzopoulos and Vos, 2010).

The primary health care blueprint adopted by the ANC in 2006, envisaged a nurse-driven practice based on the district health system, improving access to health services. The government also introduced a hierarchy of care where patients should be attended to at community health centres and clinics before being referred to secondary hospitals, except in cases of medical emergencies (Cullinan, 2006). This has placed a greater responsibility on professional nurses as nurse leaders, who are the forefront in the provision of health care at these facilities. They are pivotal to optimal operation of the units that should deliver excellent patient care (Schmalenberg and Kramer, 2009).

Nurse leaders at community health centres are the first work station where clients in the community stop; their services include preventative, curative, and counselling services (O'Mahony, Wright, Yogeswaran and Govere, 2014). They thus play an essential part in transforming the nursing profession and current health system that serve the people (Carter, Martin-Misener, Kilpatrick, Kaasalainen, Donald, Bryant-Lukosius, Harbman, Bourgeault and DiCenso, 2010). They have a huge responsibility and major role in the health system; from patient care, decision making, taking responsibility and being change agents (Jennings, 2008). This puts a lot of pressure on them. There are different coping mechanisms to deal with stressors. The coping mechanisms used are determined by individual appraisals and perceptions on the care needed for youth victims of violence. Adapting to strain and hardship is part of human development. Coping is that process whereby humans orient their thoughts and emotions towards resolving sources of stress, by managing their emotional reactions (Compas, Connor-Smith, Saltzman, Thomsen and Wadsworth, 2001).

Nurses require encouragement to sustain adequate resources of inspiration to be and productive. Stress is an inevitable part of caring and hence support structures are important to help nurse leaders to have a better quality of work life (Van Wyk and Pillay-Van Wyk, 2011). The health sector has an important responsibility in availing services not only to assist victims of violence, but also for providing support to nurse leaders (Krug, Mercy, Dahlberg and Zwi, 2002).

## **PROBLEM STATEMENT**

Nurse leaders have the responsibility of caring for victims of violence and hence become secondary victims; who experience stress symptoms while attempting to assist victims (Bride, 2007; Bride, Jones and MacMaster, 2007). Working with victims threatens emotional balance while creating negative feelings. This can cause devastating tiredness, pessimism and annoyance as well as a feeling of hopelessness (Mijakoski, Karadzinska-Bislimovska, Basarovska, Stoleski and Minov, 2015). Very little information is known on how nurse leaders deal with their experiences and emotions while managing the youth. Understanding their emotions and how they cope in their care for youth victims of violence,

will inform guidelines to support nurse leaders, thereby improving quality of care to the community.

## **RESEARCH DESIGN**

A qualitative, exploratory, descriptive and contextual design was used. A qualitative design was used because it answered the research question in terms of understanding the experiences of nurse leaders caring for youth victims of violence. An exploratory design was used to understand the nature of the participants' world and gave room for collection of information from spontaneous interactions and observations (Martin and Hanington, 2012). A descriptive design gave a detail description of events and outcomes (Houser, 2011). The use of a contextual design assisted the researcher to gather intensive data for understanding the needs, intends and processes followed by participants (Margaria, 2010).

### **Population and sampling**

The accessible population were nurse leaders working as professional nurses at a community health centre in the Western Cape. Purposive and snowball sampling was used. Purposive sampling enriched data, by only selecting participants who had the experience, characteristics and understanding of the phenomenon under investigation. The initial sample was selected by the facility manager, as those with experience in caring for youth victims of violence. Each participant then referred the researcher to a potential participant. The sample size of 9 participants was selected based on data saturation, when no new themes emerged, and data became repetitive (Macnee and McCabe, 2008).

### **Data collection**

Initially, two individual pilot interviews were conducted as they guided the researcher on the feasibility of the study as well as the interview structure, alerting to potential problems with methodology (Thabane, Ma, Chu, Cheng, Ismaila, Rios, Robson, Thabane Giangregorio and Goldsmith, 2010). The nine individual unstructured interviews were held in a quiet private room at the clinic and took around 45 minutes each. Unstructured interviews gave participants the opportunity to express themselves more openly (Flick, 2014). A voice recorder was used and observational field notes also formed part of the data collection process.

### **Data analysis**

Tesch's (1990) method of open coding was used for data analysis, a process of examining raw data in the form of words, phrases, sentences or paragraphs and codes assigned to these elements (Saldana, 2013). Data triangulation was done which required the consideration of all sources of data; namely the interviews and field notes of the perspectives, pre-conceptions, emotions and experiences undertaken during the research process that increased the study validity (Guion, Diehl and MacDonald, 2011).

### **Ethical considerations**

Ethical approval (Reference 12/5/17) was obtained for this study from a university in the Western Cape, as well as the Department of Health in the Western Cape. Participants signed a written informed consent before the interviews were conducted, that indicated their willingness to participate (Bryman, 2012). The informed consent document covered an

explanation of the principles of privacy and confidentiality, self-determination and anonymity. Participants had the choice to participate or not. Participants could withdraw from the study at any time when they felt uncomfortable (Stangor, 2014). Participants were informed that information collected, would be analysed and reported anonymously and that participants could not be identified in any of the research data.

### **Rigor**

Rigor is associated with the value of research outcomes and studies are critiqued by means of judging their rigor (Burns and Grove, 2005). Rigor was measured by credibility, transferability, dependability, confirmability and applicability (Lincoln and Guba, 1985). Credibility and dependability were achieved through prolonged engagement, persistent observation in the field, member checking, as well as data triangulation. Data collection continued until saturation was reached; this was critical for applicability (Keele, 2011). Dependability was achieved through coding and recording of data by the researcher and independent coder. Confirmability was achieved through participant validation; member checking and triangulation to ensure research findings were the participant's perspective (Obiakor, Bakken and Rotatori, 2010).

### **FINDINGS**

Caring for youth victims of violence was a personal experience that was both challenging and rewarding. Participants experienced caring for youth victims differently; different emotive responses emerged in the study. Nurse leaders caring for victims of violence reported routine contact to verbal and physical aggression, with inevitably psychological consequences (Adriaenssens, de Gucht and Maes, 2012). In caring for youth victims of violence, nurse leaders were indirectly traumatised. It is possible to be traumatised by indirect exposure during interaction with trauma victims. This is referred to as secondary traumatic stress. It includes feelings and behaviour that a person is familiar with due to being acquainted with others' painful experiences (Rueden, Hinderer, McQuillan, Murray, Logan, Kranner, Gilmore and Friedmann, 2010). The participants used different coping mechanisms to deal with their experiences.

Table 1 outlines the main themes and categories that guided self-coaching strategies as an outcome from the empirical data collected.

### **Presentation of Results**

**Table 1: Themes and categories**

<b>Themes</b>	<b>Categories</b>
Emotive responses in relation to caring for youth victims of violence	Demotivation Fear Sadness Anger
Coping mechanisms that are used by nurses caring for youth victims of violence	Faith in God Self-motivation Support from colleagues Rationalisation Suppression

## Emotive responses of nurses caring for youth victims of violence

### Demotivation

Demotivation talks about particular external strengths that reduce the underlying positive basis of an act (Dörnyei and Ushioda, 2011). Participants reported many factors that demotivated them in their care of youth victims.

Salaries of nurses in South Africa have been a constant problem for the nurses, many nurses complained about the salaries they earn compared to the number of hours put in:

*“Those that are trauma trained, they have trauma allowance. Being traumatised, they get paid for that. Trauma situation is always traumatising. I don’t get paid in this situation but am also traumatised....if we get paid of working in this situation, it won’t change the situation, but that motivating something that you are compensated, working in this condition helps” (P6).*

*“...my dear honestly as I join this career, I though it’s really, a career that is respected, honestly it’s not a respected career because the wages we earn compared to ward clerks as I gave you the examples, I don’t see myself like am respected. How wish I can demand to be respected in terms of salary” (P7).*

A participant indicated the disrespect shown to nurses:

*“They shout at us, some of them they make you feel as if your work is not appreciated. Some of them come in a very bad state and not orientated, we struggle and put up the drip and when he wakes up and is conscious, he ask where am I is it site B? They sigh ...aah, and just pull out the drip and walk away” (P3).*

### Fear

It is a distressing emotion that arises from, e.g. looming danger or pain; whether the risk is genuine or not; the sense of being scared (Collins English Dictionary, 2009).

A participant shared being afraid of her family: *“Sometimes if you came across, the patient like that you can’t even think well because you think this person can shoot me, how about my family...” (P5).* The setting is known for its violence with the youths involved as criminals as well as victims of violence (Ugur, 2012), and many of them visit the CHC. This creates a sense of fear among the nurses working there. If a person does not feel secured at work, productivity is hampered and subsequently the quality of care drops. Nurse leaders working in this community health centre expressed fear of becoming secondary victims in the hands of these youths as well as their families. Some of the participants had children who were of the same age as some of the victims and, hence, they lived with a constant sense of panic; *“what if it’s my child”*. Participants also stated:

*“...I feel very sad and scary man... in the beginning, I could not even stand it but now, its three years working here so, so its fine” (P4).*

*“...sometimes they come and they become rude you become scared also, may be now you go out, you go to the shop, what if I meet this person... sometimes you think oh... am not safe” (P3).*

Their responses emphasise the difficulty of concentrating on their jobs and giving their best when they were worried about their own safety. Under these circumstances, it was not easy to take care of another person. Some even feared that they might be attacked too, when they were outside of the facility.

### Sadness

Ekman and Friesen (1976) define sadness as a feeling of unhappiness or sorrow. Sadness occurs when we lose someone or something important. It turns our attention inward so that we can take stock and adjust (Bonnano, 2010). An individual experiencing hurt, may become subdued, and abandon others from their world. Participants expressed sadness while caring for youth victims of violence. They felt unhappy about what was happening with the youth:

*“Sometimes you feel... you don’t feel nice”* (P9).

*“You don’t see him here you see your son, your relative, you know... you know, it is painful really... it’s painful”* (P5).

It was difficult for a nurse, who was also a parent, to see another child in pain that was caused by violence: *“I can take it like if it was me. It can be me, maybe am coming from work and then, the station and then somebody can come and... and stab me or gunshot me or it can be my child that is why I feel sorry for them, I sympathise with them as it can be my child and it can be me also”* (P7). From an African perspective, a child belongs to the community and a neighbour’s child is your child too (Jegede, 2009). This caused a lot of pain and sadness as they view every young victim as a concerned parent:

*“My lowest point, the lowest point of me is that, when am looking at them, it reflects back to me that am having same age like these”* (P9).

Participants also verbalised disappointment when abused ladies still decided to return to their perpetrators. Unfortunately, the victims had the final say and sometimes they made wrong choices. It really affected nurses, as they felt it was beyond their control: *“It was painful for me, looking at her, looking at the bruises, looking at the scars (sigh), because she was not only stabbed underneath but she had cuts and the bruises also and the face was swollen né, eyes blue, but eh the lady wants to go back to the man and in that kind of case you can’t side”* (P7).

### Anger

Participants voiced a feeling of anger when they were faced with very disrespectful youths. The youths displayed no respect for those older than themselves: *“When you look yourself you say am a mother but they you don’t have that respect... They are these young and you are this old, sometimes you just want to clap”* (P5).

Another thing that worried the participants was the fact that the victims were very knowledgeable about the law and sometimes used this to their advantage. They sometimes tauntingly told the nurses what their rights were and what the nurses were obliged to do: *“Some of them come in a very bad state and when they recover through your effort, they later say they don’t want to be here and it’s their right to go”* (P7).

Some of the victims were brought to the facility under duress, when recovered, they could get up; gather their things and leave – sometimes during the course of treatment – with the excuse that they had a right to refuse treatment. Such actions made the efforts of the nurses worthless.

### **Coping mechanisms used by nurses caring for youth victims of violence**

The study revealed different coping mechanisms used by participants. More than one was used by the different depending on the experience. The coping strategies are described below according to the sub-categories.

#### **Faith in God**

Religion and spirituality continue to play an important role across many cultures. It is not surprising that this has a huge effect on many people across different phases in life (Rosmarin, Bigda-Peyton, Kertz, Smith, Rauch and Bjorgvinsson, 2013). Faith is developing shapes of conviction that directs true living and offer meaning to the current situation of inter-relating (Dyess, 2011). Religion made sense for the situations life presented:

*“...am a very religious person, I think that also helps me because there quotations from the Bible I use every day and there are stories in the Bible né , there were Josephs then and there are still Josephs today né, there were Elijahs then and there are still Elijahs today né, some may be the Samsons, some may be the Delilahs, but we are one né, so I have to choose one character that I have to live with from those heroes and the heroines” (P1).*

*“...hmmm, you just pray to God and say oh dear God just take me through” (P6).*

Those participants grounded in faith use religion as justification for their self-sacrifice and personal commitment in caring for youth victims of violence (Swidal, 2008).

#### **Self-motivation**

Motivation is a pervasive and important determinant to behaviour, being the instigation and direction of behaviour. It is a theoretical construct that symbolises the intentions for ones acts, wants and wishes (Elliot and Covington, 2001). Individuals are seen as self-governing entities with a unique design of internal characteristics (Markus and Kitayama, 1991). Self-motivation is the need to find new things, and to know one’s capabilities (Deci and Ryan, 2008). Nurse leaders used self-motivation as a coping mechanism, despite the challenges experienced.

Self-motivation helped a participant to remain focused; drawing from her inner strength: *“...am motivating myself from inside because I don’t know what awaits me at the centre where am going to” (P1).*

According to Ntoumanis, Edmunds and Duda (2009), a person who faces a stressful situation will compare the imaginable personal applicability and its effect on esteemed personal objectives. One participant stated: *“I think it’s still up to me of telling myself each and every day I wake up from my house, it’s still in my heart to tell me let me go see who needs help” (P6).*

The goal of the nurse leader was to provide care; hence, they made conscious decisions to care despite the accompanying challenges.

### **Support from colleagues**

Support is the active participation of significant others to manage stress (Chambers, Ryan and Connor, 2001). Nurse leaders identified that support from colleagues helped them to cope with their work environment. This support among the staff members, served as a motivational factor in a stressful work environment (French, Du Plessis and Scrooby, 2011). Having social support assisted them to manage task-related stress: “... *like working with people am working with... you have a room to go and share whatever even if it is a personal experience. Their ears are always listening*” (P1).

Another participant stated: “*Sometimes our senior colleagues really help us, they treat us as family especially during difficult situations at work*” (P4). Depending on each other, it is very important as it allows pressure to be shared (Van Zyl and Du Plessis, 2012). It has been shown that social support relieves stress and creates a sense of self-worth and trust.

### **Rationalisation**

This is when a person is compelled to act in a particular way while convincing themselves that they are doing the right thing (Van Zyl and Du Plessis, 2012). It is the process whereby individuals try to describe their acts with logical explanations (Oxford Advanced Learner’s Dictionary, 2015). Nurses used rationalisation as a coping mechanism when faced with stressful situations that arised from caring for youth victims of violence:

“...*it is not nice to work here with this situation but we have to work because am a nurse and I promise to do my work (laughing) so I have to do it, have to. I have to tolerate and I have to take this, I have to accept as it is*” (P4).

They considered it as a part of the job and, hence, had to accept it without any reason to complain:

“...*you know you are a nurse and you have to serve the patient because you have to see the patient*” (P2).

“...*it’s very bad but we have to tolerate them, just as it is, we have to admit because we said we are going to, we have to care for the patient no matter what. We are here for the patient so we don’t have to refuse that*” (P9).

They asked questions like ‘*if they don’t do it, who will?*’ No matter what situation they find themselves in, providing rationales for the stresses they are exposed to had little positive effect on their emotional wellbeing.

### **Suppression**

This is when a person tries to manage uncomfortable feelings and thoughts by avoiding thinking about them. Individuals prefer not to engage or talk about distressing feelings or thoughts (Dombeck and Wells-Moran, 2006).



A participant mentioned the conscious exclusion of unacceptable thoughts or desires: *"Yeah, I try to hide those emotions"* (P9).

It explains the trend to hinder the demonstration of negative moods to overcome that one's positive self-confidence be damaged (Garssen, 2007). Participants used suppression as a way of coping: *"...no it doesn't affect, because am working long hours, mos [sic] né. Sometimes I just arrive at home and it has disappeared"* (P3).

They were reluctant to talk about their work experiences, and suppression could lead to the progress and continuance of post-traumatic stress disorder (Amstadter and Vernon, 2006).

A participant stated: *"When you get home and sometimes I don't feel even like talking and you just wanna [sic] go and sleep"* (P5).

Suppression is not a good coping mechanism as sometimes the emotions are projected onto another person (Garssen, 2007). This was supported in the study as participants mentioned that they became overprotective of their own kids and their relationships with their partners:

*"..., it's the stabbing that affects me at home really, I don't even want my children to go out, more especially when its dark, I don't want them, so they think maybe they think mama is crazy"* (P5), and

*"...it affects my relationships, am very careful, each and everything my partner does, I always analyse"* (P1).

Suppression is generally seen to be inactive, still even if emotions are suppressed, it returns in another format (Garssen, 2007).

## **DISCUSSION**

Nurse leaders experienced a range of challenges while caring for youth victims of violence. They used various coping mechanisms to counteract challenges and experienced a range of emotions. Many of the coping strategies used by these nurses were primitive coping mechanisms and not very effective as a long term strategy. Although nursing schools taught nurses healthy coping strategies, refresher courses are needed. Primary health care settings should have social workers who are experts in dealing with social and psychological issues. Anger control skills and stress management skills could be valuable for nurse leaders. It is important to establish support groups for nurses to help them cope in their work environment.

### **Debriefing and counselling**

Debriefing strengthens relationships and is essential for nurses (Sundheim, 2015). It is very necessary for nurses to have debriefing sessions after every stressful or traumatising situation, and also to deal with those emotions that arise during the caring for youth victims of violence. Debriefing also meets the needs of people, who are not directly affected (Raphael, Meldrum and McFalane, 1996). Nurses expressed their need for support in coping with the challenges they were encountering at work. An internal employee assistance programme should be established for debriefing personnel after a traumatic

incident. It is important to have an internal programme as research has shown that external programmes might have limited value to the employees (Magyar and Theophilos, 2010). Discussions and professional debriefing methods should be taught to student nurses during induction to a unit and regularly thereafter during their academic programme to prepare them for future challenges and traumatic incidences.

### **Improving the work environment**

There should be open communication and frequent meetings to inform staff of challenges. Nurses' reported that their complaints were not readily attended to, therefore, nurse leaders should attend to problems that arise at the work and deal with as quickly as possible. When cases are reported, feedback is needed to solve matters. Demotivation that results from a lack of feedback to nurses should be minimised by the nurse leaders taking responsibility to follow up investigated cases. It is also important that staff members are supported timely and comprehensively when a crisis arises. The sooner an intervention takes place, the better the outcomes for the nurses. Dealing with staff should be handled in a responsive and caring manner. People are different and, therefore, react differently to situations. It is important to understand staff and handle situations in a careful and sensitive manner. Psychological guidance and counselling are important to nurses after they have been exposed to traumatic events (Adriaenssens, et al., 2012), hence, management should assume the responsibility of ensuring that the nurses have access to these services. It is also important for management to understand their staff members individually and high risk individuals should be identified for follow-up purposes. Creating a favourable environment where nurses can debate painful events and gain an understanding around their circumstances, to act effectively in the workplace at all times.

### **Support structures for nurse leaders**

Having a strong peer support group to address challenges with colleagues have been found to assist with the strong emotions that could be experienced (Adriaenssens et al., 2012). Reliable professional relationships are necessary due to the daily stressors that nurses are exposed to at work. Once a great team cooperates, members are able to rely on one another. When staff works in a team and have good relationships, it lessens work pressure and increases productivity. Support from colleagues is important as they should be there for each other. From the study it is evident that nurses relied on each other for support, therefore, this should be encouraged and fostered. Provision of a multidisciplinary forum where nurses are able to discuss challenging emotional and social trends, that may arise while treating youth victims of violence, should be encouraged.

Nurses should endeavour to create a work-life balance, by creating opportunities for de-stressing by means of team building programmes and also having confidence in one's own abilities. Training should be done to increase a sensitivity around managing situations at work that cause stress, and ways to reduce stress. Work pressures should be recorded and reported such as, rigid rules; especially during the nights and weekends where most of the violence takes place. Combatting stressful events should be a priority, for example, during busy times of the year that place heavy demands on staff such as festive seasons. Also to ensure that adequate health and safety checkups are undertaken. An established reporting system could support the protection of nurses, and alleviate fear that is associated with victims of violence, escorts, or family members.

## Referral of youth victims

Victims seen are mostly due to physical violence, but with physical violence comes emotional and psychological impacts. Therefore, it will be good to do follow up referral for these youths in terms of counselling and support services. This will help reduce the incidence and prevent the cycle from recurring.

## LIMITATIONS

This research was conducted at a community health centre in Khayelitsha, where most of the nurses working there speak predominantly isiXhosa with English as a second language. The researcher was a non-isiXhosa speaking person hence communication with some participants was slightly strained, since they found it challenging to fully express themselves in English which is their second language.

## CONCLUSION

This study provides grounds for further research on experiences of nurses caring for youth victims of violence and in developing support structures for these nurses. The specific coping strategies mentioned were emotion-focused, which is the altering of one's interpretation of circumstances.

There is great evidence from previous work to support the theory that nursing is a very stressful profession. Work done on different categories of nurses working in different departments all seem to expose similar stressors for nurses, be it staff shortages or workload (Yildirim, 2009). It is, therefore, vital that nurses employ effective coping mechanism and support structures to prevent burnt out, projection and to stay motivated in their care for youth victims of violence.

## REFERENCES

- Adriaenssens, J., De Gucht, V. and Maes, S. (2012). "The Impact of Traumatic Events on Emergency Room Nurses: Findings from a Questionnaire Survey" *International Journal of Nursing Studies* 49:1411-1422.
- Amstadter, A.B. and Vernon, L.L. (2006). "Suppression of Neutral and Trauma Targets: Implications for Post-traumatic Stress Disorder" *Journal of Traumatic Stress* 19(4): 517-526.
- Bonnano, G.A. (2010). *The Other Side of Sadness: What the New Science of Bereavement tells us about Life after Loss* New York: Basic Books.
- Bride, B.E. (2007). "Prevalence of Secondary Traumatic Stress among Social Workers" *Social Work/Maatskaplike Werk* 52(1):63-70.
- Bride, B.E., Jones, J.L. and MacMaster, S. (2007). "Correlates of Secondary Traumatic Stress in Child Welfare Workers" *Journal of Evidence-Based Social Work* 4(3/4):69-80.

- Bryman, A. (2012). *Social Research Methods* London: Oxford University Press, Fourth Edition.
- Burns, N. and Grove, S.K. (2005). *The Practice of Nursing Research: Conduct, Critique and Utilization* St Louis: Elsevier, Fifth Edition.
- Carter, N., Martin-Misener, R., Kilpatrick, K., Kaasalainen, S., Donald, F., Bryant-Lukosius, D., Harbman, P., Bourgeault, I. and DiCenso, A. (2010). "The Role of Nursing Leadership in Integrating Clinical Nurse Specialists and Nurse Practitioners in Healthcare Delivery in Canada" *Nursing Leadership* 2010:167-185.
- Chambers, M., Ryan, A.A. and Connor, S.L. (2001). "Exploring the Emotional Support Needs and Coping Strategies of Family Caregivers" *Journal of Psychiatric and Mental Health Nursing* 8(2):99-106.
- Collins English Dictionary Complete and Unabridged. (2009). New York: Harper Collins Publishers, Tenth Edition.
- Compas, B.E., Connor-Smith, J.K., Saltzman, H., Thomsen, A.H. and Wadsworth, M.E. (2001). "Coping With Stress during Childhood and Adolescence: Problems, Progress, and Potential in Theory and Research" *American Psychological Association* 127(1):87-127.
- Cullinan, K. (2006). *Health Services in South Africa: A Basic Introductory* Johannesburg: Health e-News Service.
- Deci, E.L. and Ryan, R.M. (2008). "Self-Determination Theory: A Macro Theory of Human Motivation, Development, and Health" *Canadian Psychology* 49(3):182-185.
- Dombeck, M. and Wells-Moran, J. (2006). "Coping Strategies and Defense Mechanisms: Basic and Intermediate Defenses", <https://www.mentalhelp.net/articles/coping-strategies-and-defense-mechanisms-basic-and-intermediate-defenses> (Accessed on 09/09.2015).
- Dörnyei, Z. and Ushioda, E. (2011). *Teaching and Researching Motivation* Harlow: Pearson Education Limited, Second Edition.
- Dyess, S. M. (2011). "Faith: A Concept Analysis" *Journal of Advanced Nursing* 67(12): 2723-2731.
- Ekman, P. and Friesen, W. (1976). *Pictures of Facial Affect* Palo Alto: Consulting Psychologists Press.
- Elliot, A.J. and Covington, M. (2001). "Approach and Avoidance Motivation" *Educational Psychology Review* 13(2):73-92.
- Flick, U. (2014). *An Introduction to Qualitative Research* London: Sage Publication, Fifth Edition.
- French, H. Du Plessis, E. and Scrooby, E. (2011). "The Emotional Well-being of the Nurse Within the Multi-Skill Setting" *Health SA Gesondheid* 16(1):1-9. doi:10.4102/hsag.16i1.553.

Guion, L.A., Diehl, D.C. and MacDonald, D. (2011). *Triangulation: Establishing the Validity of Qualitative Studies* Gainesville, Florida: Cooperative Extension Service.

Garsen, B. (2007). "Repression: Finding Our Way in the Maze of Concepts" *Journal of Behavioural Medicine* 30:471-481.

Houser, J. (2011). *Nursing Research: Reading, Using and Creating Evidence* Sudbury, MA: Jones and Bartlett Learning, Second Edition.

Jegede, S. (2009). "African Ethics, Health Care Research and Community and Individual Participation" *Journal of Asian and African Studies* 44(2):239-253.

Jennings, M.N. (2008). "Work Stress and Burnout among Nurses. Role of the Work Environment and Working Conditions" in Hughes, R.G. (Ed.). *Patient Safety and Quality: An Evidence based Handbook for Nurses* Rockville (MD): Agency for Healthcare Research and Quality, Volume 1: Chapter 26, 671-692.

Keele R. (2011). *Nursing Research and Evidence-based Nursing* Montreal: Jones and Barlette Learning.

Krug, E.G., Mercy, J.A., Dahlberg, L.L., and Zwi, A.B. (2002). "The World Report on Violence and Health" *Lancet* 360(9339):1083-1088.

Lincoln, Y.S. and Guba, E.G. (1985). *Naturalistic Inquiry* Newbury Park: Sage.

Macnee, C.L. and McCabe, S. (2008). *Understanding Nursing Research: Using Research in Evidence-based Practice* London: Lippincott, Williams and Wilkins, Second Edition.

Magyar, J. and Theophilos, T. (2010). "Review Article: Debriefing Critical Incidents in the Emergency Department" *Emergency Medicine Australas* 22(6):499-506.

Margaria, T. (2010). *Leveraging Applications of Formal Methods, Verification and Validation* "4th International Symposium on Leveraging Applications, ISoLA 2010" Crete, Greece: Springer Publication.

Markus, H.R. and Kitayama, S. (1991). "Culture and the Self: Implications for Cognition, Emotion, and Motivation" *Psychological Review* 98(2):224-253.

Martin, B. and Hanington, B.M. (2012). *Universal Methods of Design: 100 Ways to Research Complex Problems, Develop Innovative Idea and Design Effective Solutions* Beverly MA: Rockport Publishers.

Mijakoski, D., Karadzinska-Bislimovska, J., Basarovska, V., Stoleski, S. and Minov, J. (2015). "Burnout and Work Demands Predict Reduced Job Satisfaction in Health Professionals Working in a Surgery Clinic" *Open Access Macedonian Journal of Medical Sciences* 3(1):166-173.

Norman, R. Schneider, M., Bradshaw, D., Jewkes, R., Abrahams, N., Matzopoulos, R. and Vos, T. (2010). "Interpersonal Violence: An Important Risk Factor for Disease and Injury in South Africa" *Population Health Metrics*. doi:10.1186/1478-7954-8-32

Ntoumanis, N., Edmunds, J. and Duda, J. L. (2009). "Understanding the Coping Process from a Self-determination Theory" *British Journal of Health Psychology* 14:249-260.

Obiakor, F.P., Bakken, J.P. and Rotatori, A.F. (Eds) (2010). *Current Issues and Trends in Special Education: Research Technology and Teacher Preparation* Bingley, London: Emerald Group Publishing.

O'Mahony, D., Wright G., Yogeswaran, P. and Govere, F. (2014). "Knowledge and Attitudes of Nurses in Community Health Centres about Electronic Medical Records" *Curationis* 37(1):1-6.

Oxford Advanced Learner's Dictionary. (2015). London: Oxford University Press, Ninth Edition.

Raphael, B., Meldrum, L. and McFalane, A.C. (1996). "Does Debriefing after Psychological Trauma Work? Time for Randomized Controlled Trials" *British Medical Journal* 310:1479-1480.

Rosmarin, D.H., Bigda-Peyton, J.S., Kertz, S.J., Smith, N., Rauch, S.L. and Bjorgvinsson, T. (2013). "A Test of Faith in God and Treatment: The Relationship of Belief in God to Psychiatric Treatment Outcomes" *Journal of Affective Disorders* 146(3):146-446.

Rueden, K.T.V., Hinderer, K.A., McQuillan, K.A., Murray, M., Logan, T., Kranner, B. Gilmore, R. and Friedmann, E. (2010). "Secondary Traumatic Stress in Trauma Nurses: Prevalence and Exposure, Coping, and Personal/Environmental Characteristics" *Journal of Trauma Nursing* 17(4):191.

Saldana, J. (2013). *The Coding Manual for Qualitative Researchers* London: Sage Publication, Second Edition.

Schmalenberg, C. and Kramer, M. (2009). "Healthy Work Environments: Nurse Manager Support: How Do Staff Nurses Define It?" *Critical Care Nurse* 29(4):61-69.

Stangor, C. (2014). *Research Methods for the Behavioral Sciences* New York: Cengage Learning, Fifth Edition.

Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S. and Ratele, K. (2009). "Violence and Injuries in South Africa: Prioritising an Agenda for Prevention" *The Lancet* 374(9694):1011-1022.

Sundheim, D. (2015). "Debriefing: A Simple Tool to Help Your Team Tackle Tough Problems" *Harvard Business Review*, <https://hbr.org/2015/07/debriefing-a-simple-tool-to-help-your-team-tackle-tough-problems> (Accessed on 29/07/2016).

Swindal, J. (2008). “‘Faith and Reason’ in Internet Encyclopedia of Philosophy”, <http://www.iep.utm.edu/faith-re/> (Accessed on 07/08/2016).

Tesch, R. (1990). *Qualitative Research: Analysis Types and Software Tools* Bristol, PA: Falmer Press.

Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L.P., Robson, R., Thabane, M., Giangregorio, L. and Goldsmith, C.H. (2010). “A Tutorial on Pilot Studies: The What, Why and How Methodology” *BMC Medical Research* 10:1.

Ugur, K. L. (2012). “Violent Crime Prevention: Bridging the Divide between Practice and Policy towards a New Model for Planning Intervention”, <http://www.arber.com.tr/aesop2012.org/arkakapi/cach/phdfulltext/AESOP%20PhD%20Workshop-FullPaper-Lauren%20Kate%20Ugur.pdf> (Accessed on 23/07/2016).

Van Wyk, B.E. and Pillay-Van Wyk, V. (2010). (Review). *Preventive Staff-Support Interventions for Health Workers* West Sussex: John Wiley and Sons Ltd.

Van Zyl, M. and Du Plessis, Y. (2012). “Exploring Coping Strategies of Business Leaders during an Economic Downturn” *South African Journal of Economic and Management Sciences (SAJEMS)* 15(4):402-415.

Yildirim, D. (2009). “Bullying Among Nurses and Its Effects” *International Nursing Review* 56:507-511.