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A Study to Evaluate the Effectiveness of Puppet Play on Reduction of Anxiety Among Hospitalized Children in Selected Hospitals of Badrachalam

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Abstract

This Study was aimed to evaluate the effectiveness of puppet play on reduction of anxiety among hospitalized children in selected hospitals of Badrachalam.

Purposive Non probability Simple random sampling technique was adopted to select 100 participants. The tool used for the study is Socio Demographic data and The modified short state trait anxiety inventory in Children scale. The Results reveals that ,In experimental group majority of 80% hospitalized children had severe anxiety, 12% had mild anxiety and 8% had moderate anxiety in pre test. Whereas, 68% hospitalized children had severe anxiety, 12% had mild anxiety and 20% had moderate anxiety in post test. In control group majority of 84% hospitalized children had severe anxiety, 8% had mild anxiety and 8% had moderate anxiety in pre test. Whereas, 96% hospitalized children had severe anxiety, 4% had moderate anxiety and 0% had mild anxiety in post test. In experimental group the mean post test anxiety score was 28.32 which were lower than the pre test anxiety score of 32.28. The mean difference obtained was 3.36 and calculated't' value was 5.683 with df of 24 which was significant at 0.05 level. In control group the mean post test anxiety score was 32 which were higher than the pre test anxiety score of 31.32. The mean difference obtained was 0.68 and calculated 't' value was 0.769 with df of 24 which was not significant at 0.05 level. In comparison between mean post test anxiety score of experimental group i.e. 28.32 and mean post test of control group i.e. 32. The mean difference between post test anxiety score of experimental group and control group is 2.36. In experimental group the mean post test anxiety score was 28.32 which were lower than the post test anxiety score of 32 in control group. The mean difference obtained was 3.21 and calculated't' value was 2.70 with df of 48 which was significant at 0.05 level. The study found that puppet play is effective in reducing anxiety among hospitalized children and also there is association between levels of anxiety and the condition diagnosed, children undergoing painful procedure and children on intravenous therapy.

Keywords: Puppet play; Effectiveness; Anxiety; Hospitalized children.

Introduction

Puppetry is an old, traditional art, which is still active in almost every culture, used in many different contexts, for spiritual, cultural and educational teaching. As puppetry is primarily a visual art, it can communicate to people who are not literate or who do not understand spoken language and it has been used in this way for thousands of years. Puppetry is a form of theatre or performance which involves the manipulation of puppets. It is very ancient, and is believed to have originated 3000. Puppetry takes

many forms but they all share the process of animating inanimate performing objects. Puppetry is used in almost all human societies both as an entertainment in performance and ceremonially in rituals and celebrations such as carnivals. Most puppetry involves storytelling.

According to Jean Piaget theory, puppet play helps young children develop creative and cognitive skills by forcing them to use their imaginations. They make up the roles, the rules, the situations and the solutions. It is through imaginative play that children come to understand the differences between fantasy and reality. The real world becomes more real to children who have opportunities to pretend.

Puppets have been used for play and in education with children in a variety of contexts, including health care. There is however a dearth of literature that explains nurses' experiences when using puppets in a paediatric health care context nor any process to guide how they use puppets.

Moreover, in the past 25 years an increased numbers of child psychiatrists are being involved in close liaisons with child care hospitals and services. As the children become ill and are hospitalized they use a number of different ways to deal with the difficult stresses that they encounter, and this has contributed directly to the clinical psychiatric observations and these experiences may lead to the development of psychiatric disorders. The trend in pediatrics has shifted from concentration on diseases of childhood to a concept of comprehensive practice.[3]

For children, hospitalization has always been a stressful experience. The major concerns of hospitalized children include but are not limited to pain, separation from their family members, mutilation, loss of self control, immobility as potentially stressful.[4] So in order to develop interventions that will reduce their worries and strengthen their coping mechanism a more individualized approach needs to be used.[5]

There has been a long tradition of puppetry in India. There are references to puppets in the ancient Indian epic Mahabharat. In India there are many puppeteers and the Rajasthani puppet form is notable. There are various types of puppets such as hand or glove puppet, rod puppet, shadow puppet, string puppet. The puppet can be used in combinations such as hand and rod puppets or hand and glove puppets.

The prevalence rate of anxiety disorders rise as children get older. As the anxiety disorders are cognitive in nature so it develops as our cognitive ability increases or develops. Kids who do not receive treatment for anxiety begin to develop poor coping skills.[15]

Theory of Psychosocial Development (Erikson) stated that school aged children have a sense of industry Vs sense of inferiority. In this period of development the occurrence of situations that might lead to a sense of inferiority can have a negative impact on the children. The acquisition of certain skills is limited only to those children who are physically and mentally healthy. Illness may add the feeling of loss of control along with hospital environment. Boredom has proved to be one of the most significant problems of children in this age group.[18]

Lima de Souza GL, et al., conducted study with a vision of formulating diagnostic statements, results and nursing interventions for children in a pediatric clinic, using the International Classification for Nursing Practice (ICNP). In all 42 diagnostic concepts were being developed and the most frequent among them was anxiety from hospitalization in children accounting for 88.5%, ability to sleep and rest was 74.2%, skin discoloration was 68.5%, and normal child development, was 65.7%.[9]

Materials and Methods

The Quantitative research approach with true experimental, pre test post test design was adopted in this study. Non probability simple random sampling technique was used to select the participants (n=100). The tool used for the study is Socio Demographic data and The modified short state trait anxiety inventory in Children scale; it is organized as Section I- Socio demographic data, Section II. The modified short state trait anxiety inventory in Children scale to evaluate the effectiveness of puppetry show on reduction of anxiety among hospitalized children in selected hospitals. The scale is a standardized tool, Ten experts constituting three psychiatrists, two psychologists and five mental health nursing personnel were validated the Tool. The Karl Pearson Co-efficient correlation method was used to check Reliability. The calculated "r" value is 0.75, it indicates that the tool which is taken by the researcher is reliable, valid and predictable of the desired objectives. The data was analyzed by using descriptive and inferential statistics.

Results

Section 1: Frequency and Percentage Distribution of Hospitalized Children as per Demographic Variables in Experimental and Control Group.

Table 1: Frequency and Percentage Distribution of Hospitalized Children as per Demographic Variables in Experimental and Control Group.

(N1= 50, N2= 50)

Demographic variables		Experimental group (N1) Frequency	%	Control group (N2) Frequency	%	p-value	Inference
Age	6-8 years	24	48	20	40		
	9-11 years	14	28	14	28	1.00	NS
	12 years	12	24	16	32		
Gender	Male	22	44	32	64	1.00	NS
	Female	28	56	18	36		
Previous history of hospitalization	Yes	24	48	22	44	1.00	NS
	No	26	52	28	56		
Has undergone painful procedures during present hospital stay	Yes	38	76	40	80	1.00	NS
	No	12	24	10	20		
Condition diagnosed	Acute	38	76	42	84	1.00	NS
	chronic	12	24	8	16		
Presence of parents during present hospitalization	Yes	32	64	26	52	1.00	NS
	No	18	36	24	48		
Present length of stay in hospital	7-14 days	18	36	20	40	1.00	NS
	More than 14 days	8	16	8	16		
Child is on Intravenous therapy	Yes	36	72	40	80	1.00	NS
	No	14	28	10	20		

An independent t- test was done for the demographic variables in experimental and control group to evaluate the homogeneity among the sample. It was found to be not significant ($p>0.05$). It concludes that there is no difference in sample characteristics among experimental and control group.

Section 2: Data on Effectiveness of Puppet Play in Reducing Anxiety Among Hospitalized Children in Selected Hospitals of Badrachalam.

Table 2: Assessing the pre test and post test levels of anxiety in experimental group and control group.

Levels of anxiety	Experimental group (N1)				Control group (N2)			
	Pre test		Post test		Pre test		Post test	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
No anxiety (0-10)	0	0	0	0	0	0	0	0
Mild anxiety (11-20)	6	12	6	12	4	8	0	0
Moderate anxiety (21-30)	4	8	10	20	4	8	2	4
Severe anxiety (31-40)	40	80	34	68	42	84	48	96

As shown in table 2, in experimental group majority of 80% hospitalized children had severe anxiety, 12% had mild anxiety and 8% had moderate anxiety in pre test. Whereas, 68% hospitalized children had severe anxiety, 12% had mild anxiety and 20% had moderate anxiety in post test.

In control group majority of 84% hospitalized children had severe anxiety, 8% had mild anxiety and 8% had moderate anxiety in pre test. Whereas, 96% hospitalized children had severe anxiety, 4% had moderate anxiety and 0% had mild anxiety in post test.

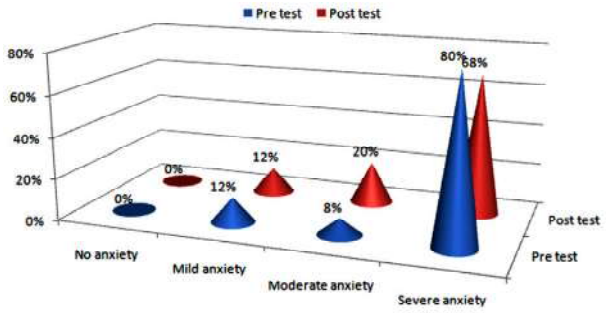

Fig. 1: Diagram showing the difference between pre test and post test levels of anxiety among hospitalized children in experimental group.

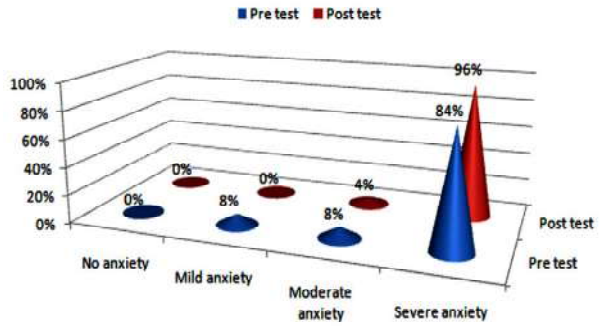

Fig. 2: Diagram Showing the Difference between Pre Test and Post Test levels of Anxiety Among Hospitalized Children in Control Group.

Table 3: Comparison of overall mean, Standard Deviation, mean Difference and Paired't' value of Pre Test and Post Test anxiety score of Hospitalized Children in Experimental Group and Control Group.

(N1= 50, N2= 50)

Group	Pre test/ post test	Mean	Standard deviation	Mean difference	't' value	df
Experimental group	Pre test	32.28	5.12	3.36	5.683	24
	Post test	28.92	5.39			
Control group	Pre test	31.32	3.92	0.680	0.769	24
	Post test	32	2.18			

Table 3 reveals that in experimental group the mean post test anxiety score was 28.92 which was lower than the pre test anxiety score of 32.28. The mean difference obtained was 3.36 and calculated't' value was 5.683 with df of 24 which was significant at 0.05 level.

In control group the mean post test anxiety score was 32 which was higher than the pre test anxiety score of 31.32. The mean difference obtained was 0.68 and calculated't' value was 0.769 with df of 24 which was not significant at 0.05 level.

In comparison between mean post test anxiety score of experimental group i.e. 28.92 and mean post test of control group i.e. 32. The mean difference between post test anxiety score of experimental group and control group is 3.08.

This indicates that the difference obtained in the mean pre test and mean post test anxiety score is true difference and not by chance. Hence H1 is accepted.

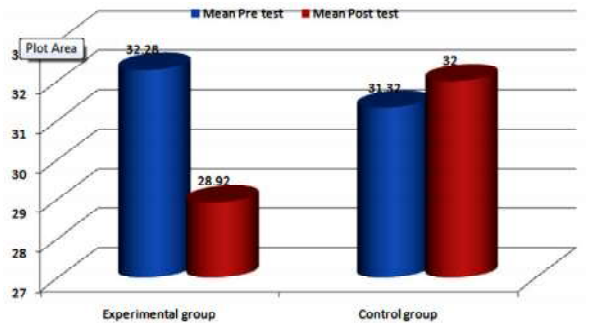

Fig. 3: Diagram showing the difference between mean pre test and post test levels of anxiety among hospitalized children in experimental and control group.

Table 4: Comparison of overall mean, standard deviation, mean difference and unpaired't' value of post test anxiety score of hospitalized children in experimental group and control group

Group	Mean post test score	Standard deviation	Mean difference	't' value	df
Experimental group	28.92	5.39	3.08	2.70	48
Control group	32	2.18			

Table 4 reveals that in experimental group the mean post test anxiety score was 28.92 which was lower than the post test anxiety score of 32 in control group. The mean difference obtained was 3.08 and calculated't' value was 2.70 with df of 48 which was significant at 0.05 level.

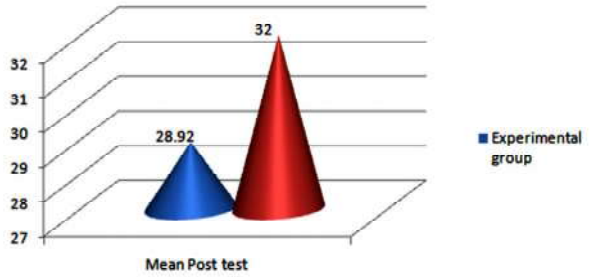

Fig. 4: Diagram showing the difference between mean post test levels of anxiety among hospitalized children in experimental and control group.

Section 3 Association between Pre Test anxiety score among the Hospitalized Children with their selected demographic variables.

Table 5 : Frequency and Chi square value of anxiety scores in experimental group.

N1=50

Demographic variables		Levels of anxiety				$x2$	Table value	Df	Inference
		No	Mild	Moderate	Severe				
Age	6-8 years	0	4	4	16				
	9-11 years	0	2	0	12	3.47	12.59	6	NS
	12 years	0	0	0	12				
Gender	Male	0	2	0	20	2.0	7.82	3	NS
	Female	0	4	4	20				
Previous history of hospitalization	Yes	0	2	2	20	0.29	7.82	3	NS
	No	0	4	2	20				

Table cont....

Has undergone painful procedures during	Yes	0	0	0	38	19.78	7.82	3	S*
	No	0	6	4	2				
Condition diagnosed	Acute	0	2	0	36	11.48	7.82	3	S*
	Chronic	0	4	4	4				
Presence of parents during present hospitalization	Yes	0	4	4	24	1.27	7.82	3	NS
	No	0	2	0	16				
Present length of stay in hospital	<7 days	0	2	0	22	4.2	12.59	6	NS
	7-14 days	0	4	2	12				
Child is on intravenous therapy	Yes	0	0	0	36	16.06	7.82	3	S*
	No	0	6	4	4				

Level of Significance: 0.05

df: degree of freedom

S*= Significant, NS= Non Significant

The chi square was computed to determine the significance of association between levels of anxiety with their selected demographic variables in experimental group. The table 5 indicates that the association between the pre test levels of anxiety with selected demographic variables i.e. has undergone painful procedure during hospital stay, condition diagnosed and child is on intravenous therapy is significant at 0.05 level of significance. While the other demographic variables such as age, gender, previous history of hospitalization, presence of parents during hospital stay and present length of stay in hospital is non- significant. Hence H_2 is accepted.

Table 6: Frequency And Chi Square Value Of Anxiety Scores In Control Group.

N2=50

Demographic variables		**Levels of anxiety**				***x*2**	**Table value**	**Df**	**Inference**
		No	**Mild**	**Moderate**	**Severe**				
Age	6-8 years	0	2	0	18				
	9-11 years	0	2	4	8	7.06	12.59	6	NS
	12 years	0	0	0	16				
Gender	Male	0	4	2	26	1.34	7.82	3	NS
	Female	0	0	2	16				
Previous history of hospitalization	Yes	0	0	2	20	1.70	7.82	3	NS
	No	0	2	2	22				
Has undergone painful procedures during hospital stay	Yes	0	0	0	40	19.05	7.82	3	S*
	No	0	4	4	2				
Condition diagnosed	Acute	0	2	2	38	4.11	7.82	3	NS
	Chronic	0	2	2	4				
Presence of parents during present hospitalization	Yes	0	2	2	22	0	7.82	3	NS
	No	0	2	2	20				
Present length of stay in hospital	7-14 days	0	2	2	16	3.03	12.59	6	NS
	>7 days	0	2	0	6				
Child is on intravenous therapy	Yes	0	0	0	40	19.05	7.82	3	S*
	No	0	4	4	2				

Level of Significance: 0.05

df: degree of freedom

S*= Significant, NS= Non Significant

The chi square was computed to determine the significance of association between levels of anxiety with their selected demographic variables in control group. The table 6 indicates that the association between the pre test levels of anxiety with selected demographic variables i.e. has undergone painful procedure during hospital stay, and child is on intravenous therapy is significant at 0.05 level of significance. While the other demographic variables such as age, gender, previous history of hospitalization, condition diagnosed, presence of parents during hospital stay and present length of stay in hospital is non- significant. Hence H2 is accepted.

Conclusion

1. Findings related to demographic variables of hospitalized children.

- Maximum numbers of hospitalized children in the experimental group and control group belong to the age group of 6-8 years. Maximum numbers of hospitalized children in the experimental group were females while in control group were males. Maximum number of hospitalized children in the experimental group and control group did

not have any previous history of hospitalization. Maximum number of hospitalized children in the experimental group and control group had undergone painful procedure during present hospital stay.Maximum number of hospitalized children in the experimental group and control group had acute diagnosis. Maximum number of hospitalized children in the experimental group and control group had their parents present during present hospitalization. Maximum number of hospitalized children in the experimental group and control group had less than 7 days of present stay in the hospital. Maximum number of hospitalized children in the experimental group and control group were on intravenous therapy

2. Findings related to assessment of levels of anxiety among hospitalized children.

- In experimental group majority of 80% hospitalized children had severe anxiety, 12% had mild anxiety and 8% had moderate anxiety in pre test. Whereas, 68% hospitalized children had severe anxiety, 12% had mild anxiety and 20% had moderate anxiety in post test. In control group majority of 84% hospitalized children had severe anxiety, 8% had mild anxiety and 8% had moderate anxiety in pre test. Whereas, 96% hospitalized children had severe anxiety, 4% had moderate anxiety and 0% had mild anxiety in post test.

3. Findings related to effectiveness of puppet play in reducing anxiety among hospitalized children.

- In experimental group the mean post test anxiety score was 28.32 which were lower than the pre test anxiety score of 32.28. The mean difference obtained was 3.36 and calculated't' value was 5.683 with df of 24 which was significant at 0.05 level. In control group the mean post test anxiety score was 32 which were higher than the pre test anxiety score of 31.32. The mean difference obtained was 0.68 and calculated 't' value was 0.769 with df of 24 which was not significant at 0.05 level. In comparison between mean post test anxiety score of experimental group i.e. 28.32 and mean post test of control group i.e. 32. The mean difference between post test anxiety score of experimental group and control group is 2.36. In experimental group the mean post test anxiety score was 28.32 which were lower than the post test anxiety score of 32 in control group. The mean difference obtained was 3.21 and calculated't' value was 2.70 with df of 48 which was significant at 0.05 level.

4. Findings related to association between pretest anxiety score among hospitalized children with their selected demographic variables.

- The levels of anxiety among hospitalized children has no significant association with their age in experimental group (?2=3.47) and control group (?2=7.06). The levels of anxiety among hospitalized children has no significant association with their gender in experimental group (?2=2.0) and control group (?2= 1.34). The levels of anxiety among hospitalized children has no significant association with their previous history of hospitalization in experimental group (?2=0.29) and control group (?2=1.70). There is significant association between the levels of anxiety of hospitalized children with whether they have undergone painful procedure during hospital stay in experimental group (?2= 19.78) and control group (?2= 19.05). There is significant association between the levels of anxiety of hospitalized children with their condition diagnosed in experimental group (?2=11.48) while no significant association was found in control group (?2= 4.11). The levels of anxiety among hospitalized children has no significant association with the presence of parents during present hospitalization in experimental group (?2= 1.27) and control group (?2=0). The levels of anxiety among hospitalized children has no significant association with the present length of stay in hospital in experimental group (?2=4.2) and control group (?2=3.03). There is significant association between the levels of anxiety of hospitalized children with whether the child is on intravenous therapy in experimental group (?2= 16.06) and control group (?2=19.05). Anxiety among hospitalized children needs to be assessed regularly using standardized tool. Anxiety among hospitalized children should be reduced using various interventions depending upon its severity. Anxiety among children pre operatively and post operatively should be addressed using various interventions.

Conclusion

The study found that puppet play is effective in reducing anxiety among hospitalized children and also there is association between levels of anxiety and the condition diagnosed, children undergoing painful procedure and children on intravenous therapy.

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Resilient Coping of Nurses working Among Patients with Covid 19 A Cross Sectional online Survey

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Abstract

Background: Resilience is the capacity to bounce back and quickly recover from the stress experienced by a person. The resilience of frontline COVID 19 Fighters, especially the working nurses needs a great deal of attention during this era of COVID 19 pandemic. Literature on the impact of supportive interventions on resilience of 92 nurses in isolation ward during the COVID-19 pandemic shows that the total resilience score was 87.04 ± 22.78, the mean resilience score was negatively associated with the scores of other domains of psychopathological symptoms. This study concluded that the high resilience promotes physical and mental health.

Objectives: The objectives were to assess the Resilient Coping of nurses working among patients diagnosed with COVID 19 and to identify the relationship between resilient coping and selected socio demographic variables.

Materials and methods: A quantitative approach with cross sectional descriptive design were adopted for the study. The data collected from 141 registered nurses from various parts of the world through online platform. The sampling technique was convenience sampling. The study included the registered nurses working in hospitals where patients with COVID–19 are treated and the study excluded nurses who have been severely affected and not able to respond to the data collection instruments provided. The data collection instruments were a socio demographic proforma and Brief Resilient Coping Scale (Sinclair and Wallston, 2004). The collected data were analysed using descriptive and inferential statistics. **Results:** This study reveals that 52% of nurses were currently working in India, 14.2% from Saudi Arabia and 7.8% from UK and UAE each. Majority of the sample 78 (55.5%) had BSc Nursing education; mostof the sample (36.7) had 6-10 years of clinical experience. Most of the sample 69 (48.9%) had low resilient coping 53 (37.6 %) had medium resilient coping and 19 (13.5%) had high resilient coping. Correlation of resilient coping scores with socio demographic variables were assessed using Karl Pearson's correlation and there were no significant relationship between resilient coping and selected socio demographic variables at 0.05 level. This study concludes that it is clinically relevant to address the resilient coping of nurses caring for patients with COVID 19 to plan and implement various resilience programmes to promote the physical and mental health of nurses working among patients with COVID 19.

Keywords: Resilience; Coping; Nurses; COVID 19.

Introduction

Resilience refers to a person's ability to adapt to major stressors such as trauma, threat, tragedy, familial and relationship troubles, job, and financial concerns.[1, 2]

World Health Organization has rightly recognised the need of addressing the mental health of staff and protect them chronic stress in order to improve their capacity to carry out their role efficiently.[3] Nurses face a variety of challenges, including risk of being infected, concerns about infecting their families, lack

of personal protective equipment (PPE), longer work hour, and distress associated with allocation of resources.[4] Acute stress and depression symptoms were considerably more common among nurses and advanced practice providers than in physicians.[5]

Lockdown restrictions forced individuals to limit their social interactions in order to decrease the risk of infections, while health care workers were required to go about their everyday duty. While undertaking difficult tasks in their work place, they were extremely worried about family members being infected and they were quiet uncomfortable among family members who may be unable or reluctant to see them owing to infection fears.[6] Many front line health workers were not prepared to deliver care to patients afflicted with a novel virus about which nothing is known.[7] As a result of the high need for healthcare, they undertake lengthy work shifts with limited resources, hazardous infrastructure and with personal protective equipment (PPE), which can cause physical pain and trouble breathing.[8]

The resilience of frontline COVID 19 (Corona Virus Disease 19) Fighters, especially the working nurses need a great deal of attention during this era of COVID 19 pandemic. A study evaluated Impact of supportive interventions on resilience of 92 nurses in isolation ward during the COVID-19 pandemic was evaluated using Connor Davidson Resilience Scale (CD-RISC). A total resilience score was 87.04 ± 22.78, the mean resilience score was negatively associated with the scores of other domains of psychopathological symptoms. This study concluded that the high resilience promotes physical and mental health.[8]

When a stressful event occurs, such as a pandemic, resilience allows us to anticipate and prepare for the occurrence, allowing us to avoid interruption of our usual routine.[9] There is lack of adequate information on the resilience level and the demographic and work characteristics that predict resilience in the critical circumstances of these professionals.[10]

A study aimed to ascertain the score of resilience among the nurses employed at the hospitals with COVID-19 patients identified low score of resilience.[11]

According to studies, effective treatments minimise nurses' job stress, burnout, and increase job satisfaction and care quality. Nurses must utilize both basic and creative safety methods in COVID and non-COVID regions to enhance their resilience while encountering the pandemic.[12, 13]

More treatments are needed to promote frontline nurses' mental health in the time of a pandemic, such as increasing self-efficacy and resilience through effective training and contagion control lectures, as well as delivering adequate social support through tele communication.[14]

Recognizing the association of COVID-19 with burnout of health workers, it is imperative to provide interventions to improve resilience in order to facilitate wellbeing.[15] Resilience can help nurses to impede poor psychosocial impact by reducing the negative consequences of burnout in health care settings.[16]

The COVID-19 pandemic is distinct from previous public health emergency of international concern in terms of social isolation; resilience may be a more fruitful reaction to regulate this scenario, which is critical to cope with stress. Hence, health workers with burnout should investigate the relevance of resilience support.[17]

As everyone is vulnerable to the pandemic, they need to be ready and resilient, policies need to be implemented for resilience support.[18]

It is crucial to structure individualized and effective resilience interventions for coping in this pandemic situation.[19] A study evaluated relative influence of personal resilience, social support and organisational support in reducing COVID 19 anxiety in frontline nurses. The study included 325 nurses working with COVID 19 cases. The result revealed that nurses who perceived high resilience, organizational and social support were less likely to report anxiety related to COVID 19.[20] Hence, the present study aims to understand the Resilient Coping of nurses working with patients of COVID-19 across the world using online data collection instruments. Researchers expect that outcome of the study may help to develop, validate and implement necessary tele intervention programmes, so that nurses being the frontline workforce in the healthcare could be helped to maintain Resilience and adapting healthy coping in order to safeguard their physical and mental health.

Objectives of the study

- Assess the Resilient Coping of nurses working among patients diagnosed with COVID 19
- Identify the relationship between resilient coping and selected sociodemographic variables.

Method

The cross sectional online survey was conducted after the first wave of COVID-19 outbreak, to assess the Resilient Coping of nurses working among patients diagnosed with COVID 19, the data collection tools were a socio demographic proforma and (BRCS) Brief Resilient Coping Scale. Sinclair and Wallston (2004) developed the Brief Resilient Coping Scale (BRCS). It

is a 4 items rating scale developed to capture tendencies to cope with stress in highly adaptive manner. It consists of 5 options for each 4 statements that is, Describes me, Describes me very well, Does not describe me, Does not describe me at all and Neutral. The reliability of the test was established by the authors and the BRCS had high internal consistency with a Chronbach's alpha of 0.82.[21] Socio demographic proforma was developed by the investigators and it consists of 12 items, which include, age, sex, education, marital status, living with spouse and children, country of origin, country of presently working etc. The data collected using online platform. Registered nurses from various parts of the world participated in this study. The sample size was 141, selected through non-probability convenience sampling. The study included the registered nurses working in hospitals where patients with COVID – 19 are admitted for treatment and the study excluded nurses who have been severely affected and not able to respond to the data collection tools provided. Informed consent was taken from the participants after obtaining the approval of Ethics Committee of Institute of Mental Health and Neurosciences (IMHANS), Kozhikode. The collected data were analysed with descriptive and inferential statistics using SPSS.

Results

The sample consists of 141 registered nurses, 2 (1.4) preferred not to reveal their gender, 42 (29.78%) males and 97(68.79) females, who were involved in the care of patients diagnosed with COVID-19 pandemic. Among 141 sample, 130 (92.2%) of the sample working in various countries reported that they were from India and the remaining sample were from Bangladesh 2 (1.4%), Ethiopia 1(0.7%), Indonesia 1 (0.7%), Ireland 2 (1.4%), Pakistan 1 (0.7%), Sri Lanka 2 (1.4%), United Kingdom 1(0.7%) and Zimbabwe1 (0.7%).

Table 1a: Frequency and percentage distribution of socio demographic characteristics (n=141).

Variable	Category	Frequency	Percentage
Gender	Female	97	68.8
	Male	42	29.8
	Prefer not to say	2	1.4
Country of Origin	Bangladesh	2	1.4
	Ethiopia	1	.7
	India	130	92.2
	Indonesia	1	.7
	Ireland	2	1.4
	Pakistan	1	.7
	Sri Lanka	2	1.4
	United Kingdom	1	.7
	Zimbabwe	1	.7

Table 1b: Frequency and percentage distribution of socio demographic characteristics(n=141).

Variable	Category	Frequency	Percentage
Nursing Education	Degree	78	55.3
	Diploma	36	25.5
	Post Graduate Degree	27	19.1
Living with Spouse and Children	No	40	28.4
	Not Applicable	32	22.7
	Yes	69	48.9
Marital Status	Living Together	1	.7
	Married	102	72.3
	Single	36	25.5
	Widow or Widower	2	1.4

The data depicted in Table 1 breveal that most of the sample 78 (55.3%) had BSc Nursing as their educational status and 36 (25.5%) had Diploma in Nursing and remaining 27(19.1%) had Post graduation in Nursing. 69 (48.9%) reported that they are living with spouse and children. With regard to the marital status 102 (72.3%) were married 36 (25.5%) were single and 1(0.7%) were living together.

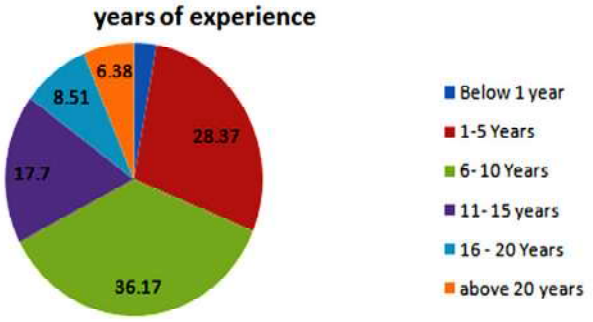

Fig. 1: Pie diagram showing percentage distribution of sample based on Years of

Clinicalexperience (n=141)

The study reveals that most of the sample 36.7%had 6-10 years, 28.37% had 1-5 years of clinical experience and 6.38% had experience above 20 years. This study identified that 52% of sample was working in India, 14.2% from Saudi Arabia and 7.8% from UK and UAE each and remaining subjects from other countries.

Table 1c: Frequency and percentage distribution of sociodemographic characteristics (n=141)

Variable	Response	Frequency	Percentage
Immediate family member	No	130	92.2
had infected with COVID-19	Yes	10	7.1
How is your appetite?	Good	129	91.5
	Poor	12	8.5
How is your sleep?	Good	105	74.5
	Poor	36	25.5
How is your digestion?	Good	116	82.3
	Poor	25	17.7

Among 141 nurses, 10 (7.1%) had their immediate family member infected with COVID-19 whereas 130 (92.2%) had none. 129 (91.5%) have good appetite, 105 (74.5%) have good sleep and 36 (25.5%) have poor sleep, 116 (82.5%) reported that they have good digestion whereas 25 (17.7%) have digestion issues.

Table 2: Percentage distribution of sample based on Resilient coping score (n=141)

Category	Range	Frequency	Percentage
Low resilient coping	4-13	69	48.9
Medium resilient coping	14-16	53	37.6
High resilient coping	17-20	19	13.5
Total	141	100	

The data depicted in table 2 shows that among 141nurses, 19 (13.5%) had high resilient coping, 53 (37.6%) had medium resilient coping and 69 (48.9%) had low resilient coping.

Table 2a: Item wise frequency and percentage distribution of scores of resilient coping of nurses working among patients with COVID 19 (n=141)

I look for creative ways to alter difficult situations	Frequency	Percent
Describes me	38	27.0
Describes me very well	10	7.1
Does not describe me	7	5.0
Does not describe me at all	9	6.4
Neutral	77	54.6
Total	141	100.0

Table 2b: Item wise frequency and percentage distribution of scores of resilient coping of nurses working among patients with COVID 19 (n=141)

Regardless of what happens to me, I believe	Frequency	Percent
I can control my reaction to it		
Describes me	58	41.1
Describes me very well	16	11.3
Does not describe me	11	7.8
Does not describe me at all	8	5.7
Neutral	48	34.0
Total	141	100.0

Table 2c: Item wise frequency and percentage distribution of scores of resilient coping of nurses working among patients with COVID 19 (n=141)

I believe I can grow in positive ways by dealing with difficult situations	Frequency	Percent
Describes me	58	41.1
Describes me very well	26	18.4
Does not describe me	9	6.4
Does not describe me at all	3	2.1
Neutral	45	31.9
Total	141	100.0

Table 2d: Item wise frequency and percentage distribution of scores of resilient coping of nurses working among patients with COVID 19 (n=141)

I actively look for ways to replace the losses I encounter in life	Frequency	Percent
Describes me	41	29.1
Describes me very well	18	12.8
Does not describe me	12	8.5
Does not describe me at all	7	5.0
Neutral	63	44.7
Total	141	100.0

The study observed that the correlation of Perceived stress scores with socio demographicvariables were assessed using Karl person's correlation and there were no significant relationship between Resilient coping and selected socio demographic variables at 0.05 level.

Discussion

The present study was undertaken to check the Resilient coping of nurses working with patients infected with COVID 19.

Reviews observed that all health professionals experience a lot of stress within their clinical practice such as time pressures, workload, multiple roles and emotional issues. Workplace stress and poor resilience can affect the physical and mental wellbeing of health professionals and result in burnout. These outcomes can affect not only on the wellbeing of health professionals but also on their ability to practise effectively.[22] Health care professionals are at an increased risk of psychological issues like high levels of stress, anxiety, depression, burnout, addiction and post traumatic stress disorder, which could have long-term psychological implications.[23, 24] The current study also found that nurses being the frontline health care warriors, 69 (48.9%) had low resilient coping.

Limitations of the study

The study subjects were selected through non-probability convenience sampling technique, using online platform. However, the study included nurses from various parts of the world, the numbers of subjects representing all countries were not equally distributed and the organizational support including adequate supply of PPE and other benefits, family support and cultural and personal characteristics contributing to resilient coping may differ. Hence, the result may varyin different settings.

Implications of the study

One of the major COVID 19 warriors is nurses, hence, it is important to assess their resilience and provide necessary intervention to promote their physical and mental health in order to maintain their enthusiasm

for quality patient care. The current study throws light in to the need to add resilient training in curriculum of all healthcare programmes including nursing to help them cope effectively when stressful situations like emerging and re-emerging pandemic outbreaks. All the healthcare organizations should focus on improving and maintaining resilience of their employees by adding resilience programmes in induction training of newly appointed staff. In service education giving priority for resilience training is vital to address and prevent burnout, boredom and stress of all healthcare professionals.

Recommendations

A similar study can be done with more number of subjects.

A study on the effects of resilience programme on stress and resilient coping can be done.

Conclusion

Resilience is the capacity to bounce back from difficult situations, being focused, and continue to be hopeful for the future; resilience is an essential characteristic for nurses to work amidst the complex nature of healthcare delivery system. It is vital to develop resilience among nurses through various psychosocial interventions.[25] The data on percentage of study subjects show that among 141 nurses, 19 (13.5%) had high resilient coping, 53 (37.6%) had medium resilient coping and 69(48.9%) had low resilient coping. This study found that it is mandatory to conduct resilience programmes for the frontline health care providers like nurses to maintain their physical and mental health status in order to provide quality patient care in all the spheres including the outbreak of this pandemic COVID 19.

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Patient Centered Care Through Communication

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Abstract

Patient centered care is the care that takes into consideration patient's values, needs and preferences and is safe, cost effective, timely and efficient. Communication in health care setting is important to assess patient satisfaction with care being rendered. Understanding patient's psychosocial context and his perspective on illness, empathetic and active listening, and involving patient in treatment related decision making process are all parts of patient centered care. Nurses, at times, find it difficult to communicate and care for some patients, such as, those who are anxious, depressed, terminally ill, aggressive, and manipulative and even distressed families of the patients. However, nurses can use some therapeutic communication techniques, such as, active listening, acceptance and respect for the patient, empathizing with patients and families and giving unconditional positive regard to the patients will be beneficial.

Keywords: Patient centered care; Communication, Empathy; Active listening; Shared decision making.

Communication

Communication is a way in which humans make sense of the world around them. Communication is a two way process or interaction, involving two or more people and can occur by verbal, non verbal, face to face or non-face to face method.Communication is viewed as a reciprocal process.[1]

Significance of communication

Communication is an important factor in patient satisfaction and complaints about care.[2]

- It plays an integral role in quality of service in all service professions including health care professions.
- Within health care, quality care has been defined by the Institute of Medicine as "care that is safe, effective, timely, efficient, and equitable and patient-centered."[3]

Patient centered care

Patient centered care is defined as care that is respectful of, and responsive to individual patient preferences, needs and values and ensuring that patents' values guide all clinical decisions.[2] Health care organizations that are patient centered engage patients as partners and hold human interactions as a pillar of their service.[4]

Goals of patient centered care

Patient centered care is based on three goals:

- To elicit the patient's take on his illness.
- To understand patient's psychosocial context.
- To reach shared treatment goals based on patient's values.[5]

Understanding patient's psychosocial context

Exploring the patient's feelings is important in assessing the emotional burden and psychological

impact of the illness. Unexpressed emotions may affect the patient's trust and confidence in medical care. We should not judge the patient's emotions as being appropriate or inappropriate and resist offering premature reassurance early in the interaction with patient.

Similarly, normalizing /belittling without first adequately exploring the concern may be perceived as blocking the patient's feelings. E.g., "many patients experience apprehension" or "this is a fairly common reaction". Patients often have concerns about future complications and disability from their medical problems. Some of these fears may be unfounded or unlikely requiring gentle exploration and eventual assurance. Often fears are realistic and require a thorough understanding of patient's values and resources. An illness can impact a person's life in ways that the health care providers may not anticipate. Discussion should explore the effects of illness on personal activities and social responsibilities. E.g., the inability to care for oneself, loss of employment.[5]

Expressing empathy

Empathy is the capacity to understand and relate to patient's illness experience and emotions. Nurses can express empathy verbally or through non-verbal gestures, such as,:

- respectful silence
- touching patient's hand or knee (if culturally appropriate)
- offering a box of tissues when patient is tearful

Techniques for experiencing empathy

- Naming the emotion by saying, "It seems like you are feeling….."
- Expressing Understanding by saying, "I can understand how that might upset you"
- Supporting and Exploring by saying, "I will be with you in this difficult time", and "How are you coping in this difficult time"?[6]

Regardless of their own emotional state, health care providers need to show concern and interest verbally and non-verbally.

Revealing a diagnosis: Breaking bad news

- Setting: Provide privacy and avoid distractions and interruptions. Involve significant others while breaking bad news for providing support and confidence to patient. Sit down and connect with patient (through eye contact, touch, if culturally appropriate).
- Detailed information about disease, diagnosis and treatment modalities, and prognosis is requested more often by patients who are younger, female and more educated.
- First assess patient's prior knowledge and understanding of the illness and patient's preference for an overview or detailed information.
- Give time to patient to absorb the news.
- Empathize with patient's emotions while limiting further information in the initial stage. You can further explore by saying, "How much information would you like to receive at this time"?and, "Do you prefer to receive information in stages or all at once"?
- Use word that are familiar to patient.Avoid medical jargon. Do not ne excessively blunt or insensitive. Provide information in small chunks and allow time for comprehension.
- Do not take away hope.
- Discuss treatment options, if the patient is emotionally ready, to maintain hope and a future oriented outlook5.

Shared Decision Making

- By discussing treatment options, health care professionals can help patients make informed choices.The pros and cons of each option should be outlined, including benefits and risks, potential immediate and long term adverse effects, costs (direct and indirect). Providing options reaffirms the patient's need to be actively involved in his or her medical care. However, the patient should not be bombarded with extensive information.
- A balanced approach involves asking patient about what he already knows about his illness, then providing small chunks of information and checking for understanding after each chunk (ask-tell-ask technique). The patient's clinical condition, health literacy, emotional state and the complexity of the medical decision may require multiple sessions with health care professional. Shared decision making can be supported by printed aids, e.g., pamphlets, leaflets etc., that visually depict clinical risks using pictographs.[5]

Communicating with 'Difficult' Patients[7]

The label of difficult patient is assigned to those whose behaviours cause distress in the health care professional that exceeds that which is either expected or accepted.Upto 15% of patient-provider encounters are rated as 'difficult'.[7] Some patients considered 'difficult' are:

- Non-adherent patient
- Patients who are receiving end of life or pallia-

tive care.

- Manipulative-dependent patient: They test interest of others, invoking guilt. They may threaten angry outbursts or even legal action. They actually may be lonely, dependent or fearful.
- Aggressive patient: Behaviours shown are - condescending, blaming, attacking, criticizing, insults, sarcasm, physical attack.
- Complaining and demanding patient: Patient complains/demands about the care, the cost, the providers and the treatment regimen.
- Patient in denial: Prolonged denial indicates towards maladaptive coping. Denial is a self-protective mechanism against the stress of disease and injury.
- The depressed or anxious patient: All patients who are subjected to hospitalization, where control is lost and routines are disrupted experience some level of anxiety and depression.
- Families are vulnerable to anxiety surrounding the diagnosis, treatment.[7]

General guidelines to follow with difficult patients

- Show respect. Patients left waiting, not explained about procedures or tests, treated not as a human being are some instances depicting lack of respect towards the patient.
- Practice unconditional positive regard for the patient.
- Show concern and interest (caring can be an underdeveloped skill in a high-tech environment)
- The highly anxious patient can only comprehend the most elemental communication. Be clear, simple and brief.
- The patient's immediate environment is usually perceived as overwhelming, therefore, it is important to remain calm, restore quiet and speak slowly, without medical jargon.
- Patients with very high level of anxiety will lack the usual abilities to care for themselves, at least temporarily. Some patients may even regress for a period of time.
- While it is important for nurses to encourage the patients to take care of their own activities of daily living (ADL), they may initially need additional assistance in their ADL, from staff and family members.[7]

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