Conceptual Model:
Psychosocial Implications of Caring for People Living with HIV among Nurses

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ABSTRACT Nursing is an occupation that is subjected to a high degree of stress. Stress had been seen as a predictor of the nature of care provided by nurses caring for people living with Human Immunodeficiency Virus (HIV) (PLWH). The purpose was to develop a conceptual model for establishment of Nurse-Environment-Patient Relationship in hospital setting. A descriptive, cross-sectional paper was conducted. The Maslach Burnout (MBI) and Beck's Depression Inventories (BDI), and Acquired Immunodeficiency Syndrome (AIDS) impact scale was used to assess the impact of caring for PLWH among nurses. The paper adopted the assumptions of cognitivism and cognitive appraisal theory. Majority of nurses reported to suffer grief and loss and identification with their patients. A moderate to high level of burnout was marked. A conceptual model of psychosocial impact of caring for PLWH is a comprehensive model that projects the impact of caring for PLWH among nurses and a link between nurses, their working environment and patients. Quality of care provided to patients is purely determined by the psychosocial state of nurses and the level of environmental stressors. Maintaining a conducive working environment and caring for caregivers is imperative in the provision of quality care.

INTRODUCTION

HIV remains a major global public health issue. Since the year 2000, about 38.1 million people became infected with the Human Immunodeficiency Virus (HIV) and 25.3 million people had died of Acquired Immunodeficiency Syndrome (AIDS)-related illnesses (UNAIDS 2015). Even though AIDS is not regarded as a new syndrome anymore, global solidarity in responding to HIV and AIDS will remain essential. Furthermore, in 2014, there was an estimated 36.9 million people living with HIV (PLWH) (with the inclusion of 2.6 million children) resulting in a global HIV prevalence of 0.8 percent. Most population of PLWH lives in low and middle-income countries. Furthermore, approximately 1.2 million PLWH had died of AIDS-related illnesses (UNAIDS 2015). However, the increasing number of infected people varies geographically between countries and regions. Nurses form the backbone of most national healthcare delivery systems, including in the Republic of South Africa (RSA). Nurses are therefore frontline providers of care to PLWH. The increasing number of PLWH has a greater impact on nurses providing care to PLWH and are said to suffer relatively high stress (Kane 2009). Stress had been characterized as "an antecedent or stimulus, as a consequence or response, and as an interaction and it has been studied from many diverse frameworks and perspectives" (Sharma et al. 2014). According to Eswari and Saravanan (2011) and Sharma et al. (2014), stress is, however, not naturally deleterious, each individual's cognitive appraisal, their perception and interpretation, provides sense to events and decides if these events are observed as threatening or positive (Sharma et al. 2014). Personalities also facilitate the stress equation because what may be overburdening to one person may be exhilarating to another (Sharma et al. 2014).

Nursing is, by its actual nature, a profession subjected to higher degrees of stress (McGrath et al. 2003). Normally, the nurse is confronted by stark suffering, grief, and death as compared to other professions on a day-to-day basis. Most nursing tasks are ordinary and fruitless. Many are, by normal instances, unpleasant, even disgusting, others are often degrading, while some

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are simply frightening (Riahi 2011). This puts enormous pressure on nurses as they experience the nerve-racking nature of the nursing role in patient care situations.

The main factor for high levels of work-related stress in nursing is lack of autonomy (McGrath et al. 2003; Mahite et al. 2014). This makes a nurse to feel unable to make decisions at least from time to time and incapable to change an unacceptable situation they are faced with (McGrath et al. 2003). Although some of the nurses felt ineffectively trained or equipped for carrying out their nursing role, it was also felt that the nursing role did not always need or utilize their nursing training and work experience. In relation to the stressors experienced in nursing in totality, many of the nurses did not have enough experience to undertake their work (McGrath et al. 2003; Mahite et al. 2014). Shortage and rationing of scarce services and resources was also felt severely (McGrath et al. 2003). The hospital-based nurses are found to be in contact with other professionals, and imposing controls, which shortened or constrained personal autonomy and emotional demands of patients as causing more stress (McGrath et al. 2003; Mahite et al. 2014).

The critical shortage of nurses, inadequate knowledge and skill mix, and uneven geographical dissemination of nurses place major barriers to achieving the health related millennium goals (MDGs) (WHO, UNICEF and UNIAIDS 2010). According to Mohale and Mulaudzi (2008), low nursing staff ratios, increased workloads and a growing population of PLWH leads to an upsurge in the utilization of personnel with less skills and deterioration in the quality of care provided. Given the rise in HIV infection, an increase in need for care rises sharply.

Nonetheless, stress had been characterized as an occupational hazard since the mid-1950s. Actually, occupational stress had been cited as a remarkable health problem (Sharma et al. 2014). According to Jennings (2008), work based stress within the nursing job was first evaluated in 1960. This was the time when Menzies acknowledged four foundations of anxiety among nurses: meeting changes, taking responsibility, making decisions, and caring for patients (Menzies 1960). The role of nurses has been regarded as stressful based on the following encounters: nursing job, patient suffering, long working hours, nurse shortage, and interpersonal relationships that

are central to the work nurses undertake (Sharma et al. 2014). As shown in evidence, nurses' work-related stress can be accelerating due to the growing use of technology, ongoing rise in healthcare costs and instability within the nursing work environment itself. This paper therefore seeks to develop a conceptual model for establishment of Nurse-Environment-Patient Relationship in hospital settings thus the conceptual model of psychosocial impact of caring for PLWH.

Objectives of the Paper

The objectives of this paper were to describe the impact of caring for PLWH among nurses, to determine level of burnout, determine the level of depression, to establish the relationship between measures of AIDS Impact Scale (AIS), Maslach's Burnout Inventory (MBI) and Beck's Depression Inventory (BDI), and to conceptualize the findings of this paper into a conceptual model of psychosocial impact of caring for PLWH.

Conceptual Framework

The paper adopted the assumptions of cognitivism and cognitive appraisal theory as the framework to guide it and utilized deductive reasoning, as the paper is quantitative in nature. The impact of caring for PLWH among nurses brings along challenges that need to be addressed for them to become better caregivers. McCulloch and Pitts (1943) claim that brain functioning and mental activity could be understood as logical operations. Furthermore, the brain was thought to be a deductive machine. In the next significant development in cognitive science, which occurred in 1956, guidelines for its development were set as according to Gardner in Stacey (2007). The central idea is that human intelligence bears a resemblance to computation so much that cognition, that is, human knowing, could be understood as a procedure of computing representations of reality (Stacey 2007). Human beings are anticipated to act on the basis of representations of their environment that are processed within their brains.

This definition as well as its assumptions is that cognitivism concentrate on nurses' mind and claims that the mind is an information processing device, which is the foundation of rational thinking. Taking the above into consideration, it can be further emphasized that the brain

is a passive mirror of reality (nurses' accurate picture) and repeated exposure makes it more accurate.

Assumptions of Cognitivism

This paper was purely based on the assumptions of cognitivism and Lazarus and Folkman's cognitive appraisal theory. According to Stacey (2007), the main assumptions of cognitivism are as follows:

- The brain is assumed to act as an inactive mirror of reality.
- The world in which human act is found, not created.
- Repeated exposure to the same environment perception would strengthen connections, and so making a perception a more and more accurate representation of reality. This would form a template, stored in a particular part of the brain, against which other environmental perceptions are compared and categorized, forming the basis of the body's response.
- There is a fixed point of reference, external reality, and the negative feedback of the gap between the interior picture and this external reality forms a self-regulating process that closes the gap.
- The biological individual is at the center of learning and acting.
- Since all the normal individuals have much the same biologically determined brain structures, and all their brains are processing symbolic representations of the same pre-given reality, there is no fundamental problem in individuals sharing the same perceptions.
- The following discussion will focus on the assumptions of cognitivism (Stacey 2007), and Lazarus and Folkman's cognitive appraisal theory (Lazarus and Folkman 1986), as follows:
- Fixed point of reference
- External reality
- Cognitive appraisal and negative feedback
- Biological individualism
- Symbolic representation of the pre-given reality

Fixed Point of Reference

This refers to the nurses' caring for PLWH. The emergence of HIV had further place a new stress factors for nurses, primarily related to their relationship with HIV patients, safe working practices and fear of contagion, to name but a few (Gordin et al. as cited in Visintini et al. 1996).

External Reality

External reality is categorized into three groups, namely job characteristics, organizational stressors and personal stressors as described by Demmer (2004) that nurses are exposed to in the workplace.

Job Characteristics: According to Koekemoer and Mostert (2006), every job has its own specific job characteristics that are organizational and personal, but it is still probable to model these characteristics, in two broad categories, namely job demands and job resources.

Organizational Characteristics: These refer to the degree to which benefits and punishment are associated with job performance. The conflict between the need for nurses to maintain their nursing role and good performance as well as the manifestation of emotional factors might be stressful. According to Demmer (2004), less organizational support, including support from the supervisors and colleagues, exposes nurses to stress.

Personal Characteristics: This comprises of various socio-demographic variables of the employee, self-efficacy, and social support. Practically, the nursing job can be demanding with increased levels of muscular-skeletal stress, ending in multiple aches and pains.

Cognitive Appraisal Theory and Negative Feedback

According to Lazarus and Folkman's (1986), "stress is a two-way process: the environment yields stressors and the individual discovers means to deal with them". *Cognitive appraisal* is a mental process by which nurses evaluate two factors: "Whether a demand (job, organizational and personal characteristics) threatens nurses' wellbeing" and "whether a nurse considers that they have the resources to encounter the demand of the stressor" (Krohne 2002). Lazarus' theory has two concepts, thus cognitive appraisal (person's evaluation of the significance of what is happening for their mental health) and coping (person's efforts in thought and action to manage specific demands). Hence, in this paper focus is paid to cognitive apprais-

al. Cognitive appraisal is comprised of two types, thus primary and secondary appraisal.

When nurses are confronted with job, organizational and personal stressors, they search for relevance of those stressors to their wellbeing (Krohne 2002). Nurses, however, may try to accomplish this through secondary appraisal, thus through coping options. The coping option may be achieved through blame or credit (who is responsible for certain events), coping potential and future expectations (Krohne 2002; Bippus and Young 2012). Hence, these patterns of primary and secondary appraisal lead nurses towards negative feedback, that is, they view their encounter as harm-loss, threat or a challenge.

The gap between interior perception and the external reality forms a self-regulating process (Stacey 2007), that is:

- *Harm-loss* refers to any kind of harm, loss or damage that has already been sustained such as injury, loss of self-esteem or loss of friendship (Lazarus 1981; Carpenter 2015).
- *Threat* refers to the predicted harm, loss or damage. In threat cases, nurses offer nursing care in fear of contagion, fear of stigma from both inside and outside the hospital setting, and fear of losing patients (Miller 1995).
- *Challenge* occurs when the judgment involves assessing whether a transaction holds the potential for harm, for mastery or for gain (Lazarus 1981). Here, nurses judge if they influence the outcome themselves (Lazarus 1981).

Biological Individualism: Emotional Exhaustion, Depersonalization, Depression and Job Satisfaction

According to Gramstad (1999), *"biological individualism"* suggests that people are all different, *as individuals*, and since these variances are natural, they are hard to change. Individuals may show different effects of their cognitive appraisal such as emotional exhaustion, depersonalization, depression and job satisfaction.

Symbolic Representations of the Pre-given Reality: Burnout and Resilience

This is characterized by burnout and resilience. The devastating effects of work related stress among nurses could manifest as burnout with signs like loss of interest in caring for PLWH, poor work performance and dissatisfaction (Visintini et al. 1996). Characteristics of the person and situation may identify resilient processes, but only if they lead to healthier outcomes following stressing circumstances (Reich et al. 2010). Resilience is said to be recovery or how well the individual bounces back and recovers fully from the challenge (Masten 2001; Rutter 1987). Hence, this leads to the nature and quality of care provided to PLWH.

MATERIAL AND METHODS

The paper design was a descriptive, cross-sectional paper. The sample comprised of nurses caring for PLWH who were recruited within a regional hospital in Vhembe district, Limpopo province. Convenient sampling was used to select the participants. Data was collected using an instrument that was incorporative of demographic and professional data, work environment, Maslach Burnout Inventory (MBI) (Maslach and Jackson 1981), Beck's Depression Inventory (BDI) (Beck et al. 1996) and the Aids Impact Scale (AIS) (Bennett 1991). Demographic information gathered included age, gender, qualification, ward allocation, period of allocation and years of service within the hospital.

The paper used a self-administered questionnaire to collect data from the nurses. The instrument comprised of five (5) sections. The first section required demographic variables such as age and qualifications, the second section asked questions on, and the 2nd, 3rd and 4th sections measured the impact of AIDS, burnout and depression, respectively.

Data Analysis

Data analysis used the IBM SPSS (statistical package for social sciences) 21 computer software. Descriptive statistics were used to describe the data and correlation was done to establish relationships between subscales of MBI and AIS, and depression. The significant level of 0.05 was set.

Ethical Approval

Following approval from the North West University Research and Ethics Committee and

since the paper was under a major paper by Professor M. Davhana-Maselesele, namely, *"Caring for carers: responding to nurses' needs"* the permission to conduct the paper, ethical clearance of the major paper was used. Voluntary participation and written consent of all nurses was sought following paper information. Collected data was stored in a locked place with names of nurses and the hospital. Nurses were informed that the paper is of no harm and they have a right to withdraw from the paper when they wish to.

RESULTS

A total of 240 questionnaires were distributed with the aim of having extras in case of other questionnaires not completely filled and 233 were returned fully completed. Table 1 reveals that about thirty-seven percent of the respondents came from the medical and palliative wards, followed by surgical wards (26.2%) and maternity wards (14.6%). The sample was mostly made up of professional nurses (PN) (47%), followed by enrolled nursing auxiliary (ENA) (28%) and enrolled nurses (EN) (25%).

Table 2 indicates that majority of nurses reported to suffer AIS grief and loss (G and L) (76%) and AIS identification with others (ID) (77%). However, about fifty-five percent had also shown to receive AIS social rewards (SR) for their involvement in caring for PLWH. It was also evident that fifty-three and eighty-three percent of nurses had a moderate to high emotional exhaustion (EE) and depersonalization (DEP) score respectively, with only about twenty-five percent having moderate to high score of personal accomplishment (PA). About fifty-seven percent of nurses reported to suffer borderline to extreme depression.

The results in Table 3 revealed a strong positive association between EE and DEP (r= 0.56, p< 0.001), with a negative significant relationship between DEP and PA (r= -0.20, p= 0.002). ID (r= 0.23, p= 0.001) and AIS stigma and discrimination (S & D) (r= 0.30, p< 0.001) had a significant association with DEP, furthermore with peer relations/loss tolerance (PR/LT) at r=0.50 (p< 0.001) and r= 0.27 (p< 0.001), respectively. There was no significant relationship between PA and S and D.

DISCUSSION

The findings of this paper are hereunder conceptualized within the conceptual framework set in chapter two of the paper. The conceptual framework was adapted from the main assumptions of cognitivism, and Lazarus and Folkman's cognitive appraisal theory. The paper focused on the nurses caring for PLWH namely, PN, EN and ENA, herein referred to as fixed point (Fig. 1).

Table 1: Frequencies and percentages of participants' professional and demographic characteristics
*highest frequencies and percentages

Demographic characteristic	PN(n=109)	EN (n=58)	ENA(n=66)
Age			
21-30	40 (36.7%)*	0	22 (33.3%)
31-40	21 (19.3%)	27 (46.6%)*	19 (28.8%)
41-50	30 (27.5%)	21 (36.2%)	24 (36.4%)*
50 and above	18 (16.5%)	10 (17.2%)	1 (1.5%)
Gender			
Male	14 (12.8%)	11 (19.0%)	27 (40.9%)
Female	95 (87.2%)*	47 (81.0%)*	39 (59.1%)*
Current Enrolment			
Not enrolled	99 (90.8%)*	32 (55.2%)*	64 (97.0%)*
Enrolled	10 (9.2%)	26 (44.8%)	2 (3.0%)
Years of Service at Hospital			
Less than 2 years	7 (6.4%)	08 (13.8%)	9 (13.6)
2-4 years	44 (40.3%)*	25 (42.2%)*	23 (34.8%)
5-10 years	14 (12.8%)	6 (10.3%)	33 (50.1%)*
11-20 years	18 (16.2%)	19 (33.7%)	1 (1.5%)
Above 20 years	26 (24.3%)	0	0

Table 2: Frequency and descriptive distribution of AIS, MBI sub-scales and BDI

Sub-scale	Level	%	Min	Max	Mean	SD
AIS-PR/LT	Low	9.0	0.00	10.00	7.07	2.56
	Moderate	30.0				
	High	60.9				
AIS-ID	Low	23.2	0.00	10.00	5.45	2.47
	Moderate	48.1				
	High	27.9				
AIS-SD	Low	45.5	0.00	8.00	3.98	2.31
	Moderate	24.5				
	High	30.0				
AIS-GandL	Low	24.5	0.00	8.00	5.22	2.36
	Moderate	19.3				
	High	56.2				
AIS-SandD	Low	75.5	0.00	8.00	2.70	2.33
	Moderate	8.2				
	High	16.3				
MBI-EE	Low	46.8	0.00	52.00	20.09	13.34
	Moderate	16.3				
	High	36.9				
MBI-PA	Low	74.7	0.00	45.00	26.88	9.84
	Moderate	21.9				
	High	3.4				
MBI-DEP	Low	16.3	0.00	26.00	10.47	6.69
	Moderate	23.2				
	High	60.5				
Depression	Low	43.3	0.00	63.00	21.30	15.68
	Moderate	27.9				
	High	28.8				

Table 3: Correlations coefficients of measures of MBI and AIS

	MBI-EE	MBI-PA	MBI-DEP	AIS-PR/LT	AIS-ID	AIS-SR	AIS-GandL
MBI-PA	-0.08						
MBI-DEP	**0.56**[**]	**-0.20**[**]					
AIS-PR/LT	0.06	0.17[*]	0.05				
AIS-ID	**0.22**[**]	0.09	**0.23**[**]	**0.50**[**]			
AIS-SR	0.05	0.13	0.04	**0.47**[**]	**0.46**[**]		
AIS-G & L	0.06	0.11	0.03	**0.37**[**]	**0.45**[**]	**0.41**[**]	
AIS-S & D	**0.32**[**]	-0.3	**0.30**[*]	**0.27**[**]	**0.38**[**]	**0.33**[**]	**0.17**[**]

Key: [**] Correlation is significant at 0.01 level (2-tailed); [*] Correlation is at 0.05 level (2-tailed)
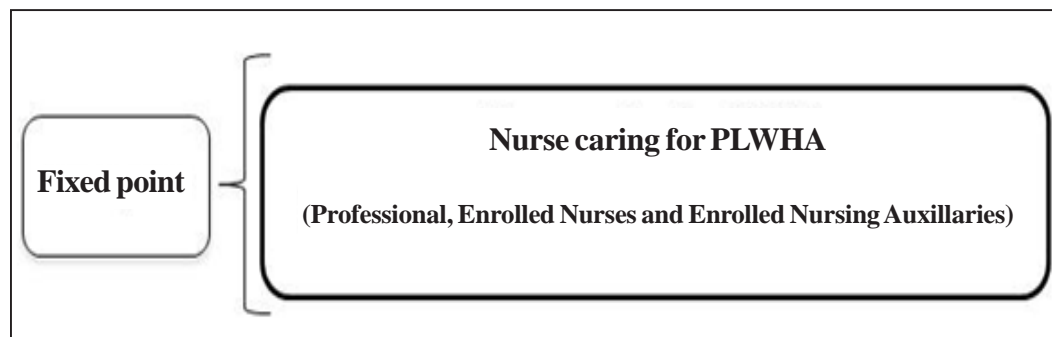

Fig. 1. Fixed point adapted from the cognitivism theory.
Source: Makhado and Davhana-Maselesele

External Reality

The paper revealed in Figure 2 that nurses are affected by their job characteristics both physically and psychologically. Emotional demands with regard to patients' needs, suffering and the environment characterized with patient death and increase in the number of those infected may place nurses in a stressful state (Hall 2004; Hudson 2001; Lee 2002; Peters et al. 2013; Khamisa et al. 2015; Valjee and Van Dyk 2014). The paper found a moderate identification of nurses with their patients and according to Bennett (1991), it was stated that when nurses tend to identify themselves with their patients they become stressed from providing extra emotional care and support.

Stigma and discrimination within nurses caring for PLWH was also revealed moderately, and enrolled nursing auxiliaries were reported to be highly stigmatized and discriminated both within and outside the hospital than the other nursing categories. This was supported by Bennett (1991), stating that nurses suffer stigma both in and out of the hospital setting due to their involvement in caring for PLWH.

The majority of nurses reported that resources to furnish them with HIV and AIDS information were inadequate. Lack of information and job related resources needed to furnish and stimulate nurses' personal growth and development exposes nurses to stress and risk for contagion (Koekemoer and Mostert 2006). Lack of information may predispose nurses to poor self-efficacy, risks and more work-related stress.

Furthermore, this may predispose nurses to poor self-efficacy, risks and more work related stress. Poor organizational support was revealed because most nurses reported low social rewards within and outside the hospital. Demmer (2004) indicated that maintaining the nursing role and good performance among nurses caring for PLWH can be stressful. Lower social and organizational rewards may expose the nurse to stress. According to Demmer (2004), less organizational support exposes nurses to stress.

The findings from this paper revealed that the majority of nurses felt used up at the end of the day as well as fatigued when they wake up in the morning and have to face another day on the nursing job. This implies that the physical demands of caring for PLWH leave nurses tired and exhausted. Azma et al. (2015) indicated that the nursing job could be demanding physically, with high levels of musculoskeletal stress, culminating in many pains and aches.

The demanding nature of the nursing job indicates that the external reality of nurses caring for PLWH is characterized by factors that have a negative impact on their psychosocial wellbeing. Whilst the job characteristics may not be easily changed, the personal and organizational stressors can be avoided to enhance a positive working environment. Thus, this will in turn improve the nursing care rendered to patients.

Negative Feedback and Cognitive Appraisal

Nurses deal with stressors differently. The paper revealed that nurses resorted to different ways of approaching the stressors. According to Figure 3, the majority of nurses resorted to harm-loss (51%). Hence, about thirty-five percent resorted to threat. Nurses (35%) felt frus-
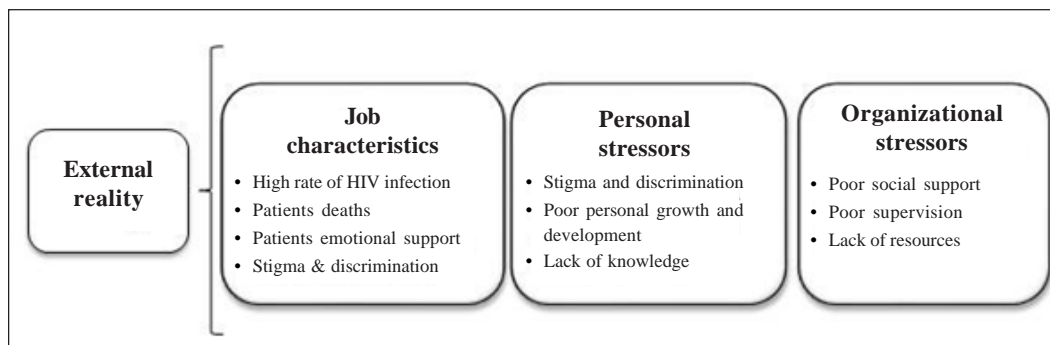

Fig. 2. External reality: Job characteristics, personal and organizational stressors
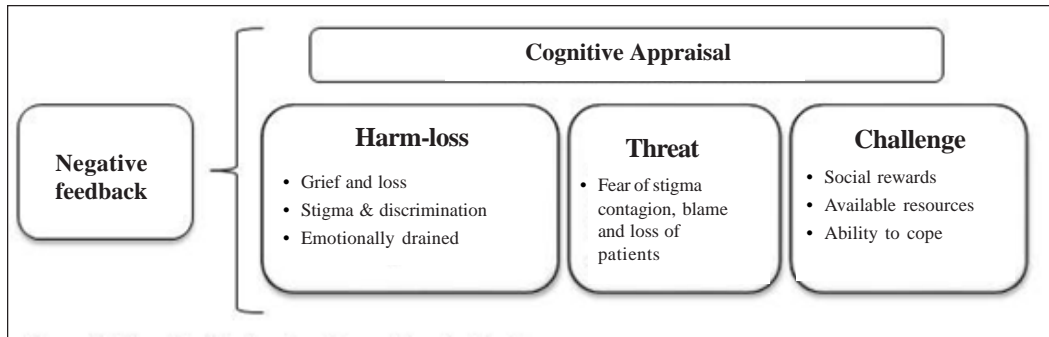*Source:* Makhado and Davhana-Maselesele

Fig. 3. Negative feedback and cognitive feedback
Source: Makhado and Davhana-Maselesele

trated about their caring role, drained emotionally from their role and felt like they are at the end of their rope. Nurses reported that they have trouble coping with the quantity of deaths within their unit, they normally feel stranded watching their patient suffer in the final stages of his/her illness, they feel powerless because no matter what they do, their patients with HIV and AIDS always die at the end and they had dealt with many losses due to HIV and AIDS. That is, they reported to suffer grief and loss. Spector and Goh (2001), in agreement, indicated that victims of stress are recognized to be at high risk, and researchers increasingly agree that nurses are also at risk of suffering grief and loss.

Furthermore, nurses fear stigma and discrimination within and out of the hospital, and they also fear blame, thus they feel that patients blame them for some of their problems. Miller (1995) and Valjee and van Dyk (2014) emphasized that nurses offer nursing care in fear of contagion, stigma and losing patients. As a result, a harm-loss or anticipated threat depersonalization and emotional exhaustion can develop, and the nurse

may have low personal accomplishment and depression (Demmer 2004). The results of this paper are consistent with Demmer's findings.

Nurses' cognitive appraisal of a negative environment leads to a negative response. This further complicates their caring role as they become emotionally drained, making it more difficult for them to render effective nursing care.

Biological Individualism: Emotional Exhaustion, Depersonalization, Depression and Job Satisfaction

As indicated in Figure 4, the paper revealed a moderate level of depersonalization and emotional exhaustion, and low personal accomplishment across all nursing categories. Hence, depersonalization, emotional accomplishment and personal accomplishment are measures of burnout. The majority of nurses reported moderate to extreme depression across all nursing categories.

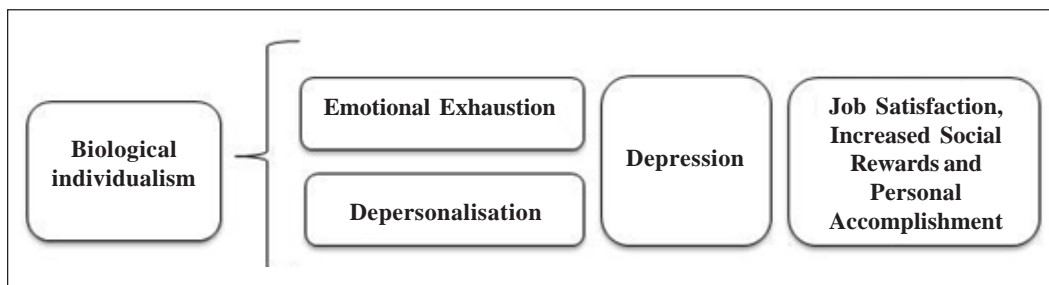A limited number of nurses caring for PLWH had low emotional exhaustion and depersonal-

Fig. 4. Biological individualism: Emotional exhaustion, depersonalization, depression and job satisfaction
Source: Makhado and Davhana-Maselesele

ization, meaning they may be free of burnout or not showing signs of burnout. These nurses chose to face the stressor or encounter as a challenge, hence only fourteen percent indicated a moderate personal accomplishment. According to Krohne (2002), nurses may see the stressor as a challenge that they feel confident to overcome and master, while utilizing the available resources. This response leads to resilience that develops among nurses as a result of caring for PLWH.

Biological individualism showed that there was less job satisfaction and moderately high depersonalization, depression and emotional exhaustion. This reveals that most of the nurses are not satisfied with the work environment and these impact the care they render.

Symbolic Representation of the Pre-given Reality: Burnout and Resilience

The majority of nurses caring for PLWH, as indicated in the discussions of the findings, reported more burnout, and only a limited number of nurses showed resilience towards caring for PLWH (Fig. 5). For nurses, the implications of burnout can be far-reaching (Coman 2010). Its impact spreads to the nurses' own health, their sense of wellbeing and overall attitude to their nursing job, career and profession (Coman 2010).

The implications of burnout may lead to poor patient care towards PLWH. On the other hand, limited number of nurses who reported moder-

ate resilience may provide quality care to PLWH. This has also been emphasized by Bam and Naidoo (2014) arguing that nurses use their internal and external coping skills to deal with the impact of caring for PLWH despite all the challenges they face. Figure 6 represents the complete conceptual model of psychosocial impact of caring for PLWH developed based on the findings of this paper. A conceptual model of psychosocial impact of caring for PLWH is a comprehensive model that projects the impact of caring for PLWH among nurses and a link between nurses, their working environment and patients. The quality of care provided to PLWH was found to purely depend on the psychosocial state of the nurses caring or providing care for them and the level of environmental stressors available to the nurses. Hence, not all nurses may show signs of burnout, as others may tend to be resilient.

CONCLUSION

The paper brought to light the different stressors nurses are faced with in their caring role. These stressor impact mainly negatively on the psychosocial wellbeing of nurses caring for PLWH. A conceptual model of psychosocial impact of caring for PLWH was developed based on the assumptions of cognitivism and cognitive appraisal theory.

The conceptual model of psychosocial impact of caring presents that quality of care provided to PLWH depends on the psychosocial
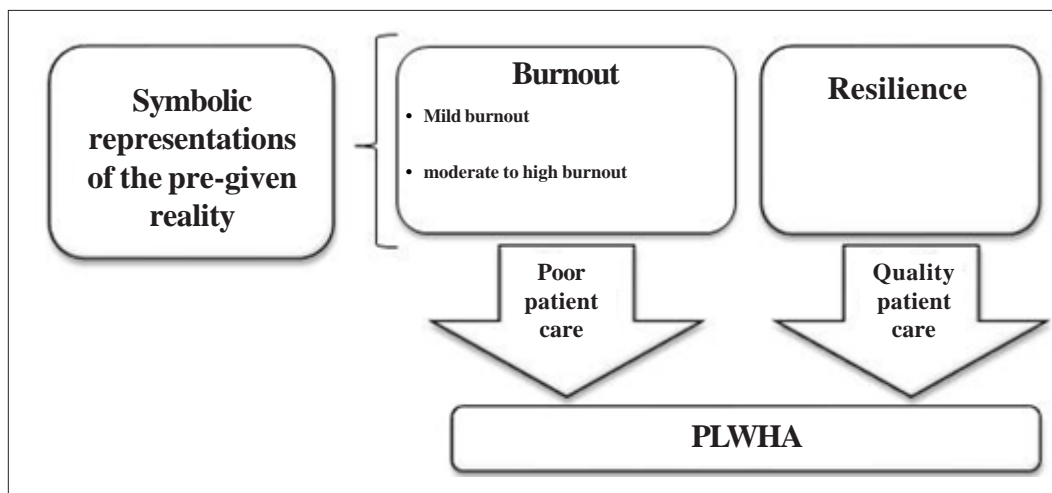

Fig. 5. Symbolic representation of the pre-given reality: Burnout and resilience
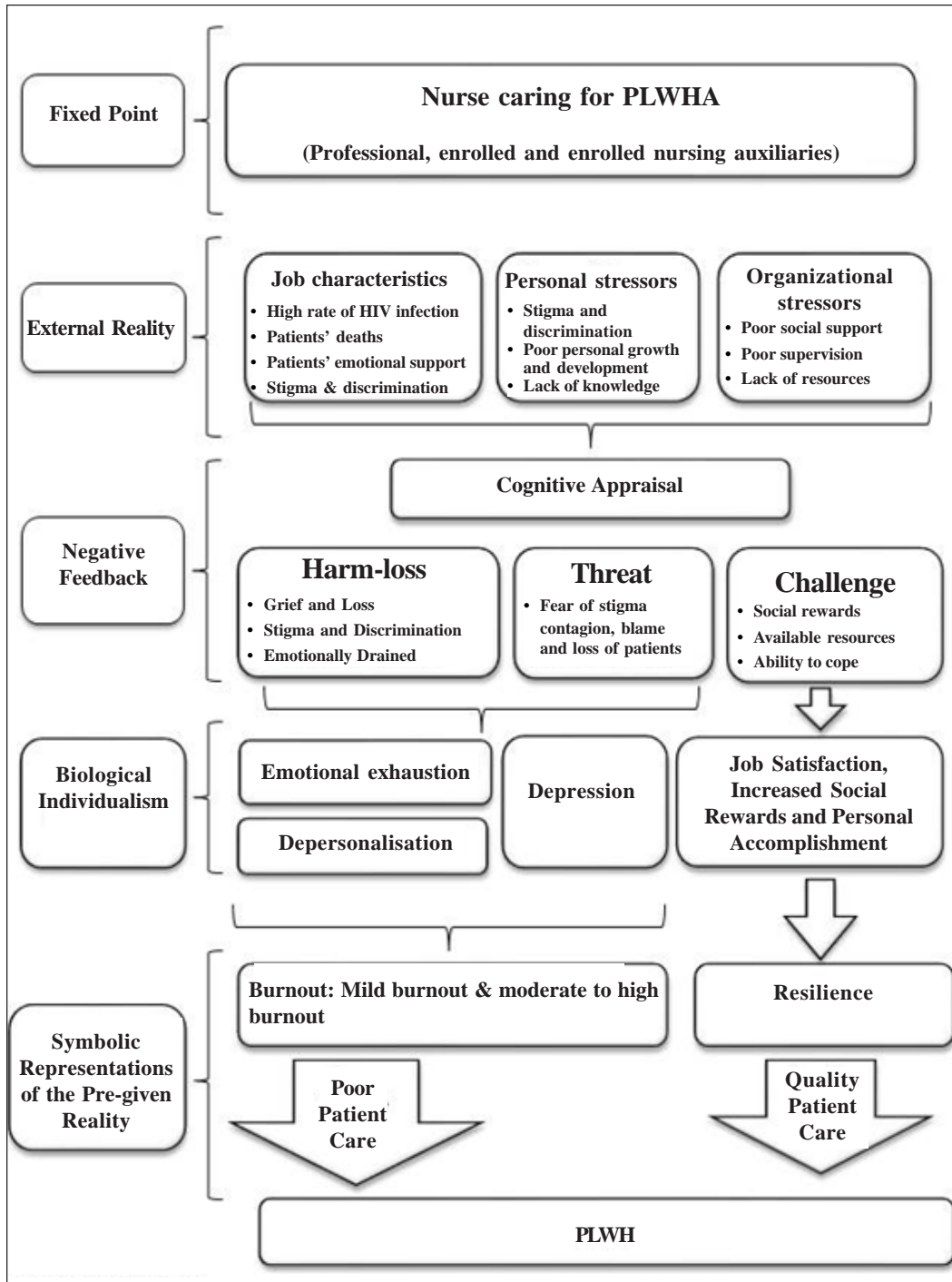*Source:* Makhado and Davhana-Maselesele

Fig. 6. Conceptual model of psychosocial impact of caring for PLWH
Source: Makhado and Davhana-Maselesele

state of the nurses caring or providing care. However, not all nurses may show signs of burnout, as others may tend to be resilient and utilize the available resources and their own ability to cope. For nurses to provide quality patient care, increased access to job, personal and organizational support need to be in place. Maintaining a conducive working environment and caring for caregivers is imperative in the provision of quality care.

RECOMENDATIONS

It is recommended that a qualitative study be undertaken in order to explore the experiences of nurses caring for PLWH as well as exploring the aftermath of their caring at an individual level. Furthermore, it is of paramount importance that guidelines for support for nurses caring for PLWH to be developed and applied in order to reduce burnout and promote resilience. It is also recommended that a conducive working environment should be ensured at all times for nurses to function effectively.

LIMITATIONS OF THE PAPER

The paper was conducted at one regional hospital in Limpopo province South Africa, where PLWH are cared for. Findings of this paper cannot be generalized to all hospitals within the province as the contexts may differ.

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