PREDICTORS OF NURSES DURING DISASTER SITUATIONS IN SAMAR PROVINCE

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APPROVAL SHEET

In partial fulfillment of the requirements for the degree, **MASTER OF SCIENCE IN NURSING**, this thesis entitled **"PREDICTORS OF NURSES DURING DISASTER SITUATION IN SAMAR PROVINCE"**, has been prepared and submitted by **HAZEL BRILLANTES,** who having passed the comprehensive examination is hereby recommended for oral examination.

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The Researcher

DEDICATION

To **GOD**, for HIS wisdom

To our **FAMILIES**, for their love

To our **MENTORS**, for their generosity

To our **TEACHERS**, for their altruism

To our **RESPONDENTS**, for their cooperation

To all of **YOU**, the researchers humbly

dedicate this academic masterpiece.

The Researcher

ABSTRACT

This study determined the extent and factors of nurse resiliency in disaster risk Samar Province. This study employed the descriptive-correlational method of research. The descriptive method was applied to describe the profile of the respondents in terms of age and sex, civil status, educational attainment, religious affiliation and religious involvement, nature of work, working area or ward, position, number of years in service, training on disaster, number of days of experience encounter in disaster; determine the extent of nurse resiliency in terms of disaster victims' health care management; and describe the factors along resiliency in terms of work commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control. The following are the salient findings of the study, In associating relationship between the perceived extent of nurse resiliency and the factors of nurse resiliency, the following evaluation was arrived at: commitment, significant; life satisfaction, not significant; spirituality, significant; attitude towards disaster, not significant; and locus of control, not significant. From the findings of the study, the following were the drawn conclusion, Of the nurse resiliency factors, commitment and spirituality proved to have significantly influence the perception of the respondents on the extent of nurse resiliency. While life satisfaction, attitude towards disaster, and locus of control was not significantly influential to the extent of nurse resiliency. Based on the conclusions drawn from the findings of the study, It is recommended that nursing administrators need to identify things that their staff nurse does not have control and refocus them on what they can control.

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Chapter 1

THE PROBLEM AND ITS SETTING

Introduction

Over the years, natural calamities and disasters have ravaged and gradually changed the geographical landscapes of any country. Not only the dynamism of such aspect but also the educational, economical, and health landscapes of countries are in jeopardy. It can disrupt the normal operations of any industries or place of work, even do some serious damages in the infrastructure, and worst, cost a lot of lives.

Globally, natural calamities kill an average of 60,000 people per year or 0.1% of deaths over the last ten years. Surprisingly, most of deaths recorded over the decade were brought about by floods and droughts followed by earthquakes and typhoons. Such disasters affected those are in poverty the most with higher deaths recorded to countries with low-to-middle income without the funds, infrastructures and plans to respond and protect people such events (Ritchie & Roser, 2018; Roser & Ortiz-Ospina, 2017).

In the Philippines, between 2007 to 2016, it had seen deaths, due to natural disasters, as low as 90 in 2016 and 7,800 in 2013 (Salazar et al., 2016). Disasters

have brought severe asset damages among communities. The province of Samar had its share of disasters, natural calamities over the years. Over the decade, the province was hit by multiple weather disturbances, typhoons and even super typhoons for that matter, occasional earthquakes and other natural calamities. Samar bore the brunt of the Typhoon Yolanda, considered as the most devastating disaster that struck the province, leaving the island isolated for weeks after the aftermath (Lagmay et al., 2015; Yamada & Galat, 2014).

The government agency that handles reduction of and management of disaster risks_estimated that 16 million people were affected, and 1.1 million houses were damaged. Disasters can have serious consequences for food security, nutrition and health (Nordin et al., 2013). Reducing the availability of food products, increase of food prices, and work set-up disturbances resulting in higher incidence of burnout in working communities (Soon, 2014). These disturbances as a result of inadequacy in food intake, health problems, or a combination of both, invariably affect the people (Jacob & Nair, 2012). Not only did it severe the nutritional pattern of all inhabitant of the province but also brought about harmful physiological and psychological effects to the people, more specifically, those who are working as essential workers that responds to such natural disasters. These essential workers that aids in emergency response during disasters includes a multitude of professionals.

In a study of Labrague (2018), it was found out that most of the nurses in the province of Samar, experience job stress at unprecedented rate especially

during disastrous events that influence their job satisfaction. The effects for such phenomenon involve registered nurses migrating to other countries that offer stable and high pay, and a safe one to boot. Such factors indicated that though highly resilient, they often wanted to stay on a safer work environment, or a place that can rehabilitate people during natural calamities.

Due to the potentially adverse psychological and physiological consequences of serving through crises, researchers have started to look at the idea of nurse resilience. The capacity to manage adversity and retain positivity, both personally and professionally, after witnessing work-related stress events is known as resilience for the healthcare professional (Robertson et al., 2016). It has been identified as one of the most valuable qualities to possess in the face of trauma since it aids in the prevention of post-traumatic stress disorder (PTSD) (Hoppes, 2012). Previous research has shown that disaster experiences in nurses can increase their risk of depression. Mixed results have been found in research that has used direct measures of an individual's resilience. Grafton et al. (2010) investigated whether the personal characteristics of age, experience and education contribute to resilience. Judkins and Rind (2015) examined the relationship between resiliency, job satisfaction, and stress among Texan home health nurses.

Findings from these studies imply that trauma encountered because of natural disasters can have pervasive and long-term consequences (Aarssen & Crimi, 2016). Additionally, previous researchers found that attitude - positive or negative (Almazan et al., 2018), locus of control - internal or external (Chung et al.,

2014; Karatas & Cakar, 2011), spirituality (Fombuena et al., 2016; Mehrinejad et al., 2015; Reutter & Bigatti, 2014), and life satisfaction (Nemati & Maralani, 2016) affects their resiliency. Clearly, resilience is a valuable trait for nurses to have, particularly in the aftermath of catastrophic and other stressful events.

However, no empirical evidences found out on these variables affecting nurse resiliency. There is a scarcity of nursing literature on disaster-related population readiness. This manuscript sought to explain the meaning of this new idea using a nursing approach for discussing principles in order to promote nursing study and practice. For nurses and nursing science users, this definition study offered predictors to the phenomena of disaster-related resilience.

The research proposes the definition, antecedents, attributes, consequences, and empirical referents of disaster-related resilience among nurses which makes recommendations for nursing education and science. It also gives nurses a solid basis for taking part in resilience-building programs that could save lives and help people heal more quickly post disaster, thus the conduct of this study.

Statement of the Problem

This study determined the extent and factors of nurse resiliency in disaster risk Samar Province.

Specifically, this study answered the following questions:

1. What is the profile of the respondents in terms of?
    1.1. age and sex;

1.2. civil status;

1.3. educational attainment;

1.4. occupation;

1.5. religious affiliation and religious involvement;

1.6. nature of work;

1.7. working area/ward;

1.8. position;

1.9. number of years in service;

1.10. training on disaster resiliency; and

1.11. number of days experienced encountered disaster?

2. What is the extent of nurse resiliency along:

2.1. disaster victims' health care management?

2.2. work commitment;

2.3. life satisfaction;

2.4. spirituality;

2.5. attitude towards disaster; and

2.6. locus of control?

3. Is there a significant relationship between the nurse resiliency and factors along resiliency?

Hypothesis

From the specific questions, the null hypothesis will be tested:

1. There is no significant relationship between the nurse resiliency and factors along resiliency.

Theoretical Framework

This study used Roy's Adaptation Model (Naga & Al-Khasib, 2014), Transcultural Theory by Leininger (Betancourt, 2015), Maslow's Hierarchy of Needs (McLeod, 2018), and Selye's Stress Theory (Tan & Yip, 2018).

This study is primarily anchored to Roy's Adaptation Model (Roy, 2019) on promoting adjustment, that occurs when people respond positively to environmental changes. Roy said that the key concepts of adaptation are made up of four components: person, health, environment, and nursing. In the theory, a person is a bio-psycho-social being in constant interaction with a change in environment. This includes people as individuals, as well as in groups such as families, organizations, and communities. This also includes society as a whole. Furthermore, it notes that fitness is an unavoidable aspect of one's life, characterized by a healthcare continuum. Health may also be described as a condition or a phase of integration and wholeness.

Roy's model is also related to this present study because according to this theory, nurses accept the humanistic method by respecting and appreciating the views and viewpoints of others. Nursing entails a great deal of interpersonal interaction. Life has a diverse goal with the overall goal of having honesty and honor. The model's aim is to encourage adaptation among nurses in disaster prone

province, thus, by identifying attitudes and influences that affect coping capacities and acting to improve environmental experiences, we will contribute to fitness, health and wellbeing, and death with dignity. Adapting the nursing care strategy depending on the patient's improvement toward wellbeing can be done by the nurse and all health care providers in the nursing practice.

Likewise, this study is equally anchored to Leininger's Transcultural Theory, also known as Culture Care Theory, which focuses on describing, explaining, and predicting nursing similarities and differences focused primarily on human care and caring in human cultures (Leininger, 1996, 1997, 2002). The theory maintains that illness and health are influenced by a variety of influences, including the patient's understanding and coping strategies, as well as his or her social status. It also stressed that cultural competence is an important component of nursing and that religious and cultural understanding are essential components of health care.

Leininger's theory is deeply related to this present study since this study focuses on resiliency of nurses that is one of the important characteristic of a nurse working in an expose change of environment that involves both external and internal factors such as culture and belief that influence all spheres of human life which is also an important menu in health care.

Next, the study is supported by Maslow's Hierarchy of Needs, a form of motivation theory where it maintains that a person must satisfy first a certain level or needs before going to the next, a bottom-up perspective which includes the

following: [1] physiological, [2] safety, [3] love and belonging, [4] esteem, and [5] self-actualization. The first four is often depicted as deficiency needs which motivate people when they unmet, a situation wherein motivation decreases as the needs are satisfied. White the last one is often referred to as growth or being needs, the desire of an individual to grow as a person, a situation wherein motivation increases as needs are gratified (Maslow, 1943).

This theory is deeply related to the study since part of what makes persons resilient is their motivation to work, and in cases of natural calamities or disasters, they are longing for the sensation of safety, being able to work with nothing to worry about except how they carry out their task as a nurse.

Lastly, this study is also rooted to Selye's Stress Theory which is based on the physiology and psychobiology of an individual. He states that a stressor, any event that threatens or disrupts an organism functioning or well-being can lead to three main responses of the body: alarm, resistance, and exhaustion. Alarm is when a stressor is introduced to a person triggering a "fight-or-flight" response and bodily resources, in the form of hormones cortisol and adrenalin, are now mobilized. Resistance is when the parasympathetic nervous system returns bodily functions to normal while the body wards off the stressors. This stage is accompanied by an increase in blood sugar levels, cortisol and adrenalin as manifested by a rise in blood pressure, breathing, and heart rates. Finally, exhaustion is when the body used every once of defense it has, and the stressors

are still beyond control. This is when the body becomes more susceptible to diseases and even death (Seyle, 1985).

This theory is related to the study since it centers its attention to stress and human responses. Nurses, when confronted with a disastrous event, could become unstable and not to mention in a lot of stress because something beyond their control is disrupting their function and work in general. It is necessary to include this theory as it can help the researcher in understanding how stress plays into the respondent's resiliency, fully aware that it can disrupt not just the physiology of the nurse but also their psyche as well.

Conceptual Framework

Figure 1 showcases the conceptual framework or the logical context of the study showing the variables involved. As portrayed in the overall design of the schema, the study is designed to determine the nurse resiliency in the province of Samar. Therefore, to realize this, the study involved nurse respondents both from the Rural health units including government and private hospitals.

First, the study collected all necessary information on the profile of the nurse-respondents in terms of their: age and sex, civil status, educational attainment, religious affiliation and religious involvement, nature of work, working area or ward, position, number of years in service, training on disaster, number of days of experience encounter in disaster. Likewise, the study

determined the extent of nurse resiliency in terms of disaster victims' health care management as perceived by the respondents.

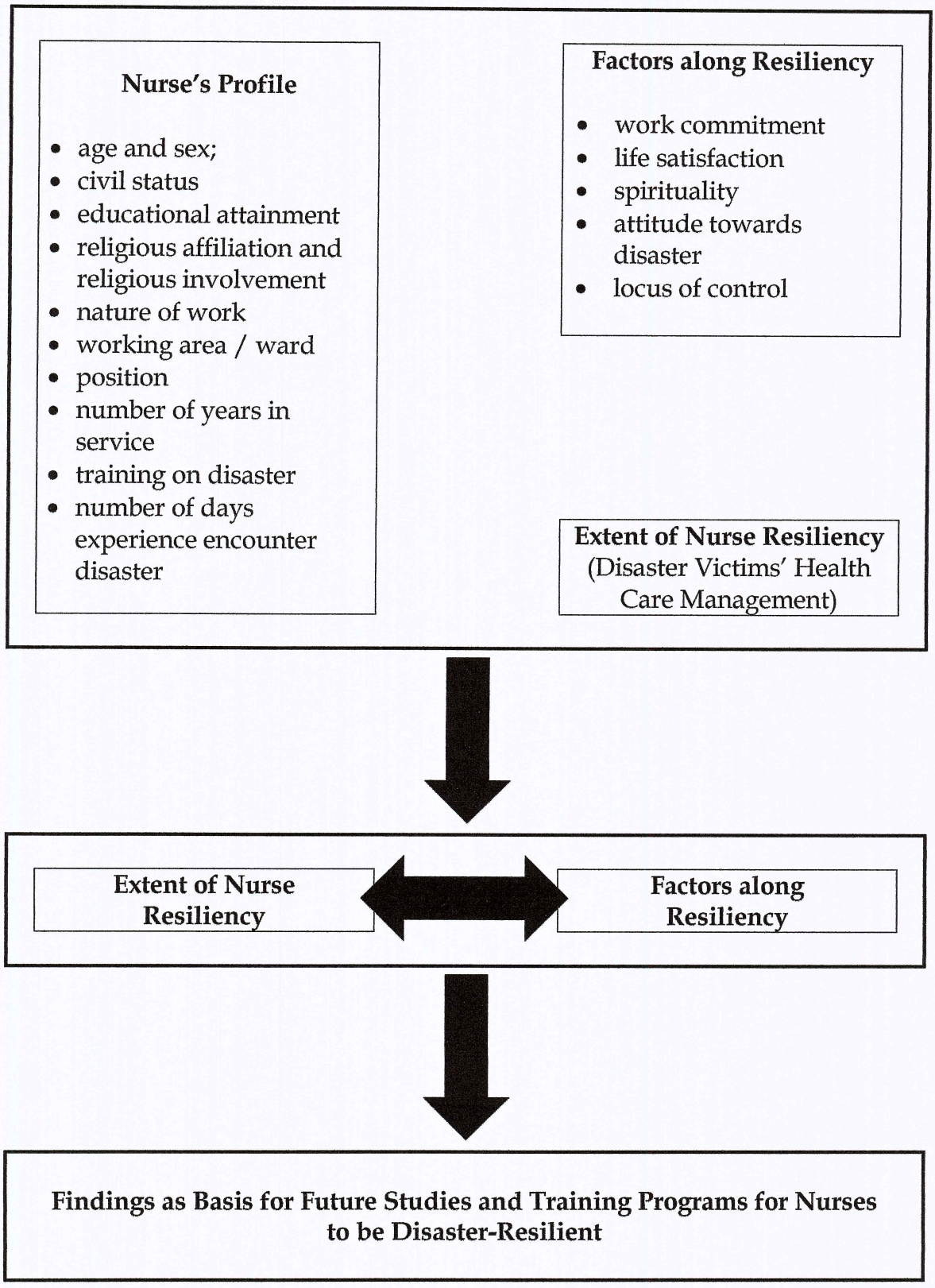


Figure 1. The Conceptual Framework of the Study

Last, the study collected information on factors along resiliency in terms of work commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control.

The next step, as reflected on the second box, is determining the relationship between nurse resiliency and factors along resiliency as denoted by a double-headed arrow.

The frame is again connected to the lowest box representing findings of the study. The findings of the study will provide the researcher the inputs in the formulation of recommendations which are helpful in the attainment of the goal of the study that is to enhance the level of resiliency among nurses and could be a source for an intervention program or a form of policy redirection, which can be utilized in revisiting, renewing and reinforcing disaster resiliency among nurses.

Significance of the Study

This research would be of great help to the nurses, health care delivery units, community nursing administration and future researchers.

Nurses. Through the findings of this study, the nurses as the primary implementers of nursing Care, this research would be of assistance in creating awareness and formulate solutions on how to become disaster resilient nurses.

Patients. Through the findings of this study, patients as the beneficiary of care, this research may be of help in the improvement and proper practice of the method that can contribute to their development and well-being.

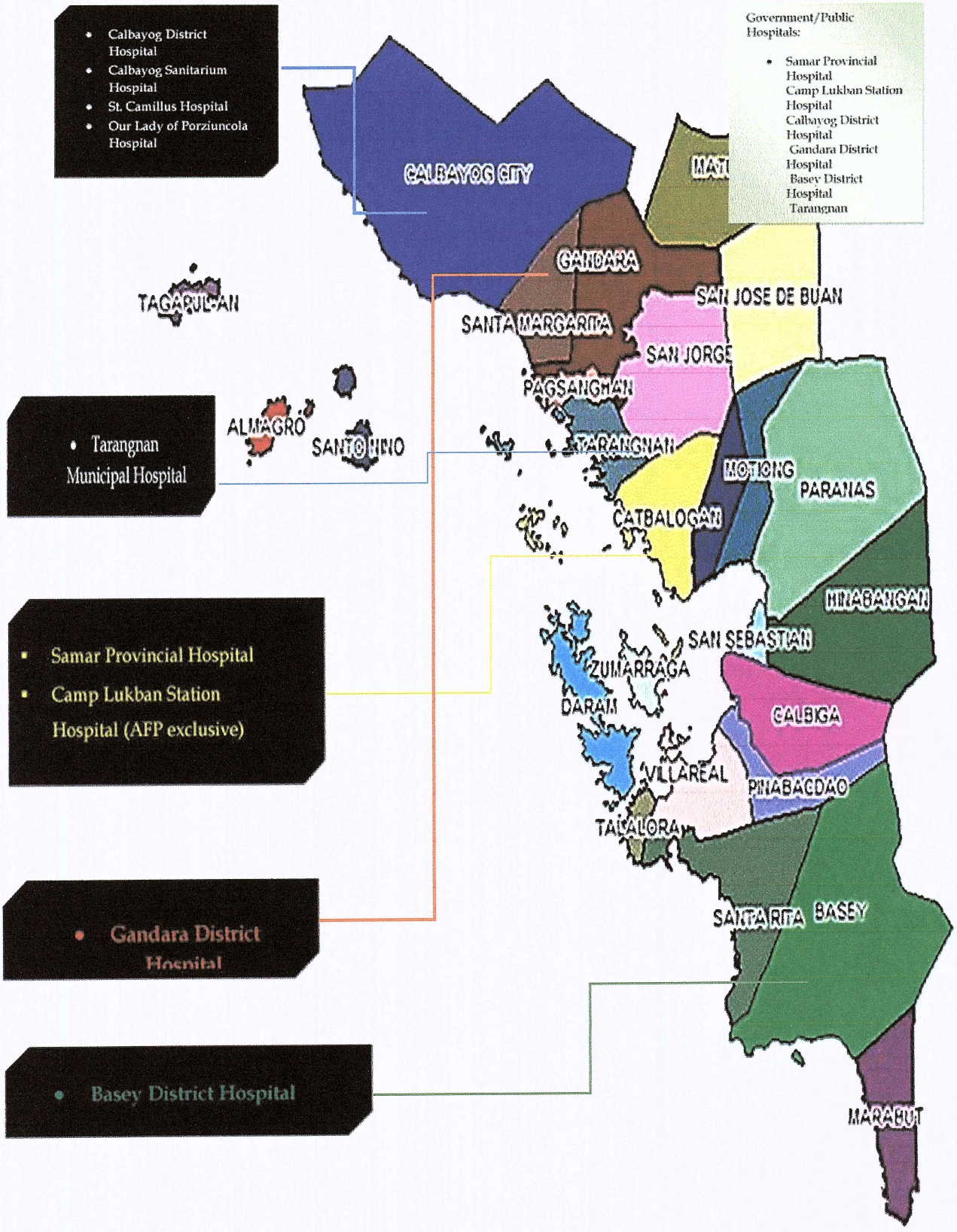
Health Care Delivery Units. The results of this study that have been generated, may provide adequate information with regards to the status of nurse's disaster resiliency which may provide ample data for quality improvement of the institution.

Nursing Administrators. Through the findings of this study, this will serve as a guide to the nursing administrators, to further improve the nursing method and make it compatible with nurses' disaster resiliency and also to help formulate new programs and methods profitable to the target population.

Future Researchers. Through the findings of this study, it can be a rich source of the future researchers' review of related studies and in the different areas of nursing that may lead to further improvement of disaster related resiliency in nurses and other programs and methods in the healthcare settings. The research design, instruments, and the conceptual framework might also be a great help in the formulation of their studies.

Scope and Delimitation

The study focused primarily on the nurse resiliency in a disaster-risk Province of Samar, Region VIII Eastern Visayas, Philippines. The study is limited to the selected nurses currently working in one of the following locations: twenty-four (24) rural health units located in all municipalities, six (6) government hospitals, and four (4) private hospital in the Province of Samar. The perceived extent of nurse resiliency in terms of disaster victims' health care management was


Calbayog District Hospital
Calbayog Sanitarium Hospital
St. Camillus Hospital
Our Lady of Porziuncola Hospital
Government/Public Hospitals:
Samar Provincial Hospital
Camp Lukban Station Hospital
Calbayog District Hospital
Gandara District Hospital
Basey District Hospital
Tarangnan
CALBAYOG CITY
GANDARA
SAN JOSE DE BUAN
SANTA MARGARITA
SAN JORGE
PAGSANGHAN
TARANGNAN
MOTIONG
PARANAS
CATBALOGAN
HINABANGAN
SAN SEBASTIAN
ZUMARRAGA
DARAM
CALBIGA
VILLAREAL
PINABACDAO
TALALORA
SANTA RITA
BASEY
MARABUT
TAGAPUL-AN
ALMAGRO
SANTO NIÑO
Tarangnan Municipal Hospital
Samar Provincial Hospital
Camp Lukban Station Hospital (AFP exclusive)
Gandara District Hospital
Basey District Hospital

correlated with the following factors along resiliency: work commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control. This study was conducted from 2018 to 2019.

Definition of Terms

The following are defined conceptually and operationally for easier understanding of the readers.

Attitude. Conceptually, this term refers to a psychological construct, a mental and emotional entity that inheres in, or characterizes a person (Businessdictionary, 2015). Operationally, this term refers to the participants' response and disposition toward sustainability issues after a disaster.

Commitment. Conceptually, this term refers to a strong sense of intention and focus. It typically is accompanied by a statement of purpose or a plan of action (Benn, 2011). Operationally, this term refers to the participants' engagement and dedication to their line of work, especially during disaster situations.

Disaster. Conceptually, this term refers to a sudden event, accident or a natural catastrophe that has unfortunate consequences often causes great damage or loss of life (Etkin, 2016; Y. Kim & Sohn, 2018; Oliver-Smith, 2005; Quarentelly, 1985). Operationally, this term refers to any calamitous event which disrupts the function of the participants.

Life Satisfaction. Conceptually, this term refers to a state of emotion, like happiness or sadness (Prasoon & Chaturvedi, 2016). Operationally, this term refers

to the degree to which the participants evaluate the overall life quality and how much they like the life they lead, in relation to the premise of nurse resiliency in a disaster risk Samar Province.

Locus of Control. Conceptually, this term refers to the degree to which people believe that they believe they have power over the consequences of situations in life, as opposed to powers outside their influence. (Cobb-Clark, 2015; Cobb-Clark et al., 2016; Heywood et al., 2017; Lee, 2013; Rubin, 2009). Operationally, this term refers to the participants' perception of life events and whether they were within their control or controlled by external forces.

Spirituality. Conceptually, this term refers to the state of being fixated with the soul or human spirit and how life is affected, perceived connection, to something bigger other than themselves (So, 2014). Operationally, this term refers to the participants' sense of connection to something higher than themselves, to others and to the world, as a response to disastrous events.

Resiliency. Conceptually, this term refers to an ability to recover readily from illness, depression, adversity, or the like (Bastan et al., 2018; Bishop et al., 2013; Laska, 2012). Operationally, this term refers to the participants' sense of control and coping ability over a stressful situation, in this case, the control and coping to disastrous events.

Chapter 2

REVIEW OF RELATED LITERATURE AND STUDIES

This chapter presents a review of some related literature and studies taken from books, journals, periodicals, unpublished thesis and other reading materials and information surfed and gathered from internet. Numerous researches conducted here and abroad were carefully considered to shower more light and information in his undertaking. All the data gathered provided the researchers better insights needed for the conduct of this study.

Related Literature

Resilience is the ability to bounce back or cope successfully despite substantial adversity. Resilient nurses would learn to overcome these difficulties and develop better coping mechanisms to address stress through exposure to difficult working situations and environments (Faye et al., 2018). Strategy to

improve resilience is to define protective factors for nurses, as well as improve key skills to protect themselves against problems in the work environment.

Rudzinski et al. (2017) discussed three recommendations to develop resilience in health professionals. The first of these recommendations is that predictors of resilience, such as during undergraduate education cognitive ability, adaptability, positive identity, social support, coping skills, spiritual connection, ability to find meaning in adversity, can be strengthened and learned by educational activities. Another recommendation is to give opportunities to reflect upon and learn from practice and from other practitioners. The third recommendation is that professional cultural generativity, demonstrated by altruism, setting a good example, mentoring, leading, coaching and motivating others should be encouraged in those entering health professions (Mealer et al., 2012).

Nurses today face the demands of responding to organic, man-made, and technical disasters, and there is a dearth of disaster preparedness material in nursing school curricula (Li et al., 2017; Zarea et al., 2014). The need for trained nurses able to respond to disasters and engage in emergency preparedness and recovery efforts is well known, and in order to address this issue, continuous development is required and of course, with_specialized education and training (G. Lowe et al., 2012). Despite all these challenges, resilience enables nurses to cope with their work environment and to maintain healthy and stable psychological functioning (Hart et al., 2014).

The problems related to workplace adversity can be negative, stressful, and traumatic, resulting in difficult situations or episodes of hardship for nurses (Liu et al., 2012). In the nursing sector, stress is a big issue. Common stressors are work overload, role conflicts, experiences of aggression, lack of time, staffing issues, shift work, lack of self-care, poor job-related interpersonal relationships, feeling powerless to provide quality care, struggling with competing demands, ensuring excellent patient care, uncertainty concerning treatment, death and dying, conflict with doctors, peers and supervisors and inadequate emotional preparation (Cocchiara, 2017; Crespo et al., 2019). Negative strain factors have an effect on nurses' well-being as well as their patient caretaking. Factors such as balance in business life, hope, control, professional identity and clinical supervision contribute to nurses' resilience (Draper-Lowe, 2016; L. D. Lowe, 2013).

Nurses also played a role in disaster relief. Nurses should have the requisite expertise and skills to serve in a crisis and to fulfill the needs of the society they are representing (Y. F. Guo et al., 2018; Y. fang Guo et al., 2019). Disaster preparedness, including risk assessment and multidisciplinary management plans at all system levels are vital to providing appropriate solutions to a catastrophe population's short, medium, and long-term healthcare needs (Roccaforte, 2014).

Work Commitment among employees has been an addressed in various scholarly works (Brewer et al., 2016; Brown et al., 2013; Clements et al., 2016; Gellatly et al., 2014; Russo & Buonocore, 2012). These researchers have taken a variety of approaches to the question of what causes differences in organizational

engagement of employees and how these discrepancies affect employee success, recruiting, and productivity. In addition, most modern scales incorporate an angled aspect in the form of a continuance pledge on some basis (Meyer et al., 2012), and more recently, the economic exchanges sub-component of continuance commitment (Taing et al., 2011).

The first major shift in the conceptualization of work commitment was marked by a change in focus from side-bets to psychological attachment. Other researchers have defined work commitment as the psychological attachment that individuals develop toward an organization (S. Kim & Wright, 2011; Nguyen & Wright, 2015; Wright & Grace, 2011). Organizational engagement is a major factor that affects a variety of organizational consequences such as employee work job satisfaction and job performance, workforce attrition, and organizational commitment, according to one of these concepts.

Klein & Park (2015) said that organizations should be interested in organizational commitment since there is a body of research that ties organizational commitment to a variety of organizational outcomes. From their perspective, organizational commitment is the relative strength of an individual s identification with and involvement in a particular organization that is characterized by three factors: 1) a deep confidence in and recognition of the organization's aims and principles, 2) a readiness to put forth significant effort on behalf of the organization, and 3) a strong desire to remain a member.

These authors contended that their definition does not exclude the possibility that a person is committed to other aspects of the environment, such as family and friends, nor does it mean that an individual will display all three of these attributes (Yahaya & Ebrahim, 2016). Ojakaa et al. (2014) viewed the concept more from a behavioral perspective and referred to organizational commitment as one's persistence in making sacrifices for the good of the organization. It is seen as a positive orientation in which an employee exhibits value-based affirmation. It incorporates the idea of the rewards that an individual perceives he or she may derive from attachment to the organization. Affective commitment incorporates the employee's emotional attachment and a sense of obligation to the organization; the latter includes moral obligations. Employees often exhibit some combination of these commitment types. Some studies measure only affective commitment because it is believed to be the type of organizational commitment most closely linked to turnover.

According to the literature, work commitment include personal characteristics, work experiences, and job characteristics. Communication is a theme among many of these antecedents. According to Luci & Zangaro (2018), when an organization communicates honestly and openly, builds a trusting relationship, and offers a sense of belonging to an employee, the organization will increase the likelihood of retaining a morally.

Cummings et al. (2010) discussed that the relative importance of negative work outcomes on nurses' overall well-being. Strategies to reduce emotional

exhaustion, enhance nurses' personal accomplishment and satisfaction with professional status, and accommodate shift preferences for work scheduling were suggested. Replicating this study with nurses from other geographic areas using random selection will be needed to increase the generalizability of the findings.

Hayes et al. (2015) mentioned that hemodialysis nurses had an adequate degree of job satisfaction and a favorable perception of their work environment, despite high levels of burnout. Nurses that were experienced and had served in hemodialysis for a longer period of time reported higher levels of happiness, less fatigue, and less burnout than younger nurses. Stress and burnout were higher in in-center hemodialysis units than in home training units.

Greater satisfaction with the work environment was strongly correlated with job satisfaction, lower job stress and emotional exhaustion. Hemodialysis nurses encountered high levels of burnout even though their work environment was favorable, and they had acceptable levels of job satisfaction (Gorton & Hayes, 2014).

Another research finding described that nurses recorded high levels of mental fatigue, mild dissociation, and low levels of personal achievement. Nurses that were younger, on shift service, or from higher-grade hospitals have a higher burden of job burnout, according to linear regression models. Both the task substance questionnaire and the effort-reward discrepancy survey models had prognostic powers of nurse burnout, but the effort-reward disparity questionnaire system was more effective in forecasting two Maslach Burnout Inventory

subscales of cognitive distress and derealization than the other. Burnout was common among Shanghai nurses, and it was closely linked to work-related distress. To alleviate the load of burnout among Chinese nurses, interventions aimed at mitigating work-related stress are needed (Xie et al., 2011).

Derealization was also higher in nurses who showed greater emotional fatigue. Personal achievement and mental depression or disengagement seemed to have an ou pas' relationship, according to the profiles. Nurses with higher levels of emotional distress or detachment did not always show poorer self-satisfaction (Gómez-Urquiza et al., 2017). In the case of cognitive fatigue, depersonalization was discovered to be a detrimental coping mechanism. Emotional fatigue should be tested for early diagnosis and intervention rather than anhedonia or expectations of personal success (Thomson & Jaque, 2018).

Nurse leaders play a critical role in this health disaster, needing relational maturity to successfully resolving internal tensions and interpersonal interactions (West, 2016). They learned social, political and analytical skills, as well as the necessary skills for preparing and executing policies in areas where nothing existed in the past. Building support mechanisms was a useful tool for resolving tensions between family and professional responsibilities, which is relevant to clinical settings (Johansen & Cadmus, 2016).

Finding an appropriate method of educating hospital staff about emergency preparedness is a critical challenge. However, the optimal strategy for implementing such education still is under debate. The Hospital Disaster Life

Support (HDLS) program was created to use a variety of instructional methods to teach emergency preparedness values to hospital staff (Baack & Alfred, 2013). Participants in HDLS demonstrated an improvement in awareness and expressed high level of satisfaction with their HDLS interactions. These findings show that HDLS is an important method of emergency preparedness training for hospital staff (Jayaraman et al., 2014).

Compassion is a universal language that cuts through races, religions, and countries (McSherry & Pearce, 2018). Responding to crises as caring and empathetic health care professionals is a fundamental obligation. Sympathy and respect can't be operationalized until caregivers act in a culturally aware, ethically sound, and morally caring manner (Barlow et al., 2017).

In addition to being accepting of spirituality other than their own, providers must read literature and familiarize themselves with the afflicted population's primary spirituality Making ethically sound decisions entails weighing the costs and rewards to the whole population. (Shah et al., 2011). Spiritual treatment is a significant aspect of overall wellbeing, so recognizing and addressing the religious needs of vulnerable communities is an important task for health care services to play (Ramezani et al., 2014).

Since disaster relief is a collaborative effort, emergency care professionals must rely on the skills and resources of other members of the team; it is critical to coordinate activities with local religious, public governmental, and non-governmental agencies to address the indirect impacts of a disaster's spiritual

influence and to avoid further disenfranchisement of the impacted population (Deal & Grassley, 2012).

Disasters happen, and the best way to lessen their devastation is to strengthen emergency preparedness and react to any tragic situation jointly and bravely (Jose, 2010). Natural or human-caused disasters and humanitarian crises cause serious and sometimes protracted distress in the affected people (Boonmee et al., 2017).Nurses have a role to play in providing assistance because women and their infants experiencing such crises have unique vulnerabilities and needs (Arbon et al., 2013).

Nurses and other female's healthcare professionals to global aid emergency relief programs, as well as the planning and training exercises they should do to prepare to volunteer for a world health assistance organization (L. M. Adams & Berry, 2012). Numerous medical complexities and concerns, as well as suggested priorities for delivering reproductive health services in disaster areas, are addressed (Drayna et al., 2012). Nurses may make significant contributions to the protection, fitness, and comfort of women and families who have endured a major catastrophe, military struggle, or illness outbreak by arriving in the field well equipped to contribute and coordinate (Sundström & Dahlberg, 2012).

Nurses comprise the highest percent of health and medical workforce. Nurses must understand the national disaster management cycle. Without nursing integration at every phase, communities and clients lose a critical part of the prevention network, and the multidisciplinary response team loses a first-rate

partner. Nurses, which make up the foundation of the health-care system and are the primary health-care professionals in close communication with the public, help to improve the health of patients, households, neighborhoods, and the environment as a whole (Riehle et al., 2013). Nursing schools have little to no catastrophe nursing education, and there is a scarcity of qualified teachers and faculty (Achora & Kamanyire, 2016).

The need for appropriate evidence-based disaster preparation of healthcare professionals at all levels, including the implementation of criteria and recommendations for training of multidisciplinary health responses in major disasters, has been designated as a high priority by the disaster response group, despite the fact that training and education have long been recognized as integral but not systematic. During crises, the nurse's role has evolved from merely healing the sick and wounded to developing the capacity to respond to a crisis in terms of resiliency, prevention, response, rehabilitation, and assessment. Nurses must have the expertise and abilities to react to sensitive circumstances in an appropriate manner. (Labrague et al., 2018).

Disasters are unforeseen disasters that claim lives, harm communities, damage property, and disrupt the environment. Some natural disasters, such as flooding, volcanoes, and hurricanes, are predicted and warned in advance, allowing health care organizations to prepare ahead of time. However, some natural disasters, such as earthquakes and tsunamis, are not predicted or warned in advance. Furthermore, magnitude of human-made catastrophes also gives no

advance warning including acts of terrorisms, chemical plant explosions, building collapse and industrial accidents. Therefore, each type of event requires and must be consider uniquely (Giarratano et al., 2014). Health care staff should be engaged in emergency preparation at all levels, particularly those that are involved in the immediate response to these incidents (Al Thobaity et al., 2017).

Developed countries can normally rebuild their economies and infrastructure, but emerging countries are more vulnerable due to a lack of disaster management funding and the impact of disasters on health services, the welfare system, and the economy of the region, and disasters can strip out years of growth in minutes. Disaster contingency planning and management plans at all spatial scales are critical to providing active solutions to disaster-traumatized people's health needs (Arziman, 2015). The emergency room of a hospital, like all prevention and crisis recovery programs, should be able to cope with heightened demand for care at those incidents. Nurses play a critical role in helping victims of such tragedies. As a result, it is important for nurses to be able to deal with the aftermath of disasters (Ahayalimudin & Osman, 2016).

Locus of control may be an important factor in the degree of independence exercised in decision-making by nursing students. These results also suggest that individuals with an expectancy for external control may be significantly compromised in their ability to be professional and accountable in their nursing practice (Goodrich, 2014).

The importance of health belief, in particular, health locus of control, in mediating health behaviors and resultant health status is discussed (Chen et al., 2012). It is proposed that it is not sufficient to accept patients' health views in isolation; health providers' beliefs must also be examined (Mert et al., 2012).

Health beliefs conceptualized in terms of Multidimensional Health Locus of Control (MHLC) were assessed in a group of nurses. Measures of 'internal', 'powerful others' and 'chance' health locus of control beliefs were obtained (Ng et al., 2014). There were significant variations in the structure of health fulcrum of control values, and it was proposed that these discrepancies may have important implications for nursing education and practice.

The association between people's views of their influence over the system and other aspects of cognitive processing and conduct has piqued researchers' attention. However, as a particular field in which to examine perceptions of power, health attitudes and habits have gained less consideration (Grotz et al., 2011). Since many wellness interventions rely on cooperative practices and many health services are based on the presumption of maneuverability, patients' expectations of autonomy seem to be a valuable place to investigate (Açıkgöz Çepni & Kitiş, 2017).

The locus of control, a social learning theory human variance construct, has shown some potential in predicting and describing complex wellbeing behaviors (April et al., 2012). However, since enforcement issues are so nuanced, they are difficult to explain in a single straightforward description. The aim of this paper is

to analyze literature that shows the importance of locus of control in understanding health-related behaviors._Using this concept as a foundation, the author would identify a mechanism for integrating the concept into the nursing practice, as well as strategies for increasing nurses' interest in strength and resilience while retaining a locus of control (Almazan et al., 2018; Chesak et al., 2015; Ng et al., 2014; Pannell et al., 2017).

In summary to this study, the life of a nurse can be challenging at times especially during disaster, quality of patient care to patients cannot be sacrificed. Nursing staff members must continually dedicate themselves to putting their best foot forward to provide quality care. Enabling work commitment, life satisfaction, spirituality level, positive attitude and good locus of control will improve their caring capabilities and enhance the level of care delivered to patients. Delivering the best possible care to patients involves a resilient sense of moral responsibility born of commitment, life satisfaction, spirituality level, positive attitude and good locus of control of control. Resilient nurse is adaptable to stress or and consistent application of best practices. Adherence to these concepts can demonstrate adaptability in the workplace.

Related Studies

A study of Hutton (2008 as cited by de Carvalho et al., 2017) "Older people in emergencies: considerations for action and policy development," demonstrating the neighborhood resilience investments can yield concrete short-

and long-term gains that parallel or outweigh the costs is crucial for lifetime engagement to resilience. The overall value of a community's properties—both higher leverage assets and those of high socioeconomic, cultural, and/or environmental value—requires a catastrophe readiness decision-making process that considers both qualitative and calculation was based.

Possession of a population's properties is also critical; ownership ensures responsibility for an asset and, as a result, the need to make sufficient resilience measures to prepare for dangers and threats. At the moment, there is no information available to help communities consider how to assign meaningful worth to any of their possessions. Competing demand for many societally related goods (education, social services) can be a significant impediment to progress in building community resilience, particularly during periods of economic difficulty.

Lee McCabe et al. (2014) study of "An academic-government-faith partnership to build disaster mental health preparedness and community resilience" provides a research basis for defining community seismic resilience as well as analytical resilience indicators that can be helpful in a concerted research project to improve this resilience. It is an early version of work that is still underway at MCEER. In this framework there are 4 dimensions of resilience: Technical (survivability of physical systems); Organizational (Capacity of key organizations to respond); Social; and Economic. They are divided into two groups, Technical and Organizational, which focus primarily on the protective side, and Social and Economic which focus primarily on the protected side. They

also consider 4 'aspects' that they intersect with their 4 dimensions: Robustness; Redundancy; Resourcefulness; and Rapidity.

A study of Subbarao et al. (2008 as cited by Walsh et al., 2014) "A consensus-based educational framework and competency set for the discipline of disaster medicine and public health preparedness," discussed Disaster Nursing, structured as a 2-week intensive course targeting senior year nursing students and graduate nurses, two texts served as the foundation for the program design in order to achieve a broader perspective. They are articulated in four categories with 10 domains. The four categories are Mitigation-prevention competencies, Preparedness competencies, Response competencies, and Recovery-rehabilitation competencies. The 10 domains include policy formulation and planning; ethical practice, legal law, and accountability; risk control, disease prevention, and health promotion Knowledge exchange and communication; education and foresight; Individuals and relatives are cared for as well as the world as a whole; person, family, and community long-term recovery; psychological treatment; and care of vulnerable groups.

A study of Bin et al. (2006) "Valuing Spatially Integrated Amenities and Risks in Coastal Housing Markets," described that separating the value of coastal amenities from the negative value of risk from coastal storms is extremely difficult using hedonic methods due to the high correlation between the two. In this study, they construct a three-dimensional measure of view that hat varies depending on the possibility of disentangling these spatially interconnected housing

characteristics, considering natural topography and constructed obstructions. To provide consistent estimates of the willingness to pay for coastal amenities and risk, a spatial hedonic model is established. Their results suggest that such techniques can be successful in isolating risk from amenities on the coast.

According to Gellatly et al. (2014) study "Staff nurse commitment, work relationships, and turnover intentions: A latent profile analysis," work commitment is a psychological force that binds employees to their organization and makes turnover less likely. High levels of commitment also contribute to the performance of required job tasks and OCB. Because commitment results from qualitatively different mindsets (Meyer et al., 2012), it is a multidimensional construct.

Based in the study of Huang et al. (2012) entitled "A multidimensional analysis of ethical climate, job satisfaction, organizational commitment, and organizational citizenship behaviors," discussed the assessment, organizational commitment is commonly conceptualized as encompassing three forms: affective, normative, and continuance.

In the study of Cantor et al. (2012) entitled "Engagement in Environmental Behaviors Among Supply Chain Management Employees: An Organizational Support Theoretical Perspective," it involves an emotional attachment to, involvement in, and identification with one organization, all of which are based on a desire to belong. It arises from the perception of positive social exchanges between the employee and organization. These exchanges are typically based on

one's perceptions of support (Kurtessis et al., 2017) and fairness (Duffield et al., 2011). It is the most widely studied base of commitment because it tends to be the best predictor of work criteria (e.g., job performance and withdrawal) relative to the other commitments (Beukes & Botha, 2013).

In the study of Klein & Park (2015) entitled " Organizational Commitment," it is thought to result from early socialization experiences with one culture and family. It has been found to relate favorably to many work attitudes and behaviors. The high correlations that have been observed between work commitment and performance have, however, led some researchers to question the usefulness work.

In the study of Jung & Choi (2016), entitled "The Perceived Possibility of a Permanent Position for Youth and Helping Behavior: The Mediating Role of the Relationship with Standard Employees and Organizational Commitment," which derived from the perceived costs of leaving, including the loss of desired investments and few job alternatives. Paralleling the social exchanges that underlie and is linked to employee–organization economic exchanges (Shore et al., 2019). According to the study, states that commitment results from the accumulation of economic investments or side-bets that would be lost if the employee discontinued membership in the organization. It is of significant interest to nurses because there are data that reveal that high levels of commitment are correlated with favorable outcomes for an organization.

Mendelson et al. (2011) study on "Perceptions of the presence and effectiveness of high involvement work systems and their relationship to employee attitudes: A test of competing models" also found that organizational success is highly correlated with employee effort and commitment. Organizational commitment levels can range from low to moderate to high. The study's findings revealed that different degrees of involvement were linked to benefits and drawbacks for both the participant and the institution.

Data from the Haq et al. (2013) further indicated that high levels of commitment could also lead to positive and negative outcomes for the individual and the organization. On the positive side, individuals may experience personal career advancement or increased income. The positive outcomes for the organization might result in a secure and stable workforce, which works to achieve organizational goals and objectives. On the other hand, results revealed that high levels of organizational commitment were related to negative outcomes for individuals such as limited opportunities for growth and success. Some of the negative consequences for the organization might be the ineffective use of personnel and lack of flexibility and adaptability for the organization.

Quality of life is a multifaceted concept that has been linked to the semantic component of emotional well-being in cross-cultural life happiness and self-worth correlations (R. B. Adams et al., 2010). Subjective well-being is described as a combination of feelings and thoughts and is closely related to mental well-being and happiness (Heizomi et al., 2015). Many factors influence mortality, including

education, income, health, and marital status, as well as psychological quality of life (Fredrickson, 2018) have been shown to play a role in determining satisfaction with life. Furthermore, elevated concentrations of life pleasure and satisfaction have been linked to a lower death rate among the stable population. Working environments, in addition to these factors, can have an effect on wellbeing. High work demand is linked to negative health outcomes such as stress, anxiety, and physical illness. Many studies have attempted to find a connection between working environments and pressure, agitation, and despair (Elbay et al., 2020).

The variables that predict life satisfaction are not well understood by nurses. Nurses work in a very delicate environment in the health-care sector. As a result, understanding variables that impact healthy working load is critical for developing effective strategies to increase nurse life satisfaction. Furthermore, quality of life is a dynamic construct that is influenced by a variety of factors, including group variables including support networks. As a result, the determinants of life satisfaction should be recognized in every country. There has been no research to date on stress, anxiety, or tension among Iranian nurses who serve in medical schools. Thus, the degree to which stress, depression, and anxiety affect satisfaction with life among Iranian nurses is yet to be determined. This was the first study in Iran, to our understanding, that looked at the impact of distress, anxiety, and depression on applied work load in employed nurses (Han et al., 2014).

A study entitled "A willingness to go there: Nurses and spiritual care" (Minton et al., 2018) discussed that the timeless interweaving of spirituality, nursing and health in human life processes gives perspective to the resurgent desire of many nurses to include spiritual care in their practice. In drawing on a relatively recent example of nursing's historical legacy, the Careful Nursing philosophy and professional practice model calls attention to the idea that spirituality in nursing is expressed primarily in how nurses' practice. While Careful Nursing itself preserves the Christian philosophy of its historical background, it can contribute to identifying spirituality-related practice values that contemporary nurses with diverse philosophical beliefs, practicing in a predominantly secular global world, can share.

Careful nursing spiritual values analogous broadly acceptable nursing spiritual values, safe and restorative physical surroundings, and concerns physical factors specifically because the total surrounding of patients is considered to be the therapeutic milieu itself. As well as physical safety which is paramount, it includes healing elements such as light, color, fresh air and sound, which can have spiritual associations and can add supportive value to nursing practice Safe and restorative environment. Patient safety is a principle concept of nursing as a professional discipline and widely recognized as a distinctive nursing practice responsibility (Vottero, 2018).

A study of Sarris et al. (2014) to continue to fulfil their age-old mandate to nurture human health. It is surely a privileged responsibility of nurse managers to

lead and share with nurses and their assistants the implementation of a spiritual approach to nursing practice. What could be more engaging and invigorating for nurses than working to create their distinctive domain and responsibility; the ward or unit to which patients come to recover from illness, injury or vulnerability; as the most wonderful therapeutic milieu possible.

In considering the careful nursing spiritual values model, nurses' first decision would be whether to use the original values or the analogous generic values. This could be discussed and decided by comparing their healthcare system philosophy and nursing philosophy or a model already in place with the spiritual philosophical assumptions of different groups. Spirituality seems written into the human heart of nursing. It is for nurse managers and their nursing colleagues to draw it out for the benefit of those who they serve in the often-pressing everyday reality of health care (Meehan, 2012).

A study of Kreps (2013) "Foundations and principles of emergency planning and management," showed that disaster management is critical for ensuring proper health services and solving disaster-related human rights issues. As a result, hospital emergency preparedness has become more essential at the local, regional, and national levels. After a natural or human-made accident, facilities will be among the first to be impacted. Hospitals must be able to accommodate such an unusual workload due to the high pressure imposed on their services after a crisis. Any hospital must have a well-documented and validated emergency recovery strategy in place to meet this requirement.

Hospitals must broaden their scope to incorporate both internal and community-level preparation to improve their preparedness for thousands of deaths.

Global thought on disaster preparedness at the turn of the century resulted in two significant developments: recognition of the core competencies required for successful disaster management, and renewed focus on preparing and implementing rescue operations. A disciplined squad, in which each participant follows specific lines of contact and acts according to specifically assigned task directives, is required for effective action.

Another study of Mulcare (2018) "Emergency Care," showcased that disaster preparedness are activities and steps taken ahead of time to ensure an appropriate response to the effects of hazards. Disaster management aims to ensure that adequate processes, policies, and equipment are in place that can provide timely and efficient aid to emergency situations, easing recovery efforts and service restoration. Emergency preparedness efforts involve identifying potential health outcomes based on the likelihood of disasters and the population's risk as a foundation for developing a disaster preparedness plan.

The study of Shittu et al. (2018) entitled "Improving communication resilience for effective disaster relief operations," classified disasters, according to hospital involvement, inbuilt incidents that occur within the health care facilities and external tragedies that occur just outside of the health care facility are divided into two categories. Intrinsic disasters are isolated within hospitals and occur more often than outward accidents. These two categories of catastrophic events are

separate but not completely exclusive. The hospital should therefore be armed for a written emergency plan that reacts to outside emergencies in designed to help casualties. However, the hospital is still prone to natural disasters that arise within its surfaces; thus, preparations for internal accidents, the most frequent of which is fire, should be made.

The study of Dewar et al. (2014) entitled "Hospital capacity and management preparedness for pandemic influenza in Victoria," showed that disaster plan is a step-by-step protocol that outlines what has to be accomplished, how, where, and by whom, both before and after a potentially catastrophic accident happens.

Pelling (2012) study on "The vulnerability of cities: Natural disasters and social resilience" discussed that by its very essence, emergency relief is an interdisciplinary, joint team work. Environmental groups, synthetic chemists, research researchers, biostatisticians, surgeons, social workers, and other professionals' partner with nurses. Nurses also played a role in disaster relief. Nurses should have the requisite expertise and skills to serve in a crisis and to fulfill the needs of the society they are representing.

Nurses today face the demands of responding to environmental, human-made, and technical disasters, and there is a dearth of disaster preparedness material in nursing schools' curricula. The need for trained nurses who are able to respond to crises and engage in emergency preparedness and recovery efforts is

well known, and in order to address this issue, specialized curriculum and training must be continually developed (Martono et al., 2019).

Holloway et al. (2014) "Updated preparedness and response framework for influenza pandemics," recommended, according to the World Health Organization (WHO), all nations should train healthcare staff for disasters, regardless of how often or infrequent they occur. Nonetheless, numerous nurses were unprepared for crises, and nurses can still be trained with the competencies available during disasters by training and support. Disaster preparation for all nurses is critical, and crisis and disaster topics are included in all nursing school curricula, which will go a long way toward enhancing disaster awareness and skills. Dealing with the complexities of disasters necessitates that each nurse learns a depth of knowledge and a minimum range of skills to help them to cope. The current research was designed to define nurses' disaster management needs by determining the extent of nurses' emergency preparedness expertise.

In the study of Nabavi (2012), the concept of locus of control, derived from Rotter's social learning theory, was identified as a way of studying individuals' self-perceptions of control. In his seminal monograph, individual differences in how individuals regard rewards versus reinforcements. Roddenberry & Renk (2010) proposed that the degree to which individuals feel that rewards are contingent on their own behavior or, in contrast, are controlled by forces not under their own control determines how they will view rewards or reinforcements. Thus, individuals' beliefs about the causal relationship between their own behavior and

the rewards that they receive are the key factors in determining their own self-perceptions of control in a given situation.

In the study of Laverghetta (2011), the importance of individual characteristics is highlighted with regard to perceptions of control. When events are not viewed as the result of individuals' own actions, then individuals' label themselves as having beliefs in external control and perceive the events as the result of luck, chance, fate, or as under the control of powerful others. In contrast, when individuals perceive events as contingent upon their own behavior, they label themselves as having beliefs in internal control. Rotter (1975 as cited by Guma, 2012) proposed that these beliefs develop from specific past experiences and reinforcement histories. Thus, similar to individuals' reaction to stressful encounters, individuals' learning histories are also important in determining the origin to which they will attribute significant outcomes.

In particular, those who have experienced and been reinforced for successful control attempts in the past will hold more beliefs of internal control than those with unsuccessful past attempts. In the study of Britt et al. (2013) "The influence of locus of control on student financial behavior" suggested that these generalized control expectancy beliefs have their greatest influence when a situation is new or ambiguous and void of any preconceived notions on how to act or react. Again, similar to an individuals' response to 10 stress, there appears to be a complex interaction between individuals' level of uncertainty with regard to a situation and their control beliefs. Furthermore, this interaction is important

in gaining a more in depth understanding of how individuals' beliefs about control impact their functioning. Initially, locus of control was viewed as a one-dimensional construct ranging on a continuum from internal to external (Arhiri & Holman, 2011).

Internal locus of control referred to individuals' beliefs that events were contingent on their own behavior. In contrast, external locus of control referred to individuals' belief that events were not dependent on their own behavior and were instead dependent upon luck, fate, or powerful others. Research has revealed that locus of control should be defined with more than one dimension. Thus, this construct may be better conceptualized as multidimensional in nature and as no longer falling on a continuum (Schjoedt & Shaver, 2012).

This multidimensional conceptualization has been composed of three independent dimensions of locus of control (i.e., internal locus of control, powerful others, and chance), with the two dimensions derived from a division of the external dimension. To examine this new conceptualization, Schjoedt & Shaver (2012) developed a scale consisting of three separate subscales so that these three dimensions could be measured independently. The identification of the three independent dimensions of locus of control allowed for further development and examination of this construct. The locus of control concept also has been adapted to understanding specific health behaviors as a result of findings that individuals' locus of control beliefs could predict health behavior (Cobb-Clark et al., 2014).

Studies assessing health-related locus of control beliefs have found that these beliefs are related to health outcomes, such as the development of health behaviors and treatment compliance, and the adjustment to health problems (Omeje & Nebo, 2011).

In summary, in relation to this study, nursing is a humanistic profession. It is recognized as a profession because of having a unique scientific body, needs for work commitment life satisfaction, spirituality level, positive attitude and locus of control. This concept is viewed as a major variable to disaster resiliency. It also has important consequences in health care services. High committed, spiritual, has positive attitude and good locus of control nurses are more responsible for delivering health care for the patients. These constructs are important because it contributes to understanding how nurses develop, make sense of, and offering the best nursing care.

Chapter 3

METHODOLOGY

The chapter presents the different aspects in conducting the study. This discusses the research design, instrumentation, validation of instrument, sampling procedures, data gathering procedure and statistical treatment used in analyzing the data pertaining to the nurse resiliency in a disaster risk Samar province.

Research Design

This study employed the descriptive-correlational method of research. The descriptive method was applied to describe the profile of the respondents in terms of age and sex, civil status, educational attainment, religious affiliation and religious involvement, nature of work, working area or ward, position, number of years in service, training on disaster, number of days of experience encounter in disaster; determine the extent of nurse resiliency in terms of disaster victims' health care management; and describe the factors along resiliency in terms of work

commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control.

Subsequently, it is correlational because it showed the relationship between the extent of nurse resiliency in terms of disaster clients' health care management and the factors along resiliency in terms of work commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control.

Instrumentation

A structured survey questionnaire was used to gather data.

Part 1 was a questionnaire gathered the respondents' socio-demographic profile (age, gender, marital status, educational attainment, occupation, religion and religious affiliations, nature of work, number of years in service, position, training in disaster resiliency, and number of days experience in disaster).

Part 2 was the level of resilience (Siebert, 2002). The questionnaire assesses an individual's sense of control and coping ability over a stressful situation in terms of disaster clients' health care management. Each statement uses a 5 point-Likert scale, ranging from 1 (Not resilient) to 5 (Very highly resilient). Scoring is achieved from the mean scores. Past research has found the test-retest reliability coefficient for the BRCS to be 0.85, with a Cronbach's alpha of 0.86.

Part 3 was the Work Commitment (Hayday, 2014) was used as the third part of the scale, which consisted of eight statement related to job commitment. The scale has a 5 likert scale (1= not committed, 5= extremely committed). Scoring

is achieved from the mean scores. A high mean score indicates that higher work commitment.

Part 4 was the Life Satisfaction Scale (Corrigan et al., 2013; Pavot & Diener, 2009) that gathered data regarding the perceived life satisfaction of respondents. It is 5-item Life Satisfaction Scale instrument that measures the degree to which respondents are satisfied with life. The 5 statements use a 5-Likert point scale ranging from 1 (Not Satisfied) to 5 (Extremely Satisfied). Scoring is achieved from the summation of all scores, with higher scores indicating greater life satisfaction. The Cronbach's alpha of the scale has been previously reported as 0.87 with a test-retest coefficient alpha of 0.81 (Corrigan et al., 2013).

Part 5 was the Spiritual Well-Being Scale. This scale was developed by Paloutzian & Ellison (1982)as a general indicator of the subjective state of wellbeing and perceived spiritual quality of life. It is comprised of 20 items. Scoring is ordered by a 5-point Likert scale as follows: 1) not at all concerned in spiritual wellbeing, 2) low spiritual wellbeing, 3) neutral spiritual wellbeing, 4) moderate spiritual wellbeing, and 5) highly spiritual wellbeing Scoring is achieved from the summation of all scores, with higher scores indicating greater life satisfaction. It has a reliability of 0.85 (Sharif Nia et al., 2018).

Part 6 was the attitude toward Sustainable Development questionnaire. This questionnaire was used to determine participants' attitude toward sustainability issues after a disaster. A set of statements were presented with five Likert-scale responses per item. The mean scores were used as the attitude toward

sustainable develop index. A higher mean score meant that the individual was more positive. Finally, past research has reported good internal consistency and reliability, 0.757 and 0.854, respectively (Biasutti & Frate, 2017).

Part 7 was the Locus of Control. The seventh part of the scale was comprised of 24-item statements related to locus of control (Smith et al., 1995). This part of the scale assessed individuals' perception of life events and whether they were perceived to be within their control or controlled by external forces. The scale has three distinct areas, 8 item were dedicated to check internal locus of control, another 8 items for external locus of control for chance, and the last batch of items for external locus of control for other powerful people. The scale was coded with "yes" (score of 1) or "no" (score of 0) response options. The total for "yes" responses were taken and served as the index for locus of control. Maximum points per category is 48 which means that each answer is multiplied to 6. This procedure was adapted from Rotter (1966). Scores per category were interpreted to check where an individual has a higher locus of control. If the individual has a high score for internal locus of control which further indicates a helpful attribute for successful behavior change. If high rate is compute under powerful others scale, typically that individual's fate is controlled by other people while if high rate is obtained in the chance scale, the individual's fate is controlled by chance. Past research has reported internal consistency of the scale to be 0.79 and the test-retest reliability to be 0.83 (Vasiliki Papanikolaou et al., 2013; Vicky Papanikolaou et al., 2012).

Validation of Research Instrument

The questionnaire is the main instrument in data-gathering and will be first validated through the following procedures:

Before the final form of the instrument was written, the test-retest reliability was conducted. The instrument was administered to the nurses in the government hospital, private hospital, and Health Care Units in western Samar Province.

Initially, a draft of the questionnaire for will be submitted to the research adviser for content validation where the latter indicated the corrections, suggestions and recommendations for the refinement of content. Upon incorporation of all the adviser's corrections, suggestions and recommendations.

Prior to the actual questionnaire administration to the field, it underwent pretesting at the government-run hospital as well as a private hospital in Tacloban City, Leyte. One hundred (100) respondents were able to answer the questionnaire. To ascertain the reliability of questionnaire, it was subjected to Cronbach's alpha. It is a convenient test that measures internal consistency, that is, how closely related a set of items are as a group. The pretest posted a Cronbach's alpha of 0.86 which is considered a good indicator since it above 0.70 which makes it consistent and not above 0.95 which means that it is not unidimensional in nature.

The questionnaire was administered to the province that will be computed with the use of the Pearson product correlation.

Data Gathering Procedure

Permission to perform the thesis was requested by the researcher_from January to February, 2018. The data gathering tool was distributed to the identified respondents by the researcher herself with the assistance of some DOH nurses. The researcher coordinated to the nursing office of each hospital, and health care units to have a copy of the duty schedule of the nurses and their availability in the unit during the various shifts.

During this time, the survey tools were circulated to the respondents, specifically the third hour of their shift (e.g. 10 AM in the morning shift, 6 PM in the afternoon shift and 2 AM in the night shift) and will be retrieved the following day at the same time.

In addition to the attached document in the questionnaire about the study, relevant information regarding the study was reiterated before requesting them to sign the informed consent and handing them the questionnaire. After the specified data collection time-line, all retrieved questionnaires will be entered in a spread sheet for analysis.

Statistical Treatment

The data gathered in the study was scored, analyzed and interpreted using appropriate statistical treatment for each problem. The following statistical tool were used to analyze the collected data:

Frequency Count. This was employed in reporting the number of respondents having the same profile, and the responses to each statement in Part 7.

Percentage. This was employed in the analysis and interpretation of data on respondents' profile, and the responses to each statement in Part 7.

Arithmetic Mean. This was used to determine the overall characteristics of the nurse-respondents' profile, and responses on Parts 2 to 6 of the questionnaire.

Multiple Linear Regression Analysis. This was employed to determine the relationship between respondents' extent of resiliency, the factors of resiliency namely commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control.

To determine whether the null hypothesis (H_0) would be accepted or rejected, the decision rule provided by Ferguson and Takane (1989) was employed which stated that if the p-computed value is lesser than the α of 0.05, the null hypothesis (H_0) should be rejected. On the other hand, if the p-computed valued match or exceed the α of 0.05, the null hypothesis (H_0) should be accepted.

Finally, 0.05 level of significance was applied in all testing of the hypotheses.

Chapter 4

PRESENTATION ANALYSIS AND INTERPRETATION OF DATA

The study's results are presented in this chapter. It likewise presents the corresponding analysis and interpretation of results based on the appropriate statistical tools used to treat the collected data.

Profile of the Respondents

This section presents the profile variates of nurse-respondents in terms of age, gender, marital status, educational attainment, occupation, religion and religious affiliations, nature of work, number of years in service, position, training in disaster resiliency, and number of days experience in disaster.

Age and Sex. Table 1 shows the age and gender of the nurse-respondents. As shown, there were 68 male respondents of the 265 respondents, of which, 28 of the respondents or 41.18 percent fall under the age bracket of 21 to 25 years old, which is the highest numbered bracket.

While there are 8 or 11.76 percent respondents under the age bracket of 36 and above years old, the lowest numbered bracket in the male respondents. It has a mean score of 26.12 years old and standard deviation of 1.24 years respectively.

Meanwhile, there were 14 or 12.39 percent of female respondents under the following age brackets: 38 to 42 years old, and 58 to 62 years old respectively. Which are the highest numbered among female respondents.

Table 1

Age and Sex Distribution of the Nurse-Respondents

Age (in years)	Sex				Total	Percent
	Male	Percent	Female	Percent		
21-25	28	41.18	103	52.28	131	49.43
26-30	21	30.88	66	33.50	87	32.83
31-36	11	16.18	19	9.64	30	11.32
36-above	8	11.76	9	4.57	17	6.42
Total	**68**	**100.00**	**197**	**100.00**	**265**	**100.00**
Mean	**26.12**		**27.24**			
SD	**1.24**		**1.18**			

On the other hand, there were 4 or 3.54 respondents have the age bracket of 18-22 years old which is the lowest number among female respondents. It has a mean score of 27.24 years old and standard deviation of 1.18 years respectively.

The data signified female dominance among nurse-respondents which indicated that in terms of number of nurses that took part in the study, the female nurses outnumbered the male counterpart. Furthermore, the nursing profession is a female-dominated line of work (Evans & Steptoe, 2002; Kikuchi et al., 2013; Simpson, 2004), which coincides with the result of this study.

Civil Status. Table 2 shows the civil status of the nurse-respondents.

As presented in the table, there were 226 or 85.28 percent of the respondents that were single while 1 or 0.38 percent is widow and married respondents shown for 38 or 14.34 percent. This shows that there more single respondents in the study. It is quite normal for nurses in their early twenties to be single (Chao et al., 2016). They often prioritized work and would dedicate most of their time in the hospital leaving little for social life (Hendrich, 2008).

Table 2

Civil Status of the Nurse-Respondents

Civil Status	Frequency	Percentage (%)
Single	226	85.28
Married	38	14.34
Widow	1	0.38
Total	**265**	**100.00**

Educational Attainment. Table 3 shows the educational attainment of the nurse-respondents. As described, more than half of the respondents were college graduate or Bachelor of Science in Nursing degree holder while only 7 or 2.64 percent were able to complete their masters.

Table 3

Educational Attainment of the Nurse-Respondents

Educational Attainment	Frequency	Percentage (%)
College Graduate	235	88.68
MA Units	23	8.68
MA Graduate	7	2.64
Total	**265**	**100.00**

This is apparent since most of the respondents were still in their early twenties, just graduated and start new in the hospital or any other health facility. Again, They often prioritized work and would dedicate most of their time in the hospital leaving little for social life (Hendrich, 2008).

Religious Affiliation. Table 4 shows the religious affiliation of the nurse-respondents. As shown, more than half of the respondents were Roman Catholic accounting for 222 or 83.77 percent while only 4 or 1.51 percent were Iglesia ne Cristo.

Table 4

Religious Affiliation of the Nurse-Respondents

Religious Affiliation	Frequency	Percentage (%)
Roman Catholic	222	83.77
Iglesia ne Cristo	4	1.51
Latter Day Saints	39	14.72
Total	**265**	**100.00**

This is an expected result since the Philippines, being a Christian-dominated country, has one of the world's largest population of Roman Catholics (Bautista, 2010).

Nature of Work. Table 5 shows the nature of work of the nurse-respondents. As presented, almost all of the respondents were contractual accounting for 236 or 88.68 percent while 30 or 11.32 percent were permanent.

Table 5

Nature of Work of the Nurse-Respondents

Nature of Work	Frequency	Percentage (%)
Contractual	236	88.68
Permanent	30	11.32
Total	**265**	**100.00**

It is a common scenario to have more contractual employee here in the Philippines (Cristobal & Resurreccion, 2014). Likewise, it can be equated to the age of respondents of which most of them were new in the profession.

Working Area. Table 6 shows the working area of the nurse-respondents. As described, there were 190 or 71.7 percent of the respondents working in Rural Health Units while 21 or 7.9 percent were working in a private hospital.

Table 6

Working Area of the Nurse-Respondents

Area of Work	Frequency	Percentage (%)
Rural Health Unit	190	71.70
Public Hospital	54	20.40

Private Hospital	21	7.90
Total	**265**	**100.0**

Majority of nurses are working in government units and hospitals since it offers higher compensation compared to that of privatized health facilities (Combes et al., 2015).

Position. Table 7 shows the position of the nurse-respondents. As described, there were 200 or 75.47 percent of the respondents working as Department of Health (DOH) Nurse, followed by public health nurse accounting to 34 or 12.83 percent.

Table 7

Position of the Nurse-Respondents

Position	Frequency	Percentage (%)
DOH-Nurse	200	75.47
Public Health Nurse	34	12.83
Job Order (Municipal paid)	10	3.80
Private Nurses	21	7.90
Total	**265**	**100.00**

Next, twenty-one (21) or 7.90 percent were private nurses while only 10 or 3.80 percent were Job Orders. Again, majority of nurses are working in government units and hospitals since it offers higher compensation compared to that of privatized health facilities (Combes et al., 2015).

Number of Years in Service. Table 8 shows the years of experience among nurse-respondents. As described, more than half of the respondents have working

experience between 1-5 years accounting for 148 or 55.85 percent while 7 or 2.64 percent have working experience 20 years and above.

The results can be equated to the age of respondents of which most of them were in their early twenties and fairly new in the profession.

Table 8

Number of Years in Service of the Nurse-Respondents

Years	Frequency	Percentage (%)
1-5	148	55.85
6-10	78	29.43
11-15	32	12.08
20-above	7	2.64
Total	**265**	**100.00**

Training in Disaster. Table 9 shows the attendance and completion of trainings in disaster management among nurse-respondents.

Table 9

Training in Disaster Management Among Nurse-Respondents

Received / Completed Training	Frequency	Percentage (%)
Yes	53	20.00
No	212	80.00
Total	**265**	**100.00**

As described, almost all of the respondents have no disaster management training accounting for 212 or 80.00 percent while 53 or 20 percent of the

respondents have training on disaster. Again, considering that the majority of the respondents were fairly new in the profession, it is no surprise that almost all of them have no training on disaster management. Nurses are less participative in disaster risk reduction and management trainings and focused more on clinical skills capability building (Alcayna et al., 2016).

Number of Days Experienced Encountered Disaster. Table 10 shows the number of days since the experience or encounter disasters among nurse-respondents. As described, more than half of the respondents have 6-10 number of days of experiencing or encountering disaster accounting for 160 or 60.38 percent with a mean score of 6.52 days and standard deviation of 1.47 days.

Table 10

Number of Days Experienced Encountered Disaster

Number of Days	Frequency	Percentage (%)
1-5	67	25.28
6-10	160	60.38
11-15	38	14.34
Total	**265**	**100.00**
Mean	**6.52**	
SD.	**1.47**	

The Samar Province, which is a part of the Philippines that is known as one of the top countries in the world at risk of climate-related disasters (Alcayna et al., 2016), often experiences natural and man-made calamities and disasters.

Extent of Nurse Resiliency

This section discloses the extent of nurse resiliency in terms of disaster victims' health care management.

Health care Management. Table 11 provides the level of resiliency among nurse-respondents. There were 18 statements included in this study whereby the

Table 11

Perceived Resiliency in health care management of the Nurse-Respondents

Statement	Weighted Means	Interpretation
1. In a crisis or disaster situation, I calm myself and focus on taking useful actions.	3.93	Highly Resilient
2. I'm usually optimistic. I see difficulties as temporary and expect to overcome them.	3.92	Highly Resilient
3. I cannot tolerate high levels of ambiguity and uncertainty about situations.	3.03	Moderately Resilient
4. I adapt quickly to new developments. I'm good at bouncing back from difficulties.	3.79	Highly Resilient
5. I'm playful. I find the humor in rough situations, and can laugh at myself.	3.62	Highly Resilient
6. I'm able to recover emotionally from losses and setbacks. I have friends I can talk with. I can express my feelings to others and ask for help. Feelings of anger, loss and discouragement don't last long.	3.95	Highly Resilient
7. I feel self-confident, appreciate myself. And have a healthy concept of who I am.	3.90	Highly Resilient
8. I'm curious. I ask questions. I want to know how things work. I like to try new ways of doing things.	4.06	Highly Resilient
9. I do not learn valuable lessons from my experiences and from the experiences of others.	2.56	Moderately Resilient
10. I'm good at solving problems. I can use analytical logic, be creative, or use practical common sense.	3.74	Highly Resilient
11. I'm good at making things work well. I'm often asked to lead groups and projects.	3.55	Highly Resilient
12. I'm very flexible. I feel comfortable with my paradoxical complexity. I'm optimistic and pessimistic, trusting and cautious, unselfish and selfish, and so forth.	3.87	Highly Resilient
13. I prefer to work without a written job description. I'm more effective when I'm free to do what I think is best in each situation.	3.48	Moderately Resilient
14. I'm not a good listener. I have good empathy skills.	2.75	Moderately Resilient
15. I'm non-judgmental about others and adapt to people's different personality styles	3.77	Highly Resilient

16. I'm very durable. I hold up well during tough times. I have an independent spirit underneath my cooperative way of working with others	3.93	Highly Resilient
17. I've been made stronger and better by difficult experiences.	4.15	Highly Resilient
18. I've converted misfortune into good luck and found benefits in bad experiences.	3.65	Highly Resilient
Grand Mean	**3.65**	**Highly Resilient**

Legend:

4.51 to 5.00 - Very Highly Resilient (Adaptation)	(VHR)
3.51 to 4.50 - Highly Resilient	(HR)
2.51 to 3.50 - Moderately Resilient	(MR)
1.51 to 2.50 - Slightly Resilient	(SR)
1.00 to 1.50 - Not Resilient	(NR)

nurse-respondents signified their level of resiliency in terms of disaster victims' health care management.

The table presents that the nurse-respondents were "highly resilient" on 14 statements with weighted means ranging from 3.55 to 4.15. Statement number 17 obtained the highest weighted mean with statements stating: "I've been made stronger and better by difficult experience." On the other hand, the nurse-respondents were "moderately resilient" on four (4) statements, with Statement Number 9, "I do not learn valuable lessons from my experiences and from the experiences of others" having the least weighted mean.

Taken as a whole, the nurse-respondents viewed themselves as "highly resilient" in terms of their disaster victims' health care management which was indicated by the grand weighed mean of 3.65. This signified that the nurse-respondents had a high regard towards their level of resiliency. Furthermore, difficult experiences can mold stronger and better individuals (Boud, 1985; Fazey

et al., 2005) or in this case nurses who have the ability to recover emotionally, focus in times of disaster and have an optimistic disposition.

Factors along Nurse Resiliency

This section discloses the factors of nurse resiliency along the following area: work commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control.

Work Commitment. Table 12 provides the perceived factors of resiliency among nurse-respondents in terms of work commitment. It appraises the factors along resiliency in terms of work commitment among nurse-respondents. There were 8 statements included in this study whereby the nurse-respondents signified their level of commitment to their work.

Table 12

Perceived Work Commitment of the Nurse-Respondents

Statement	Weighted Means	Interpretation
1. The most important things that happen in life involve work	3.93	Highly Committed
2. Work should be considered central to life	3.58	Highly Committed
3. An individual' s life goals should be work oriented	3.70	Highly Committed
4. Is only worth living when people get absorbed in work.	3.15	Moderately Committed
5. The major satisfaction in my life comes from my job.	3.27	Moderately Committed

6. The most important things that happen to me involve my work	3.51	Highly Committed
7. I feel self-confident, appreciate myself. I have a healthy concept of who I am.	3.85	Highly Committed
8. I live for my job.	3.20	Moderately Committed
Grand Mean	**3.52**	**Highly Committed**

Legend:
4.51 to 5.00 - Extremely Committed (EC)
3.51 to 4.50 - Highly Committed (HC)
2.51 to 3.50 - Moderately Committed (MC)
1.51 to 2.50 - Slightly Committed (SC)
1.00 to 1.50 - Not Committed (NC)

The table presents that, the nurse-respondents were "highly committed" on 5 statements with weighted means ranging from 3.51 to 3.93. Statement number 1 obtained the highest weighted mean with statements stating: "The most important things that happen in life involve work." On the other hand, the nurse-respondents were "moderately committed" on three (3) statements, with Statement Number 4, "Life is only worth living when people get absorbed in work" having the least weighted mean.

Taken as a whole, the nurse-respondents viewed themselves as "highly committed" in terms of their work which was indicated by the grand weighed mean of 3.52. This signified that the nurse-respondents had a take huge pride and place utmost importance towards their work. Getting things done involves action and work (Fourie & Fourie, 2013; Mansbridge, 2012; Verburg et al., 2013), in the case of nurses, amidst challenges, to complete work means committing fully to

nursing profession and the duties and responsibilities included within (Nabolsi & Carson, 2011; Vanaki & Memarian, 2009).

Life Satisfaction. Table 13 provides the factors along resiliency among nurse-respondents in terms of life satisfaction. There were 5 statements included in this study whereby the nurse-respondents signified their level of life satisfaction.

The table presents that the nurse-respondents were "highly satisfied" on 3 statements with weighted means ranging from 3.58 to 3.93. Statement number 1 obtained the highest weighted mean with statements stating: "In most ways, my life is close to my ideal." On the other hand, the nurse-respondents were "moderately satisfied" on two (2) statements, with Statement Number 4, "So far, I have gotten the important things I want in life" having the least weighted mean.

Table 13

Perceived Life Satisfaction of the Nurse-Respondents

Statement	Weighted Means	Interpretation
1. In most ways my life is close to my ideal	3.93	Highly Satisfied
2. The conditionings of my life are excellent	3.58	Highly Satisfied
3. I am satisfied with life	3.70	Highly Satisfied
4. So far I have gotten the important things I want in life	3.15	Moderately Satisfied
5. If I could live my life over, I would change almost nothing	3.27	Moderately Satisfied
Grand mean	**3.51**	**Highly Satisfied**

Legend: 4.51 to 5.00 – Extremely Satisfied (ES)

3.51 to 4.50 - Highly Satisfied (A)
2.51 to 3.50 - Moderately Satisfied (MS)
1.51 to 2.50 - Slightly Satisfied (SS)
1.00 to 1.50 - Not Satisfied (NS)

Taken as a whole, the nurse-respondents viewed themselves as "highly satisfied" in terms of their life which was indicated by the grand weighed mean of 3.51. Of most hospital systems, nurses are on the front lines (Fardellone et al., 2014), this imply that if they are recognized this will be important in delivering effective patient care. As a result, when it comes to nurse satisfaction, providing high-quality nursing care is critical. Nurses who are happy with their jobs and the environments under which they give treatment are most likely to provide high-quality service that meets the needs of their patients (L. Kelly et al., 2015).

Spirituality. Table 14 provides the factors along resiliency among nurse-respondents in terms of spirituality. There were 20 statements included in this study whereby the nurse-respondents signified their level of spiritual wellbeing.

The table presents that the nurse-respondents have "high spiritual wellbeing" on 2 statements with weighted means ranging from 4.60 to 4.76. Statement number 3 obtained the highest weighted mean with statements stating: "I believe that God loves me and cares about me." On the other hand, the nurse-respondents have "moderate spiritual wellbeing" on nine (9) statements, "neutral spiritual wellbeing" on eight (8) statements, and possessed "low spiritual wellbeing" on one statement with Statement Number 5, "I believe that God is impersonal and not interested in my daily situations," having the least weighted mean.

Taken as a whole, the nurse-respondents viewed themselves or possessed "moderate spiritual wellbeing" in terms of their spirituality which was indicated by the grand weighed mean of 3.64. These findings imply that spiritual care should be considered an important part of holistic and multidisciplinary nursing care (Connell Meehan, 2012; Ramezani et al., 2014; Royal College of Nursing, 2011). Higher spiritual wellbeing means it can have a significant impact on how they act, interact with their patients, and engage with them in order to provide spiritual support. Nurse spirituality can foster a delicate responsiveness to others' spiritual

Table 14

Perceived Spirituality of the Nurse-Respondents

Statement	Weighted Means	Interpretation
1. I don't find much satisfaction in private prayer with God	2.55	NSW
2. I don't know who I am, where I came from, or where I'm going	2.60	NSW
3. I believe that God loves me and cares about me	4.76	HSW
4. I feel that life is a positive experience	4.37	MSW
5. I believe that God is impersonal and not interested in my daily situations	2.46	LSW
6. I feel unsettled about my future	3.32	NSW
7. I have a personally meaningful relationship with God	4.31	MSW
8. I feel very fulfilled and satisfied with life	4.02	MSW
9. I don't get much personal strength and support from my God	2.61	NSW
10. I feel a sense of well-being about the direction my life is headed in	4.17	MSW
11. I believe that God is concerned about my problems.	4.60	HSW
12. I don't enjoy much about life.	2.68	NSW
13. I don't have a personally satisfying relationship with God	2.90	NSW

14. I feel good about my future	4.07	MSW
15. My relationship with God helps me not to feel lonely	4.31	MSW
16. I feel that life is full of conflict and unhappiness.	3.21	NSW
17. I feel most fulfilled when I'm in close communion with God	4.33	MSW
18. Life doesn't have much meaning	2.68	NSW
19. My relation with God contributes to my sense of well-being.	4.42	MSW
20. I believe there is some real purpose for my life	4.43	MSW
Grand Mean	**3.64**	**MSW**

Legend:
4.51 to 5.00 – High Spiritual Wellbeing (HSW)
3.51 to 4.50 – Moderate Spiritual Wellbeing (MSW)
2.51 to 3.50 – Neutral Spiritual Wellbeing (NSW)
1.51 to 2.50 – Low Spiritual Wellbeing (LSW)
1.00 to 1.50 – Not at all concerned in Spiritual Wellbeing (NCSW)

issues as well as an elevated spiritual consciousness, both of which may be beneficial in the evaluation process. (Reimer-Kirkham et al., 2012).

Attitude towards Disaster. Table 15 provides the factors along resiliency among nurse-respondents in terms of attitude towards disaster. There were 19 statements included in this study whereby the nurse-respondents signified their attitude towards disaster.

Table 15

Perceived Attitude towards Disaster of the Nurse-Respondents

Statement	Weighted Means	Interpretation
1. I look adversity in the eye with positivism	4.17	MP
2. I am contented what I have even though after the typhoon	3.84	MP
3. I complain in life for what happened to us	2.34	N

4. I motivate those around me with a positive word	4.12	MP
5. I am using the power of a smile to reverse the tone of a sad situation.	4.09	MP
6. I'm slowly getting back up after the typhoon	3.46	SP
7. I am not a source of energy that lifts those around me.	2.49	N
8. I understand that relationships are more important than material things.	4.22	MP
9. I am happy even when I have little.	4.18	MP
10. I keep on Smiling.	4.21	MP
11. I am optimistic even when others are not.	3.98	MP
12. I don't have a sense of duty and responsibility.	2.00	N
13. I can control my temper	3.85	MP
14. I admit my mistakes.	4.03	MP
15. I do not show my weaknesses to people	3.35	SP
16. I am neat in my personal appearance	3.95	MP
17. I respect other people's opinions	4.16	MP
18. I can you adapt easily after typhoon.	3.87	MP
19. I generally look at the bright side of after the typhoon.	4.09	MP
Grand Mean	**3.70**	**MP**

Statement	Weighted Means	Interpretation

Legend:
4.51 to 5.00 - Highly Positive (HP)
3.51 to 4.50 - Moderately Positive (MP)
2.51 to 3.50 - Somewhat Positive (SP)
1.51 to 2.50 - Negative (N)
1.00 to 1.50 - Extremely Negative (EN)

Locus of Control. Table 16 provides the factors along resiliency among nurse-respondents in terms of locus of control. As presented in the table, among the 8 statements of internal locus of control, Statement Number 23 stating "My life is determined by my own action" has the highest affirmation frequency of 232 or 87.55 percent.

The table presents that, the nurse-respondents have "moderate positivity" on 14 statements with weighted means ranging from 3.84 to 4.22. Statement number 8 obtained the highest weighted mean with statements stating: "I understand that relationships are more important than material things." On the other hand, the nurse-respondents have "somewhat positive" attitude on two (2) statements, and possessed "negative" attitude on three (3) statements with Statement Number 12, "I don't have a sense of duty and responsibility," having the least weighted mean.

Taken as a whole, the nurse-respondents possessed "moderate positivity" in terms of their attitude towards disaster which was indicated by the grand weighed mean of 3.70. This imply that positive attitude in health care professions can impact disaster resiliency (Cline, 2015; Freitas et al., 2014). Possessing a positive attitude towards disaster can calm nurses and focused on things and relationship that really matters (Park et al., 2014). Prioritize nursing implementation depending on the level of care a patient warrant under the disaster health care management.

Meanwhile, Statement Number 4 stating "Whether or Not I get into a car accident depends mostly on how good a driver I am" has the lowest affirmation frequency of 106 or 40.00 percent.

External locus of control has two indicators, the powerful others scale and the chance scale. Under 8 statement of the chance scale, Statement Number 10 stating "I have often found that what is going to happen will happen" has the highest affirmation frequency of 165 or 62.26 percent. Meanwhile, Statement

Number 2 stating "To a great extent, my life is controlled by accidental happenings" has the lowest affirmation frequency of 58 or 21.89 percent.

Lastly, under 8 statement of the powerful others scale, Statement Number 22 stating "In order to have my plans work, I make sure that they fit in with the desires of people who have power over me" has the highest affirmation frequency of 150 or 52.83 percent. Meanwhile, Statement Number 11 stating "My life is chiefly controlled by powerful others" has the lowest affirmation frequency 56 or 21.13 percent.

Table 16

Locus of Control of the Nurse-Respondents

Statement	Yes	Percentage
1. Whether or not I get to be a leader depends mostly on my ability	220	83.02
2. To a great extent my life is controlled by accidental happenings	58	21.89
3. I feel like what happens in my life is mostly determined by powerful people	83	31.32
4. Whether or not I get into a car accident depends mostly on how good a driver I am.	106	40.00
5. When I make plans, I am almost certain to make them work.	223	84.15
6. Often there is no chance of protecting my personal interests from bad luck	101	38.11
7. When I get what I want, it's usually because I'm lucky.	82	30.94
8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.	120	45.28
9. How many friends I have depends on how nice a person I am.	163	61.51
10. I have often found that what is going to happen will happen.	165	62.26
11. My life is chiefly controlled by powerful others	56	21.13
12. Whether or not I get into a car accident is mostly a matter of luck.	83	31.32
13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure group	99	37.36
14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.	94	35.47

15. Getting what I want requires pleasing those people above me	84	31.70
16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.	124	46.79
17. If important people were to decide they didn't like me, I probably wouldn't make many friends	76	28.68
18. I can pretty much determine what will happen in my life.	110	41.51
19. I am usually able to protect my personal interests.	187	70.57
20. Whether or not I get into a car accident depends mostly on the other driver	108	40.75
21. When I get what I want, it's usually because I worked hard for it	219	82.64
22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.	140	52.83
23. My life is determined by my own actions	232	87.55
24. It's chiefly a matter of fate whether or not I have a few friends or many friends.	112	42.26

As presented in the supplemental table, most of the nurse-respondents have a strong internal locus of control accounting for 127 or 47.95 percent.

Table 17

Perceived Locus of Control of the Nurse-Respondents

Locus of Control	Frequency	Percentage (%)
Internal Locus of Control	127	47.95
External Locus of Control: Chance	71	26.90
External Locus of Control: Powerful Others	67	25.15
Total	**265**	**100.00**

Moreover, seventy-one (71) or 26.90 percent believed their fate is controlled by chance. Lastly, sixty-seven (67) or 25.15 percent believed that their fate is controlled by other people.

As it is implied in the result, a strong internal locus of control can be helpful for successful behavior change (Rubin, 2009). Nurses are expected to have keen eyes for details and must make decisions on the dot during disasters (Veenema et al., 2017). Being able to change behavior as the need arises, especially during disasters, is an important trait a nurse has to possess. Adapting to changes in situation makes nursing care effective and holistic (Phillips, 2010). Helps in the prioritization of cases and delivering necessary care to the victims of disasters.

Relationship between Extent and Factors of Nurse Resiliency

This section discloses the relationship of extent of nurse resiliency and factors of nurse resiliency along the following area: work commitment, life satisfaction, spirituality, attitude towards disaster, and locus of control.

Work Commitment. In associating relationship between the extent of nurse resiliency and the factors of nurse resiliency in terms of work commitment, multiple linear regression was used. In the comparison of the p-value with the α, it was noted that the p-value of 0.007 turned lesser than the α equal to 0.05. This signified that the association between the aforesaid variables was significant. This meant that work commitment significantly predicts the extent of nurse resiliency. Therefore, it failed to accept the null hypothesis stating that "there is no significant relationship between the extent of nurse resiliency and work commitment".

Table 18

Relationship between Nurse Resiliency and Work Commitment

Predictor Variables	T	P	Evaluation/Decision
Work Commitment	4.126	0.007	Significant / Reject Ho

Note. *Significant at 0.05 level,
Dependent Variable: Extent of Resiliency

The findings reflected that work commitment determines the extent of resiliency among nurse-respondents. It has been seen on other studies wherein it was found out that not only work commitment can greatly influence resiliency but effectively increases work performance and innovation while reducing work stress and work errors (Moran, 2011). Work commitment and positive interpersonal relationship improves personal resilience of new nursing graduates and quickly recovers from negative stressors and may protect them from the negative effects of workplace incivility (Laschinger et al., 2013). The same findings have shown that resiliency is determined by the commitment of a person to their clients, to their craft, to their workplace, and to their profession (Thien et al., 2014).

But some researches do not support the result from this study. A recent study on career commitment, resiliency, and work outcomes, found out that commitment can fully mediate the calling-job satisfaction relation, partially mediate the calling-organizational commitment relation, and act as a suppressor in the relation between calling and withdrawal intentions; calling was associated

with somewhat greater withdrawal intentions once a person's level of career commitment was taken into consideration. On the same study, it was found out that resiliency is not mediated by work or career commitment (Duffy et al., 2011). The same findings were seen in a separate study where it showcased that resiliency was unaffected by work commitment, only activities involving work membership and sense of belongingness were greatly affected (Costanza et al., 2012). Finally, another study supported the findings, where it was found out that work commitment affects employee productivity and competitiveness and has no considerable impact to the level of resiliency of the employee. It denotes that commitment is more of strong identification to work and high level of energy and has nothing to do with resiliency or durability at work (de Fátima Oliveira et al., 2017).

Life Satisfaction. In associating relationship between the extent of nurse resiliency and the factors of nurse resiliency in terms of life satisfaction, multiple linear regression was used. In the comparison of the p-value with the α, it was noted that the p-value of 0.784 turned greater than the α equal to 0.05. This signified that the association between the aforesaid variables was not significant. This meant that life satisfaction does not significantly predicts the extent of nurse resiliency. As a result, the null hypothesis states that "no meaningful relationship exists between the extent of nurse resiliency and life satisfaction" was accepted.

Table 19

Relationship between Nurse Resiliency and Life Satisfaction

Predictor Variables	T	P	Evaluation/Decision
Life Satisfaction	0.358	0.784	Not Significant / Accept Ho

Note. *Significant at 0.05 level,
Dependent Variable: Extent of Resiliency

As it was revealed, life satisfaction does not determine the extent of resiliency of the nurse-respondents. Often, how a person is gratified with life does not entail that it applies to current work situation and environment. In a study conducted on measures of resiliency, life satisfaction was not considered as a factor instead it established links with individual's personal characteristics, social support network, initial responses to a significant and life changing event, and self-regulatory processes (McLarnon & Rothstein, 2013). The same trend was observed with a different study, of which it pointed out that it not resiliency that life satisfaction determines but the nurses' perseverance to challenges presented in the environment, interpersonal interactions, and creation of a conducive environment that prevents professional burnouts (L. A. Kelly et al., 2019).

Some studies even showed that it is not resiliency that is determined by life satisfaction but it is the level of happiness and work-life balance that a person has (Kalka & Lockiewicz, 2018; L. A. Kelly et al., 2019; Nemati & Maralani, 2016; Potter et al., 2013). It goes without saying that not all study shares the same sentiments as the findings reflected here. In a separate study by Shetty (2015), it was found

out that life satisfaction is an important factor that helps in the development of a person's successful coping mechanism. Life satisfaction had been seen to not only instil hope in the minds of the people but also germinate a philosophy of coping in, blending at, and surviving further amidst untoward events and disasters.

Spirituality. In associating relationship between the extent of nurse resiliency and the factors of nurse resiliency in terms of spirituality, multiple linear regression was used. In the comparison of the p-value with the α, it was noted that the p-value of 0.008 turned lesser than the α equal to 0.05. This signified that the association between the aforesaid variables was significant. This meant that spirituality significantly predicts the extent of nurse resiliency. Therefore, it failed to accept the null hypothesis stating that "there is no significant relationship between the extent of nurse resiliency and spirituality".

Table 20

Relationship between Nurse Resiliency and Spirituality

Predictor Variables	T	P	Evaluation/Decision
Spirituality	1.207	0.008	Significant / Reject Ho

Note. *Significant at 0.05 level,
Dependent Variable: Extent of Resiliency

As it was revealed, spirituality determines the extent of resiliency of the nurse-respondents. It shows that a person's spirituality can predict that patterns of disaster-related resiliency not only for nurses but also for their respective

patients. It was seen to that spirituality and positive attitudes were associated with disaster resiliency. Thus, the findings suggest the need for nurses to promote spirituality and encourage positive attitudes among patients to promote and maintain resiliency (Almazan et al., 2018). The same trend was observed not to registered nurses but also to nursing students where spirituality helps in the formation of resiliency at an earlier stage (Mehrinejad et al., 2015).

Spirituality of a person acts as identity for them because it can act as a way of belonging to a certain group as a form of a security blanket. By having someone believes in the same way as the person in question, it can address vulnerability and foster in developing resiliency (Abu-Ras & Hosein, 2015). In a study by Dillen (2012), resiliency was found out to be a motivation force that drives a person to pursue wisdom, self-actualization, and altruism and to be in harmony with a spiritual source of strength. It shows how resilience can be interpreted in a theological way, thereby referring to three key themes, spirituality, grace/agency and resurrection/hope. Thus, establishing the notion that resiliency and spirituality relate to one another in a more diverse sample (Washburn, 2013).

Attitude towards Disaster. In associating relationship between the extent of nurse resiliency and the factors of nurse resiliency in terms of attitude towards disaster, multiple linear regression was used. In the comparison of the p-value with the α, it was noted that the p-value of 0.059 turned greater than the α equal to 0.05. This signified that the association between the aforesaid variables was not significant. This meant that attitude towards disaster does not significantly

predicts the extent of nurse resiliency. As a result, the null hypothesis states that "no meaningful relationship exists between the extent of nurse resiliency and attitude towards disaster" was accepted.

Table 21

Relationship between Nurse Resiliency and Attitude Towards Disaster

Predictor Variables	T	P	Evaluation/Decision
Attitude Towards Disaster	2.539	0.059	Not Significant / Accept Ho

Note. *Significant at 0.05 level,
Dependent Variable: Extent of Resiliency

As it was shown that attitude towards disaster does not determine the extent of resiliency of nurse-respondents. Though most of the studies revealed that the need for nurses to encourage positive attitudes among patients to promote and maintain resiliency (Almazan et al., 2018), it does not seem to align with the results of the study. Another study also showed that resiliency involves an effective disaster management, extensive medical knowledge, proper and prescribed practices during disasters, and fostering a positive attitude (Ahayalimudin & Osman, 2016).

The reason why the study presented a different trend can be equated to the geographical and demographical landscape of a person. Geographically, the respondents live and work in a disaster-prone location can create an impression of having high tolerance to certain extreme situations (Costanzo et al., 2013). If a

person's tolerance is already high and well-adjusted, their attitude cannot be considered as a factor for resilience (Van Overwalle et al., 2012; Velan et al., 2012). It is considered as an innate trait of a person and not just an outward expression that is triggered by sudden disruption of the psyche and the workflow in general (Motahari & Rafieian, 2017).

Locus of Control. In associating relationship between the extent of nurse resiliency and the factors of nurse resiliency in terms of locus of control, multiple linear regression was used. In the comparison of the p-value with the α, it was noted that the p-value of 0.624 turned greater than the α equal to 0.05. This signified that the association between the aforesaid variables was not significant. This meant that locus of control does not significantly predicts the extent of nurse resiliency. As a result, the null hypothesis states that "no meaningful relationship exists between the extent of nurse resiliency and locus of control" was accepted.

Table 22

Relationship between Nurse Resiliency and Locus of Control

Predictor Variables	T	P	Evaluation/Decision
Locus of Control	.587	0.624	Not Significant / Accept Ho

Note. *Significant at 0.05 level,
Dependent Variable: Extent of Resiliency

As it was revealed that locus of control does not determine the extent of resiliency among nurse-respondents. Over the years, locus of control was seen to

influence to resiliency in various studies: Karatas & Cakar (2011), revealed that such factor determined not only resiliency but also to self-esteem and level of hope of a person. The same findings were supported by the study of Foret et al. (2012), were it was seen that integrating a good internal and external locus of control to response-based curriculum that supports the development of resilient individual.

The primary reason that the study revealed otherwise was that locus of control was not able to compensate the formation of resiliency in a person. It was not the need of the moment for the nurse-respondents, but it doesn't mean that it is not necessary (Ng-Knight & Schoon, 2017). Most of their goals and energy were directed to solve problems of job satisfaction and performance. People who had a good internal locus of influence were happier, more inspired, and more productive, had a high level of participation within their jobs, and did not affect to their current level of resiliency. As such, the relationship was between job satisfaction and locus of control and not with the resiliency of the person (Gangai et al., 2016). It was supported by Nowicki & Duke (2013), where they postulated that locus of control influences work-related well-being including workload, job insecurity, employability, and organizational support while resiliency was not determined by the factor.

Chapter 5

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter includes a review of the report, observations, conclusions, and guidelines based on the study's findings.

Summary of Findings

The following are the salient findings of the study:

1. The mean age of the male nurse-respondents was posted at 26.12 years old with a standard deviation (SD) of 1.24 years. Moreover, the mean age of the female nurse-respondents was posted at 27.24 years old with a standard deviation (SD) of 1.18 years.

2. Majority of the nurse-respondents belonged to the female sex accounting for 197 or 74.34 percent.

3. Almost all of nurse-respondents were single accounting for 226 or 85.28 percent at the time of data collection.

4. Majority of the nurse-respondents were baccalaureate degree or Bachelor of Science in Nursing degree holder accounting for 235 or 88.68 percent.

5. Majority of the nurse-respondents were Roman Catholic accounting for 222 or 83.77 percent.

6. Almost all of the nurse-respondents were employed as contractual accounting for 236 or 88.68 percent.

7. Majority of the nurse-respondents were working in rural health units accounting for 190 or 71.70 percent.

8. Majority of the nurse-respondents were working as Department of Health (DOH) nurse accounting for 200 or 75.47 percent.

9. Majority of the nurse-respondents were able to serve 1 to 5 years as nurses accounting for 148 or 55.85 percent.

10. Majority of the nurse-respondents have not attended any training in disaster management accounting for 212 or 80.00 percent.

11. More than half of the nurse-respondents were able to experience or encounter a disaster within 6 to 10 days accounting for 160 or 60.38 percent. It has a mean of 6.52 days and standard deviation (SD) of 1.47 days.

12. Majority of the nurse-respondents viewed themselves as "highly resilient" in terms of their disaster victims' health care management which was indicated by the grand weighed mean of 3.65.

13. Majority of the nurse-respondents viewed themselves as "highly committed" in terms of their work which was indicated by the grand weighed mean of 3.52.

14. Majority of the nurse-respondents viewed themselves as "highly satisfied" in terms of their life which was indicated by the grand weighed mean of 3.51.

15. Majority of the nurse-respondents viewed themselves or possessed "moderate spiritual wellbeing" in terms of their spirituality which was indicated by the grand weighed mean of 3.64.

16. Majority of the nurse-respondents possessed "moderate positivity" in terms of their attitude towards disaster which was indicated by the grand weighed mean of 3.70.

17. Most of the nurse-respondents have a strong internal locus of control accounting for 127 or 47.95 percent.

18. In associating relationship between the perceived extent of nurse resiliency and the factors of nurse resiliency, the following evaluation was arrived at: commitment, significant; life satisfaction, not significant; spirituality, significant; attitude towards disaster, not significant; and locus of control, not significant.

Conclusions

From the salient findings of the research, the following were the drawn conclusions:

1. The school head-respondents were young adults, at their early 20's but still far from marrying age that's why majority of them were single. Furthermore, female dominance existed among the nurse-respondents.

2. Majority of the nurse-respondents were college degree holder.

3. Majority of the nurse-respondents were Roman Catholic.

4. Almost all of the nurse-respondents were employed as contractual accounting, working in rural health units as Department of Health (DOH) nurse.

5. Majority of the nurse-respondents were considered novice in the nursing profession and have not attended any training in disaster management. This further elucidates that the current nurses' situation is characterized by numerous shortcomings that inhibit optimal decision making for disaster management.

6. More than half of the nurse-respondents were able to experience or encounter a recent disaster within 6 to 10 days.

7. Majority of the nurse-respondents viewed themselves as "highly resilient" in terms of their disaster victims' health care management. Which means better anticipation of disaster and better planning to reduce disaster losses.

8. Majority of the nurse-respondents viewed themselves as "highly committed" in terms of their work, "highly satisfied" in terms of their life, possessed "moderate spiritual wellbeing" in terms of their spirituality and "moderate positivity" in terms of their attitude towards disaster. Such characteristics define a resilient nurse capable of overcoming adversity and mitigating long term vulnerabilities.

9. Most of the nurse-respondents have a strong internal locus of control and does not solely see themselves as affected by chance and other powerful people. This means that they are willing to adapt to changing situations and readily adjust their behavior accordingly.

10. Of the nurse resiliency factors, commitment and spirituality proved to have significantly influence the perception of the respondents on the extent of nurse resiliency. While life satisfaction, attitude towards disaster, and locus of control was not significantly influential to the extent of nurse resiliency.

Recommendations

Based on the result of the research study as well as the conclusions drawn from it, the following are the recommendations:

1. As it was revealed in this study that the nurse-respondents were observed to manifest high regards to their own disaster resiliency, it is suggested that concerned agencies, being the Department of Health as well as private organization to increase risk-based capacity building, public awareness and disaster management education among nurses.

2. Practicing and performing drills and simulations for emergency situations that would encourage nurses to be more proactive not only to such dire scenarios but also to the overall development professionally especially on the premise of improving the service delivery and scope during disasters.

3. As it was also revealed in the study the absence of disaster management trainings to nurses, thus concerned agencies need to focus on improving the performance of not only the seasoned nurses but also novice nurses. Exposing them to emergency situations of increasing difficulty.

4. In like manner, provision of trainings on disaster and resiliency not only to registered nurses but all members of the healthcare team focusing on resources made available and what alternative options may be used or implemented in place over what is desired or ideal.

5. As commitment and spirituality as important determinants of nurse resiliency, clear intended goals should be given to nurses for encouragement. Empowering their voices by giving special consideration to the participation in resiliency planning and needs assessments while recognizing their unique risks and vulnerabilities.

6. Likewise, the mother agency, government hospitals and private institutions should foster a positive working environment, reward and recognition, involve and increase employee engagement in evaluating and measuring satisfaction among nurses.

7. It is recommended that nursing administrators need to identify things that their staff nurse does not have control and refocus them on what they can control.

8. A tactful and sensitive exploration of nurse's religious beliefs and spirituality should routinely be considered. Respect and be aware of nurses' spiritual/religious values and traditions.

9. Another study may be conducted in other provinces or regions to validate the findings of the study widening the scope of the study and considering other variables relative to the extent and factors of nurse resiliency.

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APPENDICES

Appendix A

RESEARCH INSTRUMENTS

PART I. PROFILE OF RESPONDENT

Direction: Kindly give the information asked for by writing in the space provided or by checking appropriate box.

Name (optional): _____ Age: _____

Sex: [ ] Male [ ] Female

Civil Status: _____

Educational Attainment:
[ ] Masters Graduate
[ ] Masters Level
[ ] College Graduate

Occupation: _____

Religious Affiliation: _____

Nature of Work:
[ ] Contractual
[ ] Permanent
[ ] Others,please specify

Working Area/Ward:
[ ] Rural Health Unit
[ ] Public Hospital
[ ] Private Hospital

Position : _____

Number of years in service: _____

Training on Disaster Resiliency:
[ ] Yes
[ ] No

Number of days experience encounter in disaster: _____

PART II. RESILIENCE (Siebert)

Direction: Below is resilience statement. Kindly assess each and signify your agreement or disagreement by checking appropriate column using the following scale:

5 - Very highly resilient (adaptation) (VHR)
4 - Highly resilient (HR)
3 - Moderately resilient (MR)
2 - Slightly resilient (SL)
1 - Not resilient (NT)

STATEMENT	5 (VHR)	4 (HR)	3 (MR)	2 (SL)	1 (NT)
In a crisis or disaster situation, I calm myself and focus on taking useful actions.					
I'm usually optimistic. I see difficulties as temporary and expect to overcome them.					
I cannot tolerate high levels of ambiguity and uncertainty about situations.					
I adapt quickly to new developments. I'm good at bouncing back from difficulties.					
I'm playful. I find the humor in rough situations, and can laugh at myself.					
I'm able to recover emotionally from losses and setbacks. I have friends I can talk with. I can express my feelings to others and ask for help. Feelings of anger, loss and discouragement don't last long.					
I feel self-confident, appreciate myself and have a healthy concept of who I am.					
I'm curious. I ask questions. I want to know how things work. I like to try new ways of doing things.					
I do not learn valuable lessons from my experiences and from the experiences of others.					
I'm good at solving problems. I can use analytical logic, be creative, or use practical common sense.					

I'm good at making things work well. I'm often asked to lead groups and projects.					
I'm very flexible. I feel comfortable with my paradoxical complexity. I'm optimistic and pessimistic, trusting and cautious, unselfish and selfish, and so forth.					
I prefer to work without a written job description. I'm more effective when I'm free to do what I think is best in each situation.					
I'm not a good listener. I have good empathy skills.					
I'm non-judgmental about others and adapt to people's different personality styles					
I'm very durable. I hold up well during tough times. I have an independent spirit underneath my cooperative way of working with others					
I've been made stronger and better by difficult experiences.					
I've converted misfortune into good luck and found benefits in bad experiences.					

PART III. WORK COMMITMENT (Hayday, 1979)

Direction: Below is Work Commitment statement. Kindly assess each and signify your agreement or disagreement by checking appropriate column using the following scale:

5 - Extremely Committed (EC)
4 - Highly Committed (HC)
3 - Moderately Committed (MC)
2 - Slightly Committed (SC)
1 - Not Committed (NC)

STATEMENT	5 (EC)	4 (HC)	3 (MC)	2 (SC)	1 (NC)
The most important things that happen in life involve work					
Work should be considered central to life					
An individual's life goals should be work oriented					
Life is only worth living when people get absorbed in work.					
The major satisfaction in my life comes from my job.					
The most important things that happen to me involve my work					
I feel self-confident, appreciate myself and have a healthy concept of who I am.					
I live for my job.					

PART IV. LIFE SATISFACTION SCALE (Diener)

Direction: Below are five statements with which you may agree or disagree. Using the scale below, indicate your satisfaction with each item by checking the appropriate column. Please be open and honest in your responding.

5 - Extremely Satisfied (ES)
4 - Highly Satisfied (HS)
3 - Moderately Satisfied (MS)
2 - Slightly Satisfied (SS)
1 - Not Satisfied (NS)

STATEMENT	5 (ES)	4 (HS)	3 (MS)	2 (SS)	1 (NS)
In most ways my life is close to my ideal					
The conditionings of my life are excellent					
I am satisfied with life					

So far I have gotten the important things I want in life					
If I could live my life over, I would change almost nothing					

PART V. SPIRITUALITY (Paloutzian & Ellison, 1991)

Direction: Below is spirituality questionnaire statement. Kindly assess each and signify your spiritual wellbeing by checking appropriate column using the following scale:

5 - Highly Spiritual Wellbeing (HSW)
4 - Moderate Spiritual Wellbeing (MSW)
3 - Neutral Spiritual Wellbeing (NSW)
2 - Low Spiritual Wellbeing (LSW)
1 - Not at all Concerned in Spiritual Wellbeing (NCSW)

STATEMENT	1 (HSW)	2 (MSW)	3 (NSW)	4 (LSW)	5 (NCSW)
I don't find much satisfaction in private prayer with God					
I don't know who I am, where I came from, or where I'm going					
I believe that God loves me and cares about me					
I feel that life is a positive experience					
I believe that God is impersonal and not interested in my daily situations					
I feel unsettled about my future					
I have a personally meaningful relationship with God					
I feel very fulfilled and satisfied with life					
I don't get much personal strength and support from my God					
I feel a sense of well-being about the direction my life is headed in					
I believe that God is concerned about my problems.					
I don't enjoy much about life.					

I don't have a personally satisfying relationship with God					
I feel good about my future					
My relationship with God helps me not to feel lonely					
I feel that life is full of conflict and unhappiness.					
I feel most fulfilled when I'm in close communion with God					
Life doesn't have much meaning					
My relation with God contributes to my sense of well-being.					
I believe there is some real purpose for my life					

PART VI. ATTITUDE (Biasutti & Frate, 2017)

Direction: Below is positive attitude statement. Kindly assess each and signify your positivity or negativity by checking appropriate column using the following scale:

5 - Highly Positive (HP)
4 - Moderately Positive (MP)
3 - Somewhat Positive (SP)
2 - Negative (NE)
1 - Extremely Negative (EN)

STATEMENT	5 (HP)	4 (MP)	3 (SP)	2 (NE)	1 (EN)
I look adversity in the eye with positivism					
I am contented what I have even though after the typhoon					
I complain in life for what happened to us					
I motivate those around me with a positive word					
I am using the power of a smile to reverse the tone of a sad situation.					
I'm slowly getting back up after the typhoon					

I am not a source of energy that lifts those around me.					
I understand that relationships are more important than material things.					
I am happy even when I have little.					
I keep on Smiling.					
I am optimistic even when others are not.					
I don't have a sense of duty and responsibility.					
I can control my temper					
I admit my mistakes.					
I do not show my weaknesses to people					
I am neat in my personal appearance					
I respect other people's opinions					
I can you adapt easily after typhoon.					
I generally look at the bright side of after the typhoon.					

PART VII. LOCUS OF CONTROL (Rotter, 1966)

Direction: Answer the following questions the way you feel. There are no right or wrong answers. Don't take too much time answering any one question, but do try to answer them all. One of your concerns during the test may be, "What should I do if I can answer both yes and no to a question?" It's not unusual for that to happen. If it does, think about whether your answer is just a little more one way than the other. For example, if you'd assign a weight of 51 % to "yes" and 49% to "no," mark the answer "yes" Try to pick one or the other response for all questions and not leave any blank. Mark your response to the question in the space provided on the left.

STATEMENT	YES	NO
Whether or not I get to be a leader depends mostly on my ability		
To a great extent my life is controlled by accidental happenings		
I feel like what happens in my life is mostly determined by powerful people		
Whether or not I get into a car accident depends mostly on how good a driver I am.		
When I make plans, I am almost certain to make them work.		

Often there is no chance of protecting my personal interests from bad luck		
When I get what I want, it's usually because I'm lucky.		
Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.		
How many friends I have depends on how nice a person I am.		
I have often found that what is going to happen will happen.		
My life is chiefly controlled by powerful others		
Whether or not I get into a car accident is mostly a matter of luck.		
People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure group		
It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.		
Getting what I want requires pleasing those people above me		
Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.		
If important people were to decide they didn't like me, I probably wouldn't make many friends		
I can pretty much determine what will happen in my life.		
I am usually able to protect my personal interests.		
Whether or not I get into a car accident depends mostly on the other driver		
When I get what I want, it's usually because I worked hard for it		
In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.		
My life is determined by my own actions		
It's chiefly a matter of fate whether or not I have a few friends or many friends.		

CURRICULUM VITAE

CURRICUL VIRTAE

Name	:	HAZEL L. BRILLANTES
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		Catbalogan Samar
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Position	:	Provincial FHSIS, Leprosy, Mental Health and
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Educational Background

Graduate	:	
College	:	Southwestern University, Cebu City
Secondary	:	Samar National High School
Elementary	:	Catbalogan III Elementary School

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