RESILIENCE IN MENTAL HEALTH NURSES WORKING IN A SECURE ENVIRONMENT

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Declaration of originality

The accompanying thesis submitted for the degree of Doctor of Professional Practice is based on work conducted by the author at The University of Northampton between 2014 and 2017. All the work recorded in this thesis is original unless otherwise acknowledged in the text or by references.

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I am hugely grateful to the nursing staff who allowed me to listen while they talked to me openly about their experiences; and to the managers who facilitated this.

I would like to thank my supervisory team, Jackie Campbell, Michelle Pyer and Merryn Ekberg for keeping the faith and for their invaluable support and encouragement throughout my journey.

Thanks to friends and family, especially Shashi, Aoife and Elisa, who always believed.

Abstract

This study explored aspects of resilience as experienced by mental health nurses in a high secure service. The aim of this research was to explore resilience for the participants and to develop a concept analysis of resilience in settings of this kind.

There have been many studies on the occupational challenges for nurses (Sabo 2006, Van Den Tooren and De Jonge 2008, Riahi 2011) although relatively few have focussed exclusively on mental health nurses (Jones *et al* 1987, Dunn and Ritter 1995, Nihiwatiwa 2001, Gilbody *et al* 2006). Several studies have noted distinct features of the work which are particular to mental health nurses: the intense nature of the interactions with patients (Cronin-Stubbs and Brophy 1985); the regular confrontation of difficult and challenging behaviours (Sullivan 1993); violence and threats from patients and relatives (Tillett 2003); and resources and staffing (Alexander *et al* 1998). Caring for patients with a personality disorder is noted in the literature as being particularly challenging and demanding for mental health nurses (Murphy and McVey 2003, Bowers 2002, Wright, Haigh and McKeown 2007, Westwood and Baker 2010, Bodner *et al* 2015, Dickens *et al* 2015, Dickens *et al* 2016.

Mixed methodology was used to profile nurses' resilience in this environment, using a validated questionnaire. In-depth semi-structured interviews were analysed using Interpretative Phenomenological Analysis (IPA). A concept analysis of resilience in this environment was developed using the data gathered in this way, synthesised with existing literature.

The profile of resilience demonstrated that that the majority of the respondents felt in control, enjoy a challenge, work to achieve goals and take pride in their achievements. The characteristics of 'hardiness', 'bounce back' and 'cognitive appraisal' emerged as key characteristics associated with resilience. Four superordinate themes emerged from the analysis of the staff interviews: management of emotions, teamwork, understanding and work-life balance.

The theme of management of emotions highlighted that boundaries were necessary, and it was essential not to get caught up in the patients' emotions. 'Giving care' rather than caring personally was felt to be important. Team work emerged as a key issue, and involved the need to talk things over with trusted colleagues, the expectation that team members and managers would notice and intervene when someone appeared to be in need of support; and having managers who were approachable and available. The theme of understanding included an awareness of the nature of

personality disorders and the effect this can have on interactions; and a need for reflection, supervision and coping with interpersonal challenges was highlighted. All of the participants spoke of the need for a work-life balance, making a conscious effort to keep the worlds of work and home separate, keeping physically healthy, and spending time with family and friends. This was embodied in the phrase 'leaving it at the gate' which was used to characterise the separation of the two worlds.

A concept analysis of resilience was developed by synthesising new empirical data along with existing literature. The study developed a practice-based definition of resilience in the context of working with personality disordered patients in a secure environment, together with the identification of characteristics of the workplace environment that can assist with and facilitate the capacity for 'bouncing back'. The three main findings of the study were that the constituents of resilience in this staff group are hardiness, bounce back and cognitive appraisal. This adds new perspectives about what helps staff to work positively with challenging patients in mental health nursing.

These new contributions to knowledge and practice can be used by organisations to develop targeted interventions in promoting wellbeing at work, reducing work related stress, and aiding recruitment and retention. In secure environments mental health nurses need organisational support and assistance with developing ways of managing difficult experiences with patients, systems that promote recovery, and the educational and supervisory support to help understand and process the effects on them.

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1 Introduction

1.1 Introduction

Levels of staff sickness absence in mental health and learning disability services have consistently remained the second highest in the NHS between 2010 and 2016, second only to ambulance services (Health and Social Care Information Centre 2016). There have been many studies on the occupational challenges for nurses (Sabo 2006, Van Den Tooren and De Jonge 2008, Riahi 2011) although relatively few have focussed exclusively on mental health nurses (Jones *et al* 1987, Dunn and Ritter 1995, Nihiwatiwa 2001, Gilbody *et al* 2006). Several studies have noted distinct features of the work which are particular to mental health nurses: the intense nature of the interactions with patients (Cronin-Stubbs and Brophy 1985); the regular confrontation of difficult and challenging behaviours (Sullivan 1993); violence and threats from patients and relatives (Tillett 2003); and resources and staffing (Alexander *et al* 1998).

As a nurse working directly with patients in secure environments I have had to withstand verbal abuse and threats, physical aggression and occasional chaos, while maintaining an outwardly calm mien. I have been conscious that both staff and patients wanted to see me remain calm and appear in control of things. I became skilled at not showing emotion and for a time this spilled over into my everyday life. In carrying out this research I was conscious that I would need to be aware of the potential influences of my own experiences as nurse and a manager. Reflexive writing was used to provide time and space before interviews commenced, to consider how the approach to the topic may be influenced by the experience of working as a manager in a similar environment, and reflect on attitude, experience and knowledge that may influence perception. Extracts from my reflexive diary are used to illustrate this process, an example is given below:

> *I was curious about how we could help nurses to work in this kind of environment, and asked questions such as what preparation and support do people need? What helps them cope, and recover from situations that can be frightening and physically painful? Why do some people thrive in these situations and maintain their compassion for caring, and others founder and leave, or worse stay and become damaged by the experience? How do people manage their responses at work but keep their private self intact; that is 'bounce back', in the language of resilience. It was these questions that fostered my interest in the resilience of nursing staff. Reflexive diary extract, April 2014.*

This study focusses on nurses working in a high secure mental health service, exploring what helps them to cope with the challenges of the work environment, and contributes to their

resilience. This chapter outlines the context of the study, introducing the patient group and the environment in which the nurses worked, and research describing the challenges of working in this kind of environment. The research aims and objectives and structure of the thesis are then described.

1.2 Context of the study

Secure mental health services are specialist services providing treatment for adults with mental disorders, who are at significant risk of harming themselves or others. Patients are detained under the Mental Health Act 1983 (HMSO 1983) and many will be convicted offenders. In this context 'secure' relates to the range of physical, relational and procedural measures put in place to ensure the provision of a safe and secure environment in which to deliver treatment (NHS England 2013). The purpose of security measures is to ensure the safety of patients and the public, to prevent escape and absconding and reduce the likelihood of patients failing to return from agreed periods of leave.

In the UK, secure mental healthcare is provided across a variety of different levels of security, which are commonly referred to in practice as low, medium and high secure. The defining features of the services are based on the level of risk of harm to self or others presented by the patient (NHS England 2013). The setting of a high secure hospital represents the highest level of security in mental health care, where patients are detained because they present a significant degree of risk to others and fulfil the criteria as defined by the NHS Act 2006; that is for people who require treatment under conditions of high security on account of their dangerous, violent or criminal propensities. The core objectives for high secure services are to:

> *'Assess and treat mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery. Secure services provide a comprehensive range of evidence based care and treatment. Care and treatment is provided by practitioners who are expert in the field of forensic mental health including nurses and consultants in forensic psychiatry' (NHS England 2013, p3).*

There are three high secure hospitals in England, with some variation in the type of services provided, for instance only one of the hospitals provides care for female patients.

High secure hospitals are a mixture of purpose built and adapted Victorian hospital wards, typically surrounded by a high fence or wall. Access to the hospital is by a staffed secure

entrance, where staff and patients are searched and access logged. Staff are issued their own keys when in the secure area, and cannot leave the premises without their keys being handed in securely. The movement of all patients is carefully controlled, with searches before and after leaving ward areas.

The Nursing in Secure Environments scoping study (UKCC 1999) highlighted that patients' mental disorder and offending patterns pose intense demands upon nurses as they are required to maintain empathic relationships while also focussing on risk management, including the prevention and management of violence and aggression. Further, patients may expose staff to other behaviours that are potentially distressing, for example severe self-harm and accounts of traumatic abuse. Although there has been research which has further highlighted the effects on nurses, the need for policy driven structures to assist and support nurses in these challenges remains.

A number of high profile practice issues at high secure hospitals have resulted in a series of inquiries. There have been inquiries into concerns about overly restrictive practices (Blom-Cooper 1992), lax security (Fallon 1999, Maden 1999) and subsequent tightening of security (Tilt *et al* 2000, Exworthy and Gunn 2003). The recent 'Jimmy Saville' investigations into sexual abuse (Kirkup and Marshall 2014) also highlighted aspects of security that compromised the safety of staff and patients. These issues have further emphasised the challenges of providing mental health care in a secure setting.

A number of studies have recommended that staff in secure services should be provided with effective support structures (Burrow 1993, Coffey and Coleman 2001, Kirby and Pollock 1995, Mason 2002, Dickens *et al* 2016, Jalil *et al* 2017) but there has been little clear guidance about implementing any specific support model. Dickinson and Hurley (2012) reported that staff working in secure environments often experience strong negative emotional reactions which can lead to antipathy and alienation, and suggest there should be educational programmes which promote the building of therapeutic alliances and increase understanding. This highlights the importance of research into this area to enhance practice. In turn, managers of nurses working in secure environments need to be equipped with the knowledge about how nurses can be helped to work in this kind of environment, and answer questions such as what preparation and support do people need, what helps them cope, and recover from situations that can be frightening and physically painful.

1.3 Patient group

All patients within these high secure environments will be liable to be detained under the Mental Health Act 1983, because of the nature and/or degree of their mental disorder. Individuals will usually have complex mental disorders, with co-morbid difficulties of substance misuse and/or personality disorder, which may often be linked to offending or seriously irresponsible behaviour. Consequently most individuals are involved with the criminal justice system, the courts and prison system and many have restrictions imposed on their discharge by the Ministry of Justice.

The service in which this study was carried out is part of the transitional arrangements associated with the new Offender Personality Disorder pathway (NHSE/NOMS 2015), and was opened in 2004 to provide a service for men with a personality disorder who require an enhanced care service within conditions of high security. The government first introduced the term ‘dangerous and severe personality disorder’ in a consultation paper in 1999 (Home Office 1999), which proposed how to detain and treat a small minority of mentally disordered offenders who pose a significant risk of harm to others and themselves. Specialist services to treat and care for these people, most of who were thought to be serious violent and sex offenders, were proposed in a subsequent white paper in December 2000 (HMSO 2000). The government strategy was to develop specialist assessment and treatment centres in prison healthcare centres and high secure hospitals in England.

The target group for this pathway is men who are likely to have a severe personality disorder, presenting a high likelihood of violent or sexual offence repetition and presenting a high or very high risk of serious harm to others (NHS England/NOMS 2015). There is likely to be a variety of diagnoses of personality disorder within this hospital population, though all will fall into the ICD 10 categories F60-F62; disorders of adult personality and behaviour (WHO 1993). The defining features of personality disorder are:

> *‘deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance’ (WHO 1993 ICD10, chapter F60-62 p.2).*

Individuals with this diagnosis will have difficulty with interpersonal communications, impulse control, and distress tolerance. As the work of mental health nurses is entrenched in the therapeutic relationship with patients, it would be expected that there would be considerable emotional labour involved in working with personality disordered patients (Collins and Long 2003, Dickens *et al* 2015). National guidance for the treatment and care of personality disordered patients in specialist environments notes that staff who are providing interventions should receive high levels of support and close supervision, due to increased risk of harm (NICE 2013).

The national strategic direction for the care and treatment of offenders who have a diagnosis of personality disorder is undergoing radical change. In 2015 NHS England and the National Offender Management Service (NOMS) published a new pathway strategy for offenders with a personality disorder (NHSE/NOMS 2015). This approach is underpinned by the recognition that offenders with a personality disorder require structured environments, with a psychologically informed approach. The preferred treatment setting is in the criminal justice system, with a service that is provided through partnerships between NHS and NOMS staff. The overall aims and outcomes of this programme are to improve public protection and psychological health of offenders through developing a comprehensive pathway of services for this complex and difficult to manage offender population.

These psychologically informed planned environments or 'PIPES' (Turley *et al* 2013) are 'specifically designed, contained environments where staff members have additional training to develop an increased psychological understanding of their work. This understanding enables them to create an enhanced safe and supportive environment, which can facilitate the development of those who live there' (Turley *et al* 2013).

1.4 Research aims and structure of thesis

All of the initial pilot services were set up with access to staff education and ongoing team and individual supervision, in recognition of the particular challenges of working with this group. Research into the experiences of staff working in these environments with personality disordered offenders has shown that team consultation has helped staff to have an increased awareness and understanding, improved ability to use a person-centred approach, and assisted in the development of formulation skills (McMullan et al 2014). In an evaluation of a psychologically informed practice initiative in a probation service, staff who completed the team training and had access to enhanced support reported both higher levels of knowledge and understanding of personality disorder, and an improved sense of personal

accomplishment than staff who had not accessed the programme (Bruce et al 2017). While these approaches have been developed in the criminal justice systems, the principles of providing enhanced staff support and promoting better understanding can be seen to be applicable to staff working in mental health services.

There has been little research that has explored factors which may promote resilience in nurses working in secure environments; this study will add new information to the existing body of knowledge by developing an understanding of the resilience of nurses in secure environments. This could be used to develop recruitment, retention, and support mechanisms. The aim of this study is therefore:

> *To explore aspects of resilience as experienced by mental health nurses in a high secure service, using a mixed methodsapproach.*

The study extends current understanding of how nurses working in a secure mental health environment manage the demands made on them psychologically, while maintaining a caring and compassionate approach to their patients. Mixed methodology will be used to meet the following objectives:

- Identify resilience profiles in this environment, using a validated tool;
- Explore the lived experience of nurses related to resilience, using semi structured interviews;
- Develop a concept analysis of resilience in this environment using data gathered by the first two methods.

The thesis is divided into eight chapters, in four parts.

Part One: Scene setting

Within Chapter Two definitions and theories of resilience are discussed, and research on the subject of resilience is presented. This is drawn from existing military research, trauma and disaster research, psychological research and perspectives on workplace stress, to provide a background understanding of how people are affected by living and working in challenging environments. Previous research on workplace stress and nursing, including nursing in secure environments is discussed and critically analysed, in relation to the aims of the study.

Chapter Three explains the overall mixed methodology, which is presented as a sequential exploratory design. The three methodologies are discussed in the three 'study chapters' that then follow, which describe each of the methods used in detail, with presentation and discussion of the results.

Part Two: Empirical research

A questionnaire-based resilience measure (Connor and Davidson 2003) was administered to identify resilience profiles in this group (Chapter Four).

A qualitative semi-structured interview was developed, which explored how nursing staff coped with difficult and stressful situations at work. Six interviews were carried out, recorded and transcribed. These were then analysed using interpretative phenomenological analysis (IPA) (Smith 2004), and four superordinate themes, with 14 constituent themes derived from clustering subthemes were identified (Chapter Five).

Part Three: Concept analysis

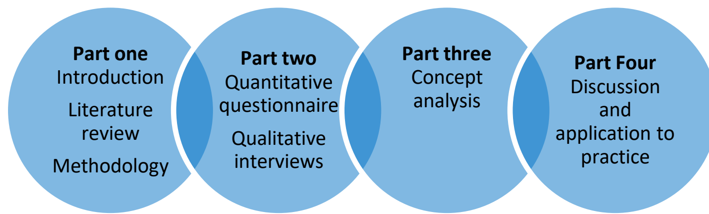
The empirical data collected as part of the study was then synthesised into a concept analysis (Walker and Avant 2005) of resilience in nurses in a high secure environment (Chapter Six). This chapter was designed to use the data gathered from the study to develop an in-depth understanding of the constituents of resilience in this population, which could then be used to inform practice.

Part Four: Discussion and application to practice

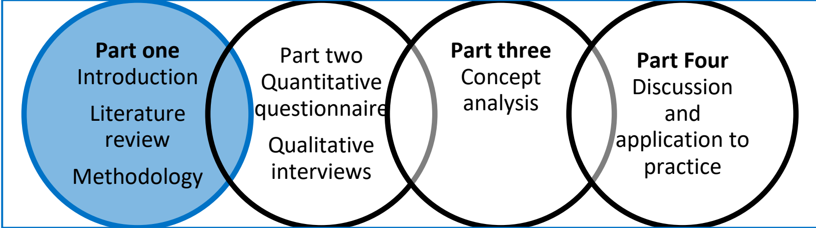
A discussion of the findings and application to practice is at Chapter Seven, under the headings of new understandings in relation to the existing literature, working with personality disorders, reflections on the research design-strengths and limitations, application to practice and future studies.

Figure 1 below shows a diagrammatical representation of the thesis structure.

Figure 1 Diagrammatical representation of the thesis structure


Part one
Introduction
Literature review
Methodology
Part two
Quantitative questionnaire
Qualitative interviews
Part three
Concept analysis
Part Four
Discussion and application to practice

2 Literature review



This chapter presents a review of literature relevant to the study of resilience. This will be explored drawing from historical accounts, psychological research, physiological and workplace perspectives, nursing and mental health nursing, and secure environments. Related research into psychological well-being in helping professions will also be examined and discussed. Examples include stress vulnerability (Hankin and Abela 2005) learned helplessness (Seligman 1972) and the concepts of burnout (Maslach *et al* 2001, Maslach and Schaufeli 1993) and compassion fatigue (Figley 2002, Adams *et al* 2015).

In the context of emergency planning for disasters, use of the term resilience has a sense of 'rebound', shifting emphasis away from external emergency planning and recovery measures, and towards the intrinsic capacity of individuals, populations and infrastructures to resist and rebound from shocks. Resilience has been defined as "the ability to successfully 'rebound' from stress and trauma and reflects the capacity to maintain equilibrium" (Barnhardt's Dictionary of Etymology 1988). According to Luthans (2002) resilience reflects an individual's ability to 'bounce back' from adversity and is commonly found in people who feel that life is meaningful and have a high capacity for improvisation and adaptation. Bonanno (2004 p.20) defined resilience as the "ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning".

Windle's (2011) review of the literature and concept analysis of resilience research adopts the following definition: "Resilience is the process of negotiating, managing and adapting to significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and 'bouncing back' in the face of adversity. Across the life course, the experience of resilience will vary" (Windle 2011 p.152). Interest in the effects of distressing and negative experiences on people can be said to have emerged from two main directions; the study of occupational hazards originating in military research (Bowling and Sherman 2008) and from the literature on major trauma such as concentration camp survivors (Eitinger 1962, Pennebaker *et al* 1989) conflict (Miller and Rasmussen 2010) and experiences of trauma or disasters (Walsh 2007).

2.1 Military research

The term 'shell shock' emerged from the First World War, and was used to describe symptoms such as fatigue, poor sleep, nightmares and jumpiness, and physical symptoms such as palpitations, chest pains, tremor, loss of voice or hearing, and even functional paralysis (Myers (1915) cited in Ørner (2012) , Salmon (1917) cited in Jones and Wessely (2005). The medical model prevalent at the time tended to explain this as an impairment of physical health (Ørner 2012, Shephard 1999). More than 16,000 cases of shell shock were recorded among British battle casualties between July to December 1916, eventually becoming the third most frequent cause of discharge from the British army in WW1. Initial responses to what was later termed 'combat stress reaction' (CSR) by Mullins and Glass (1973) cited in Solomon (2013), were not only medical, but also moralist and judgmental, which inspired disciplinary interventions. Refusal to follow orders to return to the battlefield would engender punishments until compliance was achieved. Initial formulations related the degree of CSR to the proximity of explosions or intense fighting but it was noted by Myers (1915) cited in Ørner (2012) that some soldiers with CSR symptoms had not had direct experience of intense combat, and thoughts began to emerge that there may be psychological reasons such as prolonged exposure to fear. One line of investigation suggested that lack of experience, older age and being a reservist increased risk of developing CSR, and trauma survivors were held personally responsible for their disabling states (Ørner 2012). Initial medical interventions were to remove soldiers from the front line and admit them to medical hospitals back in their country of origin.

A later intervention became known as 'forward psychiatry' and involved setting up treatment centres adjacent to the trenches (Jones and Wessely 2005), based on the concept of keeping soldiers near enough to the social and cultural environment of the military, in order to preserve their identity as soldiers. It was also believed that rapid access to treatment was a feature in these soldiers' recovery. The treatment relied on three elements: proximity to the battlefield, immediacy of response, and the expectation of recovery. This was known by the acronym 'PIE' and influenced military psychiatry into the late twentieth century (Grogan 2014). During the Second World War interest in stress research developed, as researchers began to explore the effects of war on combat personnel (Archibald and Tuddenham 1965, Grinker and Speigel 1945). Grinker and Spiegel (1945) used the term 'operational fatigue' to describe the psychological effects of combat environments on pilots in the Second World War. All the conditions described under the term of 'operational fatigue' can best be described as showing physical, mental and emotional symptoms, which

resulted from undergoing the stress of operational flying. Saul (1945) described anxiety, irritability, startle reactions, insomnia and nightmares as common components of combat or operational fatigue.

Research by Lazarus (1966) into the psychological effects of (combat) stress placed emphasis on the cognitive processes required to adapt and transform a negative event into something positive for the individual. Although moralist and judgemental attitudes remained, advocates for preventive selection, preventive measures and better officer leadership training began to be heard (Ørner 2012). This heralded a psycho-educational model of practice, and as the war progressed, preventive measures became better coordinated, through selection, training, strengthening leadership and focussing on motivation and morale. Kardiner (1941) suggested that some men were predisposed to ‘war neurosis’ and discussed possible prevention mechanisms. Grinker and Speigel (1945) began to speculate both on how to recruit individuals who were less likely to be adversely affected by combat, and on how the services could try to prevent the worst effects. A review of early interventions for soldiers during recent wars, from Northern Ireland to the Balkans, found that significant steps have been taken to ensure early intervention with soldiers, with formal processes in place to monitor provision of support structures (Wessely 2005), although attempts at preventing psychiatric disorders by screening before deployment or debriefing after, have been disappointing.

2.2 Trauma and disaster research

Post-war psychologists adopted the word resilience as a convenient metaphor for describing the capacity of individuals to continue functioning in the face of adversity. The inspiration for much of this literature can be traced back to the Holocaust; and to studies of children who survived dysfunctional family situations (Baron *et al* 1993; Sigal and Weinfeld 2001; Valent 1988). Frankl (1985) observed that the identification of purpose or finding meaning in an ordeal led to what he termed the ‘last of human freedoms’; the ability to choose one’s own attitude to adversity. He noticed that many concentration camp prisoners sought to retain interests and find meaning and purpose, such as playing board games, building models, finding purpose in focussed activity. Frankl was able to provide some distance from his experiences of the camp by stepping back and observing, which helped to focus on those parts of the experience he could control, and ignoring those out of his control. In this sense he can be described as a ‘witness to his own experience’, rather than as a ‘survivor’ (Fine 1990 p.465). ‘The prisoners who fared the best in the long run were those who could retain

their personality system largely intact , where previous interests, values and skills could to some extent be carried on' (Hamburg *et al* 1974, p.413). People who were vulnerable to stress were noted to be those who felt helpless and were passive, and lost the ability to sustain themselves.

Reviews of research into Holocaust survivors (Eitinger *et al* 1993, Lomranz 1995, Harel *et al* 1983) have shown a shift from a purely clinical orientation to a more community or sociological approach. Nadler (1996) observed that initial research concentrated on who the survivors were and whether they were healthy or unwell. In the 1970s and 1980s the focus moved to persistence and transferability of the trauma among survivors and their families (Shmotkin and Lomranz 1998). More recent study has focussed on nonclinical survivors, along with attention to the consequences of violence in general (Solomon 1995). Attempts have been made to describe the psychological concepts of resilience, but as this is a group that is ageing and potentially vulnerable, these unique characteristics limit the potential for generalisation. This has been termed the study of the 'surviving survivors' by Shanan (1988).

Protective factors that enhance resilience and coping in children were described by Rutter (1971, 1985) and Garmezy (1985, 1993). Researchers found that about one-third of the children studied who were growing up with poverty and physical risk such as war were well adjusted, happy and successful, and thoughts began about how the success of these children could be accounted for (Werner and Smith 1982; Garmezy, 1985). Grotberg (2001) reported on the 'International Resilience Research project' which was developed to research aspects of resilience in children initially. Grotberg's findings were that 'by the age of nine, children can promote their own resilience to the same extent as adults'.

2.3 Psychological research

Pinel (1794) described the risks that adverse life events could have on mental health over 200 years ago (cited in Weiner 1992). Researchers such as Bowlby (1951) and Ainsworth (1969) explored the effects of positive and negative experiences of parenting on early childhood development (Bretherton 1992). Investigators later sought to conceptualise the differing effects of life experiences on psychological wellbeing. The term 'invulnerable' emerged in a study of children who were seen as at risk from external stress such as divorce (Anthony and Koupernic 1974) to describe the quality of recovering quickly, or 'bouncing back' from adversity. In child psychiatry, the focus was on responses to different kinds of separation and deprivation experiences (Rutter 1971), to coercive family interactions (Hetherington *et al* 1982) and the potentially negative effects of divorce (Wallerstein and

Kelly 1980) and life experiences associated with increased risk of delinquency (Rutter and Giller 1983).

In adult psychiatry, this was shown as an interest in ‘expressed emotion’ as a factor in influencing the course of a schizophrenic illness (Leff and Vaughn 1980, Wing and Brown 1970), and patterns of social and emotional experience that were seen as influencing the course of schizophrenia (so called ‘schizogenic’ families) (Esterson *et al* 1965). The stress-vulnerability model (Zubin and Spring 1977) was tentatively based on the evidence that certain individual characteristics may be more susceptible to vulnerability factors and that environmental stressors could precipitate psychotic periods in vulnerable individuals. This precipitated an interest in the interactions between environmental stressors, and whether vulnerability may be static or fluid (Nuechterlein and Dawson 1984). There is also a body of research that shows that in children who have suffered seriously adverse life events it is unusual for more than half to be badly affected (Rutter 1971). In adults Paykel (1978) found that adults who had endured stressful life experiences do not necessarily become depressed.

Seligman’s (1972) initial research considered how dogs reacted when an experimental problem could not be solved and he described them retreating into a state of ‘learned helplessness’. He suggested that in humans this kind of thinking may be as a result of a ‘depressed explanatory style’ which affects the belief that a person can influence their environment and so change their experience. He later explored people’s reactions to adverse events, suggesting that it is not so much what happens to a person, but how they interpret it (Seligman 1975). He went on to suggest that other habits of thought could be learned, and his ‘positive psychology’ approach was that a ‘learned optimism’ could be developed that would emphasise thoughts and beliefs that were focused on optimism and self-efficacy.

Coping began to be seen as a major factor in the relationship between stressful life events and the psychological and emotional outcomes for individuals. A paradigm shift began which focussed on the ‘process’ of coping, rather than the previous ‘trait oriented’ approach. Trait oriented approaches focus on the disposition and personality of the individual, with little relevance to the context of the experience (Gaines and Jermier 1983, Kobasa *et al* 1982).

Lazarus and colleagues developed theories of stress and coping over a number of years (Lazarus 1966, Schaefer *et al* 1981, Lazarus and Folkman 1984). The overarching theory was

that there are two main factors that are critical mediators of how an individual responds to stress, and these influence the short and long terms outcomes for them such as experiencing depression, psychological symptoms and somatic illnesses. These two processes were deemed to be ‘cognitive appraisal’; and ‘coping’. Cognitive appraisal was seen as the process through which a person evaluates the impact an event may have on them, and what may be done to overcome or minimise any adverse effects on them. Coping was described as a person’s internal efforts to manage demands that are seen as taxing or exceeding the persons’ usual resources (Lazarus and Folkman 1984). This research was part of a growing interest in the ways in which individuals respond to stresses and the factors that can influence this, with debate about the intrinsic and extrinsic factors.

2.4 Biological aspects of stress

Cannon (1932) first described the human body’s response to stress as a ‘fight-or-flight’ reaction. This also relates to the concept of a behavioural response to stress, in that a human (or animal) assesses a threat or predator and judges that it has a realistic chance of winning the attack, in which case *fight* is likely. *Flight* is more likely if defeat is assessed as more probable. Selye (1956) termed this a ‘general alarm reaction’. Cannon (1932) presented a discussion of the steady states of the body, with the explanation of the physiological controls of these conditions. He reported the physiological effects of sympathetic nervous system activation that stimulates the adrenal medulla, producing hormones into the bloodstream, causing blood vessel contraction, dilation of bronchioles, adrenaline release, release of sugar from the liver; all effects that together prepare the human or animal to attack or run. Cannon noted that strong emotional reactions could affect hormonal and nervous system effects on the body, with the potential to cause physical symptoms that could be significant, including death (Cannon, 1932, 1957). This research led to the commonly known effects of ‘sympathetic hyperarousal’; rapid heart rate, increased blood pressure, increased respiratory rate, increased muscle tension, and an increased metabolic rate (Janeway 2009). Sarason *et al* (1978) reported on the numerous studies that have investigated the relationship between stress and susceptibility to physical and psychological problems. Links have been reported between life stress and sudden (cardiac) death (Rahe and Lind 1971), life stress and myocardial infarction (Thorell and Rahe 1971), life stress and minor and major health problems (Holmes and Rahe 1967). By the twenty first century, a large body of research showed that psychological factors can influence the hypothalamic–pituitary–adrenocortical (HPA) axis, which regulates the release of cortisol, an important hormone associated with psychological, physiological, and physical health functioning (Dickerson and Kemeny 2004).

Selye's (1956) perspective was that the stress response, which includes HPA activation, was nonspecific, which is that all stressors, whether physical or psychological, would elicit the same physiological reaction. In Dickerson and Kemeny's (2004) review of the literature suggested that acute psychological stressors can elicit cortisol activation. They also signal a wide variety of intensity of responses to different kinds of psychological threat, but strong evidence that threats to the individuals' self-esteem elicit strong cortisol responses (this is linked to a human motivation for self-preservation).

A number of negative health effects have been noted after prolonged cortisol activation, such as the development of some chronic diseases such as hypertension and diabetes (McEwen 1998). Het and Wolf (2007) showed that raising cortisol levels prior to acute stress has a protective effect on mood during stressful situations.

2.5 Workplace stress perspectives

Lazarus and Folkman (1984) applied the concept of stress as 'demand-perception-response' to the study of occupational stress and stress management. The main concept is that stress relates both to 'an individual's perception of the demands being made on them and to their perception of their capability to meet those demands. A mismatch will mean that an individual's stress threshold is exceeded, triggering a stress response' (McVicar 2004). Long (1995) suggested that interpretations or appraisals of stress should be considered an intermediate step in the relationship between a given stressor and the individual's response to it. She noted that appraisals are determined by the 'values, goals, individual commitment, personal resources (e.g., income, family, self-esteem), and coping strategies that employees bring to the situation' (Long 1988). The concept of 'job control', explained as the control that employees have over their working conditions, was seen as a major factor. Employees who were unable to exert control over their working lives were found to be more likely to have impaired health, such as job dissatisfaction, mental strain and cardio vascular disease (Sutton and Kahn 1987, Sauter *et al* 1989).

Lazarus (1991) identified three main strategies for reducing work related stress, focussing on changing the 'person- environment relationship', as shown in Figure 2 below:

Figure 2 Strategies for reducing work-related stress

1. Alter the working conditions so that they are less stressful or more conducive to effective coping. This strategy is most appropriate for large numbers of workers working under severe conditions, such as reducing noise levels.

2. Help individuals adapt by teaching them better coping strategies for conditions that are impossible or difficult to change. A limitation to this strategy is that it is costly to deal with each individual's unique transaction with the environment. Intervention strategies could include individual counselling services for employees, employee assistance programmes, or specialised stress management programmes, such as cognitive behavioural interventions.

3. Identify the stressful relationship between the individual or group and the work setting. Intervention strategies might include changes in worker assignment to produce a better person-environment fit, or it could involve teaching coping strategies for individuals who share common coping deficits (e.g., training in relaxation skills).

(Lazarus 1991 p.8)

An individual's stress threshold, sometimes referred to as stress 'hardiness' (McVicar 2004) is said to be dependent upon their individual characteristics, experiences and coping mechanisms, and on the conditions in which they are working. Arvey *et al* (1998) reviewed research into how individual's emotions interact with the demands of the job to influence emotions, emotional displays, and workplace behaviours. This review suggested that individual differences in emotionality could be measured and used to predict job performance and those emotional demands of jobs and organisations could be measured. Managing emotions for a wage has been termed 'emotional labour' (Hochschild 1983).

Grandey (2000) suggests that emotional labour involves 'enhancing, faking or suppressing emotions to modify the emotional expression'. Many workplaces have rules about the emotions that employees should show in public, for example in customer service smiles and obvious positive humour would be encouraged, whereas for therapists or judges a lack of responding and suppression of emotional expression would be expected (Van Maanen and Kunda 1989, Hochschild 1983). The suggestion that emotional labour may have detrimental

effects on employees began to emerge, suggesting that the managing of emotions at work may be stressful and lead to burnout (Hochschild 1983, Rafaeli and Sutton 1989). Hochschild (1983) offered a comparison with dramatic acting, seeing workers as managing emotions through 'surface acting' where emotional expressions are regulated, and 'deep acting' where feelings are modified to express the desired outcome. Because of the effort involved and the degree of control exerted by the organisation, Hochschild proposed that emotional labour contributed to burnout and work stress.

Ashforth and Humphrey (1993) argued that surface and deep acting may not be a source of stress for workers, if they become part of routine work and are displays of genuine emotion. In this conceptualisation, emotional labour was seen as related to 'task effectiveness' provided the customer saw it as sincere. Morris and Feldman (1996) focussed on the environment in which the interactions occur, proposing four dimensions of emotional labour: frequency of interactions, intensity, variety and emotional dissonance. Grandey (2000) reviewed situational, organisational and personal characteristics of employees in relation to emotional labour, and suggested that situational settings contribute to the emotional labour engaged in by employees, which may have consequences for health and wellbeing.

2.6 Healthcare staff and nursing

James's (1989, 1992) research in nursing uses the term emotional labour to stress the relationship between emotional and physical labour: `with both being hard, skilled work requiring experience, affected by immediate conditions, external controls and subject to divisions of labour' (James 1992). James concludes that emotional labour can be described as, `hard work', `difficult' and even `sorrowful', but that this vital part of nursing work remains `undefined, unexplained and usually unrecorded' due to its link with women's domestic caring role (James 1989). Downe (1990) has written that the state of `being' a nurse is characterised by the unmeasurable element of the truly caring vocation.

The concept of 'burnout' in healthcare clinic staff was explored by Freudenberger (1974) in terms of physical and behavioural signs that staff were 'wearing out'. Early research focussed on the experiences of people working in human services and healthcare; occupations where the goal is to help people in need. Burnout has become a conceptual description for a psychological syndrome in response to chronic interpersonal stressors on the job (Freudenberger 1975, Maslach 1986, Lee and Ashforth 1996). Maslach *et al* (2001) reviewed the previous research on burnout and note the defining characteristics as 'overwhelming

exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment' (Maslach *et al* 2001 p.420). They also noted that effective interventions to reduce burnout required change both in the workplace environment and in the individual, and suggest that a 'work setting that is designed to support the positive development of energy, vigour, involvement, dedication, absorption, and effectiveness among its employees should be successful in promoting their well-being and productivity' (Maslach *et al* 2001 p.420). In research carried out on the psychological effects of working with trauma Figley (2002) developed the concept of 'compassion fatigue' as the 'reduced capacity or interest in being empathic' or 'bearing the suffering of clients' and suggested it was 'the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by others' (Figley 2002 p.1435).

Boscarino, Figley and Adams (2004) set out to test the concepts of vicarious trauma and compassion fatigue in their study of social workers working with survivors of the September 11 (2001) terrorist attacks in New York. Results appeared to support the concept that a group of mental health professionals working with traumatised victims 'were at greater risk for compassion fatigue, controlling for demographic factors, personal trauma history, social support, and work environment factors' (Boscarino, Figley and Adams (2004 p.59). They question the idea that compassion fatigue and vicarious trauma is limited to mental health professionals, and suggest that compassion fatigue is a construct that is comprised of vicarious trauma and burnout. Exposure to the trauma of clients in mental health care has been suggested is a unique experience of mental health professionals, but evidence for this was found to be inconsistent (Sabin-Farrell and Turpin 2003).

Gustaffson *et al* (2010) explored factors that may promote resilience and reduce the potential for burnout in healthcare professionals, and found that an increased 'forbearance', the ability to let go of perceived injustice and the ability to look after oneself are protective factors. Gustaffson *et al* (2010) further suggest an important finding was that sharing difficult work experiences with colleagues and managers helps employees to understand how others are affected, and what demands are reasonable, which can in turn reduce stress and burn out.

Edward and Hercelinskyj (2007) suggested ways in which nurses could protect against burnout and work related stress through knowledge of resilient behaviours, such as the use of reflective practice, clinical supervision, formal and informal peer support, and professional development. Bolton (2000) explored the work of nurses in a gynaecological unit, and

suggests that a defining characteristic of emotional labour in nurses is the altruistic motivation behind the caring actions. The degree to which nurses involved themselves in the emotional and stressful situations of their patients was seen as offering extra emotion work as a ‘gift’ to the patient in the workplace, which extends the concept of emotion labour from the managing of the nurses’ own emotion. Riley and Weiss (2015) conducted a review of previous research in emotional labour in healthcare settings, and concluded that the degree of emotional labour involved is often overlooked, and that to help staff cope with the varied emotional demands of their workplace, support and supervision should be in place.

Jackson *et al* (2007) conducted a review of the concept of resilience in nurses as a strategy for responding to workplace adversity, and recommended that resilience-building should be included in nurse education and that professional support and mentoring should be encouraged. They conclude with a recommendation that the characteristic elements of resilience in nurses and how they can be developed should be studied (Jackson *et al* 2007).

In a review of the literature on resilience by Aburn *et al* (2016) it was noted that there was no one definition of resilience. In the Aburn study it was noted that while there were many papers written by nurses, only one paper examined resilience in nursing (Gillespie *et al* 2007). However Hart *et al* (2014) conducted an ‘integrative review’ of research that has been conducted to understand the phenomenon of resilience in nurses, and found seven papers that focus on nursing resilience, using a variety of qualitative and quantitative methods (Simoni and Patterson 1997, Ablett and Jones 2007, Gillespie *et al* 2007, Gillespie *et al* 2009, Glass 2009, Hodges *et al* 2008, Kornhaber and Wilson 2011). Aburn *et al* (2016) suggested that it was important that the contextual nature of resilience was recognised, and recommended that further research should be undertaken to understand the nature of resilience in specific population groups.

2.7 Mental health nursing and secure environments

A review of stress research amongst mental health nurses (Edwards and Burnard 2003) found that workplace stress for mental health nurses results from working closely and intensely with patients over an extended period of time. They recommended that research was needed to assess the impact of interventions that attempt to moderate, minimize or eliminate some of the stressors. Evidence that levels of work stress experienced by psychiatric nurses are unusually and especially high was presented by Brown *et al* (1995). Chou *et al* (2012) found that in jobs which required a higher frequency of interactions with

difficult patients, nurses are more likely to experience emotional exhaustion and job dissatisfaction, and recommended that organisations should provide training in effective emotional regulation techniques and creating a climate in which nurses feel supported by their organisation. Melchior *et al* (1996) found that stress and burnout in mental health nurses was associated with the intense involvement with patients with severe mental illnesses. In the 'Claybury' study (Fagin *et al* 1995) stressors for mental health ward staff were linked to staff shortages, service changes, poor morale and not being notified of changes before they occurred.

Many studies have identified psychological stressors and challenges in secure environments, (Kirby and Pollock 1995, Mason 2002, Bowers 2002, Dickinson and Hurley 2012) but little research has explored factors which may promote resilience in nurses working in secure environments. A study of the differences in levels of burnout between staff working in male and female medium secure units (Nathan *et al* 2007) showed that burnout increased significantly over time in staff in female wards, manifesting in emotional exhaustion and depersonalisation. Clinical presentations of patients in secure environments can be particularly complex and challenging, which can be a source of significant stress and psychological challenges to staff. Smith and Hart (1994) showed that intense encounters with angry patients could lead to nurses disconnecting and withdrawing from patients. The attitudes of forensic nursing staff towards patients in a forensic psychiatric ward were examined and it was found that older forensic nurses, with more professional experience, viewed patients more critically than younger participants (Oberlaender *et al* 1999).

Chung and Harding (2009) found that the personality traits of nursing staff working in a secure service for people with learning disabilities can either affect their wellbeing in a negative way or protect them from harm. Using the five global personality traits identified by Costa and McCrae (1992) (neuroticism, extraversion, openness to experience, agreeableness, conscientiousness) they found that certain personality traits affect the elements of burnout. This suggests that testing for personality types could be helpful in staff selection processes in secure care, to assist in selecting staff that are more resilient in working in these challenging environments.

2.8 Workplace stressors in mental health nursing in secure environments

Nurses working directly with patients in secure mental health environments may have to withstand verbal abuse and threats, physical aggression and other challenging behaviours, while maintaining an outwardly calm mien. Nurses can become skilled at not showing emotion and this may spill over into everyday life (Bolton 2000, Jackson *et al* 2007, Riley and Weiss 2015). Effective recruitment and retention of nursing staff is essential for the provision of patient care, and is of great concern to managers and providers of secure services.

Staff working in these environments would, by definition, be working in an environment that presents intense and stressful experiences, and will require a level of resilience to enable them to work with very challenging patients. Jones *et al* (1987) found that nursing staff in a high secure hospital reported relatively high levels of psychological stress when compared with other mental health nursing populations. Evidence that levels of work stress experienced by psychiatric nurses were unusually and especially high was presented by Brown *et al* (1995) and further research was recommended. There were some methodological weaknesses in terms of sample bias, as the Jones *et al* (1987) study was sponsored by the hospital concerned, and the Brown *et al* (1995) study related only to community mental health nurses. The conflict of therapy and custodial roles in secure environments for nurses has been noted by Mason *et al* (2008) in registered nurses working in high medium and low secure services. They found statistically significant differences in the perceptions of high secure nursing staff regarding their concerns about managing patients with personality disorders, compared to patients with mental illness.

A systematic review of stress research amongst mental health nurses (Edwards and Burnard 2003) found that workplace stress for mental health nurses results from working closely and intensely with patients over an extended period of time. Edwards and Burnard (2003) reviewed over 70 papers published on the subject of stress in mental health nurses, noting that there was little published on translating findings into practice. They recommended that research was needed to assess the impact of interventions that attempt to moderate, minimise or eliminate some of the stressors.

Chou *et al* (2012) analysed data from 240 questionnaires distributed to registered nurses in a Taiwan hospital and found that in jobs which required a higher frequency of interactions with difficult patients, nurses are more likely to experience emotional exhaustion and job

dissatisfaction. They recommended that organisations should provide training in effective emotional regulation techniques and creating a climate in which nurses feel supported by their organisation. A study of the differences in levels of burnout between staff working in male and female medium secure units (Nathan *et al* 2007), showed that burnout increased significantly over time in staff in female medium secure wards, manifesting in emotional exhaustion and depersonalisation. Gender of staff complicated these results, as on all-female wards the majority of staff were female, and this skew was also reflected on all-male wards, making it impossible to 'disentangle' the effects of staff gender. One strength of this study was that two staff groups who worked within the same managerial structure were followed up with repeated measures of burnout over an 18-month period. This study provided some support for the need for differences in support and supervision that is targeted for staff working with different genders and pathologies in secure services, but did not suggest any possible solutions.

Using grounded theory in a qualitative study on nine female registered nurses in Nova Scotia, Smith and Hart (1994) showed that intense encounters with angry patients could lead to nurses disconnecting and withdrawing from patients. The attitudes of nursing staff towards patients in a forensic psychiatric ward were examined using a well validated inpatient nursing observation scale (Honingfeld and Klett 1965), and it was found that older forensic nurses with more professional experience viewed patients more critically than younger participants (Oberlaender *et al* 1999).

There has been some research exploration of the issues for nursing staff in working in a secure environment (Jones 1987, Bowers 2002, Aiyegbusi and Kelly 2015). In a study in a high secure personality disorder service, Bowers (2002) found that the development of negative attitudes of staff can be moderated by how such factors are understood and dealt with by the individual, team and organisation. The Bowers study was conducted across the three English high secure hospitals, ostensibly to discover what was different about the nursing staff working in personality disorder units, to assist them in working positively with this challenging patient group. This was illustrated through in-depth analysis of a questionnaire survey, followed by personal interviews, and some practical conclusions are suggested. Using a sequential mixed methods study, Aiyegbusi and Kelly (2015) emphasised the tremendous emotional labour involved in working with personality disordered patients in a secure environment. Their study explored the lived experience of patients and staff in

specialist personality disorder units, and suggested developmental and training needs of staff working in this kind of environment.

A review of the literature on burnout and the effects of resilient behaviours by nurses was conducted by Edward and Hercelinskyj (2007). They suggested ways in which nurses could protect against burnout and work related stress through knowledge of resilient behaviours, such as the use of reflective practice, clinical supervision, formal and informal peer support, and professional development. Jackson *et al* (2007) conducted a review of the concept of resilience in nurses as a strategy for responding to workplace adversity, and recommended that resilience-building should be included in nurse education and that professional support and mentoring should be encouraged. The Jackson *et al* (2007) study reviewed literature from 1996 to 2006 using the keywords 'resilience', 'resilience in nursing', and 'workplace adversity' together with 'nursing', and 50 papers were then analysed by the authors for key themes and concepts. Although they do not describe in detail how these papers were analysed, beyond regular meetings to discuss themes and key ideas, they conclude with a recommendation that the characteristic elements of resilience in nurses and how they can be developed should be studied (Jackson *et al* 2007). There is a need for some translation of research findings into practice both for the individual benefit of nursing staff but also to enable services to provide quality care for patients. McElfatrick *et al* (2000) call for the best and worst coping strategies by mental health nurses to be identified so that intervention schemes can be designed.

Black (2011) discusses the need to establish a healthcare culture that promotes staff health and wellbeing, as a necessary response to the quality and productivity challenges that the NHS faces. Within these settings, managers are responsible for recruiting, developing and supporting nurses, and maintaining a workforce which has itself sufficient resilience to maintain safety and continuity of care.

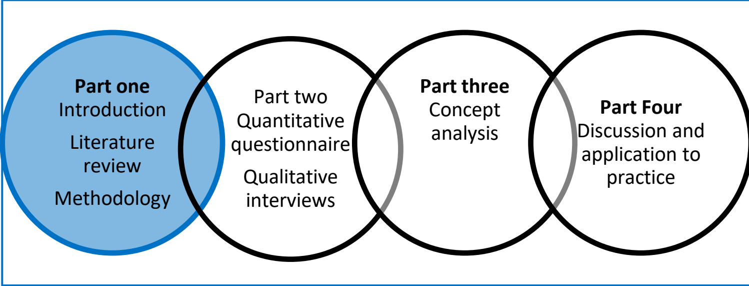
Effective recruitment and retention of nursing staff is essential for the provision of patient care, and is of great concern to managers and providers of secure services. Boorman's (2009) review of NHS health and well-being recommends that all NHS organisations provide staff health and well-being services that are centred on prevention (of both work-related and lifestyle-influenced ill-health), are fully aligned with wider public health policies and initiatives, and are seen as a real and tangible benefit of working in the NHS.

This review recommends that a ‘demonstrable commitment to, and delivery of, high-quality staff health and well-being services is also crucial to demonstrating NHS leadership in the area of improving and promoting health, that is central to its business’ (Boorman 2009 p.9). The Boorman report focussed on staff across all NHS services, recommending that organisations should invest in staff wellbeing and welfare, with improved outcomes for patient safety, patient experience and the effectiveness of patient care. Managers of nurses are responsible for recruiting, developing and supporting nurses, and maintaining a workforce which has itself sufficient resilience to maintain safety and continuity of care.

2.9 Summary

This chapter has presented a summary of the development of research and literature on the effects of psychological trauma, work related stress, resilience and work related stress issues in mental health nursing and nursing in secure environments. This literature will be drawn on in relation to the study chapters which follow, and in the discussion of application to practice.

3 Methodology



This chapter explains the rationale for a mixed methodology approach, outlines the methodologies used in this study, and describes the detail of the research methodologies used. Three separate methodologies were used to explore resilience, and these three methodologies will be introduced initially, then each will be discussed in more detail. The details of how the research was carried out, in terms of setting, participants and ethical issues are explained. The application of each individual methodology is described at the introduction to each of the relevant chapters.

3.1 Rationale for mixed methodology

This study has explored resilience in nursing staff in a secure mental healthcare environment, and gathered information about the internal and external factors that influence the resilience of nursing staff. The aim of this research was:

To explore aspects of resilience as experienced by mental health nurses in a high secure service, using a mixed methods approach.

Mixed methodology was used to meet the following objectives:

- To identify resilience profiles in this environment, using a validated tool;
- To explore the lived experience of nurses related to resilience, using analysis of semi structured interviews and
- To develop a concept analysis of resilience in this environment using data gathered by the first two methods.

As discussed in Chapter Two, resilience has both an intrinsic internal quality (Cameron *et al* 2007) and can be influenced by external factors in the individual's environment (Long 1995). The objective of this research was to develop an in-depth understanding of resilience from a number of different approaches. This information was then used to develop a concept analysis approach to explore new nursing knowledge.

In order to provide a variety of viewpoints a mixed methods approach was used, using analysis of qualitative interviews (Smith *et al* 2009), a quantitative survey (Connor and Davidson 2003), and the subsequent development of a description of the 'constituents' of resilience in this group using a concept analysis (Walker and Avant 2005).

‘Mixed methods’ approaches in research have been said to offer a ‘third paradigm’ (Sale *et al* 2002, Johnson *et al* 2007) which legitimately combines methods from qualitative and quantitative research to uncover knowledge from multiple perspectives.

Johnson and Onwuegbuzie (2009) reviewed the philosophical and practical differences in qualitative and quantitative research, and suggest that research approaches should be combined in ways that are best suited to answer research questions.

Greene *et al* (1989) identified five purposes of mixed-method research; triangulation, complementarity, development, initiation, and expansion. Caracellli and Greene (1993) further suggest that researchers should be explicit about how the analysis of both sets of qualitative and quantitative data will be carried out, and propose a structured approach to analysis, to yield specific targeted outcomes. Mixed methods studies provide opportunities for the integration of a variety of theoretical perspectives (Bowen and Rose 2017). There is no single recommended list of mixed method design (Johnson and Onwuegbuzie 2009), however mixed methods research has been described as integrating the strengths of qualitative and quantitative data in a single study (Green *et al* 1989, Tashakkori and Teddlie 2003).

Quantitative methods are often used for deductive research, when the aim is to test theories or hypotheses, gather descriptive information, or examine relationships among variables. Quantitative data can be used to give an overview of these characteristics, aspects of which are examined in more detail. Qualitative research focusses on the meanings and contexts of human lives. It is useful for the development of new knowledge and for facilitating the collection of data when quantitative measures do not exist, and/or to develop a depth of understanding of concepts (Meissner *et al* 2011).

The rationale for the use of mixed methods in this study is grounded in the intention to develop a concept analysis of resilience, using data gathered through the use of a validated tool (to gain insight into the profile of resilience) and from the analysis of semi-structured qualitative interviews (to explore and analyse nurses’ lived experience of resilience). The output of this research can be categorised as typology development;

> *‘Where analysis of one data type yields a typology (or set of substantive categories) that is then used as a framework applied in analysing the contrasting data type’ (Caracelli and Greene 1993 p198).*

This provides a framework for the research, describing both a process and an intended outcome, and can be seen as going beyond 'triangulation' to 'expansion' (Creswell 2003). Triangulation focuses on corroboration of results from different methods, and the emphasis is placed on seeking corroboration between quantitative and qualitative data. Greene *et al* (1989) described 'expansion' as seeking to extend the breadth and range of enquiry by using different methods for different inquiry components. Using C.S. Peirce's suggested definition of truth as 'what we would agree upon, if enquiry were to be pursued as far as it could fruitfully go' (Peirce 1903, cited in Anellis 2012 p88); an integrated method was developed to facilitate study into the 'wholeness' of resilience in this setting.

According to Denzin (2010) the use of mixed methods approaches is intended to combine two sources of data to study the same phenomenon in order to gain a more complete understanding of it. This can be seen to apply particularly in the study of human experience; as Phillips (1988) suggests; it may be that individually quantitative and qualitative approaches are inadequate to the task of understanding wholeness because they give an incomplete view of people. The aim in conducting this research was not only to explore and uncover the essences of resilience for the individual, but also to explore and expand from the individual's experience, in order to develop a concept analysis of resilience. This new knowledge may then be used to inform recruitment, retention and workplace wellbeing interventions, as discussed in the final discussion chapter (Chapter Seven).

3.1.1 Measuring resilience

The past two decades have seen an increase in interest in resilience research, following a move away from 'deficit' models of illness (Fergus and Zimmerman 2005, Haskett *et al* 2006). Although the challenges of developing a widely held definition of resilience are noted (Masten 2007), the commonly recognised themes are effectively negotiating, adapting to, or managing significant sources of stress or trauma (Windle 2011).

Windle *et al* (2011) offer a further definition as:

> *'Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and 'bouncing back' in the face of adversity*' (p.2).

Notwithstanding the challenges of definition, reliable and valid measures to evaluate interventions and measures designed to promote resilience are needed.

Two recent studies examined the existing resilience measuring scales (Ahern *et al* 2006, Windle *et al* 2011). Ahern *et al* (2006) evaluated resilience measures for reliability, validity, and factor structure. They reviewed 23 published articles on resilience measuring scales using an analysis table including population, settings, influencing factors, psychometric properties, and applications for use. They identified three scales that met their quality criteria: the Connor-Davidson Resilience Scale-CD-RISC (Connor and Davidson 2003), the Adolescent Resilience Scale (Oshio *et al* 2003) and the Resilience Scale for Adults (Friborg *et al* 2003). One limitation of this study is that the objective of Ahern *et al* (2006) was solely on identifying the most suitable scale for their research on adolescent resilience, rather than a wider application. Windle *et al* (2011) offer a further limitation of these results, noting that Ahern *et al (2006)* did not use clear quality assessment criteria to show what might constitute good measurement properties, or identify where any of the scales might lack specific psychometric evidence.

Windle *et al (*2011) concluded that there is no 'gold standard' for resilience measures, and set out to *'*review the psychometric rigour of resilience measurement scales developed for use in general and clinical populations' (p.1). They describe 18 criteria for assessment, including searching, screening, appraising quality criteria and data extraction and handling. They reviewed 19 resilience scales and concluded that three of these received the best psychometric ratings: the CD-RISC (Connor and Davidson 2003), the Brief Resilience Scale (Smith *et al* 2008) and the Resilience Scale for Adults (Friborg *et al* 2003).

One of the aims of the current study was to develop a profile of resilience in this population, using a validated tool. Windle *et a*l (2011) found that the CD-RISC and the 'Brief Resilience Scale' (Smith *et al* 2008) received the highest ratings when measured against their quality criteria, and the CD-RISC was the only scale that had been used to measure the response to a treatment intervention. The CD-RISC was therefore chosen for this study, because the tool also has a well validated evidence base, and has been translated into many different languages. It has also been used in in a variety of diverse populations; including general community samples, survivors of various traumas, Alzheimer's caregivers, adolescents, elders, patients in treatment for depression and PTSD, members of different cultures, and professional groups, including nurses.

Research using the CD-RISC in nursing has included resilience and burnout in acute and intensive care nurses (Mealer *et al* 2012, Mealer *et al* 2014, Amini 2014, Torgeh and Alipour 2015, Chana *et al* 2015). It has not been used to measure resilience in mental health nurses

in England. The CD-RISC is a 25-item questionnaire, originally developed to measure treatment outcomes in depression (Connor and Davidson 2003).

A validated resilience measure (CD RISC; Connor and Davidson 2003) was used to describe the resilience profile of a sample of staff working in this environment. This was used to gain insight into resilience profiles in this environment, which then informed the analysis and interpretation of qualitative data from the subsequent interview study.

This tool was readily available from the original authors, with a detailed handbook for administration and scoring, and was easily translated into an electronic survey. Web based questionnaires are designed to be user friendly and accessible, and are increasingly being used in lieu of paper surveys (Evans and Marthur 2005). An established tool, Bristol Online Surveys, was used. This tool offers secure hosting of data (meeting Data Protection Act, 1992, standards), and user friendly design for participants. Further details of the application of the CD-RISC are described in Chapter Four.

3.1.2 Interview analysis

This element of the research was designed to gather information about human experiences using semi-structured interviews. These focussed on the internal feelings and perceptions of nursing staff, rather than on their observable behaviour. In this section IPA will be introduced, along with its philosophical background and rationale for use in this study.

In-depth explorations of an individual’s lived experiences are not readily accessible with the use of more quantitative research tools, which arguably could be seen to provide more objectivity in data analysis. However, human behaviours cannot be understood without understanding the framework within which subjects interpret their thoughts, feelings and actions (Marshall and Rossman 1989). A qualitative phenomenological approach to this part of the research was chosen as the most appropriate, because the central element of a phenomenological approach is a rational and intuitive process, and the value of the phenomenological focus lies on the subjective and particular aspects of participant’s actual experiences (Hallett 1995).

This study draws extensively on interpersonal communication to develop an understanding of the experiences, emotions and reactions of nursing staff, focusing on their conscious experiences. The philosophy of phenomenology is seen as an important methodology for understanding nursing experience, as an approach to understanding the lived world (Sadala and Adorno 2002). The phenomenological approach allows the building up of knowledge in a

process of development. IPA was developed in the 1990s as an approach to how people make sense of their experiences (Smith 1996) in response to more traditional approaches in psychology that excluded understanding of the lived experience of people. It has a defined structure and procedure for analysis, making it an accessible although flexible method for those without a philosophical background (Larkin and Thompson 2012, Willig 2013). IPA focusses on personal meaning and sense making in a particular context, regarding the individual as 'experts' in their experience (Smith *et al* 2009). In this way there is a commitment to placing personal meaning in context and making sense of the experience of a few individuals in great depth, through description and interpretation (Smith *et al* 2009). This approach suited the aim of this part of the study, allowing exploration and 'sense-making' of the experiences of nurses in this environment.

Phenomenology as discussed by Husserl (1907) (cited in Sadala and Adorno 2002) is a return to the lived world. The philosophy proposes that a phenomenon should be described instead of being explained or having its causal relations searched for, and it focuses on these very things as they manifest themselves. Sadala and Adorno (2002) draw a comparison with Picasso's study 'Metamorphosis of a Bull', in that the painter displays images of a bull in a sequence that becomes increasingly abstract but remains recognisable as a bull.

The main issue in Husserl's view is that the inquiry into natural events in the current practice of experimental science relies on an uncritical conception of nature. Exact science performs its investigations in the conviction that 'natural facts' result as a matter of course from the application of methods that are elaborated according to its own previous assumptions. If one intends to discover the original phenomena that underlie previous assumptions, it is necessary to suspend the particular belief about the natural. In other words this belief should be provisionally 'bracketed' or submitted to 'reduction'. Husserl (1907) justifies this reduction by the fact that the phenomena discovered by exact or natural sciences are dealing with the essence of things. The search for truth is brought back to an ultimate object or 'essence', and this object is situated in nature. Husserlian phenomenology can be seen in this context as a search for the essence of things from a natural standpoint, taking into account the context in which they exist.

Smith *et al* (2009) and Giorgi and Giorgi (2008) sought to develop and articulate ways in which phenomenology could be 'operationalised' and developed into a research approach. Giorgi's (2007) approach is descriptive and argues against a set of identified steps, focussing solely on identifying commonalities. The descriptive nature of the research output using

Giorgi's method was felt to be potentially limiting to the depth of analysis in this study, as the aim was to explore the interactions between the individual, the context in which they were working, and explore the meaning of the experience for each individual. Smith *et al* (2009) offer a set of common approaches for analysis which can be applied flexibly, and the approach of IPA allowed for a more in-depth analysis.

Smith and Osborn (2003) describe a 'double hermeneutic' in the analysis involved in IPA, where the researcher is making sense of the participant, who is making sense of the subject. The researcher is described as wanting to adopt an insider's perspective, while also wanting to stand alongside the participant, taking a look at the subject from a different angle (Conrad 1987). This level of analysis fits well with the aims in this research; which was to uncover and explore nurses' experience of resilience, but also to interpret and analyse this from a research viewpoint.

According to Smith *et al* (1999), although the researcher is attempting to access 'the participant's personal world' insofar as this is feasible, IPA acknowledges that:

> *'Access depends on and is complicated by the researcher's own conceptions... required in order to make sense of that other personal world through a process of interpretative activity' (Smith et al 2009, p.219).*

Phenomenology as posed by Husserl maintains that it is not possible to separate out subject from object, that is that the only certain or objective knowledge humans have is attained by processes of consciousness. In phenomenology reality is comprehended through close examination of individual experiences, to capture the meaning or 'essences' of an experience or an event (Starks and Trinidad 2007).

The three key elements of IPA (idiography, inductive and interrogative techniques) are discussed in more detail below, with reference to the application of IPA in this study.

Idiography

'Idiography' involves the study or explication of individual cases or events, whose subjects are recognised as unique individuals, as opposed to a nomothetic perspective which focusses on the general properties or behaviour of people according to general rules.

IPA proposes the detailed examination of each case until a 'gestalt' is noted, that is, an event or experience that when considered as a whole, has qualities that are more than the

total of all its parts (Larkin *et al* 2006). Each case in turn is then rigorously analysed until all are completed, and this is followed by a cross-case analysis (Smith 2004). The individual analyses are then analysed across cases, attempting to notice convergence and divergence across the whole sample. This allows the themes to be developed, which can both provide information about the individual's unique experience, and cross-case themes to be understood. In this study each nurse brings a unique lived experience of resilience in their workplace and the idiographic approach of IPA is used to examine the individual's experiences in great depth and detail. However nurses in this context work in teams in a particular environment, and this method also allows an analysis of themes across the context in which they exist. Exploring the personal in great depth has been said to bring us closer to the universal (Warnock 1994) and Smith (2004) suggests that the detail gathered through IPA analysis can be seen as containing an 'essence' in the sense of Husserlian phenomenology (Giorgi and Giorgi 2003).

Inductive

'Inductive' refers to using IPA research techniques which are flexible enough to allow unforeseen issues or themes to emerge, rather than trying to verify or dispel specific hypotheses. This study was unique in exploring aspects of resilience in nurses in a high secure environment, and it was essential to approach the study without a set of preconceived assumptions which could have restricted the depth and type of material uncovered.

A semi structured interview is the most common method used in IPA (Smith *et al* 2009) and requires the researcher to develop a prepared schedule focussed on the topic of the research. However these questions are focussed on the broader research question, and should be able to absorb unanticipated material that arises from the analysis of the interviews. This can support the uncovering of new concepts and new aspects of the phenomenon that arise during the process, using the guidance of the research question to following the lead of the participants (Gioia *et al* 2012). Smith *et al* (2009) acknowledge that this inductive approach is not unique to IPA, but is 'foregrounded' in the IPA approach. In this study a set of semi structured questions was developed and shared with participants, but the interview process followed the trains of thought and linkages made by the participants themselves, allowing a depth of analysis as they made sense of their thoughts.

Interrogative

A key aspect of IPA is to 'interrogate' or illuminate existing research to contribute to psychological knowledge (Smith 2004). There is a wish to learn about the psychological and social world of the participant as far as is possible, by entering into a dialogue with each individual that generates the interview data. The intention of the study was to uncover or discover aspects of the meaning of resilience for nurses in this context, and reflect these against what is already known on the subject. IPA is concerned with exploring the meaning of the experience, not merely recording instances of it, and the analysis of the interviews should be reflected against existing literature on the topic (Smith and Osborn 2003).

Smith *et al* (2009) describe IPA as

> *'A set of common processes and principles which are applied flexibly, according to the analytic task' (p.79).*

While there is no set method proscribed in IPA, Smith *et al* (2009) suggest there is an iterative and inductive cycle to the analysis, which draws on the strategies outlined in Figure 3 below:

Figure 3 IPA analysis

- Close, line-by-line analysis (i.e. coding) of the experiential claims, concerns and understandings of each participant (Larkin *et al* 2006).
- Identification of the emergent patterns (i.e., themes) within this experiential material emphasizing convergence and divergence, commonality and nuance (Eatough *et al* 2008); usually first for single cases, and then subsequently across multiple cases.
- Development of a 'dialogue' between the researchers, their coded data and their psychological knowledge, about what it might mean for participants to have these concerns in this context (Larkin *et al* 2006; Smith, 2004), leading in turn to the development of a more interpretative account.
- Development of a structure, frame or gestalt which illustrates the relationships between themes.
- Organisation of all of this material in a format that allows for coded data to be traced right through the analysis; from initial codes on the transcript,

through initial clustering and thematic development, into the final structure of themes.

- Use of supervision or collaboration, to audit, to help test and develop the coherence and plausibility of the interpretation and explore reflexivity.
- Development of a narrative evidenced by detailed commentary on data extracts, which takes the reader through this interpretation, usually theme-by-theme, and often supported by some form of visual guide
- Reflection on one's own perceptions, conceptions and processes should occur throughout the process and is usually captured in a systematic fashion by keeping a reflexive journal.

(Smith *et al*, 2009, p.79–80)

Reflexivity

Reflexivity has been described as a defining feature of qualitative research (Banister *et al* 1994). Qualitative researchers attempt to be aware of their role in the co-construction of knowledge, and try to explain how intersubjective elements impact on data collection and analysis in an effort to enhance the transparency of their research (Finlay 2002). While being conscious of Finlay's view that reflexivity should be 'neither an opportunity to wallow in subjectivity nor permission to engage in legitimised emoting' (Finlay, 2002 p.542), the researcher was mindful of the need to have the space to explore such issues as positionality (Rose 1997, Chavez 2008) intersubjective dynamics between researcher and data (Finlay and Gough 2003) and previous knowledge and understanding (Husserl 1907).

In IPA, the importance of acknowledging oneself as part of the research has been highlighted (Smith *et al* 2009), and it is recommended that the researcher maintains a reflexive diary to record details of the nature and origin of any interpretations as they emerge (Biggerstaff and Thompson 2008). During the process of analysis of the IPA interview transcripts, notes of reflections, thoughts and observations were made. These included thoughts about the transcripts, but also the researcher's own emotions and thoughts about their own role in the process, reflected against their own experiences (Smith *et al* 2009). Reflexivity can also be said to clarify the impact of the position and perspective of the researcher (Finlay 2002). The application of the methodology, the findings of the analysis of the interviews, and discussion of the reflexive process in action is described in Chapter Five (Interview Study).

3.1.3 Concept analysis

The final element of the study developed a concept analysis of resilience in this environment, informed by data gathered in the quantitative and qualitative parts of the research. This was designed to contribute to nursing theory about resilience, using the recognised framework of concept analysis. Concept analysis is a process of inquiry that explores concepts through examination of their internal structure, use, relationships to other concepts, and/or representativeness. It has been described as an assessment process using techniques to explore the description of a concept through examination of literature or analysis of empirical data (Morse *et al* 1996).

Bixler and Bixler (1945) suggested that a first criterion to define a profession was that:

> '*A profession utilises in its practice a well-defined and well organised body of specialist knowledge which is on the intellectual level of higher learning'* (p.730).

They note that while biological and physical (i.e. medical) science was well developed, there was no equivalent nursing science. In nursing, the development of knowledge has shifted from the original emphasis on medical theory and research to an emphasis on nursing knowledge as a distinctly separate concept (Johnson 1961, Rogers 1970). Gortner *et al* (1976) reviewed the ways in which nursing research takes place, and suggested four arenas: *(1) the science of practice; (2) the artistry of practice; (3) the structures needed for optimal delivery of care; and (4) the methodologies needed for measurement and evaluat*ion. (Gortner *et al* 1976 p.507).

Mitchell (1973) maintained that the quality of personal contact was a significant factor in the person's recovery from illness. In the concept of the therapeutic use of self described by Scholes (1996), nurses strive to actualise an authentic personal relationship between two persons. Viewed from this lens, the focus of mental health nursing is on the nurses' ability to understand the others' experience, and use the quality of the relationship to explore further and develop possibilities of recovery. Nursing can be seen as a profession and practice discipline, which has developed its theoretical knowledge base in the world between the technical environment of medicine and the lay world of the patient (Benoliel 2012).

In nursing research there has been agreement that concepts are the basis of how individuals communicate (Wilson 1963, Morse 1995, Cutcliffe and McKenna 2005, Hupcey and Penrod 2005, Walker and Avant 2005). One commonality amongst these authors is the tenet that there should be systematic processes for concept development and analysis, which are

suitable for professional discourse (Duncan *et al* 2007). Morse *et al* (1996) offer the following definition of concept analysis:

> '*concept analysis is a process of inquiry that explores concepts for their level of development or maturity as revealed by their internal structure, use, representativeness, and/or relations to other concepts'* (Morse *et al* 1996, p.254).

Walker and Avant (2005) suggest three main ways in which nursing theory may be developed: concept derivation; concept synthesis and concept analysis. Concept synthesis was seen as useful for generating new ideas, examining data for new discoveries, similar to the process of pattern recognition. They suggest that the process of concept derivation uses concepts from one field of nursing and applies the thinking and structures to a new arena, hence developing a new concept. The process of concept analysis was developed by Wilson (1963) to 'order the attributes of one or more things that enable us to differentiate among them' (Walker and Avant 2005, p. 39).

In other words, it is used to examine the basic elements of a concept, where the concept itself is difficult to define. It is a structured process to distil 'what counts' when a concept is described, and according to Wilson (1963) should not be used in questions of fact, value, or relationships. This process fits well with the overall aims of this study, which is to describe the components of resilience and to understand what resilience means in this nursing population.

A method frequently used in nursing research has been the concept analysis model developed by Walker and Avant (1983) which was derived from Wilson's original process. Papers published using an applied concept analysis in nursing include fatigue (Ream and Richardson 1996), resilience (Dyer and McGuinness 1996, Earvolino-Ramirez 2007, Garcia-Dia *et al* 2013), nursing autonomy (Wade 1999), professional identity (Ohlen and Segesten 1998), adolescent resilience (Olsson *et al* 2003), teamwork (Xyrichis and Ream 2008), peer support (Dennis 2003), debriefing in simulation learning (Dreifuerst 2009), competency (Tilley 2008), best practice (Nelson 2014), and nursing workload (Alghamdi 2016).

Wilson (1963) suggested 11 steps in the analysis of a concept, which were originally intended to be used as a classroom exercise, to enable students to develop a structured approach to concept analysis, rather than as a research technique (Hupcey *et al* 1996). Walker and Avant (1983) adapted this process, and modified Wilson's procedure into eight steps. They suggest that the concept analysis may be carried out using a variety of source material; literature

review, qualitative empirical data, quantitative data, or a mixture of the three. Some criticisms of Walker and Avant's approach have been that in attempting to simplify the process they have created a 'recipe' for concept analysis that does not require the rigour of Wilson's original method (Morse *et al* 1996). Another element of the critique discussed by Morse *et al* (1996) was that nurse researchers were often unclear about the source material used, which was often through literature review, or relied too heavily on dictionary definitions.

The use of empirical data as the source material for a concept analysis, as in this study, was intended to be truer to the philosophy of Wilson's original approach. Morse *et al* (1996) and Draper (2014) criticize the use of literature alone to develop a concept analysis. The application of the methodology and the findings of the concept analysis are described in Chapter Six (Concept analysis).

3.2 Research environment and processes

Section 3.2 discusses the application of the research including the participants, the setting and the ethical issues and how they were managed.

3.2.1 The setting

Secure mental healthcare is provided across a variety of different levels of security, which are commonly referred to in practice as low, medium and high secure. The defining features of the services are based on the level of risk of harm to self or others presented by the patient (NHS England 2013). This has been explained in more detail above in the introduction Chapter (Chapter One). In the NHS England standard contract for secure commissioning these levels are explained as follows:

> *'In order to manage the risks involved the therapeutic environment is carefully managed through the delivery of a range of security measures. A number of levels of security currently exist to manage increasing levels of risk to others. Presently these consist of High, Medium and Low secure services, each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others including other patients, staff and the general public.'* *(NHS England 2013 p.1)*

Although a large proportion of secure mental health care is provided by independent sector organisations (Centre for Mental Health 2011) this is in the medium and low secure levels

only. There are four main providers of independent secure beds, which differ markedly from each other, ranging from private venture capitalists to a trading charity. Consideration was given to whether to include staff from independent providers, but these were discounted after reflection, largely because while they all provide low and medium secure beds, it was believed that the experience of staff in different providers would be too disparate, and would make it impossible to develop a useful concept analysis.

When considering a potential sample for the research; including the generalisability of findings to practice; it was considered that nurses working in an NHS secure mental health environment would provide a rich level of information, but also present with greater homogeneity in terms of staff' experience of working with patients, management, terms and conditions and management approaches. In order to gather as much depth as possible, the sample population needed to be working in an environment where the management systems, working environment and patient groups would provide a commonality of experience; allowing the opportunity to learn as much as possible about resilience, without having to allow for extraneous differences. A high secure environment was chosen because the work is carried out in a highly structured and contained environment, working with patients who present some of the highest risks in England. The setting of a high secure hospital represents the highest level of security in mental health care, where patients are detained because they present a significant degree of risk to others and fulfil the criteria as defined by the NHS Act 2006, for people who 'require treatment under conditions of high security on account of their dangerous, violent or criminal propensities'. The core objectives for high secure services are to 'assess and treat mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery. Secure services provide a comprehensive range of evidence based care and treatment. Care and treatment is provided by practitioners who are expert in the field of forensic mental health including nurses and consultants in forensic psychiatry (NHS England 2013).These staff would, by definition, be working in an environment that presents with intense and stressful experiences, offering a prime opportunity for the consideration of resilience.

3.2.2 Participants

The research department of one of the three high secure hospitals in England was approached, and a discussion took place with hospital managers about what research may be of benefit to the hospital, where resilience may be a particular concern. It was suggested by the research manager at the hospital that it could be beneficial for the service if the

research was carried out with staff in their personality disorder unit. This is a 60 bedded unit for men with personality disorders who are detained under the Mental Health Act (HMSO 1983).

Approximately 150 nursing staff are employed across five wards in the personality disorder service, which are modern buildings, designed and built for the service. Research approval was granted by the local NHS Trust research department, and a letter of access to the hospital was provided. Discussion of other approvals is included below. It was agreed that information about the research would be conveyed to nurses through the Modern Matron. This was done by email and discussion at meetings, and a number of staff agreed to participate in interviews as part of the research. A date for the interviews was agreed, which would entail the researcher seeing staff in the personality disorder service wards. The reasoning for this was operational, as it is a service that is staff intensive, so staff numbers on wards had to be maintained. Following this, a start date for the electronic questionnaire was agreed, and the electronic link to the questionnaire was conveyed to nursing staff by email from the Modern Matron.

3.2.3 Ethical issues

The use of face to face interviews gives the researcher the opportunity to observe non-verbal cues through observation of body language, facial expressions and eye contact, which can be seen to enhance understanding of what they are told (Ryan *et al* 2009). Although the interview is essentially a social interaction between two people, it is not an ordinary conversation, nor is the relationship equal. Kvale (2006) cautions against the use of the word 'dialogue' to describe the interview content, and emphasises the importance of acknowledging the power differential in research interviews. The ethical issues which have been addressed in relation to this research are discussed under the headings of approval, consent, confidentiality, positionality and participant and researcher wellbeing.

Approval

Ethical approval was granted by the University of Northampton Social Sciences Research Degrees Board and Research Ethics Committee in 2014. A review was carried out using the NHS affiliated 'Integrated Research Application System' decision tool: http://www.hra-decisiontools.org.uk/ethics/ which demonstrated that the study did not require a full Health Research Authority research committee review, because it was to be carried out on NHS

staff. Local permission for the research was granted by the relevant NHS Trust research department, and a formal letter of access to the research site was provided (Appendix A).

Consent

All the interviewees were members of staff employed by the NHS, and as such it was assumed that there were no issues of capacity to consent. Consent is the central act in research ethics, as set out in the 1947 Nuremberg Code (Alexander 1976, Schuster, 1997). In the 1964 Helsinki Declaration (Rickham 1964) it is stated that for consent to be regarded as valid it must be shown to be 'properly informed and freely given, without pressures such as coercion, threats or persuasion' (Rickham 1964 p.177).

An information sheet and contact details were provided. Participants were told that the recordings would be deleted after the interviews were transcribed and also that only the supervisors and examiners would see full transcripts. An information sheet had been circulated to hospital management prior to the day of the interviews, to introduce the research and give people information to help them decide whether they might take part. A copy of this information sheet was shared with each participant prior to the interview taking place, and all participants were given the opportunity to ask questions about the research intentions, and the process by which confidentiality would be maintained.

A consent sheet was offered to each participant, on which they were asked to indicate that they confirmed that they had read and understood the information sheet and had the opportunity to ask questions, their participation was voluntary and they were free to withdraw at any time without giving any reason, information given would remain confidential except if someone is at risk of harm, and that the interview would be recorded using a digital voice recording device. It was explained that participation would not have any impact on their employment or position. All participants signed individual consent sheets. (Appendix B).

Confidentiality

All data was locked away securely by the researcher, and password protected laptop and memory sticks were used. All paper and electronic data would be kept in the University of Northampton archive for five years and then disposed of as confidential waste. Only the researcher had access to the raw data, which will not be used for any other purpose.

Participants' details were not stored, and any individual recordings and transcripts were given codes, with any material referred to anonymously.

Participants were informed that any third party information would be treated with the same degree of confidentiality, and any issues raised which may be of concern would be reflected against Nursing and Midwifery Council (NMC 2015) Code of Conduct guidelines, and if there was any indication that patient safety or care had been, or could be compromised, this would be reported to the appropriate manager by the researcher, after discussion with the supervisor if necessary. It was made clear that there should be no reference to any patient identifiable data.

Positionality

Nursing research can bring the dual role of the researcher into focus (Ensign 2003). Darawsheh (2014) suggests one of the uses of reflexivity is to promote rigour by monitoring the researcher's subjectivity. Carrying out the interviews in the clinical practice area allowed the researcher to experience some of the atmosphere and environs of the workplace, however the potential for confusion about the boundaries of professional nurse and researcher were noted within the reflexive process. This confusion of roles could potentially have occurred within the participant or researcher. Participants may see the researcher as 'one of our own' (Houghton *et al* 2010) which may influence their perception of the purpose of the interview. Concerns about the risk of becoming over-involved in participant observation research in nursing were noted by Gerrish (1997), highlighting the potential threat to objectivity if there is over- identification with the research subjects. However self-disclosure has also been said to assist with the development of rapport and trust, which can affect the level of disclosure of the participant (Borbasi *et al* 2005). The detail of how positionality as a nurse was addressed is discussed in Chapter Five 'Interview Study', section 5.1 'method'.

Participant and researcher wellbeing

A quiet private space away from the patient area was provided for the interviews. During this process attention was given to considering that the experience of recalling and recounting difficult experiences may in itself raise emotional issues which may need acknowledging and addressing. Participants were encouraged to use nurses' own support systems, including clinical and managerial supervision, and local staff welfare provision. The information about local welfare provision was obtained in advance from hospital managers,

and conveyed to each individual. Anxiety may have been experienced regarding how their responses may be interpreted, and the researcher was careful to convey a non-judgmental open stance, through their speech and nonverbal behaviour (Ryan *et al* 2009).

The research interviews were planned to take place in the work environment, which was a high secure hospital. The hospital security guidelines for visitors were sent in advance by the hospital managers. The security guidelines and procedures at reception were adhered to, with all prohibited items, such as mobile phone, stored outside the secure perimeter in a locker. There was no patient contact planned and the researcher was escorted at all times, hence not needing a personal alarm. Reflections on the experience of carrying out the interviews were discussed in university and professional supervision.

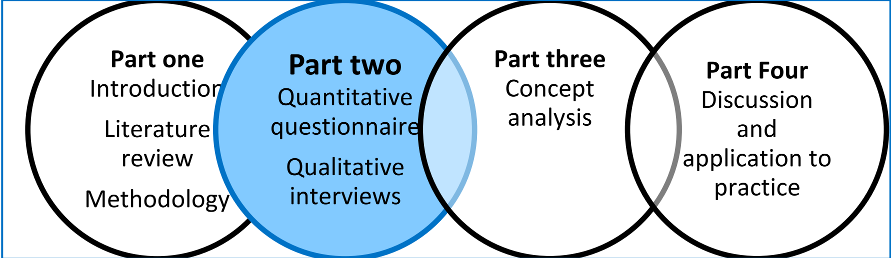
3.3 Summary

This chapter has described the background and justification for each of the methodologies used in this study. Justification for the design of the study using mixed methodology has been articulated, showing how each methodology is used to add a different component to the concept of resilience in this population, culminating in a full picture of the issue. The participants and setting have been described, ending with a discussion of how the ethical issues were managed.

A detailed discussion of how each of these methodologies was applied is provided in the following chapters: Chapter Four, analysis of the resilience survey; Chapter Five, interview study; and Chapter Six; concept analysis.

The use of the methodologies for analysis is described in each individual chapter, with a discussion of the findings.

4 Profiling nurses' resilience



This element of the study provides a profile of nurses' resilience in a high secure mental health environment using a validated questionnaire. The Connor-Davidson Resilience scale (CD-RISC), Connor and Davidson (2003) was used to gain insight into the characteristics of resilience in this staff group. The chapter contains a description of how the measure was applied, and an analysis using descriptive statistics. A discussion of the findings arising from this process is offered, with reference to relevant literature.

4.1 Introduction

The CD-RISC is a 25-item questionnaire, originally developed to measure treatment outcomes in depression. Connor and Davidson (2003) suggested that resilience may be relevant to recovery. Subsequent developments show that the questionnaire has been used to measure resilience in many nursing populations.

The scale has been validated with mean scores for normal populations (Connor and Davidson 2003) and populations with generalised anxiety, post-traumatic stress and psychiatric disorders. The CD-RISC has been tested in the general population and in clinical settings, suggesting that there are numerous potential applications for its use. It has been used to measure resilience in nurses in many different nursing specialities; personal characteristics and years of experience in operating room nurses (Gillespie *et al* 2009), relationship between burnout and resilience in intensive care nurses (Mealer *et al* 2012), feasibility of a resilience training programme for intensive care nurses (Mealer *et al* 2014), the relationship between burnout and resilience in acute hospital nurses (Amini 2014), relationships between resilience, job satisfaction and anticipated turnover among nurse leaders (Hudgins 2016), the effects of humour on burnout and resiliency of acute hospital nurses (Torgeh and Alipour 2015), reliability of the 10 item CD RISC scale among Nigerian student nurses (Aloba *et al* 2016), the influence of resilience on clinical nurses' job satisfaction (Zhao *et al* 2015) and English NHS nursing staffs' emotional well-being and caring behaviours (Chana *et al* 2015).

Although there have been studies published on the nature of stress and resilience in mental health nurses (Brown *et al* 1995, Edwards and Burnard 2003, Edward 2005, Mason 2002, Chou *et al* 2012, Dickinson and Hurley 2012) and in nurses working in secure mental health environments (Smith and Hart 1994, Oberlaender *et al* 1999, Nathan *et al* 2007, Chung and Harding 2009), no published studies were identified that measured the resilience of nursing staff in mental health or secure mental health environments using the CD-RISC. As previous studies have shown that nursing staff in secure environments are exposed to challenging and

traumatic situations (Mason 2002, Bowers 2002, Dickinson and Hurley 2012, Aiyegbusi and Kelly 2015) it was considered that the CD-RISC scale would be appropriate for the exploration of resilience in this group. The Brief Resilience Scale (BRS) (Smith *et al* 2008) was considered, but was discounted in favour of the CD-RISC following an examination of the literature. The BRS was designed to measure the ability to bounce back from stress, whereas the CD-RISC was developed to measure the protective factors which contribute to resilience, which was felt to be more directly relevant to this study. Ahern *et al* (2006) evaluated resilience measures for reliability, validity, and factor structure. Data analysis indicated that the CD-RISC has sound psychometric properties and distinguishes between those with lesser and greater resilience. Windle, Bennett and Noyes (2011) conducted a systematic review of 19 resilience measuring scales, and found that there was no 'gold standard' in the existing measuring scales in the literature. They did find however that the CD-RISC and the 'Brief Resilience Scale' (Smith *et al* 2008) received the highest ratings when measured against their quality criteria, and the CD-RISC was the only scale that had been used to measure the response to a treatment intervention.

The original paper (Connor and Davidson 2003) provides a shortened list of the 25 items of the scale, and the authors give general scoring directions. The full detailed list of questions and the manual for scoring is only available directly from the authors for copyright reasons. Permission was sought from the original authors to use and reproduce the rating scale, and a copy of the CD-RISC manual was supplied as part of this agreement.

Connor and Davidson developed this tool with over 1000 participants in a variety of settings, making this applicable to different populations (Karairmak 2010). The scale comprises 25 items that measure resilience or capacity to change and cope with adversity. There is a 5 point Likert scale response range: not true at all (0); rarely true (1); sometimes true (2); often true (3) and true nearly all of the time (4), based on how the participant has felt over the past month. The total possible score is 100, with higher scores indicative of greater resilience. Five factors of resilience were identified by Connor and Davidson; personal competence, high standards and tenacity (factor 1), trust in one's instincts, tolerance of negative affects and the strengthening effects of stress (factor 2), positive acceptance of change and secure relationships with others (factor 3), control (factor 4), and spiritual influences (factor 5).

Two briefer versions of the scale have been developed and validated; the 10 item (CD-RISC 10) and two item (CD-RISC 2) scales. The 10 item version (score range 0-40) comprises items

1, 4, 6, 7, 8, 11, 14, 16, 17, 19 from the original scale, and was developed by Campbell-Sills *et al* (2006) on the basis of factor analysis. The content of the CD-RISC questions are shown below at Table 1. The CD-RISC 2 is based on 2 items with a score range of 1-8; 'I am able to adapt when changes occur' (item1) and 'I tend to bounce back after illness, injury, or other hardships' (item 8). The CD-RISC 2 was developed as a measure of 'bounce-back' and adaptability by the original authors (Vaishnavi *et al* 2007).The psychometric properties are reported by the authors as valid in nearly all studies, although its factor structure and mean score varies with setting. For this reason, they do not recommend separate scoring of the factor subscales which were originally reported by Connor and Davidson. However Garcia-Izquierdo *et al* (2009) obtained the predictive capability of the personality factors neuroticism and conscientiousness, and found that resilience acted as a moderator variable between personality and emotional exhaustion.

Table 1: Content of the Connor Davidson Resilience Scale

1. Able to adapt to change 2. Close and secure relationships 3. Sometimes fate or God can help 4. Can deal with whatever comes 5. Past success gives confidence for new challenge 6. See the humorous side of things 7. Coping with stress strengthens 8. Tend to bounce back after illness or hardship 9. Things happen for a reason 10. Best effort no matter what 11. You can achieve your goals 12. When things look hopeless, I don't give up 13. Know where to turn for help	14. Under pressure, focus and think clearly 15. Prefer to take the lead in problem solving 16. Not easily discouraged by failure 17. Think of self as strong person 18. Make unpopular or difficult decisions 19. Can handle unpleasant feelings 20. Have to act on a hunch 21. Strong sense of purpose 22. In control of your life 23. I like challenges 24. You work to attain your goals 25. Pride in your achievements (Connor and Davidson 2003 p. 78)

Connor and Davidson (2003) suggested three applications of the questionnaire;

- Assessing efficacy of medication such as fluoxetine in depression;
- As an aid to developing resilience characteristics in clinical practice, an
- As a measure for exploring responses to interventions that promote wellbeing.

They do however acknowledge that the scale does not measure how people may become resilient or provide any information about theories of resilience. The use of the scale in this part of the study was intended to explore the profile of resilience, rather than provide any information about what helps nurses to be resilient.

4.2 Application of the scale

An electronic version of the CD-RISC questionnaire was developed using Bristol Online Surveys (https://www.survey.bris.ac.uk). This survey tool allowed a bespoke electronic survey to be developed, which could then be administered and stored confidentially, and enabled analysis of the answers received. The original survey was distributed both electronically and in hardcopy. The authors confirmed (Davidson 2017) that there was never an intention to proscribe a defined method of administration such as pencil and paper, and many studies have used electronic versions of the questionnaire (Connor and Zhang 2007, Chana *et al* 2015, Gulbrandsen 2016).

Following agreement by senior managers at the hospital, a hyperlink was distributed electronically to nurses working in the personality disorder service (approximately 150) using the hospital email system. An information sheet was sent with the link, inviting participation, explaining the research aims, and clarifying confidentiality issues. Each completed survey was automatically allocated an individual response identification number by the Bristol Online Survey programme, and these were used to identify individual scores.

The questionnaire contained the 25 items of the CD-RISC. In addition to this demographic information including job title, qualifications, gender, age and ethnicity were requested, in order to allow analysis of a range of demographic and professional characteristics. It was also intended that potential differences would be explored in those staff with a more senior management role.

The initial email circulation yielded 12 completed questionnaires. A follow up email was sent by the hospital administrator reminding staff of the questionnaire, and following this the number then increased to 25. A further reminder did not yield any more results. There are approximately 150 nursing staff employed across the unit, the completed questionnaires therefore represent approximately 16.5% of the nursing staff complement. Baruch (1999) noted that the average response rate for questionnaires in academic studies was significantly less than 100 percent, and from 1975 to 1995 a decline from 64.4 percent to 48.4 percent. Mavis and Brocato (1998) found that response rates for email surveys were

consistently lower than paper surveys, although Baruch and Holtom (2008) found more recent data indicating that among published studies, rates for emailed surveys are as high as more traditional mail surveys. Cook *et al* (2000) found that the mean response rate for 68 emailed surveys reported in 49 studies was 39.6%. Kittleson (1997) found a return rate for email surveys of 28.1%, and suggested that electronic survey returns may be partly explained by individuals reaching a saturation point in reading their e-mail messages.

The completed questionnaires provide useful information on the resilience profile of the staff and a descriptive analysis of the questionnaire results has therefore been carried out. This is reported below. The small sample size meant that statistical comparisons between groups were not sufficiently powered for the detection of small differences; however appropriate statistical tests are reported and are interpreted in the light of the sample sizes.

4.3 Results

4.3.1 Sample characteristics

Table 2 below summarises the demographic characteristics of the respondents. All but one of the respondents were of white British origin, with one African respondent. Across the United Kingdom a greater ethnic diversity was found in mental health nursing compared to other fields of nursing (RCN 2007), however findings from this hospital may reflect the local semi-rural population. National census (ONS 2011) figures showed that 97.7 % of the local population were counted as ‘white British’. Twenty one respondents (81%) had worked in this high secure hospital for more than 10 years, with only one having worked in the field for 1-2 years. Twenty one respondents were qualified nurses, and these results could suggest that this hospital has a very good rate of retention amongst qualified nurses. Ten respondents were from management roles, describing themselves as team leader, ward manager or nurse manager, for the purpose of this analysis these are termed ‘managers’.

Table 2 Sample characteristics n=25

Gender	Count
Male	8 (32%)
Female	17 (68%)
Staff role	
Registered nurse	21 (84%)
Healthcare support worker	4 (16%)
Senior nurse	10 (40%)
Ethnicity	
White British	24 (96%)
African	1 (4%)
Years of experience	
more than 10 years	21 (84%)
6-10 years	3 (12%)
1-2 years	1 (4%)

4.3.2 Questionnaire results

4.3.1.1 Whole sample

Connor and Davidson have published mean scores of the CD-RISC in a variety of different countries and populations, including university students, people with experience of trauma, PTSD and diagnosed mental disorders (Connor and Davidson 2003). In a United States general population study a mean score of 80.7 was noted, and in a population with generalised anxiety, a mean score of 62.4 was found. In a UK study of NHS nurses using the CD RISC-2 Chana *et al* (2015) found that work stressors, coping strategies and self-efficacy were significantly correlated with nursing staffs' burnout and psychological distress; however they did not report CD-RISC scores separately. Mean scores of below 50 have been found in subjects with depression, other medical or psychiatric problems and exposure to extreme trauma. Scoring of the CD-RISC 25 item scale is based on adding the scores for each item, which are individually scored from 0-4. The full range is therefore 1-100, with higher scores indicating greater resilience (Connor and Davidson 2003). This is shown in Table 3 below.

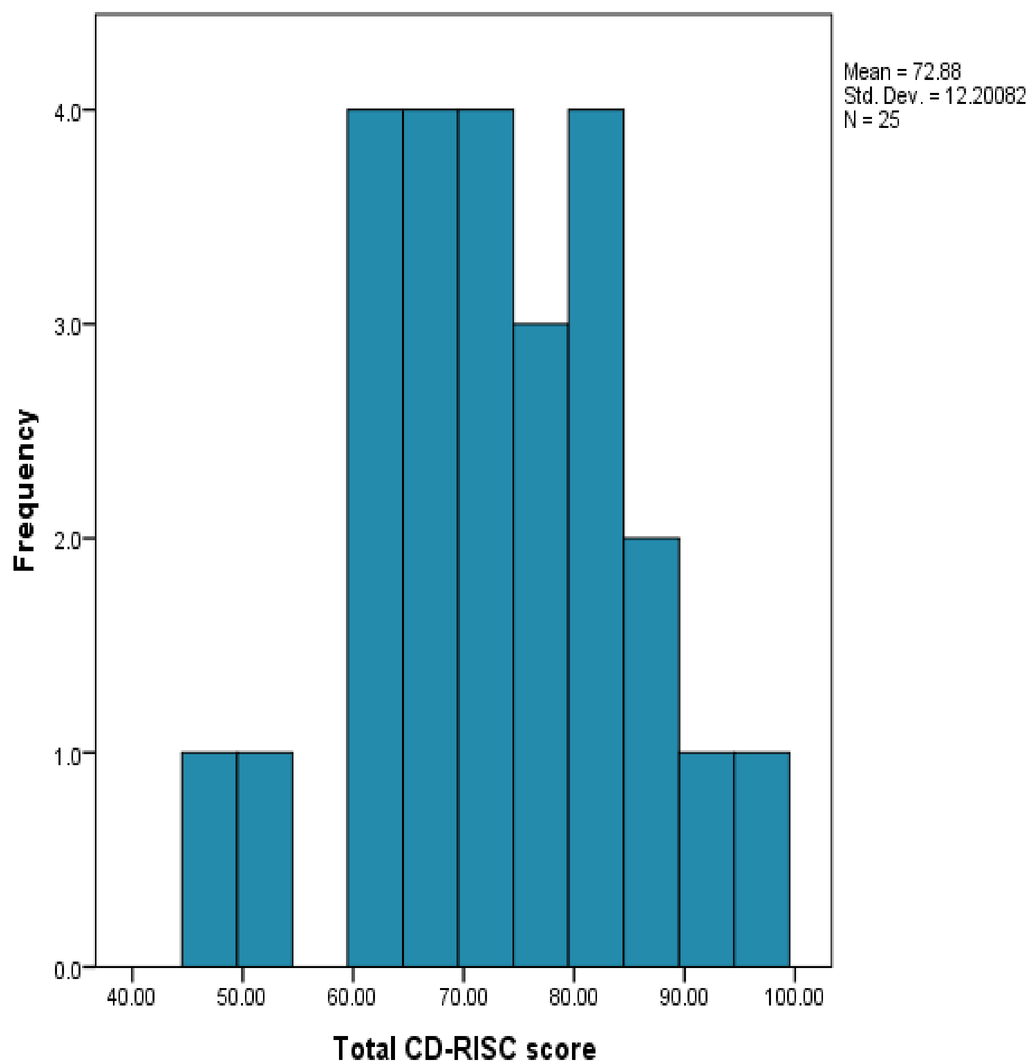
Table 3 Mean and standard deviation

	N	Mean	Std. Deviation
Total CD-RISC score	25	72.8800	12.20082

The survey results varied between a minimum score of 47 and a maximum of 98, with a mean of 72.8 for the whole sample (n=25) and a mean of 80.5 for the senior nurse respondents (n=10). The mean score of 72.8 in this study is therefore similar to Connor and Davidson's results of 80.4 for 'general population samples' (Connor and Davidson 2003), suggesting a level of resilience comparable to similar populations of this type. This result can be used as a comparator for the whole population of nurses.

The histogram below (Figure 4) shows a distribution that is not statistically significantly different from a normal distribution (Kolmogorov-Smirnov statistic=0.071, df=25, p=0.20).

Figure 4 Distribution of CD RISC score



4.3.1.2 Gender comparison

The means were compared using an independent samples t test, to assess whether there was a difference in CD RISC scores between male and female participants.

Levene's test for equality of variances was used to show that the variances of each group were not statistically significantly different. The t-test for equal variances showed that there was no statistically significant difference between male and female respondents (t=0.626, df=23, p =0.538.

4.3.1.3 Length of service

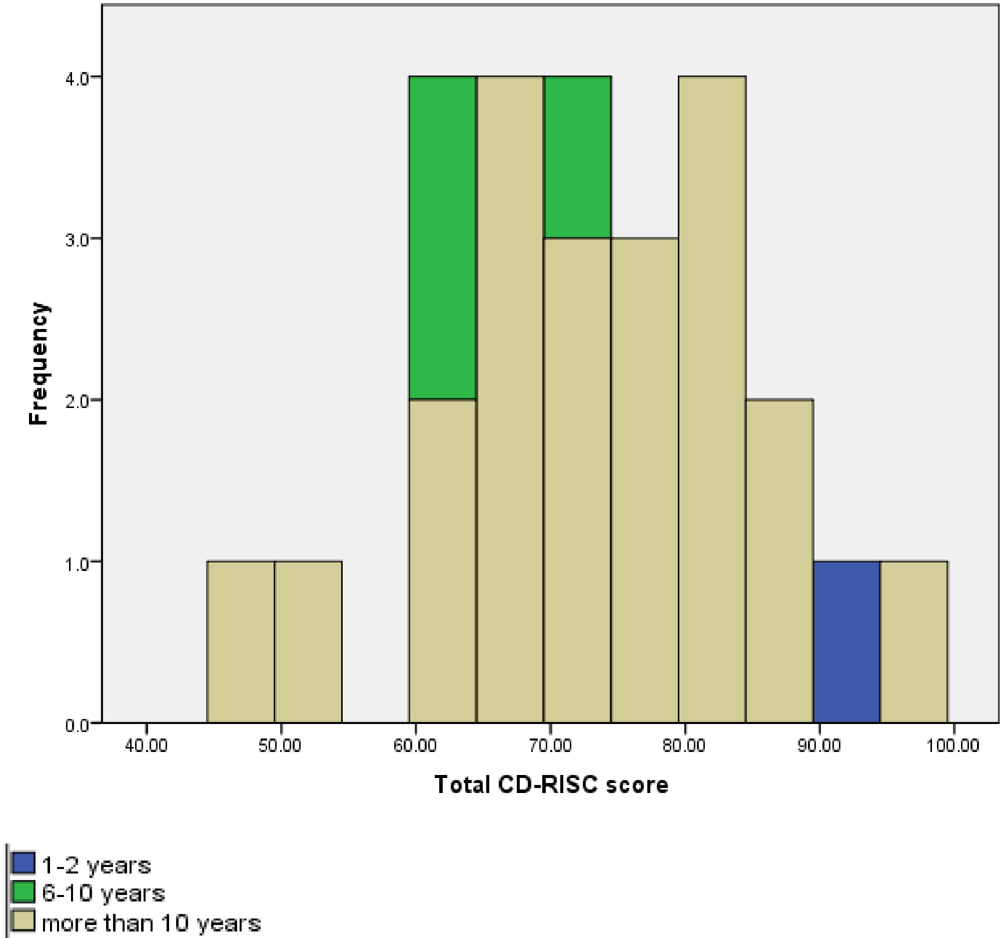
The association between length of service and resilience was investigated and the years of service of respondents is shown below at Table 4 below.

Table 4 Results for years of service

Length of service in years	Number	Mean
1-2	1 (4%)	4
6-10	3 (12%)	64.33
More than 10	21 (84%)	73.14

This information is shown in histogram form below at Figure 5 :

Figure 5 Histogram of results by years of service



The mean for 6-10 years (n=3) in secure mental health was 64.33, and for more than 10 years (n=21) was 73.14.

4.3.1.4 Comparison of roles

Differences in resilience between roles was investigated, and the CD-RISC scores for the role sub-groups defined on the questionnaire were compared (see Table 5 and Figure 6).

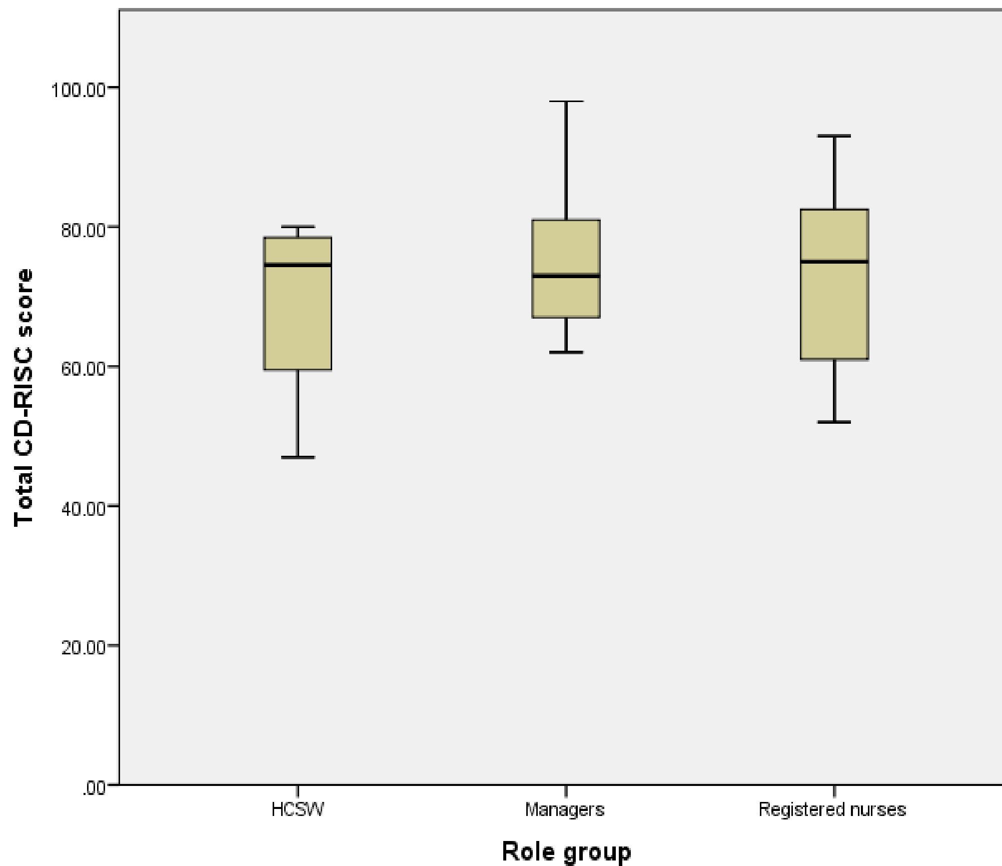
Table 5 Total score by role group

Role	Number	Percent
Health care support worker (HCSW) /healthcare assistant	4	16
Nurse Manager	3	12
Registered Nurse	11	44
Team Leader	4	16
Ward Manager	3	12
Total	**25**	**100**

The roles of team leader, ward manager and nurse manager were transformed into one group as 'managers' given that these were all management roles; making three groups: HCSWs (n=4), registered nurses (n=11) and managers (n=10).

Total scores for these three groups are shown in Figure 6.

Figure 6 Total CD RISC scores by role group



The mean for HCSWs was 69.00; the mean for managers was 74.80; and for registered nurses the mean was 72.55. A one way ANOVA was conducted to explore differences between the groups, ($F=0.311$, $df=2$, $p=0.736$), suggesting no evidence of a statistically significant difference between groups. However, as discussed above, the sample size was very small and would not have sufficient power to detect relatively small differences.

4.3.1.5 Bounce-back and adaptability

Connor and Davidson (2003) derived five factors determining resilience in their first report, with the strongest being persistence/tenacity and self-efficacy. Other factors corresponded

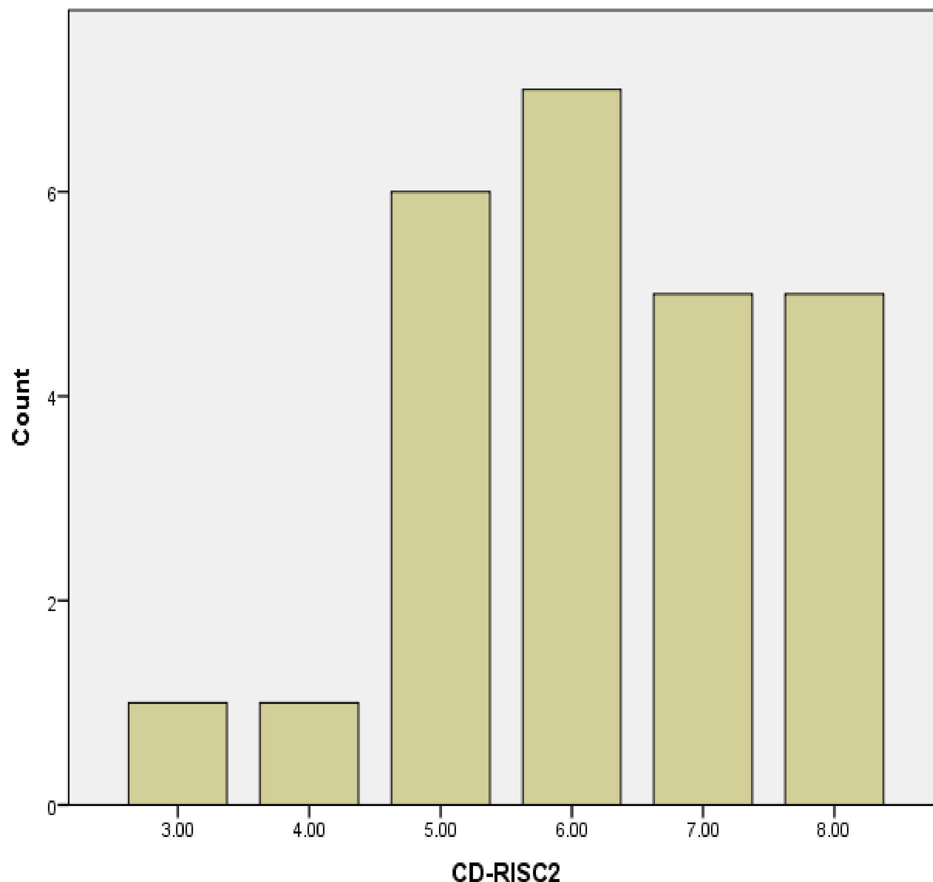
to emotional and cognitive control under pressure, adaptability, meaning and control/meaning.

In the first report describing the scale in an adult cohort (n = 577) representative of the US population, Connor and Davidson (2003) derived 5 factors, the strongest of which captured aspects of persistence/tenacity and a strong sense of self-efficacy. Other factors with lower eigenvalues (ranging from 1.563 to 1.073), corresponded to emotional and cognitive control under pressure (factor 2); adaptability/ability to bounce back (factor 3); control/meaning (factor 4); meaning (factor 5). Factors 4 and 5 are composed of only 3 and 2 items respectively and may be less robust.

4.3.1.6 CD RISC-2

The CD-RISC 2 is based on items 1 and 8 (score range from 0-8), and was developed as a measure of 'bounce-back' and adaptability by the original authors (Vaishnavi *et al* 2007). The summed scores for items 1 and 8 in this study are shown below at Figure 7.

Figure 7 Total CD RISC 2 scores



4.4 Discussion

In a general population survey of 458 US adults, mean CD-RISC 2 score was 6.91, while lower scores were observed in psychiatric groups with depression (5.12), Generalised Anxiety Disorder (4.96) and PTSD (4.70) (Vaishnavi *et al* 2007) and 4.67 in survivors of the Southeast Asian Tsunami of 2004 (Irmansyah *et al* 2010). Using these two items of the CD-RISC 2 as a measure of 'bounce-back' and 'adaptability' the mean CD-RISC score in this current study sample was 6.16, which compares well to the general population sample mean of 6.91.

The majority of respondents (21) in the current study indicated that they have at least one relationship that helps when they are stressed. While the question does not ask for any sense of whether this is a work or home life relationship, this echoes the interview findings where participants described the need to talk things over, and how helpful they found this, as discussed in Chapter Five. A recent survey by the Mental Health Foundation (MHF 2016) pointed to good-quality relationships being key in helping people to live longer and happier lives with fewer mental health problems. The Foundation suggests that the influence of social relationships on health and wellbeing is comparable to well-established risk factors for mortality such as smoking.

The highest scores given as 'often true' and 'true nearly all of the time' on the CD-RISC were in the areas of adaptability/ability to bounce back: 'I am able to adapt when changes occur' (23 respondents). These responses give strong indications of the kinds of characteristics of resilience in this group. Jackson *et al* (2007) suggest that to support the development of resilience in nurses the focus should be on promoting the strengths of all nurses for whom the workplace is seen as presenting difficult or traumatic conditions. The personality trait of hardiness has been said to help in buffering or neutralising stressful events or extreme adversity (Collins and Long 2003, Judkins *et al* 2005).

Hardiness has been described as having three dimensions:

> *'being committed to finding meaningful purpose in life, the belief that one can influence one's surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences'* (Bonanno 2004 p25).

Resilient people are regarded as able to see the positive aspects and potential benefits of a situation, rather than being continually negative or cynical (Jackson *et al* 2007). The

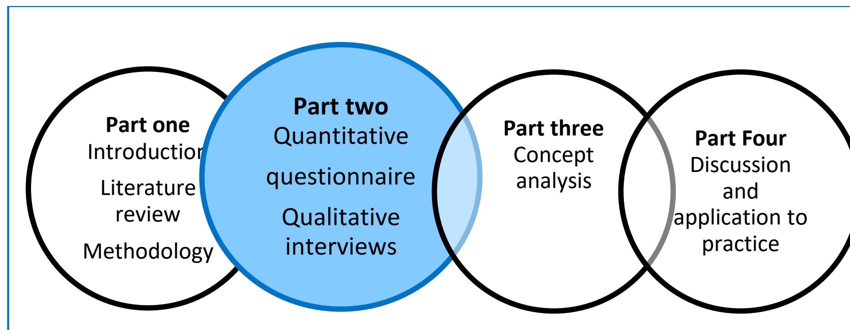
responses reported here demonstrate that the majority of these nurses feel in control, enjoy a challenge, are working to achieve goals and take pride in their achievements. These characteristics have all been noted to contribute to personal resilience (Tugade and Frederickson 2004, Bonanno 2004, Frederickson 2004).

A limitation is that this cannot be seen as a truly random sample of nurses in this environment. It is not possible to ascertain in which direction the sample may be biased, and it may be that those nurses who responded are a more resilient group. There is nevertheless a reasonable spread of answers, using this well-validated questionnaire.

The findings from this element of the study show that this sample of the population of nurses under study have demonstrated a level of resilience equivalent to that found by Connor and Davidson (2003) in normal populations, particularly in the areas of 'bounce back' and 'adaptability'.

This is used to contextualise the detailed study of the lived experience of nurses in this environment in the following chapter; which focusses on the analysis of the semi structured interviews.

5 Interview study



The focus of this element of the research was on exploring personal and organisational factors that contribute to, or hinder, resilience in a high secure mental health environment. This chapter presents the results of semi structured interviews which were analysed using interpretative phenomenological analysis (IPA). The intention in conducting these interviews was to explore nurses' views on how they manage to work with and recover from stressful experiences at work, and their perceptions of any personal and organisational factors that support or hinder this. Staff rarely referred to the term 'resilience' directly, but discussed a range of ways in which they responded to work stresses, protected themselves, and coped with working in a setting of this kind.

The chapter contains a description of the approach to the interviews, and a detailed analysis using IPA, which is presented as structured themes. A discussion of the findings arising from this process is offered following each theme, with reference to relevant literature.

5.1 Method

All of the nurses interviewed worked in the personality disorder unit of a high secure hospital, and had worked on the unit for between five and ten years. Most had also worked in other parts of the hospital. They all volunteered to take part in this study, and were interviewed in ward areas while they were on duty. Names and gender have been anonymised to safeguard confidentiality, but quotes from interviews are verbatim, and it is intended that these extracts and the analysis of the interviews will enable their voices to be heard.

The philosophy and framework of IPA was used for developing the approach and semi structured interview format (Smith and Osborn 2003) and to analyse the transcripts of the interviews. IPA has its origins in health psychology, and places the analyst in a central role in accessing and making sense of the personal experiences of research participants (Smith 2004). Smith (2004) has also suggested that IPA is concerned with 'sense making' on the part of the researcher and participant. This was felt to be particularly relevant in this situation, where the researcher had experience of working in similar environments with this patient group.

The interpretative and hermeneutic elements of IPA were chosen for this research to provide strength and depth to this enquiry, attempting to capture convergence and divergence (Smith *et al* 2009). The intention was also to 'bracket' the researcher's own perspective, using a reflexive journal, in order to approach the research 'on its own terms'

and providing a space where prior knowledge and understanding may be explored (Finlay 2008, Theobald 1997).

Reflexive writing has been an important part of the process of developing the research question and methods, as well as in the analysis of material. This was particularly relevant because the researcher had many years' experience in working in secure mental health environments, and it was important to try to ensure that this prior knowledge did not influence the outcomes or interpretation of interviews, and/or to recognise when it did. The approach to ethical issues and positionality is discussed in Chapter Three (3.2 methodology process).

Altheide and Johnson (1994) suggest that researchers should be able to explain their relationship with and knowledge of the topic, that is being aware of and able to justify how their own positions are imposed on the research process. It was important that time and space was allowed, before interviews commenced, to consider how the researcher's approach to the topic may be influenced by the experience of working as a manager in a similar environment, and reflect on attitude, experience and knowledge that may influence perception. The theoretical position that underpins any use of self as an instrument for data collection has implications for how one might represent a world or adapt a methodology, because the position adopted by the researcher in the field affects every stage of the process, from the way the question is constructed, designed and analysed, to the ways in which results are reported and presented. Higgins (1998) reflected on her research on the experiences of elderly people, where she became more of a confidante and friend than nurse researcher, and in crossing this boundary, became less able to focus on the nature of the experience of the participants, and lost her focus as a researcher.

The following extracts show how writing in the reflexive journal allowed space to explore the researchers own thoughts, ideas and reflections, and bring them into awareness so they could be 'bracketed'.

> *'From experience and reading, my thoughts were that there would be a large negative component to the experiences recounted, that nurses may feel burnt out, and that there would very likely be a negative emotional impact'. Reflective diary extract, May 2014*

> *'When trying to set out initial questions I was careful not to assume that all nurses had had stressful experiences, so settled on starting with 'have you had a stressful*

experience at work?', avoiding the use of more negative words such as traumatic or upsetting'. Reflective diary extract, June 2014.

There was an awareness that these nurses work in a very challenging environment, with patients who have committed very serious offences. This led to the reflection that it was very likely that these conditions would be difficult to work in, and would be very likely to have negative effects on the nurses. However I was keen to avoid the assumption that much of their work would be stressful and difficult.

'I mentioned that I was a nurse, sharing that I had MSU experience, partly to try to develop rapport, show I had some understanding of the environment, patient group and stresses and strains, but also to try to show some solidarity, as though I was on the 'side' of the nurses, and keen to find out what helps and what doesn't help'. Reflective diary extract, August 2015.

'But also I could see I was from 'upstairs' and was a manager, not one of them who are in it day after day- only some of my experience could empathise with that'. Reflective diary extract, September 2015.

The intention of sharing that I had experience of nursing in secure environments was to try to offer reassurance that I could understand at least some of their language, and would have an understanding of the world they were describing. It was also intended to convey that their experiences would be listened to professionally and given respect (Finlay 2002).

For the interview situation to be productive the researcher must be able to establish rapport and trust; engage the nurse in an empathetic non-judgmental manner; maintain boundaries of confidentiality, reassuring participants that information they share will not be relayed to others, and will be anonymised in the research itself. It is necessary to establish trust and rapport from the beginning, and Legard *et al* (2003) suggest that the researcher's demeanour is critical in conveying this. The role of the interviewer is described by Ryan *et al* 2009 as 'to ensure that the interviewee is at ease and not threatened; hence the correct comfortable environment is also important' (Ryan *et al* 2009 p. 311). However Burman (1997) also cautioned against the perception of the research interview as free of manipulation and instrumentality, and the need to be aware that a relationship of empathy and trust may elicit unguarded confidences. The use of an ethically approved interview structure provides support to both the interviewer and the interviewee, to maintain a focus

on the subject matter being explored. Ethical issues have been discussed in more depth in Chapter Three, section 3.23.

5.2 Interview structure

Semi structured interviews offer an opportunity to develop rich descriptions and detailed accounts of the experiences of the participants. Unlike an unstructured interview where the conversation follows the direction of the interviewee's responses (Corbin and Morse 2003) the intention was to allow for spontaneous and open ended responses, while maintaining a focus on the topic (DiCicco-Bloom and Crabtree 2006). Smith *et al* (2009) note that collecting data for an IPA study requires a method which will provide rich 'first person' accounts that can be imaginatively analysed. One to one interviews are noted to be the most commonly used method of data collection in IPA, as they are easy to arrange, enabling time and space for participants to talk and be heard (Smith *et al* 2009).

In developing the semi structured interview questions, efforts were made to ensure that the questions were open enough to allow a range of possible answers, and avoid any inference that experiences are stressful or challenging. Semi structured interviewing uses a set of open ended questions that allow for potentially spontaneous and in-depth responses (Ryan *et al* 2009). This kind of interview offers a more flexible approach to the process, allowing the possibility that the interviewee can expand on an answer to explore issues in more depth.

The skills of the interviewer in fostering an atmosphere of active participation are active listening, non-verbal communication, and the ability to interpret what the person is saying on a number of levels. 'Practice-close research' is used as a term by Baumbusch (2010) to describe nurses doing qualitative research in their area of practice, and this research can be seen in this framework. She suggests that one of the potential benefits is the pursuit of research questions that can be integrated into care delivery. The challenges raised by Baumbusch include the 'researcher's responsibility to be explicit about his or her own preconceptions about an issue, and the researcher's interactions with the study participants', p.255.

The use of the same semi structured interview questions for each participant promoted consistency in the data, which allows for in-depth personal accounts to be gathered on the same topic, then allowing the researcher to conduct an in-depth analysis to try to make sense of their experiences (Smith 2011). This was particularly relevant in this study, because the focus was on exploration of a topic that has not had much direct attention in research.

The interview questions are discussed below (for a full list of questions and prompts, see Appendix D).

Each interview was comprised of four stages (adapted from Baumbusch 2010). The first of these were introductions to each other and an introduction to the topic. This allowed the researcher to explain the purpose of and structure of interviews, giving the interviewee an opportunity to ask questions about the study and explain what would happen to the information. At this point the researcher shared that they had experience of working in secure environments with patients who have a diagnosis of personality disorder. Self-disclosure can assist with the development of rapport and trust, which can affect the level of disclosure of the participant (Borbasi *et al* 2005). However it was important for reflections on the interviews to be incorporated into the reflexive journal after the interviews, to try to maintain as much objectivity as possible, and distinguish between reflections and analysis.

The second stage of the interviews moved on to questions about their own experience, initially asking a closed question about whether they had had a stressful experience at work. The question was deliberately posed in this way after reflection, as a more directive question asking about stressful experiences was considered to be too leading and presumptive. The subsequent questions asked for further clarification about their experiences of getting through the situation, and moving on to how they responded to it. This was again a deliberate intention to focus on their experience, rather than the detail of the event itself, to prevent the conversation from becoming a reflective account of the situation. Smith *et al* (2009) suggest that an IPA interview should gradually move towards the 'specific accounts of particular experiences and the associated thoughts and feelings' (p.68) in order explore the topic more deeply and go beyond the obvious.

The third stage of the interview questions focussed on how the interviewee carries on caring for patients when the experiences are stressful, and how they looked after themselves away from the workplace. It was important not to appear judgmental about answers given, and allow the interviewee to talk at their own pace, ensuring the interview flowed smoothly (Roulston *et al* 2003). As the interviewees talked about how they coped with stresses, they were encouraged to expand on these by the use of follow on questions that facilitated a more detailed discussion about aspects of coping.

The fourth and final stage returned to less emotional questions, shifting to what workplace elements may be helpful, and in particular whether they feel training has helped them. This

information would be used to support recommendations about applying research findings to practice in the future. The researcher then closed the interview with thanking them for their time and contribution, and returned to neutral topics such as the structure of the rest of their day.

5.3 Interview process

5.3.1 Sample

Smith *et al* (2009) note that IPA as a method has matured since early studies. Sample size has decreased, which they attribute to a wider qualitative research evidence base. Smith *et al* (2009) suggest there is no right answer to the question of sample size, as the intention is to discover a detailed account of individual experience. However they state that as a rough guide, between three and six participants would be a reasonable sample size. Larkin and Thompson (2012) explicitly state that IPA requires small sample sizes, and the focus is on insightful analysis from the quality of the data rather than quantity. The sample size for this part of the research was six interviews, carried out across three of the five wards in the personality disorder unit. The choice of which wards would be involved was influenced by practical staffing issues on the day, which were out of the control of the researcher. Only one of the participants was female, reflecting that in this working environment there are high numbers of male staff.

The inclusion criteria for this phase of the research were nurses with more than one years' experience of working in the high secure personality disorder service. These more experienced nurses were chosen for the following reasons:

- They are likely to have had experience of working in the secure service in their career so far;
- They will have relevant knowledge and experience to draw on;
- The topic under investigation would have relevance and personal significance for them.

The use of this purposive sample allowed access to a group who already had knowledge and experience of the phenomenon under scrutiny. Within an IPA study, participants are selected on the basis that they provide access to a particular perspective on the subject that has relevance and personal significance for them (Eatough and Smith 2008). Smith *et al* (2009) emphasise that samples in IPA should be selected purposively, to offer the

opportunity to explore insights into a particular experience. IPA participants are regarded as experts on their own experience, and are recruited 'because of their expertise in the phenomenon being explored' Reid *et al* (2005 p.20).

Six nursing staff were interviewed in total, a mixture of male and female, registered nurses and unqualified health care workers, all of whom had at least one year of experience of working in the environment. In fact the participants had all worked in the personality disorder service for five years or more, and some had worked in the hospital for more than 20 years. All those who were registered nurses had worked as health care workers before qualifying. Table 6 below shows demographic information about the participant sample.

Table 6 Demographic characteristics of participants

Gender	Role	Years in the PD service
Female	Staff Nurse	5
Male	Team Leader	10
Male	Health care support worker	7
Male	Ward Manager	7
Male	Health care support worker	13
Male	Staff Nurse	8

5.3.2 Process

Participants were invited to take part after it was agreed that a preliminary introduction would be given by nurse managers, and the research would be discussed at nursing meetings. Because of the requirements for security relating to visitors to the service, a date had to be agreed in advance when the research interviews would be carried out. It was necessary to gain separate written permission for a digital recording device to be brought into the hospital.

Interviews were digitally recorded and transcribed verbatim by the researcher, and then analysed using IPA to explore in detail how participants are making sense of their personal and social world (Smith and Osborn 2003). The emphasis was on the depth and richness of the evidence in qualitative research rather than coverage (Tarling and Crofts 2002).

It was intended that information be gathered through semi structured interviews lasting no longer than an hour, in an office away from the ward area. Because this was a busy service, it was anticipated that there may be clinical pressures which affected the length of time that individuals may be able to spend with the researcher, and that the environment would have to be wherever was available on the day, though a private space without interruptions where possible was requested. A digital recorder was used, and each recording was coded to be transcribed later.

In fact the interviews took place in three ward areas, in interview rooms away from the patient areas. These rooms were furnished fairly comfortably, but had a utilitarian feel as they were generally used for interviews or group therapy sessions. The ideal situation would have been to talk in a neutral environment, rather than discuss stressful experiences within their work environment. It is possible that remaining in the workplace may have influenced participants responses, in terms of their feeling comfortable (or not) to discuss stressful experiences. However, discussing these issues at work does link to themes that arise from the interview analysis, such as keeping work and home separate (see Section 5.8, 'work life balance'). Ultimately it was accepted that there would be practical challenges in interviewing staff in a busy and demanding environment, and these were accepted in order to enable staff to share their experiences (Barriball and White 1994).

In order to examine nurses' experience in this context it was important to establish a setting wherein individuals felt comfortable and free from censure in disclosing feelings and relating experiences. This was achieved through trying to build rapport at the beginning of the interview as discussed, and interaction with each participant, asking clarifying questions to check understanding and ensuring that their responses were not rushed. The available time was used as productively as possible, and times ranged between 17 and 45 minutes. The aspect of researcher positionality has been discussed in the ethical section of the methodology in Chapter Three.

5.4 Analytical approach: Interpretative Phenomenological Analysis

The transcripts were analysed using IPA which is a qualitative research method committed to examination of how people make sense of their life experiences (Smith *et al* 2009). According to Larkin and Thompson (2012) IPA requires the researcher to 'collect detailed, reflective, first-person accounts from research participants. It provides an established,

phenomenologically focused approach to the interpretation of these accounts' (Larkin and Thompson, p.103).

IPA is not a prescriptive approach; it provides a set of flexible guidelines that can be adapted by individual researchers in light of their research aims (Smith and Osborn 2003). In this research there were no adaptations made, and the guidelines developed by Smith were followed: the transcripts were treated as one set of data to be analysed and several stages of the analysis were worked through. Smith *et al* (2009) suggest that there should be an external audit of the researcher's interpretations to explore reflexivity and help test out interpretations. In this study the research supervisors carried out this function by reviewing the interview transcripts and the subsequent analysis.

In the first stage each transcript was listened to and read several times, and notes were made of anything that seemed of interest or significant in the right hand margin. The intention is for the researcher to feel more 'wrapped up' in the data with each reading, allowing an in depth analysis of what is being said (Eatough and Smith 2006).

The second stage involved returning to each transcript and using the left-hand margin to transform first thoughts into more specific themes or phrases, using psychological concepts and ideas. This process moves between inductive and deductive positions, and the participant's account can bring to light issues that the researcher had not anticipated. An inductive approach starts with observations, and theories are proposed towards the end of the research process as a result of observations. No hypotheses are found at the initial stages of the research and the researcher is not sure about the type and nature of the research findings until the study is completed (Lodico *et al* 2010). Deductive research explores a known theory or phenomenon and tests if that theory is valid in given circumstances. Deduction begins with an expected pattern 'that is tested against observations, whereas induction begins with observations and seeks to find a pattern within them' (Babbie 2010, p.52). In this process the participant's account can bring to light issues which the researcher has not anticipated in the questions, and the researcher will then begin to think about how these issues can be conceptualised, taking a theoretically sensitive stance.

IPA requires 'an intensive qualitative analysis of detailed personal accounts derived from participants' (Smith 2011, p.10) therefore careful attention to content, language and possible meanings is required. Eatough *et al* (2008) advise that 'at this stage of analysis, caution is essential so that the connection between the participant's own words and the researcher's interpretations is not lost' (Eatough *et al* 2008, p.1773). IPA as an interpretative approach allows the researcher to speculate on the data and explore what the content may mean to the participants. Individual meanings can then be shown with quotes (Adams *et al* 2015).

The third stage consists of further reducing the data by establishing connections between the early themes and clustering them. These clusters are given a descriptive label (superordinate theme title) that conveys the conceptual nature of the themes. A sample interview analysis is provided at Appendix C.

Smith (2004) suggests that researchers imagine a magnet with some of the themes pulling others in and helping to make sense of them (Smith 2004, p.71). Finally, a table is produced that shows each higher order theme and the subthemes that compose it, and a brief data extract is presented alongside each theme. Eatough and Smith (2006) describe this table of themes as the outcome of a back and forth process where the researcher has examined the material through the analytic stages, checking that the analysis is as true as possible to what the participants have said. They also note that it should be possible for someone else to follow the steps of the analysis from raw data to the final output of themes.

5.4.1 Analysis

From the analysis of these interviews four superordinate theme titles emerged from the data:

1. Management of emotions
2. Teamwork
3. Understanding
4. Work life balance

The superordinate themes were comprised of 13 constituent themes derived from clustering subthemes. Each superordinate theme is developed from the subthemes identified from the interview analysis. The themes were the managing of staff emotions in interactions, the benefits of working as a team, knowledge and understanding both about the patients' disorder and of their own role, and maintaining a work/life balance. Table 7 below shows a

visual depiction of the three levels of themes, which are then discussed in detail in the sections which follow.

Table 7 Visual depiction of the three levels of themes:

Superordinate themes	Constituent themes	Subthemes
Management of emotions	boundary awareness: giving care, not caring personally	not getting caught up in the patients' emotions understanding the need for professional distance and boundaries
	not reacting	masking it and carrying on not taking it personally
	toughening up	getting used to experiencing challenging situations and not being too affected
Teamwork	consistency	knowing how others will behave team awareness of how things should be done trusting the people on shift
	talking it over	asking for help quality of the relationship
	noticing and intervening	expecting team members and senior managers to notice and act
	senior manager support	approachable, available understanding
Understanding	understanding personality disorder	awareness of the nature of the disorder, that there will be setbacks maintaining hope
	difficult interactions	coping with interpersonal challenges, able to distinguish what's about the patient and what are staff emotions
	supervision	space for reflection and validation people to talk to
Work life balance	leaving it at the gate	conscious effort to separate the two worlds
	family and friends time	focus on enjoying life with other people, away from the workplace
	physical health	understanding of the need to keep physically healthy and awareness of benefits of physical health on stress

5.5 Management of Emotions

There is a considerable body of literature on ‘emotional labour’ in nursing (Smith 1992, Bolton 2001, Smith and Gray 2001, Edward *et al* 2017, Delgado *et al* 2017). The nurses participating in this study needed to find ways of minimising the effects of ‘emotional labour’ on themselves. Bolton (2001) observes that nurses are able to ‘juggle’ the demands made of them emotionally, and present a professionally acceptable ‘face’, identifying the importance of them simultaneously. Smith and Gray (2001) describe emotional labour as a routine part of nursing, and ensuring that shifts run smoothly. Delgado *et al* (2017) found that resilience interventions can protect nurses against the effects of emotional labour and they suggest further research into resilience-building interventions. The capacity to regulate emotions was shown to be important in mitigating the effects of emotional labour by Edward *et al* (2017).

In this section (5.5) the constituent and sub themes of managing emotion (boundary awareness/giving care but not caring personally; not reacting and toughening up) are illustrated through the presentation of analysis of the interviews, and discussion of the findings in relation to the literature.

5.5.1 Boundary awareness: giving care, but not caring personally

The contributions of participants showed an awareness that their job is about giving care to patients who may present with very challenging behaviours. The care that they offered appeared to be conceptualised as something that needed to be provided in a measured way. A clear distinction was drawn between ‘caring personally’ for patients, and ‘providing care’, for example:

> *‘There’s caring, then there’s a duty of care, which in my mind are two different things. Do I care for them personally? No’* (participant 1).
>
> *‘I’m friendly towards them, but I’m not their friend’* (participant 1).

This clarity was seen as part of a need to manage boundaries, and not get drawn into the personal world of the patient.

This ‘duty of care’ was not a completely neutral, or indifferent, stance. Caring was acknowledged, and it appeared more that the nurses limited the emotion to maintain a safe distance from the patients. Caring was seen in two main parts; the practical element of ‘caring for’ and the emotional element of ‘caring about’ patients.

> *‘You’ve still got a duty of care towards them; you don’t want anything to happen to them. Yes, I think sometimes you do strike up a personal, not personal, but a relationship with them. It’s like in any environment, you can have a laugh, you can have a joke, but caring for them, on a personal level, no’ (participant 1).*

The absence of a caring connection was noticed, acknowledging that this was necessary, but missing a caring element that was seen as a fundamental part of nursing care. Differences between ‘caring for’, ‘doing for’ and ‘caring about’ were noticed and identified, and the need for these to be separate was attributed to the unique nature of working with patients who have a personality disorder.

> *‘I miss that caring side because here it is not so much caring it is just doing for them. Putting them on the phone, getting a hot drink, unlocking the door for them or passing them the newspaper. It is not so much caring for a patient it is just doing for them and I think I have lost that bit of caring side’* (participant 5).

The context identified in the use of ‘here’ is the personality disorder service, and a contrast is drawn with working with people with mental illness, where the interactions with patients were seen as less complex, and the need for the demarcation between ‘caring for’ and ‘caring about’ seemed less distinct. Participants were very aware of the need to maintain a professional distance and make sure they and the patients kept to appropriate boundaries in their interactions. It was recognised that there would always be a real possibility that patients would attempt to move staff out of their boundaries, and that staff would need to be vigilant about this. The potentially negative consequence for both staff and patients was clearly articulated.

> *‘I’ve seen it before; where those boundaries have been mixed and people have got themselves into quite a lot of bother with the patients. I mean, sort of drawn into*

> *them, because they're getting that care and duty of care boundary interlocked. So, regarding caring for them, I don't care for them, but I've got a duty of care towards them and that's part of my job. So, I think that's the way, that's the way I look at things'* (participant 1).

Participants were very aware that boundaries should not be crossed, but this did not seem to stop them from them working to ensure that patients were listened to and that knowing them well is a key part of that. Participants were aware that there needed to be balance, and not present themselves to patients as 'cold' or uncaring.

> *'You can see when a patient is struggling because you get to know them so well, so you know when there is something not right. I always go and say, "Are you alright today, do you want to chat about it? Do you want to come in for a one to one?" Sometimes they do and sometimes they don't. Sometimes they will come in and they will just talk about rubbish, utter rubbish, but they just need to know you are listening'* (participant 2).

Boundary awareness was referred to by all staff as a part of their mandatory training, and it was spoken of as training that was taken for granted. The focus of the boundary awareness training was on educating staff to be aware of their own boundaries in sharing information with patients, and on recognising how and when patients may try to find out more about individual staff. While the availability of the training was acknowledged, participants placed a high value on the knowledge that experience and observation 'on the job' had given them.

> *'I don't know if I did learn it, I think it was just something that.....well, maybe I did, maybe it was seeing the after effects of seeing those boundaries getting mixed up. I've known quite a few females who have been too involved with the patients, as it were and seeing that care and that duty of care boundary get crossed over and seeing the after effects of what has gone on. That's quite shocking. So, yes, I think a while back, I came to that conclusion of the care and the duty of care. People get those two boundaries mixed up and then you don't know where you stand'* (participant 1).

This was again clarified by noticing that the ward environment can generate emotions in staff, but it was important to know and be aware of what effects they may have, and keep your own emotions separate.

> *'No, I'm not being pulled around by any emotions. But it doesn't mean I'm emotionless'*. (participant 1).

Equally important was an ability to distinguish between what emotional states 'belong' to the patients, and which are part of participants' own experience. The management of emotions did not mean switching them off entirely, it meant not being led by them, and being mindful of how they may be used by others.

Boundary awareness and the conscious management of interpersonal boundaries is shown here to be of importance to staff working in the personality disorder service. Staff are also shown to be mindful of the distinctions between different types of caring.

5.5.2 Not reacting

The extent of participants' ability to pick up the ward atmosphere and absorb a set of impressions that can be interpreted at an emotional level was acknowledged, along with an expectation that this is part of the job; noticing and reacting appropriately. This was eloquently put by a team leader:

> *'I can tell, I can walk on the ward in the morning and know what sort of day it is going to be. You're like a cat aren't you with one eye open'* (participant 6).

Relentless exposure to difficult situations was noted to be a stressor that had to be coped with by moderating reactions. Participants shared their experiences of stressful situations by moderating their reactions, for example:

> *'I'm ex-forces and I think that prepares you. Nothing much shocks me now, having seen some of the things I've seen, so yes it has changed me'* (participant 4).

The differences between an 'everyday' reaction and the staff's reactions in this environment were noticed. Participants drew comparisons between the reactions that they might have in

non-work contexts, and those that they had in work, particularly those that they deemed especially difficult or stressful, for example:

> *'After a while, personally, I think you become slightly desensitised to certain situations, situations that people would gasp at, it becomes part of the norm, in this environment. I think it does change you. I've definitely changed since I started working here'* (participant 1).

The degree to which the abnormal can become normalised was noticed, this was illustrated by one participant in their reflections of returning to work after a period of time off:

> *'I will tell you how stressful this place is, when you have been away for two weeks or three weeks on holiday and you come back, your first shift back is like hell. You don't realise how much pressure you are under when you are away from it, and then you come back'* (participant 6).

> *If they are anxious they will literally pass it over to you to deal with their anxiety, which is quite difficult at times'* (participant 5)

Staff described being exposed to a range of challenging emotions, which are 'passed over' to them by patients. They all noted the importance of not reacting to them, and not becoming absorbed in them.

5.5.3 Toughening up

The concept of 'toughening up' emerged when participants described how they began to get used to experiencing challenging situations. Although they were aware they had developed ways of preventing themselves from being too affected, the nurses visibly struggled to articulate what helps them to work in such a structured environment;

> *'Its horses for courses I think, it just develops over time, the first biggest challenge is getting used to all the doors and locks and procedures. Some people come and they don't like it and they leave pretty quick' (participant 4).*

There was also a sense of becoming desensitised to the challenges of the environment, and developing a higher tolerance of negative situations. For example;

> *'sometimes I think you get that much abuse throughout the year that you just don't even realise you are being abused at times. New staff will come on and say, "Do you let them speak to you like that?" They have just started, and then you think, "Oh yes, I didn't realise it was that bad." But you do become desensitised to a lot of verbal abuse' (participant 4).*

The 'desensitisation' described here appeared slightly different in intensity to that described above as desensitising to certain situations; this was more about 'toughening up' to the kinds of negative things a patient may say to nurses directly, which was more about desensitising to personal verbal assault or a way of being treated, than to a frightening or stressful situation.

'Toughness' was likened to resilience, in that there was an acceptance that the job will bring difficult and challenging situations, including being physically hurt. A negative aspect of 'toughening up' was also noticed however:

> *'You lose that compassion, I feel I do. I feel I lose that compassion and caring side of me, which is why I became a nurse. I struggle with that, I do struggle with that' (participant 5).*

An underlying expectation that senior managers also accept that the job is difficult and will provide help and support for staff was very present:

> *'but like when you have been doing this for so many years, you do become resilient and you do get toughened to a lot of it. I should imagine the most serious problem is if you have had a serious assault and you are struggling with coming back. Then I think senior managers get involved and see people and you do go to staff counselling as well, you are just referred there' (participant 6).*

This seems to suggest that there are some serious situations that 'toughening up' will not be enough, and there was a hope or belief that there will be some systems provided by hospital managers that will provide extra help. It also seemed to be more straightforward to

articulate what help and support was needed, or would be provided, after a physical assault than after the effect s of verbal aggression.

5.5.4 Discussion: management of emotions

There was recognition that there was an expectation of engaging in a relationship that the patient perceived as caring, although the emotions of the staff member were not personally engaged. Hochschild's (1983) concept of 'emotional labour' recognised that the impression of effortlessness was part of the work of caring, and this resonates with the research by Grandey (2000) which suggested that emotional labour involves 'enhancing, faking or suppressing emotions to modify the emotional expression' (Grandey 2000 p.107). Grandey noted that employees who engaged in high levels of emotional labour are more likely to experience burnout; but that perceived high levels of supervisor support mitigated the effects of emotional labour. The recognition of the potentially negative effects of managing emotions at work was also found in this study, alongside some awareness of how organisational factors may help.

Another aspect however was the concept of 'providing care' as a duty of care, but without caring personally. Nurses were able to distinguish between situations where they personally care (e.g. about family) and where they care professionally, which seemed a more measured, less personal concept. In Hochschild's (1983) concepts of 'surface acting' and 'deep acting' emotional expressions are regulated, and then modified to express a desired outcome. This was viewed as a potential source of stress by Hochschild, because of the effort involved and the degree of control necessary. This study found that the emotional distance was seen as providing a protective element, in helping to reduce the potentially emotionally intrusive effects of working with patients who have difficulties in emotional regulation and interpersonal relationships. Figley (2002) uses the term 'disengagement' to describe a mechanism that workers can use to distance themselves from the negative effects of patients' difficulties, that is letting go of the patients thoughts, feelings, and the sensations associated with work, to enable them to live their own lives. Gustaffson *et al* (2010) explored factors that may promote resilience and reduce the potential for burnout in healthcare professionals, and found that an increased 'forbearance', the ability to let go of perceived injustice and the ability to look after oneself are protective factors. Riley and Weiss (2015) conducted a review of previous research in emotional labour in healthcare settings, and

concluded that the degree of emotional labour involved is often overlooked, and that to help staff cope with the varied emotional demands of their workplace, support and supervision should be in place.

The effect of the particular workplace context was noticed by participants, and this was influenced by their sense of working in an environment that was dangerous at times, where patients may be unpredictably aggressive, or verbally and physically challenging. Staff were aware of a need to become somewhat desensitised, and moderate their reactions to challenging situations. Again this is analogous to Figley's (2002) suggestion that desensitisation is useful in exposure to traumatic stressors presented by patients. In Mann and Cowburn's (2005) exploration of the concept of emotional labour in mental health nurses, they suggest that the amount of 'surface acting' undertaken is directly correlated with workplace stress, and that this could be reduced by interventions to encourage and educate nurses to increase the amount of 'deep acting' that nurses undertake in order to perform emotional labour. Bowers *et al* (2009) examined responses of mental health nurses after untoward incidents, and suggest that without organisational support, staff can feel burdened emotionally. In their review of emotional labour in mental health nursing, Edward *et al* (2017) found that mental health nurses clearly benefit from organisational structures that provide support, and the capacity to regulate one's emotions was shown to be an important factor in preventing emotional labour and burnout. Delgado *et al* (2017) concluded that resilience interventions can protect nurses from the negative effects of emotional labour and suggested a need for further investigation of the relationship between resilience and emotional labour.

5.6 Teamwork

The 'management of emotions' (section 5.5) discussed the range of ways in which participants managed their emotions. Their discussions around teamwork signalled the importance of this in relation to their resilience, often offering them support in externalising their emotions, checking their reactions to particular situations, and receiving feedback on decisions that they had taken in the working environment. This echoes the concept of reactions being influenced by how situations are interpreted (Seligman 1975). Teamwork was cited as a major influencing factor by all participants. This was seen as directly impacting on the smooth running of the ward, and therefore on the wellbeing of staff, but also of

patients. A lack of consistency was cited as a potentially major source of stress, which would destabilise the ward. The superordinate theme of team work (consistency; talking it over; noticing and intervening, and senior manager support) is discussed in this section with examples from interviews and reference to the relevant literature.

5.6.1 Consistency

A sense of togetherness and mutual trust was identified by all participants as very important, linked to their ability to manage difficult situations. For example:

> *'It is knowing that the people you work with and the people you are on shift with you can trust. You know if anything happens they are going to be there to support you' (participant 5).*

When new staff join, especially more senior staff, it takes time to get to know them and find out how they work. This was seen as difficult for staff and patients and added an extra stressful ingredient to the day. It was acknowledged that when people are unknown, no one has had an opportunity to build rapport and trust, which takes time.

> *'This team leader we have got today I have never met him, I haven't even said hello to him yet because he is brand new. It un-skittles the staff and it un-skittles the patients as well, so that makes you quite stressed. That is really quite a stressful situation to be in' (participant 5).*

This emphasised the need for team cohesion and a shared sense of purpose in this working environment. The potential for 'splitting' in the team was identified as increasing risk and stress. 'Splitting' is a common defence mechanism used unconsciously by individuals with personality disorder, primarily to cope with anxiety. In these individuals there has been a failure developmentally to integrate and accept positive and negative feelings. When feelings are projected onto the environment this can result in the individuals 'splitting' their environment into good and bad parts (Carser 1979). The experience of nursing and care teams is that they can become polarised in their views of the individual and this may lead to judgmental and negative approaches by staff (Woollaston and Hixenbaugh 2008, Dickens *et al* 2015). An example of efforts to minimise the risk of 'splitting' was offered by participant 3:

‘It puts everybody at risk, and I think most of these patients, they like it when it's a straight stick; there are no branches off it. They know where they stand. They know where you stand. You know where you stand. You all work as a team. You all go home happy and safe’ (participant 3).

Consistency of the people working in the ward area was also seen as a vital ingredient in the elements that keep people safe. Knowing each other and knowing the patients well, appeared to provide a sense of safety and consistency:

‘*Yes, because I have known the patients a long time, you know how they are from day to day. We spend a lot of time with them; we are there from eight o'clock in the morning until nine o'clock at night’ (participant 4).*

A fear of teamwork failing or of not being backed up (either consciously or unconsciously) were also noticed, and both can have an impact on the staff member concerned. This was linked to fear of how the patient may construe the inconsistency, and led to self-questioning by the member of staff involved:

‘Sometimes the littlest thing can cause stress and anxiety. Sometimes if a patient just asks something and I have said “no they can’t have it but I will go and ask”. Then another member of staff comes out and says, “Yes, they can.” That can cause quite a bit of anxiety. You think, 'Why did I say no and they have then said yes?’ (participant 5).

‘Certain things could happen on the ward and a member of staff will say, “I wouldn’t have done that”. If they are not there on that day on that shift dealing with that and dealing with everything else that is happening on the ward at the same time that is quite stressful’ (participant 5).

5.6.2 Talking it over

People were aware that there would be times when they would need to externalise (‘talk things over’), not only to offload any emotion, but also to reflect and check out their

reactions and decisions. This section has several quotes from participant 6 and participant 2, who both had management responsibilities.

> *'Talking to other people, discussing it and seeing how other people would react. Taking a step back and thinking, "Have I reacted right or should I have done this another way?" I don't think there is ever a right or a wrong in a situation, but it is how you feel after you have dealt with that situation' (participant 5).*

There was a clear expectation that staff teams will communicate openly and talk about how to approach problems, or just talk through difficult experiences. This was managed through a number of structures, both formal and informal. Structured team away days were given as an example of a formal mechanism for discussion and reflection. It was expected that staff would use this as an opportunity to talk about how things worked, and what they may want to change:

> *We have team leader away days, we have staff away days as well. Then we get to talk about each other's experiences and if anyone has had any problems or particularly bad experiences that they are not happy with or not comfortable with, we can talk about it' (participant 6).*

These were seen as positive experiences, creating opportunities for staff to discuss how they work, how they experience the workplace, and with an invitation to contribute to improvements. The need for discussion also links back to the need for consistency, so that talking about ways of working is another mechanism to promote consistency.

> *'We all talk and we all de-brief and talk among ourselves as well, we are a very supportive group. Which is the only way to work in this environment, because you have all got to sing from the same hymn sheet and work as one really' (participant 6).*

Informal everyday discussions about how the team works were expected, and it was also accepted that ideas and concerns would be brought to more senior staff for further discussion.

'They talk amongst themselves as well for ideas and if anyone has got any problems we can generally sort stuff out or give advice or point someone in the right direction' (participant 6).

The quality of the relationship when talking is needed was also noticed, with staff having a 'go to' person that they talk things over with, in a safe trusting environment. The loss of a trusted confidante was reflected on by participant 2;

'Another one, who used to be my line manager, has just retired. So it's not that I haven't got that support; I've also lost a few people I had a different relationship with. It's not fair to say that I felt safe with them, because I'd feel safe talking to my line manager now, but I just had a different relationship with them' (participant 2).

A particularly meaningful and supportive relationship was very much valued, with a sense of 'comfort' that there was at least one person available to staff who they felt understood them. There was a clear expectation that the opportunity to talk things over was a basic entitlement, and that this was necessary to externalise and make sense of interactions.

5.6.3 Noticing and intervening

There was a sense of comfort and confidence that senior staff would notice that staff were in need of some extra support and time out, and a sense of entitlement to this support. Participant 6 as a team leader appeared to feel this particularly acutely.

'Obviously the good ward manager who listens to you. Sally M (pseudonym) is good. I've said I needed a day off and she knew a lot about your background and your family life. She was very good on family life. If you've got something wrong, she can tell. She can tell if there's something wrong and she'll come and say, what's wrong? Just such and such, she'll say, "Well, do you need time off?" (participant 3).

There was an acceptance that it was a difficult job that will affect people in different ways and that it was important to be able to pick up and notice when someone needed help, and intervene to provide it or decrease the pressure on them.

> *'Yes, you have got to look out for each other in this environment, because it is a dangerous environment. At the end of the day a lot of people have got nothing to lose and you have got to have your wits about you'(participant 6).*

This approach was applied equally to themselves or others; with staff at all levels feeling that it was acceptable to ask for time out even for a short period, or notice that someone else needed time out.

> *'A few weeks ago I sent a staff nurse home because she had had a really bad day and this particular patient had been targeting her, so it is best to get them out the way and off the ward really' (participant 6).*

> *'Yes, the team's very important. Everybody goes through it at some stage, it doesn't matter who you are, everybody needs that support. I think it's just a natural thing that occurs. There have been times when I've said, "Look, I need to get away from here," and the team have said, "Yes, fine, get yourself off for how long you need to, get your head sorted" (participant 6).*

Noticing and knowing each other's strengths and weaknesses in coping was used to apply support in practice, with the expectation that staff would get to know each other well enough to have this awareness.

> *'Everyone is supportive of each other and everyone knows each other's strengths and weaknesses and if we see anyone struggling we can, you know, have a word, offer support' (participant 6).*

There is also a solution focussed element to this, where the knowledge that someone is at risk of becoming stressed is used to open the conversation about what may be helpful, such

as removing them from the situation temporarily, or involving a manager in getting further support or solutions.

> *'But like I say if someone is struggling you can tell, and we can always send that person home or move them to another ward or have a word with Sandra (pseudonym for manager) or do something like that' (participant 6).*

The physical presence of senior managers, as well as the openness to talking was seen as very important. The approachability of senior managers was also noticed and people reported feeling safe to approach them.

> *'And the person who's now my line manager is somebody I've known for quite a long time, and somebody I seemed to feel comfortable with straight away, so that's good. She's been round this morning, just chatting. She's somebody that I've been quite trusting of and whatever. The modern matron is very good. She's really, really supportive. She's always concerned, obviously, about her staff and stuff' (participant 2).*

Participant 2 and 6 emphasised the expectation of senior staff noticing and intervening, and applied this to themselves in their role.

5.6.4 Senior manager support

Senior managers were literally 'upstairs' in that the offices are above the wards on the upper floor. 'Upstairs' was also used as a distinction between 'us and them', but with acknowledgement that the upstairs 'them' were seen as benign and approachable:

> *'I think we're lucky on the ward, actually, because of the managers upstairs. I think most of them are approachable as well. So you know where to go. I can go upstairs and I think, "You can be all right up there" (participant 3).*

> *'You have got to have a strong team, a very supportive team. The teams look after themselves and if they have got any serious problems they can see senior management as well' (participant 6).*

Here however there were two different perspectives expressed about the role of senior staff in support and recognition, one suggested that the focus is always on the welfare of the patients; and the other that staff welfare can be overlooked.

> *'Likewise, on the other hand, when you have to deal with something serious, sometimes that support structure has been lacking, because everybody's been focussed on the patient and not necessarily how it's affected the staff around them' (participant 4).*

Limitations of support were also acknowledged, in that support is there but it was still a difficult job where you need your own coping skills, which could be seen as another way of describing resilience.

> *'I think we do get the supervision, we do get support from our managers and if there is anything you need to talk about you can go and talk to them or you can refer yourself to occupational health and go and talk to them, which I have done in the past. Then you are still left with your thoughts at the end of the day' (participant 5).*

Again the limitations of this are noticed, with a sense here that it may not be enough, and there are negative effects on the staff member that they have to cope with, or learn to cope with on their own.

5.6.5 Discussion: teamwork

This section discusses the different aspects of teamwork that were identified by participants. The term 'communal coping' was used by Lyons *et al* (1998) to explain that a group could provide a stronger response to adversity, providing more resilience than that achieved by individuals. Communal coping was described as 'a process in which a stressful event is substantively appraised and acted upon in the context of close relationships' (Lyons *et al* 1998 p.583). This teamwork element was seen as the group having collective responsibility for responding and discussion of joint, cooperative approaches to problem solving. Problems are seen as 'our problems' rather than 'your problems', and there is a shared responsibility for problem solving.

Tse and Dasborough (2008 p.17) found that workplace friendships can provide positive benefits to both individuals and teams, and that these relationships can be developed to increase 'relationship oriented' approaches to work. In this study there was a clear expectation that the opportunity to talk things over was a basic entitlement, and that this was necessary to externalise and make sense of interactions. The functions of talking were explained as providing support, off-loading emotions, checking out other people's reactions and understanding, and problem solving. Interestingly although this was clearly a reflective process, it was not seen as clinical supervision, which was seen as a separate, more formal interaction. Edward and Hercelinskyj (2007) suggested that the process of reflection could help nurses to work through problematic issues in both their clinical practice, to make sense of experiences and 'transcend' associated stress.

The expectation that others would notice when someone appeared stressed or needed to talk was taken very much for granted in this study. Interventions from others, including senior managers, to enquire about stress or the effects of the job were generally welcomed. A considerable degree of confidence in this as a system was noticed, and this was allied to working in a trusting environment. Riley and Weiss (2015) suggested that in organisations where emotional labour was explicitly recognised, organisational support and training would be more likely to be provided to enable staff to manage and respond more effectively. Riley and Weiss (2015) concluded that there was a need for organisations to give priority to 'putting support and supervision in place to enable staff to cope with the varied emotional demands of their work' (p.23). In Bachay and Cingel's (1999) exploration of resilience in women, they found that relationships in the workplace promoted resilience, and suggested further research was needed.

Paton (2006) developed a conceptual model of stress risk management reduction in police officers, suggesting that actions to reduce stress have to be taken at all levels in an organisation. The availability and visibility of senior managers in this hospital was seen by nursing staff as part of their support system. Although staff were able to describe how this works in practice, they were relatively unaware of the organisation's staff wellbeing strategy, taking it for granted that this was part of the role of senior managers. This suggests that awareness of a wellbeing strategy for staff may need to be communicated more widely.

5.7 Understanding

In Bowers' (2002) research into working with personality disorders in English high secure hospitals, he eloquently described working in an environment where individual actions can reflect a variety of different meanings and have a range of consequences, even when they appear to be similar. Personality disordered patients '*regularly and periodically act in ways that demonstrate they inhabit an entirely different psychological and social world, one where our normal rules for understanding and morally judging behaviours simply do not count*' (Bowers 2002 p.1). This sense of unpredictability was also noted by participants in this study in relation to difficult interactions (Section 5.7.2).

5.7.1 Understanding personality disorder

The need to understand the nature of personality disorder, and the kinds of symptoms and behaviours that may be displayed was seen as extremely important. People with a personality disorder have a significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. Impulsive behaviour which may be aggressive and or self-destructive is an enduring feature. There was acceptance that patients may be difficult to relate to, and it was the role of staff to help them work through these situations.

> *'You do see some good results, you do see some failures, some people that go out and then offend and end up back in prison. But there are one or two that you can work with and you can see the change in them when they first come in. Because they are quite scared coming from a prison environment to this place. Some of them have done horrendous offences anyway and some of them make weapons and do all that sort of stuff' (participant 6).*

There was an acceptance that patients will move backwards and forwards in their progress and these fluctuations have to be tolerated, but optimism and hope were also evident.

Participants commented on their attempts to improve the experiences of the patients, feeling that this led to changes in how interactions within the setting took place.

> *'I'm always open to new ideas. If we can make somebody's day or life that bit better-actually, if we could make that person's life a little bit better, then that relationship will get better with the staff, and it makes the staffs' working life better. Then*

everybody benefits, across the board. I don't see why we shouldn't do that. I always believe we should try to do that' (participant 1).

'They generally start to think about doing things in different ways, but it takes a long time and you do see people change. They become less violent, less aggressive, more amenable, want to work with you, but it is a long drawn out process, it doesn't happen overnight. You can get frustrated with it sometimes, because like you think you are getting somewhere with a patient and then they do something, and you think, "Oh we will have to try something new this time, because that didn't work." But it does work, people do change' (participant 6).

The potential for violence was acknowledged, with awareness that any violence would have to be managed and staff would have to work to recover a positive working relationship. There was no doubt amongst interviewees that it was the role of staff to behave in a non-judgmental way after an incident, and move on. This appeared to link back to their understanding of the ways in which patients with personality disorders may relate to others.

'You have got to have knowledge; you have got to be hard enough to how patients are and how the unit is and all that sort of stuff. Then when the patient is ready and they need your help you are there to help as well. It is like we have fought with people and got them in seclusion, we've restrained them, they have injured staff they have injured themselves. Then after they have been in seclusion for say three or four days they are back to what they were before and then they just normalise when they come out and life goes on as it did before'(participant 4).

The risk of a gradual erosion of positivity was noticed however, which was attributed to the patients' presentation, particularly in the nature of interactions. Staff suggested a change of environment and possible rotation could help with this, and this is discussed in the final discussion chapter (Chapter Seven).

'I think I am a bit burnt out with 'PDs' (sic) if I am really honest. It is not a negative thing because I have enjoyed working with them, but I don't know if it is for me anymore. This me, me, me thing' (participant 5).

'Because, the nature of the person that you're looking after, the 'PDs', they draw on your emotions a lot, I mean, a lot, and they just drain you. But, there's no rotation at all, I've been here 10 years' (participant 1).

Participants were able to articulate that they are motivated to make people's lives better, day to day, but also have to keep a professional distance, in order to protect themselves from emotional harm, as was discussed in the management of emotion section earlier. They were also acutely aware that the maintenance of a relentlessly positive outlook is difficult and does carry a risk of burnout. This is the first use of the term 'burnout' in the interviews, and is used in relation to working specifically with personality disordered patients. The potential benefit of rotation of staff through different units is mentioned by several staff, and is reflected on in the final discussion chapter (Chapter Seven).

5.7.2 Difficult interactions

Staff were well aware of the possibility of patients saying and doing things which could be seen as hurtful as highlighted by their understanding of the nature of the patients, and the need to maintain a neutral response was regarded as very important, so that they didn't become affected by potentially hurtful interactions.

'There's no point taking the emotion with you, hurtful things. It doesn't help at the end. It doesn't help your therapeutic relationship with people. Some patients, you've got a better therapeutic relationship with. It's like anybody in life, some people you can talk to, some people you can't talk to. I'm very much, "If you're all right with me, I'm all right with you." I always think you should be firm but fair and treat everybody the same and that's the way I look at things' (participant 1).

'You really have to think about how you approach them all the time. A lot of our patients because they are confined in such a close environment they have to get on. They don't get on with everybody but they have to get on with most of the clients on

the ward. Life becomes quite stressful for them and they then project it onto you' (participant 5).

These quotes also illustrate the unpredictability of the environment, and the nurses' awareness that they have to be constantly alert and aware of what is going on interpersonally between patients, and between patients and staff. Staff knowledge and understanding also has to extend past the condition, into the context in which they are working, so the setting and influence of the secure environment has to also be understood.

'It can change really quick. Like you can have a patient there screaming and bawling at you one minute, wanting to kill you, calling you from a pig to a dog. Then the next minute you are helping them with all the claims for writing home and doing all that sort of stuff, and it can be as quick as that. It is hard to put into words' (participant 4).

This next quote provides a rich example of how everyday interactions can present as complex and challenging. There is an expectation among nurses that the staff member will make the effort to decode and understand the interaction, and then later use this to help the patient reflect and learn. There is an effort to provide the patient with a safe space to explore the interaction, and consider possible different interpretations and ways of responding. While this was understood and accepted, a certain weariness is evident in having to 'watch' every interaction.

'We had an incident, it wasn't an incident it was a silly thing. I did the breakfast one morning and a patient asked for two slices of toast. I gave them two slices of toast and he wouldn't talk to me for the rest of the day. I said, "Are you alright?" He said, "No, I need to talk to you." I thought, "It is not like him." After I had a one to one it was because he asked for crust and I hadn't given him a crust. I said, "I apologise, I didn't hear you say crust I just heard you say toast, 'I want two slices of toast.'" He made such a big deal over not getting a crust and that made me quite anxious. I thought, "Was I ignoring him? Was I not listening to him?" Then after I thought, "No I did listen to him. I gave him the toast and I didn't hear him say crust. No, it was like, "I needed to check it out because you had given someone else a crust." I said, "If I'd

known you said, 'Can I have a crust?' Then of course you could have had crust, it wouldn't have mattered to me whether you'd had a crust or not. I am not pedantic and I am not nasty, I would have given you a crust." He really didn't like it. He really took offence to it all day and it simmered all day, you could tell there was something wrong with him. All of that just because I gave him a slice of toast and not crust' (participant 5).

In this example the nurse reflects on the emotions evoked by the patients' challenge, and uses this reflection to analyse and understand the meaning behind the emotion. The 'anxiety' is understood as a response to the nurse's wish to 'do the right thing' and maintain a professional approach to a verbal challenge that appears out of proportion to the real situation. This instance, seemingly insignificant to the staff member before their discussion with the patient, clearly had ramifications for the way that they reflected, as noted in the following quote, taken from later in our discussion:

'I don't know if I do make a difference if I am honest. I don't know sometimes they are just, "It is all about me." No matter what from the second they open their eyes and come into the day room it is about that one person. If things aren't going their way they will let you know in a variety of ways. (Laughter) It is difficult finding that empathy and that care when you just think, "You are just being pedantic now over a slice of toast" (participant 5).

Other participants shared similar reactions which resulted in them questioning themselves and their approach to their work. It was not uncommon for them to have an emotive response to these experiences. These spanned from concern about the involvement of outside parties (solicitors and advocates), to concern about emotional or physical mistreatment.

'You've got to be careful what you say because they'll get the advocate. Get me my solicitor. It's just human rights all the time. You're thinking, "Oh my God." You say something, you think, "Should I have said that?"(participant 3).

'I beat myself up quite a bit about things that happen on the ward and things that patients say to you (participant 5).

'Some can be really very violent, some can be very nasty and some can just like play silly games with you all the time, it just depends what mood they are in. Because a lot of them are here for a long time and they spend a lot of time watching and listening and they know everything about you' (participant 6).

Staff also described accepting that patients may be challenging in their interactions at times, but having confidence in their responses:

Most of our patients aren't bad they really get on with you; if they have got an issue they aren't afraid to tell you. You have just got to take it on the chin and say, "I am sorry if I have upset you, but it is not my fault I have to go through the right channels." They don't always like that, but as long I know I have done my job right at the end of the day I can live with that' (participant 5).

These examples can be seen as 'positioning' by nurses, in which the person brings their history as a subjective being to the particular situation, drawing on the experience of being in multiple positions and engaging in different forms of interaction (Smith 1998).

'Sometimes you doubt yourself and you doubt that you have done a good job and you have done the right thing. It is just getting that feedback sometimes to say, "There is no right thing. Everybody works differently and just because your reaction is different to the person stood next to you it doesn't mean it is wrong" (participant 5).

This quote above illustrates a sense of reassurance and resilience resulting from the staff member seeking feedback and receiving positive affirmation from others. This appears to link back to the teamwork and consistency concepts, but can also be seen as 'positioning' in relation to other colleagues. Davies and Harre (2007) note that '*it would be a mistake to assume that positioning is necessarily intentional*' (p.7). Nurses here are engaged in reflection about their position in relation to the patients, and an awareness that patients will get to know them very well (interactive positioning in which what one person says positions

another) and balancing this with the nurses' awareness of their own role in the interaction (reflexive positioning in which one positions oneself), (Davis and Harre 1990). There were examples also of intentional positioning in relation to rules, perhaps as a self-protection measure; when patients are challenging there was a recourse to rules and regulations, which felt like a way of deflecting the patients' verbal challenge.

5.7.3 Supervision

The expectation of the Nursing and Midwifery Council is that all qualified nurses will use feedback to improve practice and performance, which is gathered from a variety of sources (NMC 2015). The research setting has an organisational policy which recognises the importance of clinical supervision for all staff working in direct patient care as being central to safe and effective practice within a clinical governance framework. A local structure and process for clinical supervision was in place and available.

The hospital had a system where supervisors were released from shift duties to allow them to make themselves available to staff. There were mixed attitudes to this, with some staff welcoming this and describing the value to them of using the supervision relationship for reflection.

> *'Clinical supervision helps me. I access my clinical supervisor, I phone him up when there is something that is going on and I think, "I don't know how to deal with this." I will give him and ring and say, "What do you think of this and what do you think I should do?" (participant 5).*

Others described it as an unnecessary bureaucratic intrusion, or as something that would be easily put aside when busy. This meant that supervision did not always take place, although some staff described actively avoiding it.

> *'Yes, I do have supervision when I feel it's needed. You're supposed to have supervision as an ongoing process, every month, but sometimes you're that busy, you get that focussed on helping out on the ward and managing the ward and everything else that you sometimes put yourself to the back burner' (participant 1).*

'It's expected to have it. So they'll come and say, "Supervision? Thank you. Go back down. Don't need it. If I want it, I know where to go. I know the people to go to if I want to talk." I think that's all you need' (participant 3).

Given that there is a professional practice and policy expectation of regular supervision, there is a slight jarring here, where the function of supervision has become aligned with unnecessary structure for some nurses, and there is a risk that it is not used appropriately. This suggests that there is some local development work to do on the use of supervision. There may also be an opportunity to convey the positive and protective benefits of supervision, as at present it seems to be seen by some staff as apart from their usual support systems, rather than an integral part.

5.7.4 Discussion: understanding

This section has given an insight into the 'world' of working with patients who think, feel and see the world in a way that is different to others. In these interviews staff were acutely aware that they were working in an environment where everyday interactions would be open to intense scrutiny and possible misinterpretation by patients.

Understanding and accepting that these were realities was seen as vital to maintaining a positive approach, knowing that at times interactions might be abusive, critical or aggressive, but also being able to reflect and understand the origins of these interactions. Staff described it taking a long time for patients to change, having to try something new, or having to work at returning to normal and 'moving on' after a violent incident.

The ability to respond positively when patients also presented with positive behaviours, without staff having a judgmental or critical stance was noticeable, almost as though staff are ready and waiting to notice positive behaviours.

'Compassion fatigue' in secure mental health environments has been noted by many researchers (Martin and Street 2003, Mason 2002, Weiskopf 2005). Cashin *et al* (2010) also noted that staff may withdraw from patients who present with abusive, difficult or manipulative behaviours, resulting in 'compassion fatigue'. Bodner *et al* (2015) compared attitudes towards patients with borderline personality disorder across four professions, and found that nurses expressed more fear of suicide risk, more antagonism and less empathy than other professions. Sansone and Sansone (2013) however noted that this could be seen

as a human reaction to the complex behaviours of these patients. Dickens *et al* (2015) suggested that nurses' lack of control over their contact time with patients may be a significant factor in attitudes, and that nurses should take the initiative in developing formal and informal support structures. There is research evidence that clinical supervision can provide effective stress reduction for mental health nurses (Brunero and Stein-Parbury 2008) and reducing burnout (Edwards *et al* 2006). In the previous sections participants clearly articulated what they thought was needed, but the data presented here begins to show that putting this into practice was not always easy or possible (e.g. self-criticism, questioning of the self). In addition the formal structure of supervision, designed to support their work in this challenging environment, was not always used as intended.

5.8 Work life balance

All participants spoke of making a conscious effort to have a separate work and home life, which appeared to be influenced by a number of factors. These included the need for confidentiality regarding their work with patients, a wish to protect family and friends from the more negative aspects of the work they do, and to have a separate safe space that is not affected by the world of patients, where they can be 'themselves'.

5.8.1 Leaving it at the gate

All participants spoke of needing to have a distinct separation between home and work lives, articulated as 'leaving it at the gate'. The hospital has various sets of locked gates, including a secure locked main entrance, known as the 'main gate'. Passing through the physical barrier was seen as symbolic in helping people to make a definite transition out to their own lives.

> *'I try to leave it at the gate. I am one of these people who think once I am out of work, once I have got through that gate and I am in my car that is it, work is left. It is not as easy as that, it is really not as easy as that sometimes you do take it home and you do mull it over. Sometimes when you are off for days on end you mull it over. Then when you come back you think, "It is dealt with, so why did you get so stressed over it?" It does cause anxiety' (participant 5).*

'Once I have handed my keys in that's me finished. Then it all starts again when you come back the next morning' (participant 3).

Avoiding interactions that are about the workplace were also seen as very important, helping to maintain 'separateness' between the internal and external experiences. This extended to discussions with family and friends, who were in the main not aware of the reality of working in this context. Participants highlighted a distinction here between confidentiality policies, and their own concurrent preference to distinguish work and home life.

'You don't really talk about work and because you are not supposed to anyway. They wouldn't know in honesty what I do for a living. They don't know what my day to day work life is about' (participant 5).

'Work's work and home's home and don't take your work home with you, that's what I've learnt. Whatever you do, leave it outside the front gates. I've got two separate lives, one's here and one's there' (participant 1).

In an example where the staff member cannot switch off from thoughts about work, they present as isolated with this in their home environment.

'Sometimes you do take the stress home and sometimes it keeps me awake at night' (participant 5).

Where participants noted that they found it challenging to 'leave it at the gate', this had ramifications for time spent away from work. Drawing from the above points, which noted how little participants discussed work with others outside the setting, this left them isolated where issues arising from work continued to play on their mind.

5.8.2 Family and friends time

All participants mentioned the need to have a balance in life, and time with friends and family was cited as a very necessary part of this. All had a conscious awareness of the need to enjoy family life, and social life in general.

'I don't have hobbies as such I just like family life. I spend time with my family. If I have got a problem I don't really talk about it at home. They know where I work, but they don't know what I do really it is completely alien to them' (participant 5).

There is a distinction drawn between 'work' support and 'family' support, but with recognition that both were important:

'But I have support in that I have managers that I go to, and support within that. I have very good support family-wise. I suppose that's how I cope with it, and also trying to put things into context that yes, it is a stressful job' (participant 2).
'I spend a lot of time with the family, so family is very important to me. I do a lot of running around for the kids and that's my main focus, it just gets me away from thinking about this place' (participant 1).

The element of distraction seemed to be important, in having something positive to focus on that was not work based. Having said that clearly peoples' families do not exist to serve a 'function', it was more that there was recognition of the value of positive caring and nurturing experiences, doing 'ordinary' things that provided comfort and enjoyment.

5.8.3 Physical health

All but one of the interviewees mentioned the need to maintain physical health through exercise, and fresh air. They were very aware of the need to look after themselves physically, and noticed when physical health was affected by the stresses of the job.

'I play a lot of sports, go to the gym. There's a lot of recreational things and I just do things that I want to do' (participant 1).

'I run quite a lot. I find that very, very helpful, although I'm aching today. Yes, I run. I find that really helpful. I find that as mentally good as I do physically' (participant 2).

The use of exercise and gym facilities was directly linked to a need to use physical exercise to increase tolerance to stressful experiences.

'I manage my stress by just going to the gym, going out socialising, mixing with friends' (participant 2).

'So there are gym facilities, or if you are feeling a bit stressed, it is a big place, you can have a walk around for half an hour in the fresh air as well, you are not kept in one place' (participant 1).

'Fresh air' appeared to be a proxy for freedom from the constraints both of the physical environment, and the psychological intensity of the patient care areas. Exercise was taken at home but also at work, recognising that it could provide a release from stressful experiences at work and contribute to a feeling of physical wellbeing.

'Well a lot of people have got a good social life; a lot of people use the gyms (participant 6).

Participants described a range of ways in which they could maintain health and well-being, and relax away from work. The following contribution stands out as awareness by one participant of a more negative way of coping with stressors, which was not expressed in other interviews.

'I must admit since I have started working here I do tend to drink a lot more than I have ever done' (participant 5).

There was some regret expressed about this, as though it was something developed while working in the service, which was outside the usual norms for this participant. They did however relate it directly to the experience of working in the personality disorder service.

5.8.4 Discussion: work life balance

The need to have a completely separate home life was noted by all interviewees. While some described a definite focus on activities that enhanced their conscious enjoyment of life, others described enjoying more 'everyday' aspects such as spending time with family and friends. One staff member noticed they had started to use alcohol to relax, and was

concerned that this had become more of a habit since working in the personality disorder unit. All mentioned the benefits of physical exercise, whether this was gym, running or walking. There is widespread recognition of the physical benefits of exercise and there is much evidence an association linking exercise to physical health and overall quality of life (Edenfield and Blumenthal 2011).

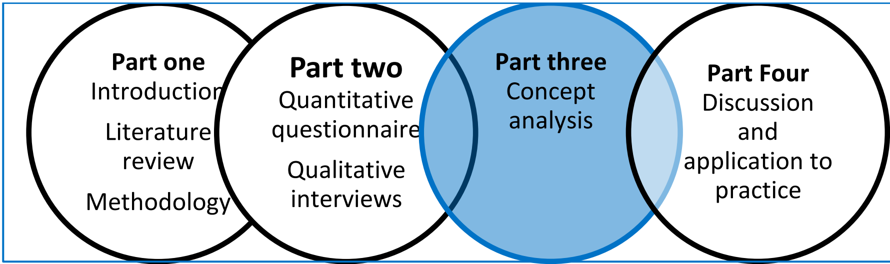
'Leaving it at the gate' had become a metaphor for the separation between the two worlds, with a conscious effort to have a physical separation between work and home. A parallel can be drawn with 'bracketing' here; where thoughts, reflections and emotions are kept consciously separate to the staff members' home life. There is obvious potential for appropriately structured, reflective supervision to help with this process which may need to be considered in local approaches.

In an exploration of emotional labour in prison nurses (Walsh 2009) the physical handing in of keys was suggested as a way of delineating the lines between home and work that provided an emotionally intelligent way of coping with the stress of working in a prison. This phenomenon was also found in this study, where participants described their intention to 'leave it at the gate'. This was expressed as a conscious effort to mark the separation between home and work, and although not stated in those terms, was intended to promote resilience by creating distance between work and home life.

5.9 Conclusions

Analysis of the interviews has demonstrated that while staff struggled to describe what was useful in developing and maintaining resilience, there was a high level of awareness that they worked in a demanding area, and were entitled to expect workplace support to maintain their wellbeing. Although it was not expressed in direct terms, there was an acknowledgment of the emotional labour of the work, and discussions about how they managed within this demonstrated an emotionally intelligent approach to their own health and wellbeing. This is new knowledge that can be used to understand what helps staff in secure environments to become and stay resilient, and applied in practical ways by the organisation. In order to better understand this, a concept analysis has been completed; using the material and themes from these interviews, and is discussed in the following chapter.

6 Concept analysis



The focus of this element of the research was on developing a concept analysis of resilience, using information derived from the literature review and empirical data from the study. Following the analysis of the resilience survey in Chapter Four, and interviews in Chapter Five, the final part of the study synthesised the information that had been gathered into a concept analysis of resilience in nurses working in secure environments.

This chapter contains a description of the approach to the concept analysis, followed by a detailed analysis using Walker and Avant's (2005) approach. The identification of the three elements of the concept analysis of resilience in this context is explained; and these are 'hardiness', that is the withstanding of adverse experiences; then 'bouncing back' or resuming shape; supported by 'cognitive appraisal' or understanding. A discussion of the findings is offered with reference to relevant literature.

The development of a concept analysis of resilience (Walker and Avant 2005) is intended to offer a wider perspective on the subject in the context of the study, in the sense of 'expansion' (Creswell 2003), referred to in Chapter Three. This provides a framework for the research, describing both a process and an intended outcome, and can be seen as going beyond 'triangulation' to 'expansion' (Creswell 2003).

Triangulation focuses on corroboration of results from different methods, and the emphasis is placed on seeking corroboration between quantitative and qualitative data. Greene *et al* (1989) described 'expansion' as seeking to extend the breadth and range of enquiry by using different methods for different inquiry components. This should uncover understanding of the meaning for individuals, and also contribute to a body of knowledge which can be generalisable. This knowledge can then be applied by nurses and those who employ nurses in secure environments, contributing to a range of ways that well-being and resilience can be understood, fostered and promoted. Aburn *et al* (2016) suggest that a view of resilience as a social construct would allow resilience to be seen as dependent on the beliefs and views of the population being studied. Southwick *et al* (2014) also make the point that determinants of resilience will be different depending on specific challenges and contexts. The context in this study is a high secure personality disorder service. Identifying the implications of a proposition is not a straightforward task of observation but raises difficult theoretical as well as normative issues. Peirce's solution is to consider all conceivable implications, but for

practical research purposes the inquiry needs to be limited to a manageable scope (Peirce 1903, cited in Annellis 2012).

6.1 Explaining concept analysis

Concept analysis is a formal and rigorous process by which an abstract concept is explored, clarified, defined and differentiated from similar concepts to inform theory development and enhance communication (Morse *et al* 1996, McCance *et al* 1997, McEwen and Wills 2002, Walker and Avant 2005). Walker and Avant's (2005) structured process is based on the work of Wilson (1963), and has been regarded as a relatively straightforward approach. This method has been successfully applied in research in many nursing arenas: a sense of belonging (Hagerty *et al* 1992), resilience (Dyer and McGuinness 1996, Garcia-Dia *et al* 2013), peer support (Dennis 2003), competency (Tilley 2008), and nursing workload (Alghamdi 2016). Risjord (2009) suggested concept analysis can be used in nursing research to make the meaning of a concept explicit, so that it can become part of practical nursing theory.

In the current study, Walker and Avant's (2005) eight step procedure was used to determine defining attributes. The structure of the concept analysis method was used to both illustrate the concept of resilience, and to integrate the results of the literature search, survey and interviews. In this process, the information and data gathered in the first two parts of the study have been synthesised with the etymological origins, dictionary definitions and existing literature, to determine the cluster of attributes that are associated with the concept of resilience. This allowed insights into the defining attributes of resilience in this environment to be explored. Concept analysis has therefore been used as a process of *explication* to achieve a better understanding of resilience in nurses working in a secure environment.

Walker and Avant's (2005) method uses eight steps, and these were applied in this study by working through them systematically using their structure, shown below in Table 8**.**

Table 8 Concept analysis process

- Select a concept
- Determine the aims or purpose of analysis
- Identify all uses of the concept that you can discover
- Determine the defining attributes
- Identify a model case
- Identify additional (borderline, related, contrary, invented or illegitimate) cases
- Identify antecedents and consequences
- Define empirical referents

Walker and Avant (2005 p.65)

What follows is a consideration of each element of the concept analysis process as discussed by Walker and Avant (2005), followed by an account of its application within the current study. As discussed in Chapter Three, one of the criticisms of this approach was that many nursing research papers cited using 'the literature' as their source of data, producing what was described as 'circular thinking' with no new knowledge (Draper 2014 p.1208). The concept analysis in this study uses empirical data derived directly from the methodologies, facilitating the development of new knowledge.

6.2 Concept selection and determining the aims of analysis

The development of a concept analysis of resilience in nurses working in secure environments was the overall objective of this study. In order to develop this as a concept, the literature on resilience was explored in Chapter Two, and this extended analysis incorporates the data gathered from the empirical research.

The aims of the analysis reflect the aims of the overall study, which is to understand the elements and constituents of resilience in nurses working in secure environments. Walker and Avant (2005) suggest that the question 'why am I doing this research?' is retained in the forefront of awareness while a concept is analysed, in order to maintain the relevant perspective on findings. As stated in the introduction (Chapter One), the primary objective of this study is to contribute to the understanding of how nurses working in secure mental health environments manage the demands made on them psychologically, while maintaining a caring and compassionate approach to the patients they work with.

6.3 Identifying all uses of the concept

Walker and Avant (2005) recommend using dictionaries, thesauruses and existing literature to identify as many uses of the concept as possible. They suggest it is important not to limit this to professional or clinical usage related to the field of study, but to use a wide range, including implicit and explicit uses of the concept.

Dictionaries and thesauruses were searched online for definitions and synonyms of resilience. The origins of the word 'resilience' are derived from the Latin 'resiliens'; the present participle of resilire, which means 'to rebound or recoil', and 'salire' which means 'to jump or leap'. Resilience is a noun generally used to refer to the capacity to recover from difficulties. Resiliency, or the state or quality of being resilient is also a noun.

Two common definitions of resilience used the terms 'elasticity' and 'bouyancy':

- The power or ability to return to the original form or position after being bent, compressed, or stretched, which is *elasticity;*
- The ability to recover readily from illness, depression or adversity, which is buoyancy**.**

Two more specific physical or scientific uses of the term were found in Webster's Dictionary (Merriam-Webster 2011). In the field of ecology, resilience was used to describe 'the ability of an ecosystem to return to its original state after being disturbed'. In this definition, resilience is seen as applying to a system rather than as an individual characteristic, suggesting that it can be used as an umbrella term to describe a number of elements in the process of recovery.

In the field of physics (Free Dictionary 2017) the term resilience was used to describe 'the amount of potential energy stored in an elastic material when deformed'. This relates to how forces may change the shape of an object. An elastic object such as a spring stores elastic potential energy when stretched or squashed. The extension of an elastic object is directly proportional to the force applied, and can then be used to return it to its original shape when the force is removed.

In the Collins thesaurus (Collins 2017) two distinct sub elements of resilience were found, that of *springiness* and *hardiness*:

Springiness embodies the concept of 'recovering from adversity' because of the ability to:

- Adapt or 'give' in a way that is pliable, that is being ;
- Able to bend or adapt to survive;
- Flexibility, elasticity and pliability are related terms.

An example to illustrate this might be trees bending and swaying in the wind, showing 'resilience' through the pliability of branches and stems. The opposite of this might be branches being blown off or trees being uprooted by a wind that it is too strong to resist. In this case the ability of the tree to 'spring back' fails and this may be for many reasons, for example disease, flood affecting its roots, or a wind much stronger than previously encountered.

Hardiness is described as:

- Strength or toughness, and;
- The capacity to adapt and survive under sustained unfavourable conditions.

To continue the example of the tree above, hardiness would be the trees' ability to withstand sustained conditions of adversity, not just how it reacts to it. So over time the tree may adapt its shape or size, for example growing close to the ground or rocks so that its physical ability to withstand periods of strong wind is sustained.

A review of the literature on psychological resilience in people found a variety of explanations, for example, Windle (2011) included elements of the concept of springiness: *'the process of negotiating, managing and adapting to significant sources of stress or trauma'* (Windle 2011 p.12). Aburn *et a*l (2016) reviewed a hundred articles on resilience, and found that there was no universally accepted definition of resilience in research literature, but there were common themes identified such as '*rising above, adaptation and adjustment, dynamic process, 'ordinary magic'* (Aburn *et al* 2016 p.980).

Springiness and hardiness can be seen in this conceptual definition of resilience;

> '*the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning'* (Bonnano 2004 p.20).

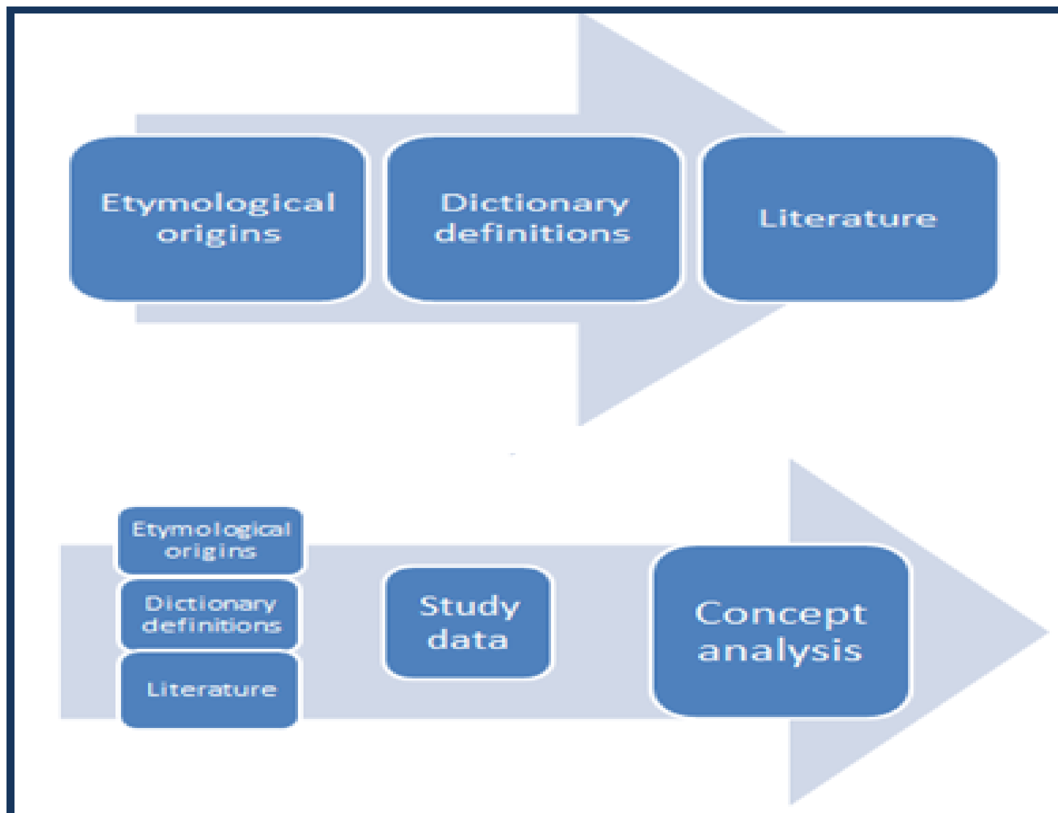
Resilience was also described by Luthans (2002) as including the elements of springiness and hardiness:

> '*the capacity to rebound or bounce back from adversity, conflict,*
>
> *failure, or even positive events, progress, and increased responsibility'* (Luthans,
>
> 2002, p. 702).

While other theories have been discussed in the literature review in Chapter Two, these three theoretical perspectives are examples of the range of literature that have been accessed to develop the concept analysis.

The meanings derived from the etymological origins, definitions and literature review are then synthesised with the empirical data from the quantitative and qualitative elements of this study. Figure 8 below shows the sources used to develop the concept analysis.

Figure 8 Sources used to develop the concept analysis



6.4 Analysis

6.4.1 Determining the defining attributes

'Defining attributes' are those characteristics that best define the concept, and are those factors which must be present in order for the concept to be identified. The analyst is invited to use references from the social or nursing care context in which the concept is to be used.

According to Walker and Avant's (2005) definition of concept analysis; 'the effort is to show the cluster of attributes that are most frequently associated with the concept, and that allow the analyst the broadest insight into the concept' (Walker and Avant 2005 p.68). As many of the different instances of the concept of resilience as possible were reviewed, and notes were made of characteristics of the concept that appeared over and over again. This process is iterative rather than linear or sequential, and the defining attributes have been 'distilled' from reading, from the literature review, the analysis of the interviews and questionnaires, and from definitions and dictionaries.

The questionnaire results and groups of themes from the interview analysis were revisited, and considered alongside the definitions from dictionaries and from the literature. Based on the use of this framework as a guiding structure, the defining attributes for the concept of resilience in this study were found to fall into three characteristics: *hardiness*, which is being able to withstand adverse experiences, *bouncing back,* which is the ability to recover or resume shape after a challenging event; and *cognitive appraisal, or* attitude to, the adversity.

6.4.2 Identifying a model case

In Walker and Avant's (2005 p.69) structure, a 'model case' is an 'example of the use of the concept that demonstrates all the defining attributes of the concept'. Wilson's (1963) view of a model case is one in which the reader has no doubt that it is an example of the case, and the characteristics are easily recognised.

Examples from the interview analysis are used to exemplify the model and additional cases, to meet the study aims of developing a concept analysis of resilience in nurses working in secure environments. The following example demonstrates a *model case* for the concept of resilience, related to nursing in a secure environment; that is all the defining attributes of bounce back, hardiness and cognitive appraisal are contained within the interview of Participant 1.

> *'Until you've done it, until you've actually seen it first hand, nobody knows how they're going to react. I think it's changed my outlook in becoming numb to certain things, whereas, before I'd be quite shocked. Now, nothing very much, shocks me now, having seen some of the things I've seen. So, yes, it has changed me.'*

This is an example of *hardiness*, where the individual is aware of the challenges of the environment, and has adapted their coping mechanisms accordingly. Participant 1 also gives an example of *cognitive appraisal*, where the individual thinks through and reflects on the experience, and forms an attitude through their understanding of it; exemplified in this quote:

> *'There's no point taking the emotion with you, the hurtful things they say. It doesn't help at the end. It doesn't help your therapeutic relationship with people. Some patients you've got a better therapeutic relationship with. It's like anybody in life, some people you can talk to, and some people you can't talk to. I'm very much, "If*

you're all right with me, I'm all right with you". I always think you should be firm but fair and treat everybody the same and that's the way I look at things. Like I said, we can't go taking it personally'.

The third element of '*bouncing back'* can be seen in this quote from the interview of Participant 1:

> *'There have been times where you think you're close to snapping. You wouldn't be human if you didn't feel like it. But, like I said, two days down the road, everything's normal. You're serving dinner, if they want something, put them on the phone or arrange all the jobs they can't do themselves, then you do it to help.'*

This case covers all three of the critical elements of resilience: hardiness, bouncing back and cognitive appraisal, exemplified in nursing with challenging patients in a secure environment.

6.4.3 Identifying additional cases, including a related and contrary case

The discipline of examining other cases that are not exactly the same is intended to assist with identifying what defining attributes have the best 'fit', and teasing out what 'counts' as a defining attribute for the concept and what doesn't 'count' (Walker and Avant 2005 p70). Related cases are cases that are instances of the concept that contain most of its attributes but not all of them. The intention of examining a related case is to help understand how the concept being studied is related to or overlaps with similar concepts.

The interview with Participant 5 is an example of a related case, an excerpt of which follows. Some of the elements are contained in the interview quote, but not all. This case is related in the sense that there is some *cognitive appraisal* of the experience, shown in this quote below.

> *'Talking to other people, discussing it and seeing how other people would react. Taking a step back and thinking, "Have I reacted right or should I have done this another way?" I don't think there is ever a right or a wrong in a situation, but it is how you feel after you have dealt with that situation. Certain things could happen on the ward and a member of staff will say, "I would have put them in seclusion for that". If they are not there on that day on that shift dealing with that and dealing with everything else that is happening on the ward at the same time that is quite stressful. I am one of these people who think once I am out of work, once I have got*

> *through that gate and I am in my car that is it, work is left. It is not as easy as that, it is really not as easy as that sometimes you do take it home and you do mull it over.*

There is the beginning of a form of *cognitive appraisal*, where the individual describes talking it over with others, and taking a step back to think about it. However there is an absence of the attributes of *bouncing back*, evidenced by further extracts from Participant 5:

> *Sometimes when you are off for days on end you mull it over. Then when you come back you think, "It is dealt with, so why did you get so stressed over it?" It does cause anxiety'.*

Rather than recovering or bouncing back, this example shows that the member of staff is caught in a cycle of revisiting the incident and does not move on from the emotions involved.

There is no evidence of *hardiness* in the interview with Participant 5; in fact concern about their own coping is expressed. They also noted that the feeling of being stressed by experiences remains even after leaving work, shown in this extract:

> *'Sometimes you do take the stress home and sometimes it keeps me awake at night. …..I try to leave it at the gate'.*

This case illustrates an instance where there is some *cognitive appraisal* or attitude development regarding the issue (Lazarus and Folkman 1984) but this is not balanced by a *hardiness* (Bonnano 2004) or an ability to *bounce back* (Luthans 2002). The consequences are that the individual is caught in a cycle of 'mulling it over', causing anxiety.

A contrary case is a clear example of 'not the concept', with no definitive examples of the defining attributes evident in the interview (Walker and Avant 2005 p70). Wilson's (1963) description of a contrary case is one where it is immediately obvious that it does not show the characteristics of the concept. Excerpts from the interview with Participant 3 were chosen as an example of a contrary case because the interview does not contain any examples of the three elements of resilience. In this example of the interview with

Participant 3 the impression given is of a rule based approach to contacts with patients, which is expected to proscribe a way of interacting. There is some illustration of thinking and 'wondering' but no clear reflection or *cognitive appraisal* of events, to understand and process them, as shown in this quote from Participant 3:

> *'I think it's changed a bit now because I think your patients have got more human rights and the advocacy, they've more time. They bring in the advocacy. You've got to be careful what you say because they'll get the advocate. It is just human rights all the time. You say something, and think "Oh My God, should I have said that?" You want to be informed about it but now you've got to be so aware of exactly what you say. It's getting more and more difficult because they know they can get away with it. Sometimes, if there's something wrong, I just think about it and then think I could have done something better and next time I'm not going to do that. Sometimes, not very often, but I think everybody takes something home and thinks about things'.*

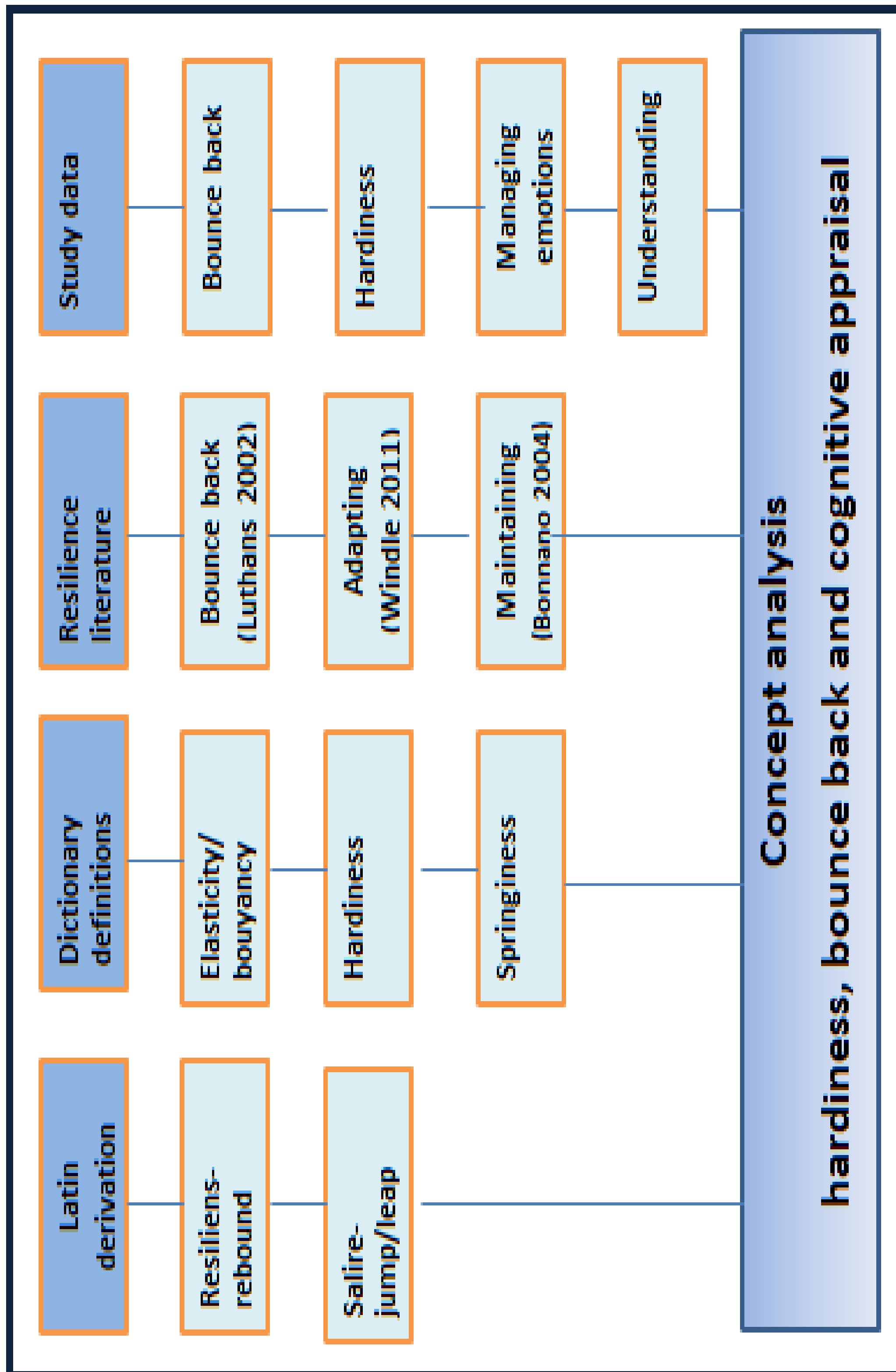
Further, in the interview with Participant 3 the staff member initially appears to be describing a way of coping. However this relies on a 'black and white' approach to the workplace, where it is assumed events will progress and be managed in a structured prearranged way with an expected outcome, illustrated in this quote:

> *'It's a straight stick; there are no branches off it. They know where they stand. They know where you stand. You know where you stand. You all work as a team, and you all go home happy and safe'.*

In this case there are no examples of either '*hardiness*' or '*bouncing back'*. The impression is of an inability to exert control over events, or manage the effects of them.

The derivation of the concept analysis is represented below in Figure 9. The diagram shows the individual elements under each heading, which have been synthesised into the final concept analysis.

Figure 9 Concept analysis of resilience



6.4.4 Identifying antecedents and consequences

The identification of the antecedents and consequences of any concept is intended to shed light on the social context in which the concept is generally used. This identification can lead to refining of the attributes and can give further examples of the contexts in which the concept may be applied. Antecedents are 'those activities, situations or events that happen before an example of the concept occurs' and are seen as the 'next step' in a concept analysis (Walker and Avant 2005 p.72). For example, in Alghamdi's (2016 p.453) concept analysis of nursing workload, the three primary antecedents were identified as 'a patient with healthcare demands requiring nursing care, a nurse who has particular skills, and a healthcare institution in which nursing services are provided'. These could also be described as the necessary circumstances that must take place to allow the concept to occur.

To identify these it was necessary to examine all the elements that need to be in place for the concept to occur. The environment presents challenges which generate the need for some kind of response from nurses. For instance, if the challenge was purely intellectual, a particular kind of response would be required.

The challenges in this environment are to physical safety and to nurses' psychological wellbeing, and nurses are required to be aware of these workplace challenges and consider and reflect on how they can be approached. The management of emotional responses is a key underpinning theme to the concept of resilience in this environment.

In this study, for the occurrence of resilience in a secure environment four antecedents are proposed:

1. *workplace adversity or challenge that requires some kind of response*

   This is an event that is experienced as difficult that has to be coped with or managed;

2. *the situation is construed as being challenging psychologically and possibly also physically*

   There are inherent challenges to the staff members' psychological and physical wellbeing;

3. *the capacity to notice and cognitively interpret adversity is present*

   This element requires the awareness of the staff member that the situation is challenging, and requires reflection and consideration;

4. *there is a realistic attitude, rather than an overly optimistic or a depressive attitude*
   This requires the acceptance of the realities of the situation, and the ability to manage emotional approaches to the situation.

Consequences are those 'events or incidents that occur as a result of the occurrence of the concept' (Walker and Avant 2005 p.72) in other words, the occurrences that are the outcomes or *sequelae* of the concept. For example, in the study by Alghamdi (2016) the possible consequences of nursing workload were identified as being in three categories: patients, nurses and health institutions. This means that the effects of the nursing workload will be in these three areas; patients, nurse and the organisation will all be affected.
In this study these possible consequences of resilience in a secure environment are proposed: *a toughening effect; effective coping; and a sense of mastery which allows other situations to be coped with.* These 'consequences' of resilience can be said to illustrate what helps staff to cope and flourish in this environment. These are the outcomes of the concept of resilience. According to Windle (2011) '*consequences are the end-points that occur as a result of the antecedents and attributes of resilience'* (p. 158). Integration and effective coping are said to clearly demonstrate the outcomes of resilience (Garcia-Dia *et al* 2013).

Defining empirical referents is the final stage in a concept analysis, and these are categories of the phenomena that demonstrate the occurrence of the concept itself by their existence. Empirical referents can help to determine how the concept may be measured, especially if the concept itself is highly abstract. Walker and Avant (2005) give the example of 'kissing' as an empirical referent for affection.

While resilience itself is a somewhat abstract concept, there are a number of well-validated measures of resilience in the literature. Windle (2011) suggests three key features that demonstrate the experience of resilience:

> *'The encounter with adversity, the ability to resist and adapt to adversity, and the avoidance of a negative outcome'* (Windle 2011 p.14).

There have been many measures of resilience developed, and there have been detailed reviews of measurement scales for the study of resilience in adolescents (Ahern *et al* 2006),

and for the study of resilience in adults (Windle *et al* 2011). These are generally self-report scales based on individual psychological resilience, and as previously noted there is no 'gold standard' resilience measurement scale. Windle *et al* (2011) suggest three questions to assess resilience:

1) What is the adversity?
2) Which assets or resources might offset the effect of the risk?
3) Is the outcome better than could be expected? (Windle *et al* 2011, p. 15).

These questions present a useful reference point by which to measure the presence of resilience in a particular context. The measuring scales offer a measurement of the presence or absence of resilience, but do not offer to measure the process of resilience, or shed any light on what may assist the individual's resilience. The development of a concept analysis of resilience is part of the aim of this study, going beyond simply measuring the presence or absence of resilience. The empirical referents are the categories of actual phenomena that demonstrate the occurrence of the concept itself (Walker &and Avant 2005, p.73).

Because this study is concerned with the constituents that help promote resilience in nursing staff, it is suggested that empirical referents in this context would be closely aligned to the defining attributes: withstanding an adverse event; bouncing back after an adverse event, and making sense of or appraising of the event. In other words, if a nurse can withstand an adverse event, make sense of it and bounce back, they can be said to be resilient in this environment. Table 9 below shows the antecedents, consequences and defining attributes of resilience in this environment.

Table 9 Antecedents, attributes and consequences of resilience in nurses in secure environments

Antecedents	Consequences	Attributes
• Workplace adversity or challenge that requires some kind of response • The situation is construed as challenging psychologically and physically • The capacity to notice and interpret adversity cognitively is present	• A toughening effect • Effective coping • A sense of active mastery so that coping with other situations is possible	• Hardiness • Bouncing back, resuming shape • Attitude to or cognitive appraisal of the adversity

The attributes identified are hardiness, bouncing back/resuming shape and attitude or cognitive appraisal of the adversity. Drawing further on the empirical data from this study, the superordinate themes identified from the interview analysis can be said to be 'influencing factors' that underpin the development of resilience in this environment, shown below at Table 10.

Table 10 Attributes of resilience and influencing factors in a secure environment

Attributes	Influencing factors
• Withstanding adverse experiences/hardiness • Bouncing back or resuming shape • Cognitive appraisal/understanding	• Management of emotions • Teamwork • Understanding • Work life balance

6.5 Discussion

Based on this concept analysis, it is proposed that there are three requirements for resilience in nurses in secure environments; withstanding an adverse event, the ability to bounce back, and the ability to cognitively appraise or make sense of the event.

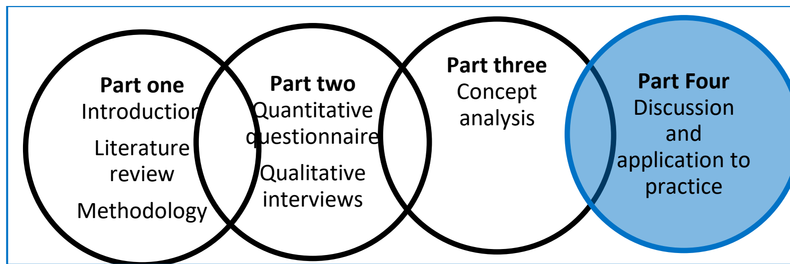
As a finding of this study, the following contextual definition of resilience is proposed:

Resilience is composed of hardiness, that is the withstanding of adverse experiences; then bouncing back or resuming shape; supported by cognitive appraisal or understanding of the adverse event.

The importance of a definition that is aligned to the context was noted by Aburn *et al* (2016), suggesting that the beliefs and attitudes of a defined community or group need to be understood in relation to resilience. Many studies have used quantitative methods and measurement scales to determine or quantify resilience (Wagnild and Young 1993, Connor and Davidson 2003, Friborg *et al* 2005, Bartone 2007, Ungar 2008). This study has developed a practice-based definition in the context of working with personality disordered patients in a secure environment, alongside the identification of characteristics of the workplace environment that can assist with and facilitate the capacity for 'bouncing back' in the face of adversity.

The intention of this chapter was to develop a concept analysis of the resilience of nurses working in a secure environment. The overall study has drawn out the factors that can be said to determine the 'constituents' of resilience in this context, referred to above as influencing factors. These 'constituents' can be applied to practice contexts by nurses, nursing administrators and senior managers, to support the enhancement of resilience in the professional context, as discussed in the final chapter. The factors influencing resilience that were identified through analysis of the interviews are *management of emotions, teamwork, understanding and work life balance.* A discussion of the possible applications to practice is in Chapter Seven.

7 Discussion and application to practice



This chapter provides a critical discussion of the findings of the research and the contribution that this study makes to the area. Because the study was carried out in a secure environment caring for patients with a diagnosis of personality disorder, the findings are discussed in relation to research in this challenging area of mental health nursing. Reflections on the use of mixed methodology are discussed, and applications to practice are drawn from the broader findings of the study. Six recommendations have been made to develop practice in this area.

The aims of the study were to explore aspects of resilience as experienced by mental health nurses in a high secure service, using a mixed methods approach.

Mixed methodology was used to meet the following objectives:

- To identify resilience profiles in this environment, using a validated tool;
- To explore the lived experience of nurses related to resilience, using analysis of semi structured interviews and
- To develop a concept analysis of resilience in this environment using data gathered by the first two methods.

The findings from the resilience questionnaire provided a profile of the resilience of nurses working in the high secure personality disorder services, showing that the majority of the respondents felt in control, enjoy a challenge, work to achieve goals and take pride in their achievements. The characteristics of ‘hardiness’, ‘bounce back’ and ‘cognitive appraisal’ emerged as key characteristics associated with resilience.

This supports the findings of Jackson *et al* 2007 who identified that resilient people are able to see the positive aspects and potential benefits of a situation, and is in agreement with the characteristics of resilience found in other research (Tugade and Frederickson 2004, Bonanno 2004, Frederickson 2004). Nurses who responded to the questionnaire indicated that having at least one relationship that helps when they are stressed was important, which echoes the interview findings where participants described the need to talk things over, and how helpful they found this.

The semi-structured interviews were analysed using IPA, and four superordinate themes influencing resilience were found. These were the management of emotions, teamwork, understanding and work life balance. A set of constituent and subthemes was identified, which provided new insights into what helps nurses to work in secure environments with personality disordered patients.

While these two methodologies could legitimately be used in separate individual studies, the intention was to develop an in-depth understanding of resilience from a number of different approaches; leading on to a concept analysis of resilience. The motivation behind this intention was to provide greater depth of understanding, moving on from description to theory development. The concept analysis was developed using the new empirical data along with existing literature, which has provided a robust evidence base for the findings.

The three main findings of the study are that resilience in this staff group is composed of hardiness, that is the withstanding of adverse experiences; then 'bouncing back' or resuming shape; supported by cognitive appraisal or understanding of the adverse event. Essentially, staff need organisational support and assistance with developing ways of managing difficult experiences with patients, systems that promote recovery, and the educational and supervisory support to help understand and process the effects on them.

These findings are discussed under the following headings: new understandings in relation to existing literature, working with personality disorders, reflections on the research design-strengths and limitations of the study, application to practice and future studies.

7.1 New understandings in relation to existing literature

This study has focussed on the factors that influence the resilience of mental health nurses, rather than on those areas which may contribute to workplace stress. When participants in the study were asked to discuss what they feel helps them to cope at work, they initially found it difficult to articulate this. After reflecting on difficult and negative experiences, they were more able to describe what helps; and what elements of the workplace environment they found supportive and have come to rely on. This supports the suggestion that resilience is developed through experiences that may have been challenging and potentially traumatising, and not necessarily through achievements or successes. Previous research has supported the concept of an inoculating effect of working through adversity, which can

enhance resilience levels over time (Bonnano 2004, Waller 2001). This approach also suggests that resilience is not an inherent characteristic of personality, but is a learnt approach to adversity, influenced by individual and systemic factors.

Lack of supportive networks has been cited as a source of stress in ward based mental health nurses (Sullivan 1993, Edwards and Burnard 2003). Taylor and Barling (2004) explored sources and effects of carer fatigue and burnout for mental health nurses and found a variety of influencing factors: employment insecurity, issues with management, inadequate resources, problems with other professions, aggressive patients, physical and emotional constraints of the work setting, nurse to nurse relationships and horizontal violence. Taylor and Barling (2004) pose a pessimistic view in their paper, citing an inability to influence change, even though research findings have consistently highlighted these issues.

Many papers propose that there should be some attention given to solutions, although these proposed solutions are presented as fairly generalised systems issues. Difficulties in working relationships between co-workers and with senior nurses were found in an American study by Trygstad (1986) and it was suggested that horizontal and vertical working relationships were the most important determinant of stress in mental health nurses. Taylor and Barling (2004) suggest that nurses should have access to regular open communication forums, and that the influence of nurses in management should be increased by attaining seniority and increasing representation. Currid (2009) stated that nursing staff need support from managers, and that support groups and clinical supervision may be helpful. Edwards *et al* (2003) conducted a systematic review of research published on stress and stress management interventions for mental health nurses, and concluded that there is much known about the occupational stress of mental health nurses, but a lack of research on the impact of interventions that try to ameliorate or minimise some of the stressors.

It may be that in a stressful working environment, team approaches and a supportive management culture are key issues; and in the current study one of the four themes that fostered resilience was teamwork. This teamwork theme encompassed a feeling of entitlement to support, the expectation that others would notice when support was needed, and mutual trusting relationships. In this study supportive working relationships both between staff and with managers were cited as helping nurses to cope in the workplace, and staff felt a sense of entitlement to this support.

Clearly there is a need for some translation of research findings into practice both for the individual benefit of nursing staff but also to enable services to provide quality care for patients. McElfatrick *et al* (2000) suggested designing supportive interventions for mental health nurses based around their own coping strategies. It may be realistic to accept that there are inherent stressors in the work of mental health nurses, and to look for ways of tackling the issues at a number of levels systemically.

In the current study, staff described maintaining hope and optimism in working with patients who have challenging interactions and behaviours. An acceptance of the difficulty was shared amongst the whole team, and there was a shared awareness that other members of the team would understand the difficulties and support other staff with coping and problem solving. This can be seen in terms of 'communal coping' (Lyons *et al* 1998) where there is a shared appraisal of stress, and a shared 'action orientation' towards managing the stressor. This has been suggested as a key factor in the resilience of social units (Reid *et al* 1996). A defining characteristic of communal coping is a shared understanding and appraisal of the stressor, and crucially a shared responsibility for acting to reduce the stress (Lyons *et al* 1998). This element was observed in the staff interviews where staff and managers noticed the stress reactions of other staff, and intervened to provide support. There was an expectation and a sense of entitlement to supportive input from others, which appeared to come from an explicit understanding that the work itself was stressful. The element of 'management of emotions' has two main aspects; using emotional intelligence to manage challenging situations, and an approach to providing care to others that protects the staff member from becoming overwhelmed by the intensity of the patients' emotions.

Salovey and Mayer (1990) defined emotional intelligence as 'the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions' (Salovey and Mayer 1990 p.189). It was suggested that the characteristics of emotionally intelligent people; which are being aware of the feelings of themselves and others, and being able to label them and communicate them; can contribute to wellbeing by successful regulation of their own emotions and the emotions of others. Bar-On (2006 p.13) uses the phrase 'emotional-social intelligence' to describe the ability to recognise, understand and regulate one's own emotions and the emotions of others. This is based in the ability to be self-aware, understanding of personal strengths and weaknesses,

and being able to express feelings and thoughts non-destructively. Interpersonally, this means being able to be aware of others' emotions, feelings and needs, and being able to establish and maintain cooperative and constructive relationships. Bar-On (2006) proposes a set of skills and competencies that can be learned and measured, and suggests that the model could be used in employment settings to enhance organisational effectiveness in recruitment, succession planning and training. In a study on emotional intelligence and resilience, Frajo-Apor *et al* (2015) found a small positive correlation between emotional intelligence and resilience in mental health professionals caring for patients with serious mental illness, suggesting that emotional intelligence may be a potential target for education and training to build resilience.

Recommendation 1:

The social-emotional intelligence model should be used to identify skills and competencies in new staff working in secure mental health environments, and to enhance and develop the skills of existing staff.

7.2 Working with personality disorders

Caring for patients with a personality disorder is noted in the literature as being particularly challenging and demanding for mental health nurses (Murphy and McVey 2003, Bowers 2002). Much of the existing research has focussed on the challenges of working with patients with a diagnosis of borderline personality disorder (Wright, Haigh and McKeown 2007, Westwood and Baker 2010, Bodner *et al* 2015, Dickens *et al* 2015, Dickens *et al* 2016). These studies have highlighted attitudes and behaviours of mental health nurses towards patients with borderline personality disorder, with Dickens *et al* (2015 p.23) finding that mental health nurses have 'relatively poor attitudes' to these patients. Hinshelwood (2002) recommended that all staff working with personality disordered patients should have training in the awareness of the feelings that are engendered in the work, and should be supported in working through these feelings. Hinshelwood does not suggest any mechanism for putting this into practice, however results of this study support this principle, and could be translated into a set of workplace interventions. Wright, Haigh and McKeown (2007 p.244) call for 'reclaiming the humanity in personality disorder', noting that negative terminology was used by a range of academic course attendees when describing people with

personality disorders, with a common ambivalence towards the person with the diagnosis of personality disorder.

Murphy and McVey (2003) identified that nursing personality disordered patients is more demanding than any other area of mental health nursing, highlighting five core areas of difficulty: patients are perceived as more demanding and less rewarding than others, initial training does not educate nurses in working with personality disorders, conflict and traumatisation are common in nursing these patients, and there are specific skills and qualities required. It is suggested that a key difference between resilience and 'coping' or 'survival' in mental health nurses is in the ability to maintain a therapeutic optimism, and retaining the ability to develop meaningful therapeutic relationships. If a mental health nurse is unable to provide these elements, they cannot be said to be resilient, but merely 'surviving' in the workplace (Shattell 2004, Sabo 2006, Stickley and Freshwater 2006). If mental health nurses are attending work with a reduced ability to engage with patients, this could be seen as a form of presenteeism (Johns 2010), where people are turning up for work but feel unable to work to their full potential. In working with patients diagnosed with a personality disorder, the quality of the relationship is thought to be the most important predictor of therapeutic outcomes (Clarkson 2003, Livesley 2003). Risks to the organisation of staff that are unable to engage therapeutically would include a reduced quality of service to patients, and potential reduction in retention of staff.

These previous studies have focussed on identifying the issues and challenges, followed by generalised recommendations about what may help nurses to work more positively with personality disordered patients. The maintenance of hope and optimism about the patients' progress was related by participants in this study as important to them in maintaining their resilience, linked to their understanding of personality disorders. Interpersonal challenges and intense negative emotional expressions were accepted and understood, and staff were able to describe 'moving on' to a more positive frame of mind and interaction through their understanding and acceptance. When reflected against a body of research that has shown that clinicians believe those with the diagnostic label of personality disorder to be more difficult to manage than mentally ill patients (Lewis and Appleby 1988, Newton-Howes *et al* 2008, Murphy and McVey 2003) it is suggested that the results of this study could be used to support positive working with personality disordered patients, that is in helping staff to

accept the inherent challenges and providing mechanisms to support their resilience in working with this patient group.

Insights from this study into how staff manage to maintain resilience in working with this patient group illustrated how important it was to manage their own emotions and boundaries, become used to experiencing challenging situations and recovering; have effective team working with time to reflect and process issues; ensure they looked after their own wellbeing and work life balance. This is underpinned by an understanding of the nature and presentation of patients with a personality disorder.

These findings are conceptualised in the three constituents of resilience in this staff group identified, which are hardiness, bounce back and cognitive appraisal.

<u>Recommendation 2</u>

Nursing staff working with patients with a diagnosis of personality disorder should be educated about the nature and presentation of the disorder.

<u>Recommendation 3:</u>

The key individual skills that staff working with patients with a diagnosis of personality disorder should be supported to develop are:

- managing their own emotions and boundaries;
- becoming used to experiencing challenging situations and recovering;
- developing the ability to reflect and;
- looking after their own wellbeing and work life balance.

7.3 Reflections on the research design - strengths and limitations

The target population in this study was nurses working in a high secure environment. The staff worked in the secure personality disorder service in a high secure hospital in England. This group of staff was chosen in conjunction with a need identified by the host service, who identified that the service management as a whole would find it useful to know more about resilience in staff working with this patient group. The high secure personality disorder

service is known to present challenges to staff working in the environment, with associated management issues of recruitment, training, retention and wellbeing.

The patient group will have had an influence on the staff concerned, and although there is a substantial amount of research, previously cited, on the challenges of working with personality disorders, one of the key features of the patient group in this study was that they were well known, having a length of stay measured in years rather than weeks or months. While this could be seen to limit findings to the unique environment of personality disorder services, the findings can also be seen as contributing new knowledge to support the development of resilience in staff working with longer stay patients with challenging behaviours.

Whilst the illustration of the lived experience of resilience of nurses in the secure environment derived from analysis of the semi structured interviews forms the bulk of the empirical data, the mixed methodology design of this study was intended to provide a depth of understanding of the concept of resilience. While each research method used has its own internal validity and therefore potential application to other similar populations, the intention of the study was to use the application of a mixed methodology approach to ensure robustness and validity.

The questionnaire respondents make up approximately 16% of the total nursing staff group, and cannot be seen as a truly random sample of nurses in this environment. It is not possible to ascertain in which direction the sample may be biased, and it may be that those nurses who responded are a more resilient group. The location of the service in a semi-rural setting will have had an influence on the diversity of cultural mix amongst the staff, in contrast to an urban area. There is nevertheless a reasonable spread of answers, using this well-validated questionnaire. The resilience questionnaires were completed by staff who had all worked in the service for more than six years, with 21 of the 25 respondents having worked for more than 10 years. While this is a self-selected sample, it is encouraging that there are staff with this level of retention in a service that is by its nature challenging to work in. The level of resilience reported was equivalent to a ‘normal’ population (Connor and Davidson 2003). However there were higher resilience scores for more senior staff, of whom nine out of ten had worked there for more than ten years, suggesting that there may be elements of the workplace that have contributed to their resilience.

Recommendation 4

The organisation should use this as a pilot study, and use the resilience questionnaire to enable wider learning about resilience in this staff group.

The sample size in the interviews analysed using IPA is in line with the suggestion of Smith *et al* (2009) of between four and ten interviews. Smith *et al* (2009) do not proscribe an optimum number for IPA interviews, but suggest that a creative analysis of between four and ten should be sufficient to explore a topic in depth. The aims of IPA are to produce an in-depth analysis that tells the reader something interesting about the individual's experience, rather than to produce findings that are generalisable to other populations. The double hermeneutic of IPA supported this, allowing the staff to offer their interpretation of the experience of resilience, and for the meaning of their interpretations to be understood by the researcher (Smith *et al* 2009). Healthcare professionals are the intended audience of this research, and their understanding of resilience in mental health nursing and secure environments can be enhanced by the findings, which may then be applied to practice.

Developing a concept analysis required the researcher to pick up the threads of information from the qualitative and quantitative methods that pointed to resilience, and synthesise these with available literature. This was a challenge, and although the process of concept analysis proposed by Walker and Avant (2005) has an accepted structure, applying the model required that the researcher became immersed in the material and ensure that all elements were incorporated. Many previous concept analyses of resilience in nursing research have used the existing literature (Dyer and McGuinness, 1996, Garcia-Dia *et al* 2013, Gillespie *et al* 2007, Earvolino-Ramirez 2007) to inform the concept analysis, and the empirical data from original research in this study provides a depth of understanding not previously evident in other studies.

Reflexive writing was used throughout the research, from the development of interview questions to analysis. This helped to maintain as much objectivity as possible, using journal writing to distinguish between reflections and analysis when working with the interview transcripts. This was particularly relevant because the researcher had many years' experience in working in secure mental health environments, and it was important to try to ensure that this prior knowledge did not influence the outcomes or interpretation of

interviews, and/or to recognise when it did. The approach to ethical issues and positionality has been discussed in chapter 3 (3.2).

7.4 Application to practice

A shift in society's approach to research in resilience has been seen since events of 11 September 2001 (Bonanno *et al* 2006) the more recent global terrorism threat and natural disasters (Speckhard 2002, Kilmer *et al* 2010, Mc Entire 2015).

Models of workplace wellbeing and intervention are emerging that recognise the stresses on their workforce, and provide tailored interventions for prevention and intervention (Kirk and Brown 2003, Amati and Vohra 2008, Spence-Laschinger and Fida 2014). For example, the US military has pioneered a programme to invest in and develop resilience in military personnel, entitled 'comprehensive soldier fitness' (Cornum *et al* 2011). A concept analysis of resilience in military personnel was carried out (Simmons and Yoder 2013) which was then used to develop a comprehensive resilience building programme in the US military. This is a service wide strategy that provides an individual assessment, universal resilience training, and then individual resilience training based on a set of individual scores. This approach is supplemented with 'master resilience trainers' who are non-commissioned officers with day to day contact with soldiers, and are trained to enhance the resilience of others.

The United Kingdom has a strategy for mental health care of military personnel (British Army 2015) which involves measures to reduce risk and increase awareness of mental health issues, and a system called 'Trauma Risk Management' (TriM) which aims to identify staff at risk of developing post-traumatic stress disorder symptoms, and provides support and interventions.

A focus in the United Kingdom on mental health awareness by charities such as the Mental Health Foundation and Mind has been to try to reduce stigma associated with mental health disorders generally, and this direction has been extended to include mental health in the workplace. A programme of research, intervention and evaluation was instigated by MIND (MIND 2015), following research that shows high levels of mental health problems in emergency services personnel (Collins and Gibbs 2003, NICE 2005, Bennett *et al* 2004). This MIND 'blue light' programme has developed an awareness package to support a workplace

approach to challenging stigma about mental health issues, and promoting positive wellbeing within the workplace in emergency services.

The Health and Safety Executive (HSE 2004) produced a strategy in 2004 for the reduction of work related stress, and provides clear management standards that are intended to promote a high level of health, well-being and organisational performance, which has some correlation with this approach (HSE 2004) . The Health and Safety Executive was part of a European Union focus on healthy workplaces in 2014-2015, and one of the HSE priorities for 2017/2018 is to establish and begin a three-year programme to reduce levels of work-related stress, and other occupational ailments (HSE 2017).

Jackson *et al* (2007) conducted a review of the concept of resilience in nurses as a strategy for responding to workplace adversity, and recommended that resilience-building should be included in nurse education and that professional support and mentoring should be encouraged. They conclude with a recommendation that the characteristic elements of resilience in nurses and how they can be developed should be studied (Jackson *et al* 2007). Eren and Sahin (2016) called for studies that investigate the emotional reactions and attitudes of mental health staff towards people with personality disorders and the influence of these factors on treatment outcomes.

The findings of this study can be used to inform the workplace strategies that support staff in working with people with personality disorders. In a study by Itzhaki *et al* (2015) of mental health nurses' exposure to work related violence, it was shown that staff resilience is a factor that could be important in mental health nurses' ability to cope with demanding situations. The findings of this current study suggest that a resilience-building model would be beneficial for mental health nurses working in secure environments, based on the new knowledge and concept analysis that has been developed.

The organisation where the study was carried out has a comprehensive policy that provides guidance to managers on preventing work related stress and ensuring staff well-being, and this guidance is structured to link to the areas identified in the HSE management standards referenced above. It is suggested that the findings of this study could be used to support the development and implementation of workplace strategies and guidance such as this, by providing a model of resilience whereby the effects of the workplace on mental health

nurses can be understood, and interventions to support resilience could be tailored. One suggestion from staff in this study suggested rotation of work environments may help, noticing that maintaining positivity in the same workplace was very challenging.

The HSE (2004) work related stress management standards are shown below in Table 11, along with possible applications of these research findings. Each element of the standards was considered and reflected against the findings of the study. The interview analysis has been the source of much of the possible applications, and the theme identified in the IPA analysis around working relationships, demands, support and role have been mapped readily to the HSE categories.

Table 11 HSE work related stress management standards

HSE 2004	Applications
Demands	Workload, work patterns and the work environment. **Application: Possible rotation, working in consistent teams, ensuring breaks are taken, space away from clinical areas, gym equipment available.**
Control	How much say the person has in the way they do their work.
Support	This includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues. **Application: team culture, supervision, visible managers, encouraging personal wellbeing.**
Relationships	This includes promoting positive working to avoid conflict and dealing with unacceptable behaviour. **Application: fostering trust, supportive relationships, maintaining hope.**
Role	Whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles. **Application: understanding of staff roles and the nature of the patients' presentation and its possible effects, support to manage emotion generated by difficult interactions**

Change	How organisational change (large or small) is managed and communicated in the organisation.

A systems approach might be the development of policies that would assist in prevention of stress, minimising the effects of stress, and assistance for those who are experiencing the effects of stress. A study of resilience in mental health clinicians (Edwards and Warelow 2005) suggested that resilience as a coping strategy may help staff to deal with changes, reframe negative experiences and create positive outcomes. Edwards and Warelow (2005) suggest that these insights could be used to assist in training, recruitment and retention and selection of staff. The theme of investing in resilience as a helpful concept is further developed by Zarea *et al* (2012) whose research suggests that mental health nurses need to become more empowered by 'learning new ways of coping, such as seeking social support, accepting responsibility, considering escape or avoidance, thoughtful problem solving, learning positive reappraisal and attaining psychological hardiness' (Zarea *et al* 2012 p.704).

The notion of risk and protective factors with regard to resilience was examined by Jenson and Fraser (2005) and they suggested that protective factors can reduce or buffer the impact of risk, interrupt a chain of risk factors that may be present, or prevent the onset of a risk factor. In this study it is suggested that the themes presented through the analysis of the research interviews could be regarded as protective factors in the workplace. Two key questions are what do mental health nurses need protecting from; and what might be the benefits of resilience in their workplace?

If it is understood and accepted that the essential elements of mental health nursing are rooted in the therapeutic relationship, the findings of this study add to the knowledge about what helps staff to work positively, given that carer fatigue and burnout has been cited as presenting significant risks to working effectively with challenging patients. Studies of staff burnout in secure environments have described emotional exhaustion, depersonalisation, and withdrawal from patients (Oberlaender *et al* 1999, Nathan *et al* 2007, Chung and Harding 2009). Jalil *et al* (2017) found that nurses who were exposed to repeated verbal aggression of a humiliating or demeaning nature were more likely to be provoked to anger than those who experienced physical aggression, and suggested that nurses need help to regulate their emotions to specific types of aggression.

Training and development could be tailored to meet the needs of staff at different levels, and the concept of a ‘master resilience trainer’ could be introduced. These could be key members of staff who have received an enhanced level of training in emotional intelligence and resilience building, whose role includes enhancing resilience in other staff. These interventions could be woven into the HSE ‘management standards’ structure, to provide a more comprehensive organisational approach. Robertson *et al* (2015) reviewed workplace resilience training programmes and found that employees reported improvements in mental health and wellbeing as outcomes. Pipe *et al* (2012) found that resilience-building interventions in a nursing staff group were effective in reducing the experience of stress. Sarkar and Fletcher (2017) propose a framework for workplace resilience training and emphasise that content and delivery need to take the working context into consideration, and is more likely to be successful if the facilitators show a depth of understanding about the working environment.

A systems approach to embedding the promotion of resilience would complement the strategic approach to promoting staff well-being and minimising workplace stress, both in this organisation and in the wider health service. The results of this study will be fed back to the host organisation and may be used to inform further training, policies and support developments for nursing staff.

Recommendation 5

Senior management should incorporate measures of staff resilience as part of existing management strategies to promote well-being.

7.5 Future studies

As this study used a combination of three methodologies, each with their own results; any one could be utilised individually to increase the range and/or depth of findings. The early findings were presented to a group of professionals in the host organisation, as part of a continuing professional development afternoon. Part of the feedback was that the staff group were very experienced and used language that was part of the culture of the original unit set-up. It was suggested that it would be very interesting to replicate aspects of the research on new starters, or staff that had worked in the unit for less than one year, and contrast their experiences. The hospital has started to develop new systems to support staff

in managing challenging situations and recovering from assaults and the new insights from these findings could be used to develop resilience building interventions, which could then be implemented and evaluated.

Replication of the study in other environments, including in other patient groups and levels of security, would also extend understanding of what helps staff to maintain wellbeing in other environments. This study was carried out in an environment where all the patients were male. Previously cited research has shown that nursing staff working with women in secure environments showed that burnout increased significantly over time in staff in female medium secure wards, manifesting in emotional exhaustion and depersonalisation. Exploring aspects of resilience in these environments would be very worthwhile, and could be used by organisations to aid retention.

Recommendation 6

Exploration of resilience in nursing staff working in other environments including in other patient groups and levels of security should be carried out, to extend understanding of what helps staff to maintain wellbeing in secure environments.

7.6 Conclusion

This study has been an exploration of resilience in mental health nurses working in a secure mental health environment. As a result of this study, new insights into what helps nurses working in a secure environment have been produced. The themes of managing emotion, team working understanding and work life balance are illustrated as contributing to the resilience of nurses working in this challenging environment. Developing hardiness, the ability to bounce back and having a good understanding of the patient group and their challenges are the concepts that an organisation can use to develop and target interventions to support staff in working well.

Six recommendations are offered which can be applied to develop practice in this area:

Recommendation 1

The social-emotional intelligence model should be used to identify skills and competencies in new staff working in secure mental health environments, and to enhance and develop the skills of existing staff.

Recommendation 2

Nursing staff working with patients with a diagnosis of personality disorder should be educated about the nature and presentation of the disorder

Recommendation 3

The key individual skills that staff working with patients with a diagnosis of personality disorder should be supported to develop are:

- managing their own emotions and boundaries;
- becoming used to experiencing challenging situations and recovering;
- developing the ability to reflect and;
- looking after their own wellbeing and work life balance.

Recommendation 4

The organisation should use this as a pilot study, and use the resilience questionnaire to to enable wider learning about resilience in this staff group.

Recommendation 5

Senior management should incorporate measures of staff resilience as part of existing management strategies to promote well-being.

Recommendation 6

Exploration of resilience in nursing staff working in other environments, including in other patient groups and levels of security should be carried out, to extend understanding of what helps staff to maintain wellbeing in other environments

An overarching personal aim was to give voice to the experience of nursing staff working in difficult circumstances. Far from being an abstract concept that some people possess, resilience has been found to stem from everyday processes and interactions, and from the

'ordinary magic' (Masten 2001 p.235) of normal human resources, and it is hoped that some of these findings can help nursing staff in these environments to "leave it at the gate".

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Appendices

Appendix A research permission

19/05/2015

Dear Carol

Letter of Access Research site: Nottinghamshire Healthcare NHS Foundation Trust

As an existing Niche Patient Safety employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is responsible for ensuring such checks as are necessary have been carried out. This letter confirms your right of access to conduct research through **Nottinghamshire Healthcare NHS Foundation Trust** for the purpose and on the terms and conditions set out below. This right of access commenced on **19/05/2015** and ends on **30/09/2015** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation.

You are considered to be a legal visitor to **Nottinghamshire Healthcare NHS Foundation Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **Nottinghamshire Healthcare NHS Foundation Trust**, you will remain accountable to your employer but you are required to follow the reasonable instructions of your nominated manager in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance **Nottinghamshire Healthcare NHS Foundation Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **Nottinghamshire Healthcare NHS Foundation Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on

Nottinghamshire Healthcare NHS Foundation Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises
as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.
You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.
Nottinghamshire Healthcare NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.
You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.
We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.
If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.
Yours sincerely
Shirley Mitchell

Head of Research and Development

Appendix B consent form

CONSENT FORM

Title of Project:

A concept analysis of resilience in nursing staff in secure environments

Principal Researcher:

Carol Rooney BA RMN MSc

NB. This form should be read in conjunction with the information leaflet provided.

	Please initial under Y or N	Y	N
1	I confirm that I have read and understand the information sheet dated May 2015 for the above study and have had the opportunity to ask questions		
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason		
3	I understand that that any information given by me will remain confidential except if someone is at risk of harm		
4	I understand that the interview will be recorded using a digital voice recorder		
5	I agree to take part in the above study		

Participant's Name………………………………………………
Participant's Signature…………………………………………….
Date…………………………….
I confirm that I have explained the nature of the study, as detailed in the information leaflet, in terms, which in my judgement are suited to the understanding of the subject.

Signature of Researcher……………………………………Date ………….

Appendix C sample interview analysis

File: Dave.MP3 Duration: 0:32:21 Date: 01/09/2015 **Emergent themes**	**Original transcript** 1. management of emotions 2. teamwork 3. Understanding 4. work life balance	**Exploratory comments**
struggle to define it stress mgment I think it changes you Toughen up	Interviewer: Okay, Dave, I'll just go through a few questions, but hopefully it will become more of a conversation. So, have you had a stressful experience at work? Dave: Yes, quite a few. Interviewer: Yes, anything in particular that stands out that you could tell me about? Dave: Personally at work? Interviewer: Yes. Dave: I've been assaulted a number of times. Interviewer: Have you? Dave: Yes. I think it's just work in general, it can give you a high stress environment sometimes. The patients you have to deal with. Sometimes, as well, that's another thing that can place extra stress on you. Interviewer: Right. Dave: So, yes. Interviewer: Could you think about a particular situation, or certain situations, what sort of thing helps you recover from the stressful experience? Being assaulted sounds a very difficult experience, you're hurt as well. What helps you recover? Dave: I think supporting peers helps, definitely helps. But, I think it's the personality as well, what sort of personality you are and how resilient you are to stresses. After a while, personally, I think you become slightly desensitised to certain situations, situations that people would gasp at, it becomes part of the norm, in this environment. I think it does change you. I've definitely changed since I started working here. Personally, I think it's a job you can either do or you can't do. Interviewer: It has interesting parts; I'm trying to understand what makes that	Personality , desensitised, I think it changes you people would gasp, to us its the norm Seeing horrific stuff, having to deal with it

	difference. You've mentioned that you've changed, how do you think you've changed? Dave: I think just some of the things I've seen. I mean, I'm ex-forces and I think that prepares you, well, it prepared me for a lot of life skills. I think having to deal with and see some of the stuff, horrific stuff, that goes on in this environment, before, I experienced it.	
Numb, tough, changed	Until you've done it, until you've actually seen it first hand, nobody knows how they're going to react. I think it's changed my outlook in becoming numb to certain things, whereas, before I'd be quite shocked. Now, nothing, very much, shocks me now, having seen some of the things I've seen. So, yes, it has changed me. I think personality-wise as well, it's changed me. My wife said I've changed since working here, not necessarily for the better, not necessarily for the worse. It just it does affect you, because you spend quite a lot of time working with people who have severe problems. They're not my problems and sometimes it can be quite horrific and I think I've changed.	Numb to things, nothing shocks me Wife said I've changed , not better or worse Spending time with people with severe probs. Def not my problems Can be short tempered, quick to snap, notice- it does change you
Teamwork	I can be short-tempered sometimes, at home. Sometimes I can be quick to snap and I think you have to take a step back and just take stock of things, because it does change you, it does change you, sometimes, without even realising it.	
Brave face	Interviewer: What sorts of support systems are there in the hospital? Does the hospital help or hinder?	
Team support	Dave: I've had quite a traumatic year, this year. Interviewer: Have you? Dave: Yes. My wife was diagnosed with kidney cancer early on this year. Interviewer: I'm sorry. Dave: The support structure here, it's been very good, actually, to tell you the truth, they have helped out a lot. They are good at some things and they're not as good at other things as well. That's my experience. Sometimes, they need to give more support to people after serious incidents at work. Sometimes, I feel that they do nothing. A lot of us put a brave face on after something's happened and we do have supervision days. But, it's very rare that people take those supervision up, in my experience. Interviewer: Do you have supervision? Dave: Yes, I do a supervision when I feel it's needed. You're supposed to have supervision as an ongoing process, every month, but sometimes you're that busy, you get that focussed on helping out on the ward and managing the ward and	
Put yourself on the back burner,	everything else that you sometimes put yourself to the back burner.	Good support, debriefs rare

focus on the pt Supervision Teamwork Security Personality ?	I think that's when people start getting more stressed because it just keeps building up, building up, building up, until there comes a point where you can't function. I've experienced it at (XXX). So, yes, support for me, from my wife, has been very good, very good, I can't complain about that. Likewise, on the other hand, when you have to deal with something serious, sometimes that support structure has been lacking, because everybody's been focussed on the patient and not necessarily how it's affected the staff around them. Interviewer: Is there anyone that can be called on to come and do either an initial debrief or then individual time with people? Dave: Well, ideally, after a serious incident, you've got a Post Incident Review, which should be 72 hours, straight after that incident. I know about that because I used to be an MVA instructor. It's very rare that I've had PIR. Interviewer: Is it? Dave: Very rare. Likewise, sometimes things get put on the back burner and they start focussing more on the patient care and not so much on how it's affected the staff around them. Usually, if somebody's affected quite severely by it, they usually end up going sick. Interviewer: So, you may not get to a 72 hour review or debrief in time, so what happens with your feelings around that, or your experience? Dave: You just rely on one another. One of the lads, today, has thanked me, because he's been targeted by one of the patients here. But,actually just giving him support at that time, so I think, in a way, you just help one another. It's a team environment, so you get a lot of support from your peers. Interviewer: Right, so the team is important. Dave: Yes, the team's very important. Everybody goes through it at some stage, it doesn't matter who you are, everybody needs that support. I think it's just a natural thing that occurs. There have been times when I've said, "Look, I need to get away from here," and the team have said, "Yes, fine, get yourself off for how long you need to, get your head sorted." Interviewer: Just take some time off to walk off the floor. Dave: Yes, so I've done that before, in the past. So yes, I think the team is very important, to get you over certain experiences. Interviewer: Does the environment help? Dave: This environment? Interviewer: Yes. The physical environment. Dave: No. Yes, there are doors and there are fences, but sometimes, even if	Builds up until you can't function You just rely on one another Support for peers, team Doors, fences, sometimes you feel you can't escape it

	you're outside the environment, in another room, you're still inside the environment, you're still there. There are still reminders, so yes; sometimes you feel like you can't escape from it, it's always there. It's part and parcel of the job, isn't it? That's why I look at it, it's one of those jobs, you can either cope or you can't cut it.	Some people seem to cope, push on, personality ?
	Interviewer: Yes and I suppose it's the distinction of what makes a difference, really. Is it your personality? Dave: Yes, I think a lot of it is personality, yes. I've seen people come in here for less than a week and they're good people, but they just can't cope with it, whereas, other people just seem to just push on by, just manage the situation and just get cracked on with it. So, yes, I think it's down to the personality of the person.	
Asking for help	Interviewer: Their personality? Dave: Yes. Definitely down to the personality of the person. Interviewer: Does the way that you cope with change over time as you get more experienced? Dave: Yes. Interviewer: What sorts of changes? Dave: I think, me personally, I'm not frightened of saying, "Right, I'm feeling stressed out here, I need to go and see a doctor," or whatever, for something specific, whereas, before, I would not have even dreamt of doing that. But I know how much mental stress this place can put people under. It's not physical; it's all mental, because you're constantly bombarded all the time.	Not frightened to ask for help
Look after yourself outside	But, there's got to come a tipping point, where you've got to say, "Enough's enough, I need help." But, it's that realisation when you need to say it, before it does get worse. Some people have got that and other people haven't. It just comes to a point where they're just drained or something, I don't know.	Look after yourself outside of work too Family, kids, dog , friends Sport , gym
leave it at the gates	Interviewer: Do you do things outside of work to look after yourself? Dave: Yes. Interviewer: What sorts of things? Dave: I spend a lot of time with the family. I've got three kids, a wife, a dog, so family is very important to me. I play a lot of sports, go to the gym. There's a lot of recreational and just do things that I want to do. I do a lot of running around for the kids and that's my main focus, it just gets me away from thinking about this place. I think, sometimes, you've got to be able to switch off from it. Work's work and home's home and don't take your work home with you, that's what I've learnt.	Work's work & homes home, leave it at the gates 2 separate lives
Physical	Whatever you do, leave it outside the front gates. I've got two separate lives, one's	

Training Change	here and one's there. Interviewer: Okay and you do that? You can leave it? Dave: Yes. Interviewer: Yes, not take it home. Dave: Yes. It's very rare. Sometimes, I have a really stressful day, I'll have a drink when I get in, but otherwise I don't drink much, I don't smoke and I keep myself healthy. Interviewer: Healthy? Dave: Yes, that's the main thing. I coach rugby and that's a big thing for me. It just gives me something to focus on. Interviewer: When you started, did you have an induction? Dave: Yes. Interviewer: Was it helpful? Dave: Yes, it was. I've worked on four wards now. Interviewer: Different parts of the hospital? Dave: No, always on the XXX. I started from AAA, three years on AAA, three years on BBB, three years on CCC, now I'm here. Interviewer: Are they quite different to each other? Dave: Well, three treatment wards and one HDU, High Dependency Unit, which is BBB. But, the three wards are very similar and one, very different. Interviewer: High Dependency. Dave: Yes. Interviewer: Does it help to change around? Dave: For me, yes. I mean, the majority of people on the unit know me anyway, so I can fit virtually straight onto a ward without any trouble. It's just one of those things, isn't it? Some people have only been on one ward, whereas me, I've been on four wards. I must be either very good at my job or very crap at my job. Interviewer: Has the training you've had been helpful? Dave: Yes, especially, I've been down at MVA for 4 years. Interviewer: Oh, were you? At the training centre Dave: Yes, before I had the job, I was ___. That helps, that has helped a lot. Like I said, people see you in a different context, I think, as well. I think they know who I am and what I'm like to work with and that's the main thing. Likewise, I don't have any problems fitting in anywhere, really. Interviewer: Yes. So presumably you do mandatory training. Dave: Mmm.	Keep healthy Rugby coach Training Change wards is good , training helps a lot its hard to get away tho

Its physical , you have to accept it Put personal differences aside,	Interviewer: And you've obviously had the MVA training, but is there other training that's available for you? Dave: Yes. Sometimes, I think it's very hard to get away from here. Interviewer: To be released, you mean. Dave: Yes, to be released. I think that sometimes you have to fight your corner, which is annoying sometimes, because sometimes I feel like people just see you as an NA, they really see anything else you can do until you actually do it. Interviewer: Right. Dave: Yes and that's the annoying thing sometimes that people aren't familiar with skill set. It's like, I've got a teaching qualification and I've got a Higher National Diploma in Business and Finance, but nobody knows these things. I've told people and they go, "You do your job, that's it, you get on with it." Sometimes you feel you've more to give than what you're doing in this environment. I think sometimes it's hard to step away from that, partly because sometimes you feel you get comfortable where you are and other times, you don't feel like you're getting the opportunities for people to see a different side of you. After my wife's cancer, she had an operation, I had an eight-week spell across the CRB, I don't know if you know where the CRB is, it's the learning centre, it's where they do all the education. I really enjoyed it. Part of the skills I've got, it's quite teaching orientated and that's what I enjoy doing. Maybe some time down the road, I might look into that further. Interviewer: Did you stop being an MVA instructor? Dave: Yes, because I've had too many shoulder operations, so I'm hoping to get back into it. Whether they release me or not, that's another thing as well. Yes, my shoulder's fine now. Interviewer: Right, so it's quite physical. Dave:Yes, it's quite physical. It is what it is, I got injured. It's part of life, isn't it, you've just got to accept it, there's no point in crying over spilt milk, you've just got to get on with it. Interviewer: It's quite a physical job then, between training and injuries, being assaulted as well. Dave: Yes, there have been quite a few injuries. I think the older you get, as well, the more prone you are to picking up injuries. I tore a hamstring a few weeks ago. It is what it is and it's like saying,, I mean, some days you're not fighting them all the time or being physical with them all the time, that's only a small part of it. But, sometimes things are quite serious. The majority of the time, 90% of the time,	Its physical , you have to accept it Spilt milk, you have to get on with it

some people cant	you’re just looking after the day-to-day. Interviewer: How do you keep caring with all that going on, because it’s hard, it’s challenging, quite stressful at times? Dave: How do you mean? What, with the patients? Interviewer: Yes, the patients, how do you keep caring for them?	
	Dave: Sometimes it’s tough, but you have to think, at the end of the day, all I think is, “I’ve got a duty of care towards them,” that’s my job, that’s what I’m employed for, that’s what my role is. You’ve got to put any personal differences aside. It is tough. Some people can’t do that; some people take it personally, whereas I don’t. Interviewer: Right. Dave: Whereas I don’t, I just think of it as a job that you’ve come to, you’ve got to do and when you leave, you leave, that’s it.	Duty of care, its tough –but thats my job
Verbal abuse, no point taking the emotion with you	Interviewer: When someone’s verbally aggressive or physically aggressive, in a way that, to me, would shock people ordinarily, you don’t take it personally, how does that work in your head? Do you just know it’s not about you? Dave: No, I don’t think well, “You’re not speaking to me as me,” because sometimes it does affect you. I think, if it was continuous, it would affect you more, but two days down the line, the patient could be quite civil and quite normal towards you.	Put personal differences aside, some people cant I don’t take it personally
	Interviewer: You don’t hold it against them? Dave: No. Sometimes you have to hold it at the time and that’s usually the case, sometimes you have to really reign it in at the time, but after that, it’s just like, “Okay, it’s another day at the office,” you just carry on as normal. Interviewer: Right.	Verbal abuse, no point taking the emotion with you you have to hold it at the time
Managing emotion, no grudges	Dave: There’s no point taking the emotion with you, hurtful things. It doesn’t help at the end. It doesn’t help your therapeutic relationship with people. Some patients, you’ve got a better therapeutic relationship with. It’s like anybody in life, some people you can talk to, some people you can’t talk to. I’m very much, “If you’re all right with me, I’m all right with you.” I always think you should be firm but fair and treat everybody the same and that’s the way I look at things. Interviewer: Right, so it’s your own view of the world. Dave: It’s my own view of the world, yes, definitely. Interviewer: And people.	we can’t be taking it personally , you wouldn’t be human if you didnt feel . then 2 day later everything back to normal
Knowing don’t take it home	Dave: Yes. Like I said, we can’t go taking it personally. There have times where you think you’re close to stabbing them. You wouldn’t be human if you didn’t feel like it. But, like I said, two days down the road, everything’s normal. You’re serving dinner, if they want something put on the phone or arrange all the jobs they can’t do	

	themselves, then you do it to help. Interviewer: I'll move on, to talk about what helps you let it go. Dave: I don't know. For me, personally, I think, like I said before, I don't take it home with me. It's separate. I separate work from home life. Interviewer: Okay. Dave: Yes, it's always a case of, "Right," you know. I don't think, "Well, it's a job," I don't think that, it just happens. It's just one of those things that just happens and I can't put my finger on why I don't take it personally. Interviewer: No, but you're describing quite a good balance. Dave: Yes, I think you need a good balance, personal and work life. It's when you start getting the balances wrong, that's when trouble happens.	Separate work from home life . cant put my finger on why I don't take it home
not reacting as much as some people good balance, personal and work life	Interviewer: Yes, you could say it's not an easy job. Dave: It's not. People say, "I don't know how you can do it." It is what it is. Like I said before, you can either manage it or you can't. But, I don't know what the difference is between different personalities; people who can work here and who can't work here.	
	Interviewer: No, no. It's interesting, I don't think it's one thing, well, it isn't one thing. Dave: No. Interviewer: But, yes, it would be interesting to say- Dave: Yes, there must be some similar trait in a person, there has to be some sort of common denominator to say, "That person can function in an environment like this," compared to somebody else. Whether that's being somewhat emotionless, I don't know, or whether that has something to do with it. Interviewer: Right, yes. Emotionless, presumably you don't mean not having emotions, do you mean not reacting? Dave: No, not reacting so much as somebody who's-, I mean, my wife, she's very emotional sometimes and sometimes things will affect her, I'm thinking, "Really?" Whereas, me, it's a case of, well, it wouldn't really affect me at all. So, I don't know. I don't know whether it's your physical or your mental make-up, I don't know, I really don't know.	good balance, personal and work life It's when you start getting the balances wrong, that's when trouble happens. Traits, maybe somewhat emotionless- not reacting as much as some people
Caring for then duty of care, not caring personally	Interviewer: It's interesting though, isn't it? Dave: Yes. Interviewer: Because there's something about surviving, not just surviving, as well. Surviving could be that you just come to work and are a bit emotionless at work, because you have to actually care, don't you?	

Giving people care, rather than caring Boundaries, PD interactions Not being pulled around by emotions Boundaries The line gets drawn	Dave: Mmm. Interviewer: So, it's interesting. You have to keep a caring face on, or a caring way of being with the patients. Dave: I don't know. There's caring, then there's a duty of care, which, in my mind are two different things. Do I care personally for them? No. Interviewer: Okay. Dave:No, but have I got a duty of care towards them? Yes. And that's the way I look at it. I'm friendly towards them, but I'm not their friend. That's the way I rationalise things with them. I've seen it before; where those…..	Caring for then duty of care. Not caring personally , friendly but not their friend (boundaries) Giving people care, rather than caring Not being pulled around by emotions, separate, apart Not getting drawn into their personal world The line gets drawn at becoming part of their experience

PD interactions Teamwork Stress starts to show		No rotation Stress starts showing after a while Team, self-perpetuates, runs itself Some days it feels like a battle , those are hard days

Appendix D interview questions

Interview questions

1. Have you had a stressful experience at work?
2. Can you tell me about it?
3. How did you get through it?
4. What helps you to recover from difficult work situations, at work or outside work?
5. Have your strategies changed as you have become more experienced?
6. How do you carry on caring for patients?
7. What do you do to look after yourself when you are away from work?
8. What support is there for you at work?
9. Is it formal or informal?
10. How does the hospital help you to keep caring?
11. Is there anything particular about your workplace that helps you keep going?
12. Did you have an induction and was that helpful?
13. What training is provided, and is it helpful?
14. How do you think the hospital could help you to do your job?

Additional questions for managers:

15. How do you support your staff?
16. What made you become a manager?
17. What experience of working in this area did you have before becoming a manager?
18. What management training or development have you had?