SURVIVING AND THRIVING IN THE FACE OF WORKPLACE ADVERSITY: AN INTERVENTION TO IMPROVE PERSONAL RESILIENCE IN NURSES AND MIDWIVES

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy University of Western Sydney

© Glenda Elizabeth McDonald

June 2010
Dedicated to the participants of this study, whose generosity of
spirit, commitment and support for this work inspired me to
follow my instincts and undertake research that would
ultimately mean something to them

“The Lord said...Leave your country, your people and your father’s household and
go to the land I will show you...Lift up your eyes from where you are and look north
and south, east and west. All the land that you see I will give to you…”
- Genesis 12, 13

The familiar life horizon has been outgrown:
The old concepts, ideals, and emotional
patterns no longer fit; the time for the
passing of a threshold is at hand.
- Joseph Campbell
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I am deeply grateful to my study participants for entrusting me with your stories, and for your whole-hearted participation in the study. I hope this work honours your contribution.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not previously submitted this material, either in full or in part, for a degree at this or any other institution.

_____________________
Glenda McDonald
Outcomes of this thesis

Publications


Conferences/ Research dissemination

11th – 14th April 2010: Attendance and presentation at the 3rd International Nurse Education Conference, Sydney

Podium presentation: An educational intervention to promote personal resilience in nurses and midwives.

2nd-4th June 2009: Attendance and presentation at the University of Western Sydney’s College of Health and Science Research Futures Postgraduate Forum

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Podium presentation: Continuing connections: fostering mentoring relationships between retired and working nurses and midwives.

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TABLE OF CONTENTS

Dedication.................................................................................................................. i
Acknowledgements..................................................................................................... ii
Statement of Authentication....................................................................................... iii
Outcomes of the thesis ............................................................................................. iv
Table of Contents...................................................................................................... v
List of Tables............................................................................................................. x
List of Figures.......................................................................................................... x
Thesis Abstract........................................................................................................ xi

CHAPTER 1: INTRODUCTION
Abstract................................................................................................................... 1
1 Introduction............................................................................................................. 2
1.2 Study Background............................................................................................. 3
1.3 Purpose of the Study......................................................................................... 5
1.4 Research Questions.......................................................................................... 5
1.5 Significance of the Study................................................................................ 6
1.6 Definitions of terms used in this thesis.......................................................... 7
1.7 Thesis structure................................................................................................ 8
1.8 Summary........................................................................................................... 9

CHAPTER 2: LITERATURE REVIEW
Abstract................................................................................................................... 10
2.1 Introduction....................................................................................................... 11
2.2 Workplace Adversity in the Contemporary Nursing Context....................... 12
2.3 Causes of Workplace Adversity....................................................................... 12
2.4 Working Conditions......................................................................................... 12
  2.4.1 Extended Hours.......................................................................................... 13
  2.4.2 Casualisation of Nursing and Midwifery workforce.................................. 14
  2.4.3 Workplace Autonomy............................................................................... 15
  2.4.4 Staff Support............................................................................................ 16
  2.5 Work Environment....................................................................................... 18
  2.5.1 Heavy workload....................................................................................... 18
  2.5.2 High physical demands........................................................................... 19
    2.5.2.1 Shift work........................................................................................... 20
  2.5.3 Low personal satisfaction....................................................................... 20
  2.5.4 Autonomy................................................................................................ 21
  2.5.5 Working relations.................................................................................... 23
  2.5.6 Workplace bullying and aggression....................................................... 24
  2.6 Daily challenges faced at work.................................................................... 26
    2.6.1 Quality of patient care............................................................................. 27
    2.6.2 Role overload........................................................................................ 28
    2.6.3 Adverse events and medical errors....................................................... 29
    2.6.4 Work injuries........................................................................................ 29
      2.6.4.1 Use of pain medication................................................................. 30
  2.7 The Effects of Workplace Adversity on the Wellbeing of Nurses and
    Midwives......................................................................................................... 30
    2.7.1 Work stress............................................................................................ 31
    2.7.2 Respect and recognition...................................................................... 32
    2.7.3 Physical health of nurses and midwives.............................................. 33
  2.8 Personal Resilience....................................................................................... 34
2.8.1 Introduction………………………………………………………………………… 34
2.8.2 Personal Resilience in the Contemporary Nursing Context………… 35
2.8.3 Hardiness………………………………………………………………………… 36
2.8.4 Nurturing Positive Networks and Relationships…………………… 37
   2.8.4.1 The Role of Mentoring………………………………………………… 39
2.8.5 Maintaining a Positive Outlook……………………………………………… 41
2.8.6 Intellectual Flexibility………………………………………………………… 44
2.8.7 Emotional Intelligence………………………………………………………… 45
2.8.8 Work Life Balance……………………………………………………………… 47
2.8.9 Spirituality……………………………………………………………………… 48
2.8.10 Reflective and Critical Thinking………………………………………… 50
2.9 Work-based learning programs…………………………………………………… 51
2.10 Justification of this study…………………………………………………………… 52
2.11 Summary……………………………………………………………………………… 54

CHAPTER 3: METHODOLOGY AND METHODS

Abstract………………………………………………………………………………………… 55
3.1 Introduction……………………………………………………………………………… 56
3.2 Methodology……………………………………………………………………………… 56
   3.2.1 Case Study Design…………………………………………………………… 57
   3.2.2 Case studies in research literature………………………………………… 59
3.3 Collective Case Study………………………………………………………………… 60
   3.3.1 The current study…………………………………………………………… 62
3.4 Research Study Design……………………………………………………………… 65
   3.4.1 Phase 1: Pre-Intervention…………………………………………………… 67
      3.4.1.1 Recruitment of nurse/midwife cases………………………………… 67
      3.4.1.2 Qualitative Interviews………………………………………………… 67
   3.4.2 Phase 2: Intervention………………………………………………………… 68
   3.4.3 Phases 3 and 4: Post-Intervention………………………………………… 68
      3.4.3.1 Phase 3: Immediate Post –Intervention………………………… 68
      3.4.3.2 Phase 4: Six Months Post-Intervention…………………………… 68
3.5 The Setting……………………………………………………………………………… 69
   3.5.1 Ante-natal Ward……………………………………………………………… 70
   3.5.2 Delivery Suite………………………………………………………………… 70
   3.5.3 Post-natal Ward……………………………………………………………… 70
3.6 Entering the Field……………………………………………………………………. 71
3.7 Participants…………………………………………………………………………… 71
   3.7.1 Recruitment………………………………………………………………… 71
   3.7.2 Participants for each cycle………………………………………………… 73
      3.7.2.1 Cycle 1…………………………………………………………………… 73
      3.7.2.2 Cycle 2…………………………………………………………………… 74
3.8 Data Collection……………………………………………………………………… 74
   3.8.1 Pre-Intervention Phase: Qualitative Interviews……………………… 74
      3.8.1.1 Field notes……………………………………………………………… 75
   3.8.2 Post-Intervention Phases: Qualitative Interviews…………………… 76
3.9 Management and Analysis of Data……………………………………………… 76
3.10 Ethical Process and Practice…………………………………………………… 78
   3.10.1 Consent…………………………………………………………………… 79
   3.10.2 Confidentiality……………………………………………………………… 79
   3.10.3 Respectful treatment of Participants…………………………………… 81
3.11 Limitations to the Method………………………………………………………… 81
CHAPTER 4: SETTING THE SCENE: PARTICIPANTS’ EXPERIENCES OF WORKPLACE ADVERSITY

Abstract

4.1 Introduction

4.2 Participants

4.3 Difficult interactions with colleagues, management and clients

4.3.1 Difficult interactions with colleagues

4.3.1.1 Lack of teamwork

4.3.1.2 Bullying

4.3.1.3 Nursing hierarchy

4.3.1.4 Difficult interactions with physicians

4.3.1.5 Lack of interpersonal communication skills

4.3.1.6 Ineffective conflict resolution

4.3.2 Difficult interactions with management

4.3.2.1 Difficult interactions with the NUM

4.3.2.2 Interactions from management decisions

4.3.3 Difficult interactions with clients

4.4 Lack of support and recognition

4.4.1 Lack of support/recognition from colleagues

4.4.2 Management’s lack of support for nurses and midwives as clinicians and workers

4.4.3 Lack of support/recognition from ‘outside influences’

4.5 Workload and work pressure

4.5.1 Aspects of workload

4.5.2 Aspects of work pressure

4.5.2.1 Dissatisfaction with quality of care

4.6 Work/life imbalance

4.7 Summary

CHAPTER 5: WORKPLACE ADVERSITY: ITS IMPACT AND RESOLUTION PRE-INTERVENTION

Abstract

5.1 Introduction

5.2 The Impact of Workplace Adversity Pre-intervention

5.2.1 The impact of exhaustion and shift work

5.2.1.1 Coping with shift work

5.2.2 The impact of emotional labour on relationships

5.2.3 The impact of stress

5.2.3.1 Coping with stress

5.2.4 The impact on general health, diet and exercise

5.2.5 The impact on fulfilment and commitment to stay

5.3 The Resolution of Workplace Adversity Pre-intervention

5.3.1 Organisational initiatives for resilience

5.3.1.1 Autonomy

5.3.1.2 Nature of work

5.3.2 Collegial support and resilience

5.3.3 Personal initiatives for resilience

5.3.3.1 Support from significant others

5.3.3.2 Self-care

5.4 Summary of the pre-intervention phase
CHAPTER 6: THE INTERVENTION: DEVELOPMENT AND IMPLEMENTATION

Abstract .................................................................................................................. 162
6.1 Introduction .................................................................................................... 163
6.2 Development of the Workshops................................................................. 163
6.3 Learning goals and outcomes .................................................................... 164
6.4 Adult Education Philosophies....................................................................... 170
   6.4.1 Andragogical approach ........................................................................ 170
6.5 Learning Materials ....................................................................................... 171
6.6 Learning Activities ....................................................................................... 172
   6.6.1 Collaborative Learning Activities ....................................................... 172
   6.6.2 Self-reflective Learning Activities .................................................... 173
   6.6.3 Creative Learning Activities ............................................................... 173
   6.6.4 Therapeutic Learning Activities ....................................................... 174
6.7 Implementation of the Workshops ............................................................. 180
   6.7.1 Participation Rate .............................................................................. 181
   6.7.2 Format and Content of the Workshops .............................................. 181
6.8 Forming the group....................................................................................... 182
6.9 Participant Reflections on the Intervention ............................................... 186
6.10 Development of the Mentoring Program ................................................ 188
6.11 Mentors ..................................................................................................... 188
   6.11.1 Recruitment of Mentors ................................................................. 190
   6.11.2 Cycle 1 Mentors ............................................................................. 191
   6.11.3 Cycle 2 Mentors ............................................................................. 192
6.12 Mentors Information Day ......................................................................... 193
6.13 Matching Mentoring Partners ................................................................... 194
6.14 Ongoing Support of Mentors ................................................................... 195
6.15 Mentor Reflections .................................................................................... 196
6.16 Challenges of the Intervention .................................................................. 197
6.17 Recommendations .................................................................................... 200
6.18 Summary .................................................................................................. 201

CHAPTER 7: POST-INTERVENTION FINDINGS

Abstract ................................................................................................................. 202
7.1 Introduction .................................................................................................. 203
7.2 Building, strengthening and maintaining resilience ..................................... 205
7.3 The Mentoring Program ............................................................................. 205
7.4 Personal gains from the mentoring program ............................................. 206
   7.4.1 Confidence in solving problems ....................................................... 206
   7.4.2 Receiving support and friendship .................................................... 207
   7.4.3 Gaining a role model and confidential advisor ................................ 208
   7.4.4 Withstanding workplace adversity .................................................. 209
   7.4.5 Benefits for vulnerable nurses and midwives ................................. 210
7.5 Professional gains from the mentoring program ........................................ 211
   7.5.1 Increased assertiveness ..................................................................... 211
   7.5.2 Greater professional networks......................................................... 212
   7.5.3 Raised self-esteem and sense of value ............................................. 213
   7.5.4 Career development/progression ..................................................... 213
   7.5.5 Taking on new challenges in the workplace ................................. 215
   7.5.6 Renewed passion for nursing/midwifery ......................................... 216
7.6 The Workshop Program ............................................................................. 217
7.7 Personal gains from the workshop program

7.7.1 An experiential learning opportunity

7.7.2 Creative self-expression

7.7.3 Exposure to new ideas and strategies

7.8 Professional gains from the workshop program

7.8.1 Increased assertiveness at work

7.8.2 Improved workplace relationships and communication

7.8.3 Increased collaborative capital

7.8.4 Understanding self-care

7.9 Personal resilience initiatives

7.9.1 Letting harmful emotions go

7.9.2 Nurturing supportive relationships

7.9.3 Contributing to the resilience of colleagues

7.9.4 Re-defining resilience and setting new standards

7.9.5 Awareness of self and resilience

7.10 Impact of resilience on health and wellbeing, fulfilment and Commitment to stay

7.11 Resilience and health and wellbeing

7.12 Resilience and fulfilment

7.13 Resilience and commitment to stay

7.14 Meanings of resilience

7.15 Defining resilience

7.16 Making meanings of resilience through creative expression

7.17 Summary

CHAPTER 8: DISCUSSION

Abstract

8.1 Introduction

8.2 Building resilient nurses and midwives

8.2.1 Knowing about the personal attributes of resilience

8.2.2 Regaining hope and a positive outlook

8.2.3 Developing self-care and improving health and wellbeing

8.2.4 Improving individual practice with personal resilience

8.2.5 Creating authenticity

8.3 Nurses and midwives who thrive and their personal resilience

8.4 Nurses’ and midwives’ perceptions of resilience

8.5 Building a better workplace with personal resilience

8.5.1 Building effective communication in the workplace

8.5.2 Building support networks in the workplace

8.5.3 Building collaborative capital with improved personal resilience

8.5.4 Building personal fulfilment with work through personal resilience

8.6 Building personal resilience through a work-based intervention

8.7 Conclusion

8.8 Summary

CHAPTER 9: CONCLUSION

Abstract

9.1 Recapping the findings

9.2 Implications for nurses and midwives

9.3 Implications for nursing managers and health care organisations

9.4 Recommendations for future research

9.5 Limitations of this study
9.6 Strengths of this study ................................................................. 283
9.7 Summary ................................................................................... 283
REFERENCES ................................................................................ 285
APPENDICES .................................................................................. 314
Appendix A Summary of Research Literature .................................... 315
Appendix B Ethics approval letters ................................................... 319
Appendix C Study poster and brochure (participants) ....................... 322
Appendix D Participant Study Information package ............................ 325
Appendix E Pre-intervention Phase Interview Schedule ..................... 331
Appendix F Immediate Post-intervention Interview Schedule ............. 333
Appendix G 6months Post-intervention Interview Schedule ............... 335
Appendix H Poem ............................................................................ 337
Appendix I Participant Evaluation Form ........................................... 338
Appendix J Mentoring agreement ..................................................... 340
Appendix K Mentor Selection Form ................................................ 341
Appendix L Mentor Recruitment Flyer ............................................. 342
Appendix M Mentor Study Information package ............................... 344
Appendix N Mentors Information Day program ............................... 350
Appendix O Participant Awards List ................................................ 352
Appendix P Participant creative artworks ....................................... 353
Appendix Q Participant representations of resilience ....................... 355
Appendix R Participant personal shields ........................................ 356

LIST OF TABLES
Table 3.1 Demographic Profile of Local Government Area (LGA) ........ 69
Table 3.2 Cycle 1 Participants .......................................................... 73
Table 3.3 Cycle 2 Participants .......................................................... 74
Table 4.1 Participant Information ..................................................... 85
Table 4.2 Overview of Pre-intervention findings ................................ 86
Table 4.3 Themes of Difficult interactions in the workplace ............... 87
Table 4.4 Themes of Difficult interactions with management ............ 100
Table 4.5 Themes of Lack of support and recognition ..................... 106
Table 4.6 Themes of Workload and work pressure ......................... 114
Table 5.1 The Impact of Workplace Adversity Pre-intervention .......... 129
Table 5.2 Themes of the Resolution of Workplace Adversity Pre-intervention 151
Table 6.1 Overview of Intervention Workshops ............................... 166
Table 6.2 Learning activities of the intervention ............................... 175
Table 6.3 Cycle 1 Mentors ............................................................... 192
Table 6.4 Cycle 2 Mentors ............................................................... 192
Table 7.1 Overview of Post-intervention Findings ........................... 204
Table 7.2 Themes of Building, strengthening and maintaining resilience 205
Table 7.3 Sub-themes of Personal gains from mentoring program .... 206
Table 7.4 Sub-themes of Professional gains from mentoring program 211
Table 7.5 Sub-themes of Personal gains from workshop program ....... 217
Table 7.6 Sub-themes of Professional gains from the workshop program 221
Table 7.7 Sub-themes of Personal initiatives for improved resilience .... 225

LIST OF FIGURES
Figure 1 Research Design for Participants ..................................... 66
ABSTRACT

The problems caused by the worldwide nursing shortage, generally negative workplace experiences and deficits in health and wellbeing are recognised aspects of nursing and midwifery in the contemporary nursing workplace. The deleterious effects causing many nurses and midwives to become disillusioned and dissatisfied with the realities of nursing work are attributed to workplace adversity. Low retention rates have been a characteristic of the nursing and midwifery workforce for some time. The necessity of exploring additional ways of halting the harsh effects of workplace adversity by developing, strengthening and maintaining personal resilience has instigated the current study.

An integral part of this thesis was a work-based, educational intervention comprised of workshops and a mentoring program to enhance the personal resilience of the participants. A major premise of the study was that the devised intervention could assist nurses and midwives to enhance and maintain their personal resilience. The study used a collective case study methodology to guide the deep exploration of a group of nurses’ and midwives’ perceptions about their experiences of both workplace adversity and personal resilience in a specific women’s and children’s health setting. Qualitative, semi-structured interviews and field notes were used to gather the insights of fourteen nurses and midwives who volunteered to participate. Data were collected over four sequential phases in two cycles. Insights were also collected from twelve mentors regarding their experiences and understandings of mentoring the study participants. For the purpose of analysis, all participant insights from both cycles were combined to form a collective case. Findings emerged from participant
narratives and were categorised by an inductive analysis process. Categories and themes were used to draw substantive descriptions of the phenomena under investigation.

Major study findings were in relation to building resilient nurses and midwives and better nursing workplaces. The study findings indicate there were a number of substantial personal and professional benefits perceived from developing, strengthening and maintaining resilience. Professionally, most participants felt more autonomous in their careers, ready to take on workplace challenges and were more hopeful about their futures in nursing and midwifery. Increased resilience was demonstrated through assertiveness and enhanced self-esteem. Improved workplace relationships, communication and collaboration were perceived to have resulted from the positive experiences of mentoring partnerships and the guiding influence of mentors.

Significant participant outcomes from the intervention in the personal sphere were also found. Positive changes were characterised by new ideas and strategies of self-awareness, self-monitoring and self-care. Personal resilience initiatives were found to impact on the previously experienced negative outcomes of workplace adversity. Improved individual practice was indicated by resilient thoughts, attitudes and behaviours. Creating authenticity emerged as an important aspect of personal fulfilment that assisted the growth of resilience. An important finding was the role of personal resilience on positive perceptions of general health and wellbeing, sense of fulfilment at work and commitment to stay.
The experiential and creative techniques provided in the intervention led to meaningful definitions and interpretations of personal resilience. Working creatively provided an innovative access point for participants to analyse their current perspectives on health and wellbeing and to explore individual ways to reduce stress and develop the protective characteristics of resilience. Successful mentoring partnerships established for the first time between senior and retired nurses and midwives and the study participants emphasised the uniqueness of the study intervention.

This study provides understandings about the efficacy of a work-based intervention to enhance resilience on reducing workplace adversity in a stressful and challenging workplace. The study findings suggest one way of intervening in the current situation of lost nursing knowledge and experience through dwindling retention rates and early retirement due to workplace adversity. It is hoped that the understandings gained from this thesis will make a significant contribution to research knowledge. This thesis offers both individual and organisational strategies for developing, strengthening and maintaining the personal resilience of nurses and midwives at any stage of their nursing career and despite the presence of workplace adversity.
CHAPTER 1: Abstract

This chapter introduces the principal concepts of this research study, workplace adversity and personal resilience in the Australian nursing and midwifery context. There are global concerns about the problem of workplace adversity, the term given to the various negative outcomes associated with working amidst the current environmental conditions and challenges of the nursing workplace. The chapter presents the study’s main focus of using an educational intervention of workshops and mentoring to investigate the phenomena of personal resilience as a protective mechanism against workplace adversity. The research framework is a collective case study of a group of nurses and midwives working in a women’s and children’s health service in Australia. The background and significance of the study is explained and the thesis structure outlined.
CHAPTER 1: Introduction

1.1 Introduction

Workplace adversity is understood to be one of the primary reasons nurses and midwives fail to flourish in the workplace, and eventually leave nursing. The major elements of workplace adversity in a nursing context are the negative and dissatisfactory features of working conditions, the work environment and the daily challenges faced by nurses and midwives in the course of their work. The phenomenon of workplace adversity also includes the impact on physical, mental and emotional health and wellbeing.

Nurses and midwives work in environments of organisational change that contribute to workplace adversity, and generate perceptions of the workplace as being potentially damaging to employees. Research studies have outlined the number and variety of organisationally-induced sources of workplace adversity that can result in negative health outcomes for workers (Borges & Fischer 2003; Budge, Carryer & Wood 2003; Hutchinson, Vickers, Jackson & Wilkes 2006; Pryce, Albertsen & Nielsen 2006). Organisational change frequently leads to resistance and anxiety which can take shape as illness (Morante 2005). This thesis describes an intervention including workshops and mentoring partnerships to build the personal resilience of a group of nurses and midwives working in adverse conditions.

There are few studies that investigate personal resilience as a strategy to heighten nurses’ and midwives’ abilities to withstand workplace adversity. This chapter presents the conceptual elements of this research study: developing and maintaining personal resilience in the face of workplace adversity through an educational work-based intervention, in the context of the contemporary Australian nursing workplace. This thesis will build on workplace adversity research already conducted and explore more about effective ways to reduce negative outcomes through increased personal resilience. The main impetus of this thesis is to extend understandings about personal resilience in nurses and midwives by exploring the potential of education and development to enhance personal resilience.
1.2 Study Background

The shortage of experienced nurses and midwives is one of the major challenges currently facing health care provision. Health care organisations in particular have unique features that make them challenging environments for workers, as they are large and almost constantly changing (Speedy 2004). In Australia and globally there is continuing research interest in the nursing workplace due to the ongoing shortage of nurses and midwives. The current situation of nursing deficit seems likely to continue for some time to come (Duckett 2005). This shortage has been linked to the organisational factors that make up workplace adversity: heavy workloads, pressured work environments, lack of autonomy and recognition, interpersonal conflicts, workplace bullying and poorly managed organisational structures and policies such as conflict resolution procedures (Boychuk Duchscher & Cowin 2006; Hutchinson et al. 2006; Joiner & Bartram 2004; Pryce et al. 2006).

Despite the climate of adversity that characterises the nursing workplaces many nurses and midwives choose to remain in nursing, continue to survive and even thrive. A primary focus of this investigation was the role that maintaining personal resilience played in enabling some nurses and midwives to offset the negative aspects of their workplace; in fact to thrive where others had not even survived. This thesis proposed that these nurses and midwives may have greater personal resilience than those who were less able to cope with workplace adversity and that personal resilience may have been a key factor in their successful coping. A deeper understanding was sought of how experienced nurses and midwives used their personal resilience to counteract the effects of working in a physically demanding and stressful environment. Discovering the beliefs and attitudes that informed their protective strategies and methods could contribute to improving the current situation of falling nursing retention rates and maintaining a healthy and effective nursing workforce.

Personal resilience describes the capacity to withstand significant change or adversity (Jacelon 1997; Wagnild & Young 1993). In this study the current ways that the personal resilience of nurses and midwives is understood informed insights about the relationship between resilience and general health, wellbeing, fulfilment and
commitment. A number of identified key traits of resilient people, namely hardiness, hope, self-confidence, resourcefulness, optimism, flexibility, emotional insight, emotional intelligence, reflection and a positive outlook were already identified in the research literature (Jackson, Firtko & Edenborough 2007). These characteristics informed the development of the intervention workshops and assisted the selection of mentors.

There has been theoretical discussion of resilience in nursing research, and of the relationships between resilience and particular variables such as work-related stress in health care professionals (McAllister & McKinnon 2008). This study represents progress in the exploration of personal resilience in a workplace or occupational context and required a work-based approach. This study was one of very few that included an organisational perspective in targeting the needs of nurses and midwives coping with workplace adversity. This meant the approach to the study acknowledged that both organisational elements, as well as individual changes in nurses and midwives, were required for improving the nursing workplace and reducing the harsh effects of workplace adversity.

The research literature of recent years has provided some indications about how the resilience of nurses and midwives can be understood (Gillespie, Chaboyer, Wallis & Grimbeek 2007; McAllister & McKinnon 2008; Perry 2008). New findings and insights continue to be discussed about the influence of resilience on such areas as staff support, autonomy and the health and workability of nurses and midwives (Lundman, Jonsen, Norberg, Nygren, Fischer & Strandbergis 2010). This current study continued the research focus on the influence of workplace adversity and resilience on the personal aspects of nursing work.

The current study included an educative intervention with the aim of using innovative strategies to engage nurses and midwives in learning about personal resilience. There have been previous efforts made to engage nursing students in their learning through experiential means. Nurse education programs have long included arts and humanities to teach students about a number of key nursing concepts, such as health, illness, caring and empathy (Darbyshire 1994; Jackson & Sullivan, 1999; Johnson & Jackson, 2005). The focus of these programs was on increasing nursing students’
insights relating to human experiences, and by doing so improve their nursing practice. The current study provided the potential for implementing a learning program that would use arts and humanities to inform the reflections of the study participants, working nurse and midwives, on their own personal resilience. The study intervention was an engaging and creative learning experience, one that drew from various sources of art, media, language, creative and expressive therapies, traditions of spirituality and caring, philosophies of living well and shared personal experiences.

Many mentoring programs have been implemented in nursing and midwifery over the past decade (Davis-Dick 2009; Gordon 2000; McKinley, Denise & Pettrey 2004; Mills Francis & Bonner 2008). Their outcomes have established the role of mentoring in the growth and development of nurses and midwives. It has been claimed an important prerequisite for mentors was their tacit knowledge and experience with the organisational culture of nursing that they could pass on to other nurses and midwives (Bally 2007). There is a need for further research to determine more fully the benefits for mentees of utilising the knowledge and expertise of senior and retired nurses and midwives as mentors.

1.3 Purpose of the study
The major purpose of this instrumental collective case study is to extend current understandings of the personal resilience of nurses and midwives amidst the presence of workplace adversity, and to explore the potential of a work-based intervention to enhance their ability to deal with the challenges associated with working in the current nursing workplace.

1.4 Research questions
The thesis will explore these research questions:
- What are the characteristics of workplace adversity present in the case setting and how is the phenomenon experienced by the collective case?
• Why are some nurses and midwives surviving, and even thriving, in a difficult and challenging workplace environment?
• What can the benefits of personal resilience bring to reducing the effects of workplace adversity, maintaining health and wellbeing and increasing fulfilment and commitment?
• How does a work-based, educative intervention affect the development, strengthening and maintenance of resilience in nurses and midwives?

1.5 Significance of the Study
This study provided a multi-layered range of values and benefits, from an individual to organisational level and beyond. It was anticipated that, on an individual level, it would provide the participants with new information and learning experiences and opportunities to reflect on and strengthen their own personal resilience. In terms of the progression of research discourse, it would provide up to date, reliable and current findings about the personal resilience of nurses and midwives and its effects on general health and wellbeing, sense of fulfilment and commitment to stay. The findings will provide recommendations for relevant improvements to the nursing work environment that may increase retention and lower recruitment costs. It was also important to provide information about the nature and extent of surviving and thriving in the Australian nursing workplace, and encourage a more sensitive and proactive approach to resilience in the workplace. Finally, the study would provide a valid model for building personal resilience that may help address the acute shortage of nurses and midwives in Australia and abroad.

This study extended current knowledge about best practice in resilience training by virtue of the work-based intervention at its centre, one that showed potential as a valuable learning experience that assisted participants in both professional and personal spheres. The thesis also extended knowledge and understanding of a specific case of nurses and midwives working in a women’s and children’s health setting, revealed more about the scope of personal resilience and its potential to assist them in the contemporary nursing workplace.
1.6 Definitions of terms used in this thesis

The following definitions of terms are important in the context of this thesis:

**Resilience**: The capacity of individuals to cope successfully and avoid the potentially harmful effects of significant change, adversity or risk.

**Workplace Adversity**: The cluster of negative, stressful, traumatic or difficult situations or hardships stemming from working conditions, the work environment and the daily challenges encountered in an occupational setting.

**Registered nurse (RN)**: A person licensed to practise nursing by the relevant registration board. Entry requirement is a bachelor degree or higher qualification in nursing.

**Registered midwife**: A registered nurse who has successfully completed the prescribed course in midwifery and is licensed to practise as a midwife by the relevant registration board. Midwives work in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period.

**Endorsed Enrolled nurse**: An enrolled nurse works under the direct or indirect supervision of a registered nurse, to monitor the impact of nursing care, provide support and comfort and help with daily living activities. Where state law, organisational policies and education allow, enrolled nurses may administer prescribed medications or monitor intravenous fluids.

**Clinical Nurse Specialist**: A registered nurse who has extensive experience and knowledge in a specialist area of nursing, who contributes to leadership, nursing skills and ongoing development nursing skills in the workplace.

**Mentor**: A person who takes the role of critical friend and supporter of a younger or less experienced person in a mentoring relationship.
**Mentee:** A person who is supported by a mentor in reaching their professional and personal goals through positive, productive and supportive interactions

**Mentoring relationship:** A partnership established between two people of differing levels of knowledge, skills and experience that foster professional and personal growth and development.

### 1.7 Thesis structure

This chapter, Chapter 1, presents an overview of the research study at hand and provides the study background, research aims and significance.

Chapter 2 reviews the current and past research literature that relates to workplace adversity in the contemporary nursing workplace, both here in Australia and in the international context. The chapter also reviews the research literature surrounding the concepts of personal resilience.

Chapter 3 details the research process used in this study. The underlying principles of case study method and the way it was applied in this study is discussed. Explanation and justification is given for recruitment, data collection and analysis methods. Considerations taken for ethical research practice and rigour are provided.

Chapter 4 sets out the pre-intervention findings about the participants’ experiences of workplace adversity, in both personal and workplace environments.

Chapter 5 presents the findings related to the impact of workplace adversity on the health and wellbeing of the participants, their personal enjoyment of work and retention beliefs in the pre-intervention phase of the study. The resolution of the negative effects of workplace adversity from the participant interviews is also discussed.
Chapter 6 provides an overview of the study intervention, discussing the learning goals, outcomes and activities. The chapter also details the format, content and pedagogical approach that directed the intervention. It presents the findings concerning the formation and facilitation of the group. Evaluation of the intervention by participants and mentors, and subsequent recommendations are also included.

Chapter 7 discusses the post-intervention findings related to building, strengthening and maintaining resilience, and the impact of resilience on health and wellbeing, personal satisfaction and job retention. The chapter also discusses the participants’ personal meanings of resilience and the ways meanings were constructed through creative expression.

Chapter 8 discusses the primary findings of the study and makes interpretations in light of relevant literature. The chapter will elucidate advances in research knowledge and new findings from this study.

Chapter 9 provides an overview of the entire study and presents the implications and recommendations for nurses and midwives, nursing managers and organisations, and for future research.

1.8 Summary

The current chapter sets the scene for the main premise of the research study. As the theoretical development of personal resilience and its role in the professional and personal lives of nurses and midwives continues, it is intended that this thesis will contribute to existing research knowledge. Workplace adversity continues to be a serious concern for health care organisations. Research studies that engage with finding helpful ways of counteracting its negative outcomes, such as the development and enhancement of personal resilience, provide additional hope for the reduction of this problem.
CHAPTER 2: Abstract

This chapter presents the research literature that is central to the parameters of this research study: workplace adversity and personal resilience. The discussion of workplace adversity concentrates on the three areas of work environment, working conditions and daily challenges. The literature reviewed brings together the Australian and international discourses surrounding the phenomenon of workplace adversity in contemporary nursing and midwifery. The review also discusses the capacities associated with personal resilience, including past and present perspectives of ten characteristics contained within the concept. In addition, this chapter will present relevant research findings regarding work-based learning programs in nursing and midwifery. This section of the review will seek to elucidate programs that complement the research aims in the current study: exploring and developing strategies of coping well in a stressful workplace. The chapter concludes by placing this study within the research discourse, identifying research gaps and justifying this investigation.
CHAPTER 2: Literature Review

2.1 Introduction

A large body of research literature surrounds the two main themes of this thesis – the causes of workplace adversity and the development and maintenance of personal resilience in individuals. The cluster of negative outcomes experienced by workers in the workplace is termed workplace adversity. This term describes aspects of the working environment, conditions or challenges faced by workers that are experienced as being negative, difficult or potentially harmful to feelings of wellbeing (Cline, Reilly & Moore 2003; Jackson et al. 2007). Workplace adversity has a wide range of negative effects on the health and wellbeing of nurses and midwives. Personal resilience may provide a protective mechanism against the harmful effects associated with workplace adversity. The advantages of possessing or adopting certain characteristics of resilience have been previously identified (Edward & Warelow 2005; Gillespie et al. 2007; Jackson et al. 2007; Lundman et al. 2010), which indicates that resilience may be an effective strategy for assisting nurses and midwives to mediate the difficulties they face in their workplace.

A search of the literature from 2000 to 2010 was conducted by using several terms associated with resilience, workplace adversity, work-based learning and nursing as keywords, individually and in combination. The databases searched included CINAHL Plus with Full Text, Health Business Fulltext Elite, Health Source Nursing/Academic Edition, MEDLINE and PsychINFO in the first instance. Further searches were carried out of related databases, such as the management, psychology and sociology literature. A detailed summary of the research literature relating to this study is presented in Appendix A.
2.2 Workplace Adversity in the Contemporary Nursing Context

Curbing the continuing loss of experienced nursing staff is a major challenge now facing health care providers and is set to be a major issue for health organisations well into the next decade (Duckett 2005). The major causes of nurse shortage have commonly been linked in the research literature to structural problems of excessive workload, lack of autonomy and constant organisational change (Adkins 2004; Burke 2003; Speedy 2004). There is a volume of research literature that attests to the negative effects of their work on the physical, mental and emotional wellbeing of nurses and midwives (Harrison, Loiselle, Duquette & Semenic 2002). The caring imperative of nursing and midwifery work makes the work environment both stressful and distressing; dealing as it does with illness, pain, loss, trauma and other human vulnerability. Nurses and midwives are required to participate in emotional labour as a result, which can result in several negative personal outcomes including emotional burnout.

2.3 Causes of Workplace Adversity

There are a range of factors that affect negatively on the experiences of nurses and midwives in their occupational roles. These factors are termed workplace adversity. The following review of workplace adversity literature focuses on the leading causes of workplace adversity: working conditions, work environment and daily challenges of nurses and midwives in the contemporary nursing workplace.

2.4 Working Conditions

A major cause of workplace adversity in staff of health care organisations is the working conditions. Many international research studies refer to organisational culture as a contributory factor of the contentious issues in the current nursing workplaces (see for examples: Fischer, da Silva Borges, Rotenberg, do Rosario Dias...
de Oliveira, Soares, Santa Rosa, Teixeira, Nagai, Steluti & Landsbergis 2006; Holman, Thomas & Brown 2009; Pryce et al 2006). The factors of work organisation most commonly cited as causes of stress for nurses and midwives include the extended hours, unpaid overtime, staffing provisions, shift work and lack of support (Barnes-Farrell, Rumery & Swody 2002; Button 2008; Estryn-Behar, Kreutz, Nwzet, Mouchot, Camerino, Salles, Ben-Brik, Meyer, Caillard & Hasselhorn 2005; Watson, Gardiner, Hogston, Gibson, Stimpson & Wrate 2009). Research studies have shown that unpaid overtime is a seemingly unavoidable expectation of nursing work. Australian nurses may work between one and four more hours than scheduled per shift (Dorrian, Lamond, van den Heuvel, Pincombe, Rogers & Dawson 2006). The difficulties associated with attaining an adequate balance between work and life, especially for female nursing staff, has also been attributed to their experiences of overwork and dissatisfaction (Baltes & Heydens-Gahir 2003; Brown & Adebayo 2004; Pryce et al. 2006).

2.4.1 Extended Hours

There has been an increasing drift towards working longer and extra hours in Western economies such as Australia, and nursing workplaces are no exception (Hochschild 1997; Pocock 2003). Connell (2005) found in his study of public sector workplaces that working longer hours was a response to the shortage of resources, especially long-term or chronic staff shortage; and to show one’s willingness to work in order to secure future prospects or promotion. However, working long hours has been associated with a range of health problems, including increased levels of stress and anxiety, and sleeping problems (Fischer et al. 2006). Working long hours can also have serious social disadvantages by increasing feelings of isolation and disrupting relationships (Peters de Rijk & Boumans 2009; Trinkoff, Geiger-Brown, Brady, Lipscomb & Muntaner 2006). In nursing and midwifery, extensive hours of work was one of the major causes of job dissatisfaction cited in studies of retention and staff turnover undertaken over the past decade (Borges & Fischer 2003; Cash, Daines, Doyle, von Tettenborn & Reid. 2009; Cline et al 2003). The situation has been mainly blamed on the continuing serious shortage of experienced nurses and
midwives, producing workplaces where remaining staff are required to work extra shifts, forego leave and work overtime on a regular basis.

2.4.2 Casualisation of the nursing and midwifery workforce

The numbers of Australian women taking up part-time and/or casual work continued to increase over the past several decades (Connell 2005). As household consumption rates raised dramatically, the need for and value of women’s contributions to family incomes became more significant. Changes in the caring responsibilities of women for home and family have not changed in line with added work responsibilities, despite the broad changes to the marketisation of child care (Pocock 2003). Female-dominated fields such as nursing and midwifery have reflected these overall changes in women’s work patterns. The pressure to work more hours also resulted in negative personal outcomes to do with negotiating work/life balance, high staff turnover and poor job satisfaction (Hegney, Plank & Parker 2006; Judkins & Ingram 2002).

Pocock (2003) devised a model of Australians’ work and care spheres to illustrate the links between work and domestic life. It was based on the concept of a work/care regime that resulted from the interaction between the culture, institutions and individuals’ behaviour and preferences. She argued that over time these factors influenced each other in an interdependent way and were affected by gender, state and class influences within society. Pocock believed there was a mis-alignment between institutional and cultural values and behaviour and preferences around work and care in the Australian context. She argued that a well articulated relationship between work and care spheres would benefit individuals by bringing about a “better functioning, fairer labour market, lower personal risks, and higher satisfaction (2003: 34).” It can be argued that the negative outcomes at present for both nurses and midwives and health care organisations are set in a framework of a troubled work/care regime. Further articulation of the work/care regime in health care workplaces from what is already known about the way nursing work is organised could assist nurses and midwives to achieve a greater sense of fulfilment and result in better retention results.
2.4.3 Workplace autonomy

Autonomy was another facet of working conditions shown to produce negative effects for nurses and midwives. Pryce et al. (2006) asserted that choice over the work schedule played a primary role in the relationship between health and work. They found introducing a self-scheduled roster system was effective in enhancing personal job satisfaction and co-operation between nursing staff. Their study participants reported that they were happier with their hours and less likely to change shifts. Both management and staff agreed that self-scheduling had improved staff insight into the operations of the department, the importance of utilising available resources and how these affected the maintenance of quality care. Most importantly, the self-selected system significantly increased participant work/life balance and job satisfaction. Staff choice and control over having to work longer hours affected their acceptance and produced better health outcomes than those given little flexibility or power to self-schedule (Budge, Carryer & Wood 2003; Stevens, Faragher & Sparks 2000).

Several other studies explored the relationship between workplace autonomy and health (Ala-Mursula, Vahtera, Kivimaki, Kevin & Pentti 2002; Budge et al. 2003). Ala-Mursula et al (2002) measured two types of control over work; firstly over scheduling of shifts, vacations and leave; and secondly over events such as starting and finishing times, break times and attending to private matters during work time. These researchers found that poorer health and psychological distress were most prevalent in the female participants with the lowest levels of autonomy. Ala-Mursula et al (2002) concluded that these gender-specific results were explained by two factors of the experiences of working women: they typically had a higher total workload and were less able to control their work. Connell (2005) concurred that household responsibilities concerned more women than men, and that men increased their control over work as they rose within an organisational hierarchy while women did not. These findings suggested that there may be a relationship between autonomy of work and protection against workplace adversity for women. This current study seeks to know more about relationships between personal resilience, personal autonomy and workplace adversity.
2.4.4 Staff support

Staff support has been presented in the literature as a necessary but often neglected concept of nursing and midwifery, both in Australia and abroad (Legg 2007). The term has been used in nursing research literature to signify support through diverse means, from education and training provision to professional career progression programs and workplace counselling and welfare initiatives. Research findings indicated that nurses and midwives experience high levels of personal and professional stress, often caused by a lack of staff support (Morante 2005). A national Canadian survey of the health of nurses found that approximately half of the sample felt they received low co-worker support (Canadian Institute for Health Information 2005).

However, even in the highly pressured and challenging contemporary nursing workplace, many research findings reported that collegial relationships between nurses and midwives were a positive element of work and useful for relieving stress (Button 2008; Healy & McKay 2000; Joiner & Bartram 2004). While the literature suggested there were organisational efforts being made to support nursing staff as they faced the stresses of their everyday roles (Jarman & Newcombe 2010; Pryce et al 2006), this often did not seem to be an ongoing or regular feature of many health care organisations. In addition, recent changes in health care caused a tendency for organisations to shift staff support responsibilities away from nurse educators to clinical staff nurses, who were perhaps not allocated time or resources to cope with the role (Lockhart 2006). Bannister and McInnes (2002) noted that health care organisations have not carried through with enough practical or psychological support after traumatic events. Morrissey (2005) argued that the attitude of health organisations towards staff support needs remodelling, and that staff support should be seen as part of the mature and professional practice of health professionals rather than as a coping strategy for weaker individuals.

One staff support strategy that was found to have protective effects on staff members was the introduction of regular, facilitated staff group meetings. Morante (2005)
instituted a regular weekly staff meeting where mental health nurses explored and reflected on their defence mechanisms relating to the care of challenging and seriously ill patients. Her study found that the implementation of staff meetings led to positive benefits for the nursing staff as problems were aired and practices and beliefs questioned. Cooperative inclusion of the experiences of colleagues began to occur and staff felt less afraid about acknowledging the challenging nature of their everyday efforts to care for clients. Morrisey (2005) also discussed the need for debriefing sessions in the context of emergency nursing. She found the benefits were appropriate sharing of information and the creation of a supportive environment. A recent UK study also found that similar measures of staff support mechanisms in palliative care nursing were effective in sustaining staff members (Duggleby & Wright 2007). Baverstock and Finlay (2006) found similarly in their UK study of acute paediatric nurses that protective mechanisms against workplace adversity occurred through in-house training programs on team support and mentoring. These studies indicate a gap in existing literature regarding the efficacy of such strategies in the Australian nursing context, and in a setting of chronic nursing shortage. This current study will explore the effectiveness of an intervention aimed at staff support and education that also seeks to have a sustaining and transformational effect on the nurses and midwives who participate.

Staff development in nursing and midwifery has suffered when perceived by management as a costly, rather than a value-adding activity (Legg 2007). Legg (2007) pointed out this was usually an erroneous view, as moves that supported and developed staff saved far more when considered against the costs associated with high staff turnover and absenteeism. Legg proposed that investing time and money in providing job orientation, in-house training, nurse education programs, staff mentoring and coaching were important and effective for optimal patient care and best nursing practice, while still meeting the requirements of economic management. The role of staff development in curtailing falling retention rates was also canvassed in the literature; Cash et al (2009) concluded that professional development and training opportunities directly influenced the improvement of staff retention. Links have also been made between staff training and development in nursing and midwifery and improved staff satisfaction levels, and less absenteeism and staff turnover (Boychuk Duchscher & Cowin 2006; Deppoliti 2008; Grant, Potthoff & Olson 2001; Green &
Baird 2009; Humphries, Brugha & MGee 2009). The accuracy of this view in previous literature may be further illuminated in the current study.

2.5 Work Environment

The environment that nurses and midwives work in was another major cause of workplace adversity. While this was a very broad term for the purposes of review; there were some features of the work environment that were identified as detrimental for the health and wellbeing of staff. These concepts included heavy workloads with high physical demands, poor autonomy and working relations, and a limited sense of personal reward from work.

Several researchers argued that the nursing environment was significantly influenced by the nursing shortage ,Boychuk et al. 2006; Buerhaus Steiger & Auerbach 2000). Laschinger and Finegan (2005) expanded on Kanter’s (1993) framework of organisational empowerment that proposed the situated aspects of the workplace rather than the individual characteristics of workers influenced attitudes and behaviours creating environmental conditions. Their study found that organisational structures of empowerment positively influenced nurses’ perceptions of justice, trust and respect within the workplace. Other research findings suggested organisational empowerment was a way of forming work environments that provided greater fulfilment for nurses and midwives (Joiner & Bartram 2004; Laschinger 2004; Laschinger, Finegan, Shamian & Wilk 2001). Therefore, it is necessary to view the policies and practices of health care organisations and communities as contributory to exacerbating the nursing shortage problem; rather than considering only individual factors such as the ageing of nurse populations.

2.5.1 Heavy workload

The changing nature of the nursing environment worldwide has meant a significant increase in the workload of nurses and midwives. Australian nurses too have increased their workload in recent years (International Council of Nurses (ICN)
One research article listed increases in both age of the nursing population and demands for health care as chief explanations of this phenomenon (Dorrian et al. 2006). However, governmental reports have emphasised other causes to explain elevated nursing workloads, like current practices and pressures in the health care industry that dictated nurses and midwives cared for more acutely ill patients for shorter periods (Australian Health Workforce Advisory Committee 2003). The general solution to the demand on the nursing workforce was to increase the amount of overtime that nursing staff undertook, which directly contributed to negative impacts on the health and safety outcomes of both patients and nursing staff (Dorrian et al. 2006). There was evidence that changing models of care, new financial policies, lack of public funds, technological advances in treatment and increased expectations of health care workers all contributed to the problem of overwork for nurses and midwives in a globalised nursing workplace (World Health Organisation 2006).

Fradd (2006) suggested that in developed countries such as Australia, the emphasis on chronic health care will continue into the future. However, due to ageing populations and the increasing inability or unwillingness of families to care for their aged relatives themselves, pressures will continue on both basic and specialised nursing care. Policies that fostered shorter term stays in hospital and increased dependency on the work of nurses and midwives were expected to continue, impacting on the physical and psychological well-being of the nursing workforce.

**2.5.2 High physical demands**

In view of the ageing nurse workforce, 43.7 years was the average age of nurses in Australia in 2007, it was assumed that the high physical demands of nursing work affected the work ability status of staff (Australian Institute of Health and Welfare 2007). A study undertaken in Brazil of nursing staff (n=696) used a work ability index to analyse several environmental conditions of the workplace (Fischer et al. 2006). The researchers found that the most prevalent stressors were lifting heavy objects and patients. Upper and lower back problems and back injuries were amongst the most self-reported health problems of the respondents (Fischer et al. 2006).
2.5.2.1  **Shift work**

The demands of shift work and its effects on performance, health and maintaining work/life balance were the focus of various studies indicating the physical and mental health of workers. Geiger-Brown et al. (2004) found that shift work impacted on a range of mental health problems such as anxiety and depression in their study of nursing assistants (n= 473) in aged care. Further, it was shown that mental health problems increased with each characteristic of shift work that an individual had to contend with; for example if they worked longer and extra hours as well as double or rotating shifts, at night or on weekends. Those nurses and midwives who worked with two or more of these adverse conditions had an almost five times greater likelihood of a current depressive disorder. Other research findings confirmed that shift work had a significant effect on sleep, digestive and cardiovascular problems (Borges & Fischer 2003; Costa Sartori & Akerstedt 2006; Portela Rotenburg & Waissman 2004). The difficulties associated with working irregular hours from an organisational perspective were also examined. Shift work was found to have negative effects on staff productivity levels (Hughes & Stone 2004; Keller, Berryman & Lukes 2009). Whether these findings about the adverse effects of shift work, and the high physical demands on nurses and midwives in general, have an effect on the ability to develop and maintain personal resilience is yet to be determined.

2.5.3  **Low personal satisfaction**

Low satisfaction with environmental factors of the workplace was commonly linked with the high turnover and low retention of nurses and midwives. Conversely, providing favourable environmental factors at the organisational level by supporting work/life balance and committing to appropriate reward for effort systems has been found to attract and retain staff. This premise was well documented in the discussion of Magnet hospitals in the USA, which were shown to score significantly better than conventional hospitals on levels of personal satisfaction and intentions to leave (Boychuk et al. 2006; Laschinger Almost & Tuer-Hodes 2003; Stordeur, D’Hoore & the NEXT-Study 2007).
A primary motivation for people entering the nursing profession is to provide healthcare in the community. The current literature suggested that nurses and midwives’ professional satisfaction was diminished when they felt unable to give quality patient care due to a lack of time, resources, knowledge or support (Duggleby & Wright 2007; Olthuis Leget & Dekkers 2007). However, there was also research evidence that nurses and midwives maintained a sense of purpose and fulfilment, even though workplace adversity was present. Duggleby and Wright (2007) found in a study of palliative care nurses that, despite stressful working conditions associated with dying clients, participants reported high personal satisfaction and rated their jobs as non-stressful. Their feelings of hope were supported by the sense of value they gave to their work, the quality of relationships they had with colleagues, clients and their families, and the quality of care they believed they were able to provide. The findings of Duggleby and Wright informed the current study’s investigation of the components of professional fulfilment in the case, and helped determine conclusions drawn about the role of a sense of purpose on withstanding workplace adversity.

2.5.4 Autonomy

Autonomy was an important factor of the workplace for nurses and midwives; on professional terms in advocating for health care decisions on behalf of their clients; and on personal terms in making their own decisions about work. Autonomy in the nursing discourse is defined as self-direction and control over one’s own work (Mrayyan 2005). Autonomous decision-making and control over practice influenced the retention and satisfaction of nurses and midwives across a wide range of clinical settings. Scott-Cawiezell, Schenkman, Moore, Vojir, Pratt and Palmer (2004) examined the attitudes of nurses to work and reported nurses perceived that low personal autonomy caused feelings of powerlessness and dissatisfaction with unit operations, patient care and leadership.

The research literature also suggested that even in hierarchical health care organisations, the autonomy of nurses and midwives could be promoted and
enhanced. Listening closely to the needs of new graduates, promoting primary nursing care and encouraging positive behaviour towards patients, colleagues and units were suggested managerial actions (Maryyan 2006). In addition, Gould and Fontenla (2005) found that nurses working in more recently created roles, for example nurse practitioners, clinical nurse specialists and clinical practice facilitators, had more professional autonomy and control over their own practice than conventional nursing staff. They worked more flexible and sociable hours and their roles assisted them to better manage work/life balance and created greater satisfaction with their work in general.

The research literature regarding autonomy also addressed the issue of nurses and midwives creating their own autonomy in the workplace. Kaplan and Brown (2006) called for a break in the nexus of authority held by physicians in the USA over other health care practitioners, in particular nurse practitioners. Mrayyan’s (2005) protocol for autonomous decision-making included the premise that the workplace environment upheld nurses’ decision-making capabilities. In Mrayyan’s ideal context for autonomy, nurses were perceived as seeking responsibility for decision-making, and recognising that autonomy increased their power. Mrayyan proposed a range of strategies that brought about greater autonomy, from encouraging problem solving, reflection on the impacts of personal decision-making, collegial collaboration and peer review. These strategies were thought to increase nurse autonomy over patient issues, staffing, schedules and education.

Researchers also discussed nursing autonomy in terms of moral decision-making (Georges & Grypdonck 2002; Olthuis et al 2007). Mathes (2005) identified the strategies that nurses used to assist them in situations of moral distress, the term used when a person feels forced to betray their own values in the workplace due to a lack of position, involvement or authority in the decision-making process. Mathes described nurses’ autonomy as usually a matter of making “a virtue of necessity” (2005: 396), by aligning their moral decisions with compliance to those in authority, such as physicians or organisational managers, as expected of them. Mathes argued that by taking a position between the patient, health care provider and health institution policy yet understanding all their concerns, nurses and midwives were uniquely positioned to apply their autonomy covertly to the decision-making process.
Mathes (2005) posited the idea that autonomy should be re-conceptualised into a collaborative process where the autonomy of the decision-makers -- physicians, nurses, patients and others -- was recognised only to the extent that they could convince the others by reason and shared experience. The current study may shed further light on improving the personal and professional autonomy of nurses and midwives, despite an environment of changing health care policies, practices and delivery systems, and on the potential for greater autonomy to positively affect both nursing and patient outcomes.

2.5.5 Working relations

Collegial support is yet another aspect of the work environment that influences worker wellbeing. Nursing research literature has attested to the personal and organisational benefits of supportive, productive relationships between colleagues (De Cicco, Laschinger & Kerr 2006; Harrison et al. 2002; Scott-Cawiezel et al 2004). There are obvious links between autonomy and appropriate working relations, as nurses and midwives need to express opinions and make requests to carry out their work and advocate for clients. Timmins and McCabe (2005) surveyed Irish nurses and midwives about their assertive behaviour in the workplace. Their respondents perceived they used assertive communication with their staff colleagues more than with management or medical practitioners. They reported that personal responsibility to clients, education, knowledge and values motivated them to use assertive behaviour. Lack of confidence in managers and the work environment, and fear of negative consequences or damage to current working relationships were dis-incentives to assertive communication.

Scott-Cawiezel et al. (2004) found similar results in their study of long-term care staff. The hierarchy of nursing roles influenced satisfaction with communication and leadership. Clinical staff perceived less support from their leaders than from their colleagues. Nursing staff were also less satisfied with communication at work than the allied health clinicians and leaders surveyed. Scott-Cawiezel et al. (2004) also suggested that effective and supportive communication between all health care
practitioners is crucial for a vigorous work environment. These researchers believed health care organisations were responsible for initiating strategies and structures that promoted open communication in upward, downward and outward directions within the workplace (Scott-Cawiezell et al. 2004).

Researchers called for assertive communication training, action research projects to strengthen relationships between nurses and midwives and managers and medical staff, and mechanisms throughout the health care environment to support this (Hurst & Koplin-Baucum 2005; Jordan & Troth 2002). One example of this kind of mechanism was an innovative and nurse-led approach to supportive nursing teams (Jackson 1999). Jackson’s model of support, the Nursing Support Team (NST) was examined in a family services unit, that incorporated ante-natal, post-natal and paediatric health care. Nursing teams responded to paediatric emergencies and high-risk deliveries which enabled the regular staff to cope with the unpredictable fluctuations in workload. Over time one place on the team became rotational between the team and the wards so that skills were not lost from the unit. The participants evaluated the program highly for support of a variety of clinical staff, flexibility of roles and responsibilities for team members, introduction of new developments in health care provision and opportunities for community liaison and staff education. Such an approach seemed to encapsulate many of the perceived professional goals of nurses and midwives in the contemporary context.

Perspectives of nursing and midwifery are currently undergoing rapid redefinition and reconstruction in many ways. The extension of nursing roles in particular is beginning to break through many of the past theoretical influences on the provision of health care by large organisations. It is timely to investigate the best ways for nurses and midwives to be empowered within their workplaces and create greater personal autonomy for themselves and those they provide care for.

### 2.5.6 Workplace bullying and aggression

There was little doubt that the results of an oppressive workplace -- cliques, abusive interactions and bullying, were counter-productive for nursing staff (Duddle &
Boughton 2007). The devastating destructiveness of workplace abuse and bullying, in particular systemic bullying, has been a focus of nursing research over recent times (Farrell, Bobrowski & Bobrowski 2006; Hutchinson, Vickers, Jackson & Wilkes 2006; Vessey, DeMarco, Gaffney & Budin 2009).

Interpersonal difficulties are among the key causes of workplace bullying according to some of the research literature (Hutchinson 2009; Jackson Mannix & Daly 2001). The concept of horizontal violence, or nurse to nurse bullying, has been discussed previously in the research literature (Duffy 1995). Earlier perspectives were that bullying occurred when members of an oppressed group attacked each other in frustration borne out of the powerlessness they had in common. This perspective required the view that nurses and midwives were in a collectively inferior position within their profession. However, other researchers argued this assumption led to the exclusion of other analyses that can also identify and explain the sources and processes of bullying (Hutchinson et al 2006). For example, researchers also argued that workplace bullying in nursing and midwifery stemmed from a culture of taken-for-granted-ness (Jackson Clare & Mannix 2002). Bullying then became an almost normalised phenomenon within the acculturation process of new nursing graduates. Studies portrayed nurses’ acceptance of bullying in the workplace because it was seen as part of their superiors’ efforts to maintain order and their colleagues’ need to organise work (Hutchinson et al 2006). Randle (2003) suggested that role-modelling the norms and behaviour of other nurses during nursing training was not necessarily beneficial in this regard, and called for re-examination of the ways students progressed through their training in a learning context of relative powerlessness within an oppressive hierarchy.

Other studies focussed on the view of bullying from a hegemonic perspective; that bullying was a hidden process in the work environment and that invisible organisational processes and practices worked to uphold it. There was evidence that conflicts escalated into bullying in organisations where there was little capacity to resolve them (Zapf 2001). When the work environment included intense time pressures there was little time for conflict resolution. In addition, if the workplace had potential for individuals to lose their identity because of compliance to organisational needs there was a higher incidence of bullying (Randle 2003).
Organisational practices such as unclear goal-setting were found to cause rivalry between staff members and departments which instigated behaviours of bullying, criticism, isolation and favouritism (Zapf 2001). These arguments suggested that greater access and implementation of conflict resolution mechanisms were an important part of more equitable nursing workplaces.

Research has shown that both physical and verbal abuse of nurses and midwives by patients and their relatives was on the increase in recent times, with an Australian study reporting extremely high levels of multiple incidents of aggression (O’Connell, Young, Brooks, Hutchings & Lofthouse 2000). It has been known for some time that nurses experienced high levels of occupational violence against them in settings such as emergency and mental health care (Catlette 2005). Other studies have claimed that all clinical areas may be equally hazardous for nursing staff (Jackson et al 2002). The literature provided evidence that the nursing workplace, regardless of clinical setting or location, was a potentially violent one (Luck Jackson & Usher 2008; Luck et al. 2009; Wilkinson & Huntington 2004). The current study sought to determine whether a work-based intervention could effectively empower nurses and midwives and encourage attitudinal and behavioural change in relation to bullying and aggression.

2.6 Daily challenges faced at work

The daily challenges nurses and midwives faced at work was another area well documented in the literature as the precursor to potentially negative outcomes. The everyday work of nurses and midwives placed them in situations of shock, stress, even physical danger, on a regular basis. This review included literature covering aspects of work that determined the experience of daily challenges; such as providing quality patient care, role overload, adverse events and errors, and work injuries.
2.6.1 Quality of patient care

Duggleby and Wright proposed that possessing the coping mechanism of hope, the focus of their investigation, influenced the capacity of nursing staff for “providing comfort, establishing relationships and communicating with patients and families” (2007: 48). Hope was the crucial link between the nurses’ experience of personal reward in doing their work and high-quality performance of their role. The trait of hope was described as “a positive feeling about the future, an interactional process between themselves and those for whom they care” (Duggleby & Wright 2007: 43). However, the changing face of the nursing workplace severely limited the opportunities for many nurses and midwives to participate in fulfilling interactions with those they provided care for, especially for clinical nurses in the public sector (Hegney et al 2006). Hegney et al. found that the current Australian nursing workforce was in a state of crisis in terms of the intrinsic values perceived of their work. The findings suggested that nurses and midwives may find that, although opportunities to raise their satisfaction were not accessible often, increasing their sense of hope potentially influenced their sense of purpose and satisfaction in their work. These three factors of hope, sense of purpose and quality of care were potentially inter-dependent (Duggleby & Wright 2007).

Nurses’ and midwives’ needs and individual learning processes were also important considerations in achieving better quality of care (Kemeny, Boetther, DeShon & Stevens 2006). Some literature suggested that quality of care was influenced by the self-esteem, as well as the personal and professional identities of nurses and midwives (Olthius et al. 2007). Olthius et al. (2007) proposed that self-esteem depended on appreciation and support extended by others; therefore nurses and midwives were vulnerable to experiencing negative consequences if their environmental conditions caused them to feel under-valued, and this could decrease the quality of the care they provided. Other links were drawn in the literature between job satisfaction and quality of care. The Canadian National Survey of the Work and Health of Nurses (Canadian Institute for Health Information 2005) reported that staff perceived they had delivered fair or poor quality of care in the past year and had observed poor care practices in colleagues. In such a work environment, it was assumed workers would
experience an increase in hopelessness, powerlessness and job dissatisfaction. Some researchers asserted this could be an additional reason for falling retention rates, absenteeism and general ill-health in the workforce (Hegney et al. 2006; Lambert, Lambert, Itano, Inouye, Kim & Kuniviktikul 2004).

2.6.2 Role overload

One expected outcome of exposure to long periods of a stressful working environment was the development of signs of role overload, commonly known as ‘burnout.’ Burnout is characterised in three main ways: emotional exhaustion, depersonalisation, and decreased perception of one’s accomplishments (Chen & McMurray 2001; Maslach 2003; Sherring & Knight 2009). There was a body of research studies that attested to the existence of professional burnout and its negative health outcomes across a range of nursing and other disciplines like medicine, social work and organisational management (Acker & Lawrence 2009; Armon 2009; Melamed, Shirom, Toker, Berliner & Shapira 2006). In addition, cross-cultural nursing researchers found the same stressor, dealing with death and dying, caused nurses and midwives from both Eastern and Western cultures the most severe physical, mental and emotional consequences (Lambert et al 2004).

Professional burnout was also associated with the social climate within an organisation. Garrett and McDaniel (2001) proposed that uncertain environmental conditions imposed negative consequences such as burnout on nurses and midwives. They claimed that periodically monitoring staff perceptions of supervisor and peer support were important to maintain social networks in the workplace and could help diminish the risk of professional burnout. The relevance of establishing greater networks for peer support through a workplace learning group will be further explored in the current study.
2.6.3 Adverse events and medical errors

Minimising adverse events and errors was a global research direction in nursing and midwifery over the past decade. Nurse researchers were highly motivated to examine the situation from the perspective of nurse outcomes, especially in view of the relationship between errors and the negative effects of workplace adversity. Predictably, the frequency of adverse events and errors in Australian health care coincided with the increase in working hours and fatigue levels. Dorrian et al (2006) reported a significant relationship between fatigue and nursing errors made in an Australian nursing population; and suggested that the amount of nurses’ sleep directly predicted when an error would occur. Exhaustion after shifts was also given as the prime cause of near-misses or accidents when driving or bicycling home after work. The results of a Canadian study were that over 18% of respondents (n=18,348) self-reported they made medication errors occasionally or frequently (Kondro 2007). The study found nurse shortages, workload pressures and health concerns were the causes of the errors made; the same shortages and pressures present in Australia suggest a similar situation could exist here. Another study found that work concerns were either partly or fully responsible for participants’ sleep disturbances 12.5% of the time (Dorrian et al 2006). The incidence of sleep disturbance also affected nurses’ safety levels at work as they made more errors and there was a decreased likelihood that sleep-deprived nurses would catch their colleagues’ mistakes.

2.6.4 Work injuries

Nurses are the most likely of any professional group to sustain work injuries (Jackson et al. 2002). Approximately half of those surveyed in the Canadian National Survey of Work and Health of Nurses (Canadian Institute of Health Information 2005) reported injuries by needle-stick or other sharp objects, with over 10% being injured in the last year. Overtime was found to predict nurse injuries in the United States, and the risk increased with the length of overtime, representing significant costs in paid sick leave and replacement costs (Bureau of Labour Statistics 2007). In developing countries too, work injuries were found to severely affect nursing staff. Fischer et al.
(2006) found that almost 25% of their 996 respondents reported being injured in their current job. Other studies highlighted the frequency of staff injuries in aged care nursing; lifting and moving patients and the relative age and health of nurses working in this area accounted for the prevalence of back and knee injuries.

2.6.4.1 Use of pain medication

The situation has already been outlined regarding the large numbers of nurses and midwives worldwide who sustain injuries at work. In fact, in 2002 in the United States there were more injuries from nursing than from both mining and manufacturing industries combined (Li, Wolf & Evanoff 2004). Therefore, the use of pain medication by nurses and midwives has also been a research topic in recent times. Pain and fatigue were both early indicators of body stress or strain and likely to negatively affect health and wellbeing (Trinkoff Storr & Lipscomb 2001). Trinkoff et al. (2001) found in their study of 3,727 registered nurses that their use of pain medication increased with the physical demands of their work. The Canadian Institute of Health Information (2005) reported that 37% of their 18,348 nurse respondents across the country had experienced activity-limiting pain in the previous year, with three-quarters of them reporting their pain resulted from work-related factors (Canadian Institute for Health Information 2005). The current study will extend understandings about the influence of personal resilience in improving the health and wellbeing of nurses and midwives.

2.7 The Effects of Workplace Adversity on the Wellbeing of Nurses and Midwives

Workplace adversity was shown to impose a range of negative effects on individuals working within organisations (Noblett 2003). The effects may include aspects of their physical, mental or emotional health; experienced as work-related stress, continual fatigue and exhaustion, body soreness and pain, and feeling one’s work was unrecognised or unappreciated (Severinsson 2003; Sherring & Knight 2009).
Organisations also identified stress as a major concern because the attendance and participation of individuals was diminished. Absenteeism caused by work-related stress incurred large human and economic costs to organisations (Noblett 2003).

2.7.1 Work stress

Work stress in nursing has been studied for some considerable time (Arnold Cooper & Robertson 1995; Nolan, Dallender, Soares, Thomsen & Arnetz 1999; Hegney et al. 2006; Joiner & Bartram 2004; Tyler & Cushway 1995), and has been defined as the “response to a work situation that places special physical or psychological demands on a worker” (Matteson & Ivancevich 1987: 56). The transactional model of stress and coping (Lazarus & Folkman 1984) also included a person’s appraisal of whether the stressor exceeded their resources. Recent research studies using transactional models of stress found that stressors and stress reactions were mutually influential, for example nurses’ health and environment (Gelsema, Van der Doef, Janssen, Akerboom & Verhoeven 2006). The most commonly found sources of work stress for nurses related to the physical environment of the workplace, harsh workloads and inadequate staffing levels (Chang, Bidewell, Huntington, Johnson, Wilson & Lambert 2007; Healy & McKay 2000; Joiner & Bartram 2004). Shift work and the associated work/life balance, role conflict between administrative tasks and patient care, under-resourcing, and nurses’ perceived inferior status within their workplace were also commonly cited as additional causes (Joiner & Bartram 2004). Another recent research study asserted that work stress in nursing and midwifery would remain high, morale low and would continue to drop (Hegney et al. 2006).

Australian researchers Healy and McKay (2000), in their study of work stress amongst Victorian nurses, found a positive relationship between situational job stressors, such as workload, uncertainty about treatment, and conflict with physicians and colleagues, and negative mood. Situational factors were found to determine the type of coping strategies used, such as problem-solving, social support, self control or avoidance. The consequences of work stress were typically regarded as absenteeism, poor job satisfaction and leaving the profession (Humpel & Caputi 2001; Humpel
Caputi & Martin 2001). Common psychological responses to work stress were anger, anxiety and depression (Humpel et al. 2001).

As well as raising issues around work stress in the contemporary nursing workplace, the research literature called for innovations to reduce it. Joiner and Bartram (2004) found that, for nursing staff, the two most important factors in reducing work stress were the development of social support from both colleagues and nurse managers, and increasing their sense of empowerment. They suggested that the implementation of staff forums, informal discussion and socialisation activities for new staff members could all improve communication, sense of support and feelings of belonging to the organisation, which were seen as important for reducing job stress. Other writers recommended the advantages of a teamwork model whereby respect, social support and communication networks were created (Kalisch, Weaver & Salas 2009; Schroeder & Worrall-Carter 2002; Stordeur et al. 2007).

2.7.2 Respect and recognition

Public opinion polls have consistently showed that nurses were amongst the most highly respected professionals in society (Donelan, Buerhaus, Desroches, Dittus & Duttwin 2008), a result that highlighted the respect that people have for nursing and nurses. As an important principle of ethical nursing practice; respect permeated most codes of conduct as a fundamental part of interacting with every other individual. Milton, a nursing ethicist, wrote that respect was about “mattering, an affirmation that other people matter in the same way as oneself matters” (2005: 20).

Feeling respected for one’s own contribution was also an integral part of how nurses and midwives’ perceived the quality of their workplace, both for themselves and their patients. Several studies outlined how nurses valued work settings that provided respectful relationships between co-workers and between nurses and leaders (O’Brien-Pallas, Thomson, Alksnis & Bruce 2001). Being taken seriously and feeling appreciated has been shown to be linked with nurses’ well-being and job satisfaction (Mikkelsen Saksvik & Landsbergis 2000). Studies have also found that professional nurses did not feel that they were thought of or treated with respect by supervisors and
management (Laschinger 2004; Laschinger et al. 2001; Laschinger & Finegan 2005). Physicians’ disrespect of nurses has had such a long-term precedent that research studies focused on less conflict rather than none (Lambert et al 2004). Other studies have shown that although a majority of respondents felt that they were not respected by their managers a similar amount did feel respected by their co-workers (De Cicco et al 2006). The continuing concern of low levels of respect and recognition found in the nursing workplace highlight the need to implement new and innovative strategies that provide support, raise self-esteem and address assertiveness amongst nurses and midwives.

2.7.3 Physical health of nurses and midwives

The health of nurses and midwives has been the subject of long-term investigation; two examples of ongoing health studies of large nurse population samples are the Nurses Health Study in the USA and the Danish Nurse Cohort in Denmark (Friis, Ekholm & Hundrup 2005; Nelson 2000). As indicators of general women’s health status, they have contributed over a decade of information regarding major chronic diseases and issues of postmenopausal health. Findings from the Danish study have given a favourable view of nurses’ lifestyles in relation to health; they smoked less and were more physically active than the general female population (Friis et al. 2005).

Women with chronic work-related health issues are commonly faced with a number of challenges associated with their roles as women, mothers and workers. The serious environmental conditions of the nursing workplace around the world directed an exploration into the negative effects of chronic health conditions on nursing staff, including back problems, arthritis, and consistent pain (Fischer et al 2006; Plach, Heidrick & Waite 2003). Frequent findings of musculo-skeletal strain and injury amongst nurses are widespread in the literature (Hasselhorn, Tackenberg, Camerino & Conway 2005; Trinkoff et al. 2001; Waters, Collins, Galinsky & Caruso 2006). These findings have been linked to both the physical work environment, such as the demands of working in particular practice settings like aged care, and the health outcomes of participating in stressful work situations.
Nurses and midwives in both developed and developing countries were found to be susceptible to negative psychological symptoms, such as fear, anxiety, and feelings of depression. In general, predictors of mental health problems in nurses and midwives included low social support, less clinical experience, heavy workload, dealing with frequent stressful and emotionally provoking situations at work, death of patients, or dying patients and their relatives (Arafa, Nazel, Ibrahim & Attia 2003; Lambert et al. 2004; Piko 2003). A more recent study linked higher than average levels of somatic symptoms, such as fear, anxiety and psychosis with working between 10 and 20 years and holding a senior position at work (Yao, Zou & Huang 2006). The conclusions Yao et al. drew, that older nurses with higher work pressures had relatively poor physical and mental health, concurred with earlier researchers, (for example Guppy and Gutteridge 1991). Researchers also looked at the differing types of physical and mental health outcomes for nurses from different work settings and experience levels, rather than attempting to measure divergent mental health status in nurses by age (Callaghan, Tak-Ying & Wyatt 2000; Lee 2003).

Understandings of the previous and current knowledge about the effects of workplace adversity provided important background to inform the current study. These findings informed the study’s approach to the intervention design and implementation. This review also substantiated the need for finding additional ways of effectively addressing the continuing problem of workplace adversity in nursing and midwifery.

2.8 Personal Resilience

2.8.1 Introduction

Personal resilience was defined as the capacity of individuals to cope successfully with significant change, adversity or risk, and avoid the potentially harmful effects of stress (Jacelon, 1997; Wagnild & Young 1993). Resilience has been widely used as a concept to explore the development of children and families in circumstances of
illness, trauma and poor life-chances (Insook, Eun-Ok, Hesook, Young Sook, Misoon & Youn Hwan 2004; Laditka, Laditka, Cornman, Davis & Richter 2009; Rak 2002). In the nursing and midwifery field, resilience has been examined as a means to guide professional practice and personal wellbeing (Ablett & Jones 2007; Glass 2009; Hodges, Keeley & Troyan 2008). It was found to be enhanced by protective factors within both individuals and environments (Rew, Taylor-Seehafer, Thomas & Yockey 2001).

The research literature identified a number of characteristics that were associated with personal resilience, and these characteristics were the key areas targeted by the workplace intervention informing this thesis. The characteristics were previously identified in a review of the literature by Jackson, Firtko and Edenborough (2007) and included: personality hardiness (Bannano 2004), positive and nurturing relationships and networks (Tusaie & Dyer 2004), optimism and a positive outlook, even when in the midst of stress and hardship (Tugade & Frederickson 2004); emotional insight and emotional intelligence (Gerits, Derksen & Verbruggen 2004), balanced perceptions of work, home and leisure time (Brown & Adebayo 2004), feelings of connectedness and spirituality (Strang, Strang & Ternestedt 2002) and the ability to develop and practise reflective skills (McGee 2006).

2.8.2 Personal Resilience in the Contemporary Nursing Context

The fluid nature of the contemporary nursing workplace, characterised by constant, pressured movement of both patients and staff throughout the health care system, brought a particular need for resilience building for nurses and midwives (Jackson et al. 2007). The research evidence about the process of developing resilience suggested it may develop over time through normal stages of life, cycles of disruption leading to reintegration, or it may be articulated through turning-points of extreme change (Jacelon 1997). Jacelon (1997) suggested that exploring the means by which resilience was communicated to another and measuring the ability of individuals to learn resilience was an important research goal. She argued that as the changing
health care industry moved the focus from hospital to community care the capacity of nurses to foster resilience in the clients they cared for, as well as their ability to build and maintain their own personal resilience, became more vital. McGee argued in her treatise on nursing in a homeless men’s shelter, “there is a pressing need to cultivate and foster personal growth in nurses because we cannot give our patients what we do not possess ourselves” (2006: 43). The development of personal resilience may be crucial to nurses and midwives advancing through the ever-present and difficult decisions of nursing – how to reconcile their personal and professional lives, how to cope with large-scale changes to the health care industry and how to deal with chronic work stressors.

2.8.3 Hardiness

Kobasa (1979) conceptualised personality hardiness as the beliefs a person held about themselves and the world. He understood the concept as the manifestation of three key components: control, commitment and challenge. Kobasa believed these were the most important features of an individual’s belief that they had control over events, their efforts were valuable, and that change was a normal part of life. These beliefs enabled them to withstand and progress in the face of adversity or stressful situations. Other researchers concentrated on devising a set of characteristics of a hardy person. In general the research literature listed that hardy people believed stressors were changeable and could be controlled, they had a willingness to act, were deeply involved in their own lives and those of others, and held the view that disruptions, setbacks, or pressures had long-term rewards (Judkins & Ingram 2002).

Initial research discovered that hardy individuals became sick less often and could turn negative events into opportunities for advantage (Kobasa 1979). More recent organisational research evidence showed that higher levels of hardiness in workers provided a range of advantages for organisations, including problem-solving capabilities, coping skills, and increased levels of job satisfaction, productivity, commitment and retention (Judkins 2001; McNeese-Smith 1997).
The concept of personal hardiness also found currency in nursing research. It was cited as a factor in building resistance to burnout in nurses (Tierney & Lavelle 1997; Balevre 2001), and improving patient outcomes (Shullangberger 2000). Studies of nurses and personal hardiness explored a variety of work settings, such as the intensive care unit (Hurst & Koplin-Baucum 2005) and roles, such as the development of personal hardiness in nurse leaders (Judkins & Ingram 2002). The relationships between hardiness and nursing stress and psychological distress were also examined (Harrisson et al. 2002; Walker 2006). Workplace issues associated with sick leave, commitment to organisation and mission, and adjusting to a rapidly changing healthcare environment and their connection to hardiness were topics of nursing research (Luthans & Jensen 2005; Judkins, Massey & Huff 2006). This knowledge contributed to the current study by indicating key understandings of ways the current study participants may utilise hardiness to protect against professional burnout, and how strengthening hardiness may be approached in the intervention.

2.8.4 Nurturing Positive Networks and Relationships

Supportive and caring relationships with others are required for good psychological health; making it important to initiate and maintain satisfying personal and professional relationships and networks. Research indicated that positive collegial relationships and networks were no less important for nurses and midwives working in the contemporary nursing environment. It was deemed vital for resilience that nurses were able to share meaning and construct knowledge together socially (Tusaie & Dyer 2004), and participate in mutually beneficial supportive relationships (Daly, Speedy & Jackson 2004).

Recent nursing research contributed to understandings of the ways social relationships intersected with personal and community health. Taylor (2002) stated that the work of nursing is professional ‘tending,’ or caring for clients to support healing, and likened it to the co-operative networks of women in kinship groups that historically succeeded in many caring purposes, such as protection, encouragement, nurturance and role-modelling for each other. These insights pointed to the need for further
Tucker’s (2004) doctoral dissertation concerned the author’s observations of a group of nurses that were afforded a great deal of credibility by their colleagues due to their clinical experience and advanced theoretical knowledge. He categorised them as ‘nurses of influence’, and found that they had created a caring culture in their practice, often amidst an opposing culture in the health organisation they worked within. Tucker (2004) found that these nurses promoted and used several processes that embodied a caring culture for themselves and others, such as positive and supportive relationships with colleagues, connectedness, reciprocal respect and empowerment through mentoring, especially to promising nurse leaders from ethno-racial minorities. Tucker (2004) believed that these nurses were representing an holistic philosophy of caring for both their patients and those they worked with, and that active participation of this kind heralded the future for nursing as a discipline.

Other research studies formed around the idea of nurses and midwives making sense and creating meaning for their work via the bonding practices of social networks (Morgan-Witte 2005; Muncer, Taylor, Green & McManus 2001). Morgan-Witte (2005) found, from studying the stories that nurses told each other in the workplace, that nurses’ narratives served to create care-giving beliefs, actions and outcomes for the nursing team members and informed their practice as nurses. They also served to create or suppress certain perspectives of nursing, depending on the preferred narrative in the group. Earlier researchers asked a group of 48 nurses in the United Kingdom to use a network-drawing technique to indicate the causes of their work stress (Muncer et al. 2001). Although the key cause of stress was found to be inadequate support from managers, other sources were also found, such as inappropriate advice from colleagues, conflicts within the multi-disciplinary team or doctors, bureaucracy and lack of emotional support. This type of network analysis suggested that forming and maintaining positive relationships and networks at work were beneficial for both nursing staff and health care organisations.

Good team interaction was found to have an effect on workplace morale in general. Factors of consultation, professional recognition and team interaction were significant
indicators of personal morale in a study investigating 343 registered nurses in Queensland (Day Minichello & Madison 2007). The results suggested that organisational strategies that improved the interactional atmosphere in the workplace improved team morale. Speraw’s (2004) review of Taylor’s (2002) book on the instinctive nature of nurturing relationships and nursing, reiterated the statement that forming bonds is the everyday work of nurses and midwives, “to forge a human, interrelated connection with the person who talks to us on the phone, sits before us or lies under the sheets….Nursing is nothing if it is not about connection” (2004: 749).

2.8.4.1 **The Role of Mentoring**

Mentoring was defined as “a deliberate pairing of a more experienced person with a less experienced one, with the mutually agreed goal of having the less experienced person grow and develop specific competencies” (Murray, 2001: xiii). It has been understood as an alliance between “two people with varying degrees of experience in order to provide support and learning opportunities” (Mills, Lennon & Francis 2006: 32). Mentoring relationships were revealed to be two-way interactions that had the potential to benefit both parties (Clutterbuck & Lane 2004). This process-driven relationship involved learning, critical reflection and drawing upon understanding in relevant situations (Zachary 2005). Research literature confirmed that the benefits of participation in mentoring relationships were increased self-confidence, competence, professional identity and career advancement (Kram 2004; Shea 1997).

In nursing and midwifery, there were numerous mentoring initiatives used over the past decade to foster supportive relationships across a range of contexts, including under-graduate and new graduate nurses, rural and remote nurses and nurse managers. (Davis-Dick 2009; Mills Francis & Bonner 2008; Waters, Clarke, Ingall & Dean-Jones 2003). Mentoring was viewed as a potential antidote for many current nursing problems, from improving staff retention, promoting high standards of practice to working in inter-generational nursing teams (Belcher 2008; Halfer, Graf & Sullivan 2008; Wieck 2007).
In the Australian nursing context, there was some overlapping of the terms mentoring, preceptorship and clinical supervision (McGloughen, O’Brien & Jackson 2006). However, mentoring should be considered as a much more complex, interactive and committed phenomena than the more structural processes involved in preceptorship or supervision (McGloughen et al. 2006). McGloughen et al. (2006) argued that mentoring in nursing and midwifery had not yet become well established in Australia, revealing a research gap in knowledge about the influence and benefits of mentoring partnerships.

Formal mentoring programs were also mentioned in research literature as a method of instigating self-confidence and supportive relationships, in the interests of improving work related stress (Grindel & Hagerstrom 2009; Joiner & Bartram 2004; Wagner & Seymour 2007). Recent nursing literature has demonstrated the successful outcomes of mentoring programs using senior nurses as mentors for their less experienced colleagues. Ho (2006) reported that a successful mentoring initiative piloted in two hospitals by the Californian Nurses Association, using veteran staff nurses as mentors, had sparked a series of similar programs. An article presenting the innovative retention strategies for senior peri-operative nurses in six United States hospitals reported that building bridges between nurses of different generations through active mentoring programs was effective for improving staff satisfaction levels (Anonymous, 2008). Preliminary evaluation of a mentor training program in New Zealand, involving 91 senior nurses working as nursing managers, specialists or educators, suggested participants improved their professional relationships, career development and personal insights about resilience (Hedgecock & McClelland 2009).

Bally (2007) proposed that the creation of positive mentoring cultures within health organisations was dependent on mentors knowing and understanding the core culture of those they sought to mentor. She viewed mentoring as engaging in a process of transformational leadership, based on the four dimensions of leadership devised by Bass: inspirational motivation, individualised consideration, idealised influence and intellectual stimulation (Bass 1994). Mentors needed to be “interested, motivated, value-driven individuals” (Bally 2007: 146), who had the ability to understand the uniqueness of a mentee’s issues, needs and interests. They exemplified the vision and values of the culture through role-modelling. Bally (2007) argued that mentors who
were conversant with the culture of the mentee stimulated positive analysis of the workplace and nature of nursing, by virtue of their mutual experiences and knowledge of the culture they both belonged to.

The literature also discussed the characteristics of mentees that were required for successful mentoring relationships. Previous research suggested that mentees should possess initiative, openness, commitment and a strong self-image (Vance & Olsen 1998). There is a need for studies that provide nurses and midwives, especially those vulnerable to workplace adversity, opportunities to experience inspirational leadership (Hendel, Fish & Galon 2004; Kanste, Kyngas & Nikkila 2007), and for those that explore the use of retired nurses and midwives as mentors. It is envisaged that the mentoring partnerships established in the current study may contribute to existing research knowledge about the effectiveness of pairing working nurses and midwives with senior and retired nurses and midwives for the purposes of meeting the mentees’ personal and professional goals and strengthening their personal resilience.

2.8.5 Maintaining a Positive Outlook

Experiencing positive emotions was found to enable individuals to recover quickly or ‘bounce back’ from negative moods or trauma (Tugade & Fredrickson 2004; 2007). McCraty, Atkinson and Tomasino (2003) demonstrated in another study that when employees experienced an enhanced positive outlook they were more satisfied with both their own sense of contribution and with the workplace in general.

The discourse surrounding positive psychology has led to many insights regarding positive outlook. Seligman (1991), who pioneered the field, found that a positive outlook depended on an optimistic or pessimistic appraisal of life events and circumstances. This was termed an individual’s explanatory style, also described as a person’s unique interpretation of their own life-chances and experiences (Adams 2007). Seligman (1991) asserted that a person’s explanatory style was fairly constant and that the skills of optimism could be learned so that setbacks were viewed in an encouraging way and one’s quality of life and health outcomes improved. Since then
further research has supported the finding that a positive outlook is a learnable faculty, and an individual may be motivated to become more positive and endure through difficult times, despite being natural optimists or pessimists (Segerstrom 2006).

Research has proposed new understandings of optimism that have moved on from the initial ideas of how positive outlook is formed. Neimark (2007) spoke of ‘grounded optimism’ and categorised true optimists as realistic, flexible and actively engaged in solving problems. These people hoped for the best outcome in any situation but also worked hard to achieve it. They were more persistent, paid attention to detail, and were able to amend and refine their earlier goals in light of ensuing circumstances. Seligman also proposed “flexible optimism” which did not require sacrificing realism (1991: 208).

A positive outlook was also linked to positive physical health outcomes. These included enhancing the immune system (McCray et al. 1996) and counteracting the effects of disease such as congestive heart failure (Lushkin, Reitz, Newell, Quinn & Haskell 2002); and hypertension (McCray et al. 2003). Recently researchers argued that optimists were healthier because they were actively engaged in their lives and took steps to solve their problems, and not because they possessed a bio-chemical immunity to pessimism (Neimark 2007).

Likewise, research studies investigated the relationship between a positive outlook and mental health, for example in depression and cancer patients (Adams 2007). The research discourses of psychology and organisational behaviour consistently found that negative beliefs and attitudes resulted in higher rates of stress and depression (Smith 2006). Aside from the deeply negative impact of depression to personal experiences and enjoyment of life, work stress and emotional distress resulting from depression were proven to be among the most significant and costly health problems for organisations, including health care (Goetzel, Anderson, Whitmer, Ozminkowski, Dunn & Wasserman 1998).

There have been detractors of the findings of positive psychology, from both humanistic and scientistic branches of psychology. The main objections to the
positive psychology approach ranged from the view that it was overly preoccupied with individuals and personal achievements, it trivialised some human experiences and that feelings and intuition were valued over logic and rational thought (Fulmer 2007; Schneider, Bugental & Fraser Pierson 2001). Other writers have cast the positive psychology perspective as oppressive and prescriptive of character attributes and human virtues (McDonald & O’Callaghan 2008). However, despite its detractors, positive psychology conveyed the key ideas of the ‘self’ and the rights of people to move toward self-actualization into mainstream culture and thought (Schneider et al. 2001).

Current research also discussed the limitations of optimism, especially as it related to health enhancement (Neimark 2007). Some research studies cautioned that although optimism led to experiences of well-being, in the short-term it could result in raising stress, cause fatigue and suppress the immune system due to the maximum efforts that optimistic people made. In the case of failure, greater disappointment and distress could result, especially when high expectations of success were present (Neimark 2007).

Maintaining a positive outlook was also shown to optimise one’s emotional health and wellbeing (Smith 2006). It has an important role in aiding the development of an individual’s social and emotional capacities; capacities that were necessary to survive, as well as thrive, in the contemporary nursing workplace. The attributes of an emotionally healthy adult included being progressive in a constantly changing world, taking initiative in negotiating the myriad of choices incumbent with modern living, and the ability to learn new things across the life span (Adams 2007). Research studies supported the belief that a positive outlook had protective factors for optimal emotional health, enabling people to respond to adversity with resilience, flexibility and resourcefulness across the life span (Adams 2007; Neimark 2007).

Research literature provided evidence that fostering positive feelings and attitudes boosted workers’ potential and performance from an organisational perspective (Charlson, Boutin-Foster, Mancuso, Peterson, Ogedegbe, Brigs, Robbins, Isen & Allegrante 2007; Gooty, Gavin, Johnson, Frazier & Snow 2009). Isen and Reeve (2005) concluded that the trait of positivity could bring improvements to several
important criteria for a smart and viable workforce; from intellectual flexibility to creative problem analysis and decision-making. Other research found that a positive outlook also improved job performance, satisfaction, and achievement (Avey, Luthan, Smith, Smith & Palmer 2010; Wright & Staw 1999). Positivity was also linked to decreased absenteeism and conflict among staff members (Iverson & Deery 2001; Schreuder, Roelen, Koopmans, Moen & Grodhof 2010). It is hoped that the current study will extend research insights into how positive emotions may influence personal resilience in nurses and midwives working in a stressful work environment.

2.8.6 Intellectual Flexibility

Another characteristic of a resilient personality examined in the research literature was that of intellectual flexibility. Although it came mostly from the perspectives of staff development and recruitment, intellectual flexibility was identified as a key characteristic of the prized professional worker in the information society (Harkonen 1996). New and faster communication technologies have brought about the need for intellectual flexibility; namely, parallel thinking, or the ability to process quantities of information in parallel and at the same time. In the information society, learning depends not only on mental acuity, but also on emotional capacities, like inner strength and determination. Health service provision has also defined intellectual flexibility as a concept, especially in the area of leadership, as “the facility to embrace and cut through ambiguity and complexity” (NHS Institute for Innovation and Improvement 2005: 19). These insights have influenced nursing researchers to explore the advantages of intellectual flexibility in various contexts of nursing and midwifery.

The benefits of an intellectually flexible workforce were discussed from the perspective of the professional development of nurses and midwives. In the healthcare workplace, there was a definite need perceived for nurses and midwives to be competent, if not expert, at autonomous decision-making, independent thought, health promotion, analytical, investigative skills and effective reflection (Harriss 2004). Harriss outlined a scenario of how nursing educators in occupational health
3.7 Nursing used curriculum development groups made up of senior members of the nursing profession to integrate the theory-practice gap. Harriss (2004) claimed these examples showed how intellectual flexibility could be used progressively in nursing and midwifery. Developing intellectual flexibility may well assist nurses and midwives to deal with some of the current problems facing them, at least to predict and deflect some of the negative outcomes of their everyday work.

2.8.7 Emotional Intelligence

Nursing work environments were revealed to be settings of emotional as well as physical labour. Nurses and midwives participated in emotional labour as part of their everyday work situations (Hochschild 1983). Emotional labour, the consequence of nurses and midwives generating the expected emotions of their role according to their patients, their organisation, or even themselves, requires hard work. It was found to be an essential part of the therapeutic relationship between nurse and patient, but it also led to negative outcomes of stress or depression if not properly managed (McQueen 2003).

Emotional intelligence may be viewed as an important capacity for individuals who are required to use responses of emotional labour during the course of their work. The original definition of emotional intelligence was an individual’s ability to monitor one’s own and others’ emotion, to discriminate among the positive and negative effects of emotions, and to use emotional information to guide one’s thoughts and actions (Salovey & Mayer 1990). Goleman (1995) broadened the notion of emotional intelligence to include other social capacities, such as personality traits and personal beliefs. The main components of emotional intelligence were believed to be the perception, assimilation, understanding and management of emotions (Mayer & Salovey 1997). Vitello-Cicciu (2003) found the main actions leading to emotional intelligence were higher emotional awareness of self and others. He believed emotional intelligence was a learned attribute and improved with age.

Emotional intelligence was claimed to be a useful clinical competency for nurses and midwives because of the importance of building rapport quickly with patients to
access information that could assist their recovery (McQueen 2003). Emotional intelligence contributed to how nurses and midwives resolved conflicts and maintained networks in the workplace. Existing literature reported that females were more likely than males to use collaboration and compromise styles of conflict resolution. Collaboration was the most beneficial response to conflict and was found to be the principle method used by people with high emotional intelligence (Jordan & Troth 2002). Research has shown that high emotional intelligence points to the use of collaboration over the other types of conflict responses of avoidance, accommodation and force.

Freshwater and Stickley (2004) posited that emotional intelligence was a partnership of the rational and emotional minds working harmoniously to increase one’s intellectual abilities. As such it related to the accomplished nursing practitioner, one who displayed a theory and practice of both tacit and experiential knowledge. Emotional intelligence was also associated with successful teamwork as it connotes an awareness of the emotions of others (McQueen 2003). Some research focussed on the elements of nurses’ and midwives’ practice that were improved by emotional intelligence, such as listening empathically to patients and learning with and from them (Price 2006).

The literature also looked at the relationship between emotional intelligence and organisational aspects such as employee burnout, sick leave and adaptive success. Gerits et al (2004) investigated the emotional intelligence profiles of 380 nurses and found a clear link to their successful practice, mental health and avoidance of burnout. Jordan and Troth (2002) believed that organisations prepared to teach nurses and midwives strategies and skills linked to high emotional intelligence were equipping them to display greater professionalism and to handle conflict situations with patients and colleagues. Recommended strategies included training in decision-making, mediation, self-awareness, emotional management, using social networks and supportive communication (Jordan and Troth 2002). Nurse leaders with high emotional intelligence scores were found to use meditation, self-help books, stress management, emotional journaling and expressing empathy to manage their emotions (Vitello-Cicciu 2002; 2003).
2.8.8 Work Life Balance

The contemporary world of work, with its global economy, advanced communications technology, longer work hours and changes in family roles, has impacted on the control individuals have over their work and personal life. These features gave rise to the notion of a ‘work-family conflict’ (Guitian 2009), a term which referred to the consequences of the dichotomous pull between work and personal life that disrupted the possibilities for life to be enriching and individuals to flourish. A variety of research disciplines examined the role of work/life balance as a means of restoring harmony and reducing stress in the lives of workers (Greenhaus & Powell 2006; Sang, Ison & Dainty 2009; Swody & Powell 2007). The general conclusion was that although it was difficult to juggle the responsibilities of a professional and a personal life, it was vital for a person’s health and happiness that they engaged in fulfilling their physical, emotional, social and spiritual needs. Strategies for maintaining work/life balance emerged from research sources, such as utilising flexible work options, gaining time management skills, rethinking household cleaning standards, self-nurturing, protecting recreation time, fostering support systems of family and friends, and seeking professional help when life was too chaotic to manage (Mayo Foundation for Medical Education and Research 2006). Recent organisational management research also explored the role that organisations played in supporting their employees to find work/life balance more explicitly. Warner and Hausdorf (2007) argued that organisations could do much to support their employees in satisfying the three major human psychological needs of self-determination: competence, autonomy and relatedness (Deci & Ryan 1983). Warner and Hausdorf (2007) proposed managers reduced the work-family conflict for employees by developing opportunities for life enrichment and supporting competence, autonomy and interpersonal relationships in the workplace.

Nursing research has continued to show the importance of keeping a balance between the activities of work and life for nurses and midwives. Research showed that striking a balance between work and other areas of life was the catalyst for female nurses and midwives to flourish (Andrews, Cowan & Atkinson 2004), as it was for female workers in general (Connell 2005). A study in Scotland found that the major issues for maintaining life balance for nurses and midwives were life commitments in caring
for family, living with a disability, travelling or working overseas, taking study leave or approaching retirement (Andrews et al. 2004). These researchers also concluded that the presence of flexible health care organisations was most important in enabling nurses and midwives to make changes to their work lives and sustain a healthy life balance. They viewed flexible working opportunities, such as flexitime systems, part-time work, job sharing, and team-based self-rostering as practical solutions that would change the culture of health organisations. Other writers considered the potential risks of a lag in implementing work/life balance to the nursing workplace were considerable and damaging (Pryce et al. 2006)

Another nursing research direction was the exploration of more personal definitions of work/life balance, and the means of creating it in a person’s life. An example of this was Fuimano’s (2005) proposition that envisioning life balance was different for each person, and to find balance one must “identify what [did not] work, eliminate those practices, then identify and add new behaviours” (2005: 23). She argued that removing the most deleterious stressors created ‘space’ in one’s life to bring into play talents, skills and strengths. This concept of assessment of stressors and replacement with changed behaviours extended to thought processes, such as exchanging perfectionism with self-awareness. This current study will explore the ability of a work-based intervention to impact on work/life balance, common stressors and life enrichment.

2.8.9 Spirituality

Spirituality was long regarded as integral to holistic nursing care (Herman & Sassatelli 2002; Sellers & Haag 1998). There has been a traditional understanding in nursing and midwifery of the professional, ethical and legal obligations of consistently providing spiritual care (Pettigrew 1990; Wright 1998), and meeting the spiritual, religious and cultural needs of clients is a standard of nurses’ duty of care (Ledger 2005).

Although spirituality has been defined in research literature in a myriad of ways, for the purposes of this review it was perceived as:
“A quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and especially comes into focus as a sustaining power when the person faces emotional stress, physical illness or death”

(Murray & Zentner 2001: 3)

Research found that in mostly secular societies, understandings of spirituality were wider than only religious meanings, allowing considerations of spiritual needs in the absence of practice in any religion or faith (Strang et al. 2002). Therefore current research incorporated broader perspectives of spirituality; spiritual issues, religious issues and the four central tenets of existentialism; meaning, freedom, isolation and death (Yalom 1980).

Research findings suggested that many people nominate a religious or faith affiliation in general, and spiritual needs have been portrayed in the research literature as a significant need for patients (Ledger 2005). A conflicting perspective also emerged, arguing that for many people for whom the concept of spirituality was meaningless, to overlay normal therapeutic communication between nurses and midwives and their clients with themes of spiritual care was unhelpful (Draper & McSherry 2002). Nurses reported using a variety of spiritual care interventions, such as active listening, validation of clients’ feelings, and conveying acceptance and hope (Sellers & Haag 1998). However, spiritual nursing care has also been described as a neglected area of practice (Narayanasamy & Owens 2001). This has led in some cases to a failure to give spiritual and religious care and meet the needs of patients (Ledger 2005).

Nursing research literature also investigated nurses’ and midwives explorations of their own spirituality in order to reduce stress and enhance their own well-being. Past research explored strategies to enhance the spiritual health and wellbeing of nurses (Carson & Green 1992; Hawks, Hull, Thalman & Richins 1995). Walker (2006) explored a nursing education intervention using an experimental technique, the HeartTouch Technique (HTT). The researchers taught the participants to become aware of their thoughts and feelings, and intentionally adjust them to more positive
ones during episodes of stress, anger and anxiety, or even when thinking about such a situation. Walker (2006) reported marked changes in the attitudes, emotions and behaviours of the nurses relating to stress management. The participants were also able to make more positive spiritual connections between themselves, their personal sources of spiritual wholeness, and others. They experienced significant improvement in their spiritual wellbeing and meaning and purpose of life (Walker 2006). Findings related to the use of nurses’ spiritual beliefs and practice will inform the current study’s aims of exploring strategies to withstand workplace adversity and whether spirituality can assist the development and maintenance of personal resilience.

2.8.10 Reflective and Critical Thinking

This review revealed the many sources of stress and distress in the current nursing environment that impact on the health and well-being of nurses and midwives. This situation directed research into areas of exploring knowing, wisdom, and ways of being, thinking and reflecting. Nurse researchers explored self-reflection as a means to emotional, psychological, physical and spiritual healing (Becker Hentz & Lauterbach 2005; Lauver 2000; Thorpe & Barsky 2001). Thorpe and Barsky (2001) used a reflective thinking model comprised of three stages, awareness, critical analysis and new perspective, to study a small group of mid-life, female nurses’ potential to effect self-healing by reflection. An underpinning theory of their research came from Pierson (1998) that reflection was made up of calculative and contemplative thinking. Thorpe and Barsky (2001: 762) concluded that reflective thinking depended on trust, “to share one’s thoughts, feelings and experiences honestly.” This study’s participants reported that healing through self-reflection brought realisations of the need to make positive changes in their spirituality, attitudes to caring for self and others and development of eustress, or a positive response to stress (Thorpe & Barsky 2001). Therefore, reflection was critical for the development of self-awareness, self-care and self-development.

McGee (2006) also spoke of her own healing via self-reflection as an aspect of developing resilience as a nurse. She believed her development of resilient survival skills as a child came to her aid when she began working as a nurse in an emergency shelter for homeless men, “my earlier life experiences had taught me well to function
highly in chaotic and dangerous situations” (2006: 50). She ascribed to the need for self-nurturing and reflecting on the traits of resilience for nurses in order to improve their practice. Other nurse theorists have commented on the challenge of examining one’s own meanings of life and death and cultivating authentic caring practices for self and others (Kirby 2005; Watson 2003).

2.9 Work-based learning programs

A wide range of research literature existed regarding the need for and implementation of work-based learning interventions for individuals and groups. These studies were justified as a means of discovering more about how organisations may assist workers to perform their role and achieve best practice. Additional research was aimed at helping people, including nurses and midwives, to deal more effectively with the constantly changing and stressful organisational environments they were a part of. Research most relevant to the current study pertained to the introduction of work-based learning programs for better health and wellbeing outcomes, and those studies that positioned the workplace as the situated context of learning. Bryson, Pajo, Ward & Mallon (2006) revealed the importance of expansive workplace environments for fostering learning and development at work, for learners to become engaged and feel less restricted within the organisation. The exploration of how learning and development can be fostered in a workplace learning group will be an important aim in the current study.

In nursing and midwifery, the need to find education and training responses to redress some of the most pressing problems has driven recent research studies, especially given the continuing problem of nursing workforce losses and the aging nature of the nursing community. Nursing work-based learning programs in recent years have covered a range of learning objectives and needs, including therapeutic use of the self and reflective practice (Kemp, Rooks & Mess 2009; Stupans & Owen 2010), engaging with patients (Phillips 2009), aggressive and challenging behaviours from clients and colleagues (Farrell & Salmon 2009), and horizontal violence awareness (Rice & Vaughn 2010). The current study will concentrate on learning and
development aimed at reducing workplace adversity and its negative effects on worker health and wellbeing, sense of fulfilment and commitment to stay.

Another area of nursing research identifying learning needs related to the skills and experience needed for the socialisation or transition of new graduates and early career nurses and midwives into clinical areas and health care organisations (Jarman & Newcombe 2010). A further area of interest was developing specific nursing populations with unique teaching and learning needs, such as clinical nurse educators or registered nurses who work night shifts exclusively (Mayes and Schott-Baer 2010; Stupans & Owen 2010). The current study will seek to explore the health and wellbeing needs of nurses and midwives in a particular setting, and address them through experiential learning experiences that resonate with the concept of personal resilience.

Other industries characterised by organisationally induced stress, such as the police service, initiated work-based learning projects to encourage staff to address workplace stress and become better informed about their own health and wellbeing (Love & Edwards 2005; Murray-Gibbons & Gibbons 2007; Stevens, Muller & Kendall 2006). In addition, specific times of change in organisational life, such as during restructuring and economic downturn, were studied in the context of programs designed to enable workers to manage stress, reflect on their strengths and continue to perform in an uncertain future (Cooper 2004; Svensson, Elstrom & Aberg 2004). Another research direction was fuelled by the new learning technologies available in an e-learning society and the rise in favour of the concept of a ‘learning organisation’ as a model of continuous innovation and improvement, and one that facilitates greater work/life balance for employees (Allan & Lewis 2006; McInnes 2002; Snell & Hui 2000). The findings of these studies will inform the current study in the aim of responding to the learning needs of study participants with appropriate strategies.

2.10 Justification of this study

Even though the literature attests to the severity of workplace adversity in the nursing and midwifery work environment and the negative effects on nurses and midwives, so
far the problems remain chronic and acute. (Duddle & Boughton 2007; Fischer et al. 2006; Keller et al. 2009). The incidence of workplace adversity is a substantial problem facing nurses and midwives, and health care organisations in general. These issues are continuing to affect the number of nurses and midwives entering and staying in the field and require further study (Boychuk Duchscher & Cowin 2006; Cash et al. 2009; Zander, Hutton & King 2010). There is also a current gap in research on workplace adversity from a women’s health setting perspective. This study will use a collective case study approach to explore the experiences of nurses and midwives working in this area and facing workplace adversity.

Further research is needed to ascertain what preventative strategies are helpful in assisting nurses and midwives to withstand workplace adversity. Previous research indicated that there are several advantages and competencies associated with the phenomenon of personal resilience McAllister & McKinnon 2008; McGee 2006; Perry 2008). This study will use an intervention that seeks to address workplace adversity by exploring the protective and strengthening abilities of personal resilience. The current study will explore the phenomenon of personal resilience in a group of nurses and midwives, and assess its efficacy as a strategy that influences their health, wellbeing, fulfilment and commitment to stay in their employment. The need for continuing research in this area evidenced by existing literature provides a strong rationale for this study. This study will investigate whether personal resilience may be a major contributory factor associated with health and wellbeing in nurses and midwives, and particularly helpful as a protective mechanism against the negative effects of workplace adversity.

Existing research indicates that, because of the vulnerability of nurses and midwives to negative consequences associated with workplace adversity, there is an additional need to find effective education and training interventions that are conducive to positive experiences and outcomes (Farrell & Salmon 2009; Kemp Rooks & Mess 2009). This study will utilise an intervention that explores the positive effects of education and training from a resilience perspective. The intervention will utilise experiential learning opportunities and creative strategies to maximise engagement with learning. It is imperative that further research be undertaken concerning the
most effective and worthwhile interventions to develop and maintain personal resilience.

2.11 Summary

This review of the literature demonstrates that the problem of workplace adversity is a concern to the health and wellbeing of nurses and midwives working in the contemporary nursing workplace. The explication of both the causes and characteristics of workplace adversity, and the components associated with personal resilience, emphasises the need for research into how building and maintaining personal resilience may be a mechanism to protect nurses and midwives against workplace adversity. These insights will inform the investigation of the phenomenon of workplace adversity in a group of nurses and midwives. They will also provide key understandings of the experience of personal resilience, and support the design and implementation of an intervention to develop, strengthen and maintain personal resilience in nurses and midwives. The next chapter will present the instrumental collective case study design used in this research study.
CHAPTER 3: Abstract

This chapter gives a review of the literature surrounding case study methodology, and indeed collective case study method, as a valuable and appropriate way of undertaking research inquiries of this kind. In this chapter, the structure of the instrumental collective case study design is explicated. The major research tasks of the four sequential phases of the research design are presented and the study setting is described. The chapter also reports on the process of undertaking the semi-structured, qualitative interviews and analysing the emergent insights. The limitations of the method are also discussed. Finally, the chapter sets out the research framework for the ethical process and practice of the study.
CHAPTER 3: Methodology and Methods

3.1 Introduction

The current study aimed to illuminate a specific phenomenon: the development, strengthening and maintenance of personal resilience in a group of nurses and midwives. To achieve this aim it was necessary to gain a deep understanding of the group as individuals and the events and systems of the workplace they were a part of. Case study is a method of research based on in-depth investigation over a period of time; it is a systematic way to observe events, relationships and processes, and gather and analyze information about a specific case (Yin, 2003). This chapter sets out the research process of the case study with the aim of defining the steps taken to meet the research aims. Bassey (1999) asserted that the research process should be a creative, critical and systematic activity. Therefore, the chapter details the research methods used in each phase of the study; the selection of cases, the collection of data from a number of sources, the intervention of workshops and a mentoring program, and the process of data analysis. The relevant ethical issues and limitations of the method are also discussed. The chapter provides an explanation and justification of why case study was chosen for this inquiry and why it proved to be an appropriate framework to investigate the research questions.

3.2 Methodology

A collective case study methodology was chosen as it best matched the descriptive and evaluative nature of the research aims and revealed the depth and richness of investigation required (Creswell 2007; Yin 2003). Qualitative research methodology is useful for describing complex phenomena, especially from the situated context of the case setting. This methodology also enabled the examination of social or theoretical constructs such as resilience (Johnson & Onwuegbuzie 2004).
3.2.1 Case Study Design

Case study research is characterised by units of analysis that are bounded in space and time; or explicitly categorised, for example, by locale, culture, processes or institution (Hancock & Algozzine 2006; Stake 1995; Yin 2003). Case study examines the particular or specific among others (Stake 2000); however, to do this thoroughly may require an understanding of further cases that provide context for the particular case. A case is a bounded system of specific behaviours, patterns and sequences (Cohen Manion & Morrison 2000; Stake 1995). The case study approach has been further defined as “a detailed, intensive study of particular contextual and bounded phenomena that is undertaken in real life situations” (Luck Jackson & Usher 2006: 104). Case studies seek to establish complex and full explanations of phenomena. They provide both nomothetic explanations, or those that flow from the investigation of causal factors within a larger number of cases; and idiographic explanations that seek to dig deeply into fewer cases and develop as complete an understanding of them as possible (de Vaus 2001). Case studies also rely on multiple sources of evidence (Robson 1994). Case study method calls for collection of a broad range of information including “categorical data, perceptual and attitudinal dimensions, and real-life events” (Yin 2003: 33).

As well as having the potential for exploring the presence of specific phenomena, case studies may gather insights about a particular group (Stake 2000). Like other methods, case study research positions participants as expert sources of information (Yin 1994). A case study requires focused inquiry into the complexity of each single, specific case even if the researcher is most interested in making possible generalisations about a number of cases, a population or a phenomenon (Stake 2000). The method can also provide deep understandings of processes and behaviour within organisations.

One type of case study design is the descriptive case study, which provides narrative accounts (Yin 2003). De Vaus (2001) proposed that the ability to describe cases adequately is a significant part of determining the case. However, although a case study aims to describe the whole case, de Vaus argued it is impossible to include everything about a case, and so descriptions will emphasise the aspects of the case
that reflect the focus of study. Each description will also reflect the theoretical approach used and the conceptual understandings of the researcher.

Descriptive case studies may include single and multiple cases. Typologies, or a collection of ideal types, may be used to describe cases in multiple case studies. These ideal types convey the elements of the case theoretically; although there may not be any actual examples of the type in the real-life case (Coser 1977; Merton 1968). Deductive typologies can be useful in guiding analysis of the case because they set a standard that actual case can be compared to (de Vaus 2001). Inductive typologies are those that compare actual cases by grouping those that have similar dimensions into a characteristic type, and then using it to consider a research question (de Vaus 2001).

Case studies are also characterised by other types of research design; they may have either parallel or sequential designs (de Vaus 2001). Parallel case studies have researchers investigating different cases at one time and comparisons are made at the end. In sequential case studies, as in the current study, information is collected and analysed from each case and pre-emergent understandings may inform and influence the investigation of subsequent cases. Another element of case study design is the time dimension of the study (Yin 2003). A retrospective design collects information some time later than the event or period that the case study relates to, using multiple data sources such as records, documents and interviews with the people involved in the events. A prospective design investigates events as they occur and considers changes into the future (de Vaus 2001). They may take place over an extended period depending on the types of cases studied. In either retrospective or prospective designs the analysis of the sequence of events and issues occurring within the case provide convincing causal explanations (Yin 2003).

Another way of defining case studies is by considering the primary interest. Stake (1995) referred to three types of case study – intrinsic, instrumental and collective. *Intrinsic case studies* are carried out to understand the case itself; in other words, there is an intrinsic interest in the case rather than a broader interest in the abstract constructs surrounding the case, such as resilience or workplace adversity. *Instrumental case studies* examine a particular case to draw conclusions about an
external issue; and understanding of that issue is facilitated by understanding the case. Ragin used the question “what is this - the research subject - a case of?” (1992: 6) to discover what study of the particular case explained about an issue. A sub-category of instrumental case study is the collective case study. Stake defined this type as being the instrumental case study of several cases (2000). Individual cases that may share common characteristics are selected to form a collection, in order to represent an even larger collection. The degree to which they share common characteristics may not be evident when they are selected. Stake argued that, regardless of the type of case study methodology used, case study researchers must proceed with a balance between particular and general interest: “in general there is no line distinguishing intrinsic case study from instrumental; rather, a zone of combined purpose separates them” (2000: 137).

The current study was an instrumental case study with sequential phases of pre-intervention, intervention, immediate post-intervention and 6 months post intervention. The study investigated a collective case of nurses and midwives and implemented an intervention, to both better understand the case and to determine how the phenomena under investigation, personal resilience, could be improved.

### 3.2.2 Case studies in research literature

The strength of case study research has developed over time so that it is now considered a significant and valid research design, especially when dealing with complex or experimental topics, and in the context of exploration and evaluation. Case studies have become a proven method of approaching qualitative, quantitative and mixed methods research, discussed extensively in the literature and used frequently in practice (de Vaus 2001; Hancock & Algozzine 2006; Luck et al 2006; Merriam 1998).

Case studies have been applied to a wide variety of topics in many different fields, including nursing, medicine, law, policing, education, community health, welfare, industry and management (Chaboyer McMurray & Wallis 2010; Nelson 2003; Nilsen 2001; Zander 2005). Case study methodology has been considered preferable in
instances where there is a scarcity of information about the research topic. For example, Lo and Lamm (2005) adopted a qualitative case study methodology to inquire into occupational stress in the hospitality industry in New Zealand, as the current levels were not known. Their study compared the experiences of employers and employees in two sites of differing organisational structures -- an international chain and a locally owned hotel -- to understand the prevalence of occupational stress, existing attitudes to managing stress and the industry’s current approach to dealing with it. The authors believed that case study methodology was best given the exploratory nature of their inquiry; and a similar rationale existed for its use in the current study.

Case study methodology is also frequently implemented where there are complex contextual factors that defy understanding of precisely what is occurring, for example in environments of constant or broad changes. A major area affected by wide-ranging change has been large organisations. Case study is particularly useful in studies of organisations as it “may be defined by role or function, may be shaped by organisational or institutional arrangements” (Cohen et al. 2000: 182). This was helpful in the current study as the case investigated was situated in an organisational context. Several recent case studies have examined issues related to organisational and workplace learning, workplace processes and change in both public and private sectors (Betts & Holden 2003; Cooper 2004; Coupland Blyton & Bacon 2002; Duncan Mouly & Nilakant 2001).

3.3 Collective Case Study

In this research study, a collective case study methodology was used. Collective case studies are those that report on several cases in one inquiry and estimate the size and strength of an effect, as opposed to the generalisable effect in a population (Tashakkori & Teddlie 2003). A collective case study may consist of several individual cases used to examine a phenomenon, group or general condition (Stake 2000). Collective case studies have been utilised across many disciplines, such as education, psychology and health administration (Au & Blake 2003; Fitzgerald 1998; Mestemacher & Roberti 2004; O’Connor 1997; Patterson 1999).
Collective case studies have been used in a variety of research contexts; however, frequently they have been used when the primary research aim was to gain insights into health, educational or employment programs or outcomes for under-served populations. For example, Wright, White and Gaebler-Spira (2004) used the collective experiences of five children with cerebral palsy to explore the use of an adapted physical activity. Crudden (2002) investigated the issues faced by ten visually-impaired people attempting to retain their employment after vision loss and Van Niekerk, Furnaux, Percy, Roberts and Seider (2004) studied the influences on work experiences for people with psychiatric disabilities. Other collective case studies have dealt with assessing the educational needs and experiences of disadvantaged groups, such as Afro-American high school students, Native American nursing students and bi-lingual students (Katz 2005; O’Connor 1997; Torres-Guzman, Abbate, Brisk & Minaya-Rowe 2002).

Collective case studies have also been used to examine and evaluate issues for larger organisations (Jiang 2001; Macher 2004; Stevens et al. 2006). Collective case studies have been used to develop theory about the process of change, and the role of leaders during change in organisations, including health care organisations (Altman 2005; Denis Lamothe & Langley 2001; Murray & Elston 2005). In the field of education, collective case studies have been undertaken in particular when evaluating new technologies (Lim & Barnes 2005; Patterson 1999) or aspects of educational reform (Karvonen, Flowers, Browder, Wakeman & Algozzine 2006).

A third research area where collective case studies have been applied is where the focus was on understanding aspects of little-known human experiences and phenomena. For example, collective case study was used to analyse the vocational choices of female exotic dancers (Mestemacher & Roberti 2004). Perly (2006) explored the phenomenon of physicians’ ‘curbside consultations’ with their colleagues to ascertain the speed, veracity of information given and physicians’ access to clinical knowledge. Stake pointed out that studying phenomena should not be undertaken without considering the “situational uniqueness” (2006: x), or the specific contextual complexities of their occurrence in the case under investigation, especially when policy or environmental changes are the anticipated outcome of the research.
Nursing research studies have also adopted collective or multiple case studies to explore issues of policy, nursing roles and phenomena (McDonnell, Jones & Read 2000). Kolanko’s (2003) study of nursing students with learning disabilities combined an assessment of the educational needs of students with special needs and reported on the personal interpretations of students’ experiences of studying nursing with a learning disability. Another collective case study was used to describe the metacognitive strategies of baccalaureate nursing students (Wissman 2002). A collective case study by Luck et al. (2009) shed new light on the phenomenon of violence directed at rural and regional nurses by patients and their families and friends.

Therefore, collective case studies have proven a rich research method when complex research foci are present - broad social or contextual factors that impact small populations, or an investigation of under-researched phenomena, roles or behaviour in human experience. It is also possible that both broad-ranging and under-researched aspects of study intersect in one case study inquiry.

3.3.1 The current study

The particular characteristics of the current study – examining the presence and development of an abstract phenomenon, personal resilience, among a group of nurses and midwives working in the real-life context of a specific workplace – closely matched the definition and aims of collective case study research. The ‘case of’ the nurses and midwives working in the chosen women’s and children’s health service with its specific geographical, cultural and procedural boundaries could be identified as a bounded unit. Each nurse/midwife could also be identified as a single, or individual case within the larger bounded collective case.

Continual and rapid change was a feature of the bounded case, driven by increasing health care demands being placed on the organisation and an ongoing shortage of experienced nursing staff. This situation caused various difficulties for the nurses and midwives working within the system, and complex questions to emerge about their personal resilience. The specific context of the case; namely the abstract nature of the
phenomena under investigation and the complex nature of the case itself made case study a preferable strategy (McDonnell et al. 2000). The current study gathered the participants’ opinions, beliefs and attitudes about resilience in a series of interviews before, during and after the intervention. The study followed the experiences of each participant as they were involved in the intervention, six resilience workshops and a mentoring program. Case study method, with its ability to focus on and evaluate smaller elements of complex information, provided the evidence to assess the potential of the intervention to be transformational or emancipatory in its influence on the participants.

The current study employed an explanatory research design (Yin 2003) that sought to determine the ‘how’ and ‘why’ of the events or processes occurring and the ways they predicted certain outcomes (Yin 1994). Therefore, individual case interpretations of abstract constructs as well as the whole or ‘collective case’ explanations about cause and effect relationships were part of the theoretical framework (Bassey 1999).

In addition to exploring the phenomena of personal resilience in the collective case, the study sought to elucidate human experiences, in particular the subjective nature of the participants’ experiences. This required the recognition and valuing of lived experiences, and the perspectives of those telling their personal stories. Martin and Booth (2003), in their review of Braud and Anderson’s categories of research questions (1998), argued that case studies were an adequate research method when subjective qualities of experience were a chief research interest.

This research study required the in-depth study of more than one case to comprehensively understand the main concepts of workplace adversity and personal resilience. A collective case study best enabled the researchers to compare and contrast the shared and differing patterns across the cases (Borbsai Jackson & Langford 2008). In the current study each participant from each cycle was seen as an individual case within the larger bounded case of the group. Their narratives consisted of their experiences and insights prior to, during and after their participation in the intervention. Individual cases were perceived as illustrators representing the range of different experiences, attitudes and beliefs within the larger bounded case. Indeed, this method was found to greatly assist with guarding the “original voice”
(Webb, 2003: 42) of those with their own experiences to direct their stories. This capability to make between-case comparisons has been considered a methodological strength of case study (McDonnell et al. 2000).

Although it was clear that similarities between the individual cases were present; it was felt that a diverse collection of cases, in terms of attitudes and experiences, would strengthen understanding of the phenomenon of personal resilience (Stake 1995). However, it was also important to understand the individual cases within the context of the whole. De Vaus (2001: 221) stated that “case studies are designed to study wholes rather than parts.” Uncovering the underlying theoretical explanations of several individual cases gave the capacity to theorise about the larger collection (Hancock & Algozzine, 2006). By doing both ‘within-case’ and ‘cross-case’ comparative analyses, similarities and differences were identified (Cresswell 2007).

Collective case study method is particularly useful when there is potential for shared understandings between cases (Dempsey & Dempsey 2000). In the current study the participant shared common understandings related to their work experiences, work stresses they encountered and the effects on their wellbeing and ability to cope. Participation in the study was also a common experience they had all shared. In keeping with narrative research tradition (Clandinin & Connelly 2000; Gilligan 1982, 1988), their narratives revealed, at least to a degree, the essential aspects of the phenomenon of developing, strengthening and maintaining personal resilience.

The ability to better conceptualise current theories has also been a stated aim of case study method (Stake 1995). It was possible, by using the collective case study approach, to generate theories about the phenomena from one case, or between phases of the study, to build further areas of inquiry into the process of change in other cases (Denis et al. 2001).
3.4 Research Study Design

Research design can be understood as the logical structure of a study or the plan by which obtainable evidence is gathered to answer the initial research questions (de Vaus, 2001). The current study adopted a comparative, collective case study design. It consisted of four sequential phases. The research design was conducted twice in the interests of replication and so there were two cycles of different participants. The figure below summarises the study phases for participants (see Figure 1).
Figure 1: Research Design for Participants

Participants

Pre-Intervention Phase
- Qualitative interview regarding current perceptions of health, wellbeing, resilience, features of workplace adversity; working environment, daily challenges

Intervention Phase
- Resilience Workshops
  A day workshop each month x 6 months enlarging on the characteristics of personal resilience:
  Topic 1: Establishing positive nurturing relationships and networks and the mentoring relationship
  Topic 2: Maintaining a positive outlook and building hardiness
  Topic 3: Developing intellectual flexibility and emotional insight and intelligence
  Topic 4: Achieving a life balance and enabling spirituality
  Topic 5: Encouraging reflective and critical thinking
  Topic 6: Moving forward and planning for the future
- Facilitated formal mentoring program
  A program providing support from a retired or senior nurse/midwife mentor for the intervention period

Post-intervention Phase
- Qualitative interview regarding their perceptions of the intervention and its effect on personal resilience

Six Months Post-intervention Phase
- Qualitative interview regarding their perceptions of the permanency of learning and its effect on personal resilience
As indicated, this was a study of an intervention. The intervention included workshops and a mentoring program. The detailed description of this intervention is presented in Chapter 6.

This section will describe the research aspects of the thesis i.e: the collective case study of the phenomena of personal resilience and use of the intervention to investigate the phenomena in nurse and midwives. Therefore, the following section will describe in detail the data collection and analysis of data in the various phases of the study.

3.4.1 **Phase 1: Pre-intervention:** Two major tasks were addressed in the pre-intervention phase of this research study: recruiting the participants and interviewing them to provide the beginnings of the case study. Data from this phase were collated and analysed to inform Phase 2.

3.4.1.1 **Recruitment of nurse/midwife cases:** Participants were invited to join the study via posters and pamphlets placed in the study setting. The nurses and midwives that volunteered were sent an information package including details of the study and consent forms. The only inclusion criteria were that they currently worked for the selected women and children’s health service. Recruited mentors were successful senior nurses and midwives with extensive experience. They were recruited through advertisement in nursing and local media publications, and from flyers distributed amongst the nursing community at a large multi-campus School of Nursing.

3.4.1.2 **Qualitative Interviews:** Upon recruitment into the study, each participant took part in an in-depth interview that was conducted at a convenient time for them. The purpose of the interviews was to explore their pre-existing understandings of resilience, survival and thriving in the workplace, as well as issues of concern to them that could be addressed during the intervention workshops. The findings of these interviews provided the detail of the case study prior to the intervention and the details of the workplace environment as presented in Chapters 4 and 5.
3.4.2 **Phase 2: Intervention:** Each cycle of the intervention took place over a period of six to seven months. The intervention phase involved participants attending a one-day workshop each month and participating in a mentoring program designed to build and reinforce resilience for six months. The framework of the workshops was designed to develop knowledge, confidence and skills in key aspects of personal resilience through individual exercises, small group work, and facilitator and guest speaker presentations. The workshop content was partially informed by findings from Phase 1 interviews. The mentoring program included facilitation conducive to establishing good mentoring dyads between each mentee and their choice of a senior or retired nurse/midwife mentor for the period of the intervention. During this phase, the mentoring partners met or spoke together regularly to enhance learning, and work towards personal and professional objectives of the mentees. Because of the importance of the development and implementation of the intervention in the case study, the details are presented in a sequential manner after the pre-intervention phase in Chapter 6. The reflections of the researcher as facilitator, the participants and mentors are also presented in Chapter 6 to provide the reader with enhanced detail of the intervention.

3.4.3 **Phases 3 and 4: Post-Intervention:** The post-intervention aspects of the case study are presented in Chapter 7. This chapter provides the final conclusions of the case study; showing the outcomes of the intervention and the impact of both the workshops and the mentoring program on the enhancement of personal resilience in the participants.

3.4.3.1 **Phase 3: Immediate Post Intervention:** In the month after the intervention concluded, the participant interviews were repeated to gather information about the participants’ experiences and their perceptions of the efficacy of the intervention in building their resilience.

3.4.3.2 **Phase 4: Six Months Post Intervention:** Six months after the end of the intervention, the participants were interviewed for a final time. Each nurse/midwife was asked to evaluate the perceived permanency of learning and behaviour changes arising from the intervention that could be attributed to an increased understanding of the attributes and process of personal resilience.
Outcomes and recommendations supported by the intervention were reported back to the health organisation research partner and other relevant groups.

3.5 The Setting

The hospital was part of a large state Area Health Service servicing a number of satellite hospitals and located in an outer suburb of a large metropolitan city. Table 3.1 below provides certain aspects of the community’s demographic profile from the 2006 Census (Commonwealth of Australia 2007).

Table 3.1: Demographic Profile of Local Government Area (LGA)

<table>
<thead>
<tr>
<th>Profile Characteristic</th>
<th>Total (LGA)</th>
<th>(%)</th>
<th>Total (National)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>172 140</td>
<td>--</td>
<td>19 855 288</td>
<td>--</td>
</tr>
<tr>
<td>Total Families (coupled/single parent &amp; children)</td>
<td>46 186</td>
<td>70.2</td>
<td>5 219 165</td>
<td>61.1</td>
</tr>
<tr>
<td>Dwellings owned by State govt. housing authority</td>
<td>2 547</td>
<td>16.7</td>
<td>306 697</td>
<td>14.9</td>
</tr>
<tr>
<td>Median weekly family income</td>
<td>1 285</td>
<td>-</td>
<td>1 171</td>
<td>--</td>
</tr>
<tr>
<td>Population aged 24 yrs and under</td>
<td>66 430</td>
<td>38.6</td>
<td>6 641 485</td>
<td>33.4</td>
</tr>
<tr>
<td>Persons born overseas</td>
<td>35 357</td>
<td>20.5</td>
<td>4 416 037</td>
<td>22.2</td>
</tr>
<tr>
<td>Indigenous Persons</td>
<td>4 048</td>
<td>2.4</td>
<td>455 031</td>
<td>2.3</td>
</tr>
<tr>
<td>Unemployed Persons</td>
<td>4 654</td>
<td>5.3</td>
<td>503 804</td>
<td>5.2</td>
</tr>
</tbody>
</table>

The study setting was a number of wards in a 57-bed maternity department situated in a women and children’s health service at a level six tertiary referral hospital. The wards were categorised by the focus of services provided: antenatal, delivery suite and post-natal. Consumers of the service were public and private patients as well as general practitioner shared-care recipients. The department provided midwifery student placements from three universities, and offered midwifery refresher and Reconnect\(^1\) course placements.

\(^1\)A state government nursing retention initiative that includes additional education and training for Reconnect nurses and midwives returning to service after several years out of the nursing field.
3.5.1 **Ante-natal Ward**: This was a 24 bed ward with a 6 bed day stay attachment. The antenatal service operated on weekdays from 8:30am to 4:00pm. There were fifteen full time and sixteen part-time staff employed, with typically seven or eight midwifery staff working in the service. Shifts were predominantly made up of 2 to 3 midwifery staff and a mix of first year new graduate nurses, student midwives and enrolled nurses. The service incorporated gynaecological, antenatal and paediatric clinics, and provided for post-natal overspill. It gave approximately 2500 occasions of service per month. This service provided care for women with low risk pregnancies as well as a range of high-risk health conditions including diabetic, endocrine and renal dysfunction, and drug and alcohol use. Adolescent and Indigenous women were also cared for under shared-care arrangements with local community health clinics. Women from two local correctional centres also received nursing care from the service.

3.5.2 **Delivery suite**: The delivery suite comprised of eight birthing rooms and ensuites. There were also four beds used for assessment of clients presenting to delivery suite for review by a midwife or doctor. Staff worked on a shift basis to cover a 24-hour, 7 day service. There were twelve full time employees and twenty-three part-time employees. The unit cared for high-risk women that were greater than twenty weeks gestation from across the state. There were approximately 3600 deliveries per year. The service also provided a high standard of midwifery education with senior midwives committed to teaching students. Australian Defence Forces members and Indigenous health workers were involved in clinical placements with the delivery suite.

3.5.3 **Post-natal Ward**: This was a 30 bed ward, with an additional four cots in the attached nursery for babies requiring special care. There were eleven full-time and eighteen part-time nurses and midwives. This area provided care for the women who had recently given birth and their newborn babies, and so had a complex mix of clients, as in the ante-natal ward and delivery suite, and included women recovering after caesarian section. Many family members and friends of the clients also visited the area. Typical patient stays were brief, ranging from 4 hours post-delivery to 2 or 3 days after birth.
3.6 Entering the Field

Following ethics approvals (see Appendix B), consent to gain access to the field was obtained from the Director of Nursing at the site. An oral presentation about the research study was provided on-site to publicise the study amongst the nursing management and staff of the organisation. The presentation was attended by the Regional Cluster Director of the area health service. Permission was also given for the researcher to speak about the study at a Nursing Unit Managers meeting attended by approximately fifteen departmental nursing managers. At the meeting those in attendance were informed about recruitment procedures, expectations and potential benefits for the participants. Their co-operation was sought and received regarding distributing brochures publicising the study amongst staff members in the cluster of wards.

3.7 Participants

3.7.1 Recruitment: All nurses and midwives working in the specific women’s and children’s health unit were eligible to participate. Recruitment into the study was entirely voluntary. After gaining ethics approval and presenting a study overview to the executive and nursing managers of the Area Health Service, recruitment posters and brochures were given to the relevant nursing unit managers. Brochures were distributed to staff at team meetings and placed in common staff areas. Three A3 size laminated study posters were also placed on the walls of the selected wards and in the staff room. The brochures and posters (see Appendix C) set out information about the study and provided contact numbers for those interested to telephone the researcher to discuss their participation.

When potential participants made contact with the researcher they were informed about the general purposes of the study, the role and expectations of participants, the estimated time their participation would take and the potential benefits for them. They were informed that they could withdraw from the study at any time they wished, and that any information they gave would remain anonymous and confidential. Potential participants were informed that any information given would be de-
identified and they would be provided with pseudonyms. They were asked to take part in three face-to-face, semi-structured, qualitative interviews that would be audio-taped and transcribed into text for the purpose of thematic analysis. Information was provided that participants would be allowed time away from work for interviews to take place or they could come in at another time if they preferred. The potential recruits were also given a brief overview of the workshop topics, content and activities. They were informed that their attendance at the workshops would be viewed as paid study leave by their employer. The potential benefits of the mentoring program and workshops were explained to potential participants, as well as the expectations of them as mentees.

If the nurse/midwife agreed to participate in the study, a convenient time was made for them to come to the clinical nursing research unit at the hospital for an interview. Upon arrival, they were given the opportunity to again discuss any questions, issues or concerns about the study or their participation. In this way a high standard of informed consent was maintained. The participants were asked to read through the participant information statement and consent form with the researcher and sign if agreeable (see Appendix D). They were also asked to complete a demographic information form that asked about their age, gender, qualifications, education, and marital and socio-economic status (see Appendix D). They were asked for permission to carry out validation by member checks at later stages of the research. Nine nurses and midwives agreed to participate in Cycle 1 and five in Cycle in 2, giving a total of 14 cases that formed the collective case.

In addition to the recruitment strategies above, Cycle 1 participants were asked to assist with the recruitment of participants for Cycle 2. Each person was asked if they were willing to speak to work colleagues about their participation in the study. If they agreed to participate, they were sent four letters of invitation via the internal mail system and four study brochures to pass on to colleagues.
3.7.2 Participants for each Cycle

Table 3.2: Cycle 1 Participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Years Nursing</th>
<th>Position</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rose</td>
<td>53</td>
<td>&gt;19</td>
<td>Clinical Nurse Specialist</td>
<td>Full time</td>
</tr>
<tr>
<td>Patrice</td>
<td>53</td>
<td>23</td>
<td>Enrolled Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Lynette</td>
<td>51</td>
<td>31</td>
<td>Registered Nurse/ Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Marika</td>
<td>51</td>
<td>31</td>
<td>Clinical Nurse Specialist</td>
<td>Full time</td>
</tr>
<tr>
<td>Jodie</td>
<td>45</td>
<td>18</td>
<td>Clinical Nurse Specialist</td>
<td>Part time</td>
</tr>
<tr>
<td>Alice</td>
<td>40</td>
<td>3</td>
<td>Registered Nurse/ Midwife</td>
<td>Full time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(left after Phase 1)</td>
<td></td>
</tr>
<tr>
<td>Lauren</td>
<td>39</td>
<td>10</td>
<td>Enrolled Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Neralie</td>
<td>37</td>
<td>20</td>
<td>Enrolled Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Gillian</td>
<td>30</td>
<td>8</td>
<td>Registered Nurse/ Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Tina</td>
<td>26</td>
<td>3</td>
<td>Registered Nurse</td>
<td>Full time</td>
</tr>
</tbody>
</table>

3.7.2.1. Cycle 1: In the first cycle there were nine female nurses and midwives aged between 26 and 53 years (see Table 3.2). There were a variety of nursing and midwifery qualifications and work experiences amongst the group. Five were registered midwives and nurses, including three of whom were also clinical nursing specialists. Clinical nurse specialists are “registered nurse/midwives who apply a high level of clinical knowledge, experience and skills in a specific area of practice, contribute to the development of clinical practice in the unit, act as a resource and mentor to others in relation to clinical practice and actively contribute to their own professional development” (NSW Health 2009: 2). One participant was a general registered nurse, and three were enrolled nurses. They had been employed by the health service from 18 months to 22 years. The group worked in positions across the department in ante-natal, delivery suite and post-natal wards. Although all the participants were working in the maternity department of the hospital at the beginning of the study; one of the registered nurse participants transferred to a paediatric ward after the second workshop. Six participants worked full-time and three in a part-time capacity. Seven of the participants reported they had tertiary nursing qualifications, with six of those holding an undergraduate degree in either nursing or health science. Five had gained a post-graduate degree in midwifery. Five participants were married. Four were single; one of whom was divorced. Six participants were Australian born residents, and three had migrated from European and Asian countries.
Table 3.3: Cycle 2 Participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Years Nursing</th>
<th>Position</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicky</td>
<td>59</td>
<td>15</td>
<td>Registered Nurse/Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Lisa</td>
<td>48</td>
<td>3</td>
<td>Registered Nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>Talia</td>
<td>46</td>
<td>20</td>
<td>Registered Nurse/ Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Karin</td>
<td>41</td>
<td>18</td>
<td>Clinical Nurse Specialist/</td>
<td>Part time</td>
</tr>
<tr>
<td>Monica</td>
<td>34</td>
<td>0.6</td>
<td>Registered Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(left after Phase 1)</td>
<td></td>
</tr>
<tr>
<td>Lucinda</td>
<td>33</td>
<td>12</td>
<td>Registered Nurse/ Midwife</td>
<td>Part time</td>
</tr>
</tbody>
</table>

3.7.2.2. **Cycle 2:** The nurses and midwives were all females, aged from 33 to 59 years at the time of recruitment (see Table 3.3). There were five Australian-born participants, and one who had migrated from a European country. All were employed part time in the maternity department of the selected hospital, three in the antenatal wards, one in the neo-natal intensive care unit (NICU) and one in postnatal wards. The participants worked a variety of shifts covering days, nights and weekends. One participant worked only night shifts. All participants were married or in long-term partnered relationships. Four of the participants worked on a part time basis; one worked full-time.

3.8 **Data Collection**

3.8.1 **Pre-Intervention: Qualitative Interviews**

In order to determine the learning goals of the intervention phase of both cycles, data were collected at pre-intervention, immediate post-intervention and at 6 months post-intervention phases using qualitative interviews with the participants. As well, field notes were maintained by the researcher. The pre-intervention phase interviews were carried out over three weeks and took place at the researchers’ office at the hospital. The unit was located onsite but in another area away from the participants’ workplace. The main aim of the interviews was to begin to formulate a profile of the complexities of the case as well as the individual participant cases and to build rapport with them.
The interviews were guided by a list of trigger questions that were given to each participant before the interview (see Appendix E). This was to allow participants to familiarise themselves with the kinds of information being requested and to feel more relaxed about the interview. They were also used to develop the conversation between researcher and participant. Open-ended questions were grouped together under headings of the research aims, such as

- ‘to explore participants’ understandings of surviving and thriving in the workplace,’
- ‘to explore participants’ understanding of resilience’ and
- ‘to discover if the participants have issues/concerns that could be addressed at workshops or by a mentoring relationship.’

The interview questions related to workplace networks, workplace environment, current stressors and perceived support for and from the organisation. Participants were also asked to describe their feelings about their own personal resilience level, personal meanings and understandings they held about the nature of resilience and the relationship between health, wellbeing and resilience. In addition, they were asked questions about the type of mentor they would value, if they had any particular issues or concerns regarding the workshops, or areas of specific interest that they would like to explore in the intervention.

### 3.8.1.2 Field notes

Field notes are typically used as a source of data in case study research (Cohen Manion & Morrison 2000; Yin 2003). They record significant information that is observed by the researcher during data collection. They may take the form of spoken words, non-verbal cues and individual or group behaviours. In the current study, field notes were made during group discussions in the workshops. Field notes were also written after the mentor meetings capturing pertinent comments and observations made by the researcher. The researcher also kept a reflective journal of observations and experiences of the intervention. These data sources were stored appropriately as electronic files on the computer in the research office.
3.8.2 Post-intervention Phases: Qualitative Interviews

Participants were contacted by phone, email or letter to arrange a convenient interview time for their interviews, within a month of the end of the intervention phase for their immediate post-intervention interview and six months later for their final interview. This was made easier by regular email and phone contact maintained with the participants. All interviews took place in a private office removed from the participants’ workplace. The immediate post-intervention phase for Cycle 1 took place from February to March 2008, and from January to February 2009 for Cycle 2. The six months post-intervention phase for Cycle 1 took place in September and October 2008, and in June and July 2009 for Cycle 2.

In the post-intervention phases the participants were asked to participate in face-to-face, semi-structured interviews. The interviews were audio-taped and transcribed for analysis. An interview schedule was given to the participants beforehand that contained clustered questions around the chief research interest; their personal resilience at each phase of the study (see Appendices F, G). Additional questions that had emerged from the analysis of the preceding phase were asked if necessary for further depth and validation of generated theories.

3.9 Management and Analysis of Data (Participants and Mentors)

The researchers had previously established confidentiality of the participants and mentors that was approved by the relevant ethics committees. The participants and mentors were each assigned a pseudonym which was used to label the interview audio-tapes and they were sent to an external professional transcribing service. Interview transcripts were made from the tapes with all confidential identifying information concerning participants, mentors and others removed. Audio-tapes and hard-copy transcripts were kept in a locked cupboard in the research office. Each transcript was also stored electronically in a computer file in the researcher’s computer.
Transcripts of all qualitative interviews were checked against the relevant audio-tapes to make sure they were correct and consistent with the original words and perceived syntax and emotional tone (Borbasi Jackson & Langford 2008). A process of content analysis by reading and re-reading the transcripts in order to become deeply immersed in the interview data then commenced (Cohen et al. 2000; Sturman 1997). Data immersion is understood as “dwelling” closely with the data to ensure familiarity (Borbasi et al 2008: 148). In the current study, the process began with written notations in the margins of the transcripts (Thorne 2000). A record was kept of initial themes and sub-themes emerging from this process.

The analysis process consisted of discriminating between the parts of the participants’ and mentors’ descriptions of the phenomenon and articulating essential statements about the experiences (Borbasi et al 2008). This method was used to explain how the participants’ perceptions of their resilience were formed, how they were influenced and whether they countered the effects of workplace adversity. The analysis also included an examination of the current workplace events and environment that affected resilience in the case. The analysis method was also used to explore the relationship between the practice of resilient strategies and self care and maintaining resilience. Rival explanations were also explored (Kelling & Coles 1996; Yin 2003).

The explicit discussion and interpretation of data is essential for good case study analysis (Kelling & Coles 1996). In the current study, the analysed data formulated the study findings, using illustrative descriptions that showed the key aspects of the phenomena being explored; firstly within each single case and then as a collective case (Hancock and Algozzine 2006). Careful use of the participants’ narratives was used to portray the case experiences and perceptions, the ultimate aim of collective case study analysis (Stake 2006).

Concepts and relationships were validated through the use of shared theories, such as social cognitive theory (Bandura 1989). The use of substantive theories as a context for comparison with the study data was used to determine validity and authenticity of the data and enriched the analysis process. In addition, reviewing the results of previous qualitative studies of personal resilience in individuals from a range of
disciplines was useful during analysis; helping to identify and develop the important theoretical elements of the current study.

The analysis process was assisted by the use of computer software NVivo 6, which assembled the interview data into clusters, or nodes, of thematically related pieces of narrative. This process also revealed the validity of the tentative assertions made about the case findings (Stake 2006). This was an invaluable step in the cross-case analysis process as it allowed the true strength of themes to be revealed. Use of the computer software system also ordered the narratives quickly and easily, and systematically managed a large amount of qualitative data (Borbasi et al 2008; Stake 2006).

3.10 Ethical Process and Practice

Ethics approval for the study was given by the university and selected area health service human ethics review commissions (see Appendix A). This research depended on the participants’ voluntary willingness to divulge and reflect on deeply held, personal opinions as well as sensitive elements of their own life stories. Therefore, it was imperative that the highest standard of ethical principles be upheld. The focus of these principles was on three main areas: consent, confidentiality and anonymity, and the respectful treatment of participants and their information.

Due to the fact that the study recruits were nurses and midwives currently employed by a health care organisation, they could be regarded as people in dependent or unequal relationships with the researchers (National Health & Medical Research Council 2007). In addition, this research involved relationships between employees and those that they may have considered as representatives of their employers, who were acting as researchers and facilitators of the implementation of the research study. Therefore it was necessary to pay particular attention to the process of negotiating consent and to minimise the impact of the participants’ dependency. During the consent process, potential participants were encouraged to take time with the written information about the study provided, in order to think over and discuss their
participation with others who were independent and able to support them in their decision-making.

It was also seen as important for the researchers to counteract any unrealistic expectations that participants may have had about the benefits of the research for them. The researcher reinforced the perceived benefits of the study at the beginning of each workshop, making it clear that the main focus of the intervention was exploratory rather than definitive in nature, even though its learning agenda had been informed by substantial research literature.

3.10.1 Consent

Informed consent is important for the safeguarding of research subjects and allowing them self-determination (Polit & Beck 2006). Informed consent was gained from each participant and the potential consequences and personal benefits of their participation were fully discussed. The participants were given as much detail as possible about the process of the research, such as the number and type of interviews they would be asked to participate in. They were informed of the expectations of their role as participants. Participants were informed that they would benefit from paid study leave days to attend the workshops and they would be released from work for their interviews if necessary. They were informed that they could withdraw from the study at any time without penalty or negative consequences. Each participant was given their own copy of consent and study information documents for later reference.

3.10.2 Confidentiality

Regardless of the approach used, participant confidentiality is a revered principle of qualitative research (Cresswell 2007). It is the responsibility of the researcher to protect the privacy of participants. Researchers also ensured that all interview data was kept strictly confidential. The participants were given pseudonyms at their initial interviews and these were used in research team discussions so that only the researcher knew the identity of the participants. All documents concerning the
participants were managed and stored confidentially in the nursing research office at the site.

In the current study confidentiality was particularly important due to the small number of participants and the potential for recognition of individuals from the presented findings. Similar problems have arisen before in research studies in other hospitals, settings which may be described as “small social systems,” (Archbold 1986: 158). McDonnell et al (2000) argued that preserving anonymity at the cost of losing the rich flavour of the individual cases was ethically defensible, but qualitative depth may be lost. Therefore, in the current study the appropriate approach was taken to the presentation of personal narratives; if necessary identifying features of the narratives were changed without losing the essential spirit and sense of the story. Case study research calls for the development of a composite portrayal of the case rather than individual ones (Cresswell 2007). Confidentiality was also an important consideration in the facilitation of the mentoring program. Principles of confidentiality were discussed with mentors at the Mentor Information Day to ensure they maintained participant confidentiality (see Chapter 6 for more information about this day). The same principles were used with information disclosed in discussions between mentors and the researcher.

In the current study there were also relationships, sometimes pre-existing, between the participants and the study setting was a shared workplace. During the intervention past personal experiences, work incidents and conversations referring to others were disclosed during discussions between participants. Therefore it was vital that the researcher took care to reiterate during the intervention that respectful treatment of co-participants included keeping information disclosed in the workshops confidential. It was also necessary to protect the confidentiality of participants’ comments about their workplace, and about others they worked with outside the group. The importance of keeping group members’ disclosures confidential was comprehensively dealt with in the first workshop. The participants were fully engaged in formulating group guidelines, which included regarding any and all comments made by participants within the workshops as confidential information. The appropriate ethical approach was also used when collecting data from observations of participant conversations; it was necessary to maintain awareness that the complex interactions and relationships
between the participants would continue beyond the period of the research study and their anonymity to others, apart from the primary researcher, needed to be protected.

3.10.3 Respectful treatment of participants

Ethical research includes the preservation of individuals’ beliefs, opinions, customs and culture (Polit & Beck 2006). It involves a fair, faithful and congruent account of participants’ words, experiences, meanings and knowledge (Borbasi et al. 2008). In the current study it was essential that integrity was a prime component in the relationship between the researcher and researched. The contributions of all participants to the research study were contingent upon the trust and respect with which participants and researcher regarded each other.

3.11 Limitations of the Method

Although case studies are well known for the deep and rich understanding they can provide about a case, they have been criticised for their lack of external validity. The understandings about a case cannot necessarily be transferred to any other case (de Vaus 2001). In the case under investigation, conclusions relied on the replication of findings from multiple cases, rather than being generalisable to other contexts.

Another limitation to case study method is the propensity for reflexivity of the researcher. Nisbet and Watt (1984) argued that a weakness of case study research was its tendency to have problems with researcher subjectivity and observer bias. Threats of reactivity are difficult to avoid in studies like the current study, which dealt with a small, inter-connected group of individuals and where the researcher used field notes and interviews to gain their insights. The researcher was also in regular contact with the participants for a relatively extended time, over 12 months, and so the potential for threats of reactivity was increased. De Vaus (2001) claimed that, in those instances, researcher reactivity would inevitably change the behaviour of the group and therefore the case. However, in this case study behavioural and attitudinal change was one of the stated aims of the study, so this limitation was somewhat reduced.
Data analysis was made more challenging by the fact that the researcher was also the intervention program facilitator. There was a potential for changes predicted pre-intervention to be observed. As well, during the phases of intense engagement with participants in the field, the validity of interpretations made about participants’ perceptions was influenced by the researcher’s capacity for reflexivity, or her awareness of pre-conceived notions and partialities. It was essential the researcher’s reflective journal entries included personal values and biases that had the potential to influence the interpretations made and that the practice of self-critique was continued during data collection and analysis (Lincoln & Guba, 1985).

3.12 Summary

This chapter presented the general research strategy followed in undertaking this collective case study. It set out the theoretical propositions and justification for the choice of collective case study method. The chapter explained the various research techniques that were used in managing the complex and valuable information of the participants. It also demonstrated the depth of effort and consideration given to ethical process and practice through appropriate treatment of the study participants, and to producing a high-quality case study through meaningful analysis processes. Above all, the chapter sought to indicate the systematic approach to undertaking this case study. The following chapter will reveal the pre-intervention findings related to the participants’ experiences of workplace adversity pre-intervention.
CHAPTER 4: Abstract

This chapter presents the pre-intervention findings of the participants’ perceptions of workplace adversity in the course of their experiences in the workplace. The presence of workplace adversity in the case study setting is explained through evidence of difficult interactions between the study participants and colleagues, management and clients; an absence of adequate support and recognition for the nurses and midwives, heavy workloads and pressures and difficulties associated with work/life balance. Some of the findings in this chapter have been previously published.
CHAPTER 4: Setting the Scene: Participants’ Experiences of Workplace Adversity

4.1. Introduction

This chapter deals with a key area of the pre-intervention findings, understanding the collective perspectives of the workplace the cases are a part of. These findings are based on interviews and surveys collected during the pre-intervention phase, when participants were asked about their work and their workplace. During their interviews, they were asked to identify the three main workplace adversities they faced, and how they perceived their effects.

A selection of the excerpts of the participants’ own words are used to provide the reader with deep and rich understandings of the collective case at this phase of the study. Each participant is identified only by a pseudonym to preserve anonymity; brackets and three ellipses (…) replace the names of specific wards, colleagues or friends and family members. The demographic information of the participants is given in Table 4.1.

4.2. Participants

There were 16 nurse and midwife participants in the pre-intervention phase. As Table 4.1 indicates, they came from a wide cross-section of the nurse population in age, ethnic background, role, qualifications and length of time spent working in nursing and midwifery. Four participants were Clinical Nurse Specialists (CNS), registered nurses or midwives who were accredited with having a high level of clinical knowledge, experience and skills in their nursing specialty, as well as related skills that improved the resources and professional development of their unit (NSW Health 2009). Eleven of the participants were working at least some rotating shifts that consisted of morning, afternoon and night shifts. The night shift component was sometimes for a month block. There were three permanent day shift workers, and two permanent night shift workers.
Table 4.1: Participant Information

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Years Nursing</th>
<th>Position</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monica</td>
<td>34</td>
<td>0.5</td>
<td>Registered Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Lisa</td>
<td>47</td>
<td>3</td>
<td>Registered Nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>Tina</td>
<td>26</td>
<td>3</td>
<td>Registered Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Alice</td>
<td>40</td>
<td>7</td>
<td>Registered Nurse/Midwife</td>
<td>Full time</td>
</tr>
<tr>
<td>Gillian</td>
<td>30</td>
<td>8</td>
<td>Registered Nurse/Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Lauren</td>
<td>39</td>
<td>10</td>
<td>Endorsed Enrolled Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Lucinda</td>
<td>33</td>
<td>12</td>
<td>Registered Nurse/Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Vicky</td>
<td>59</td>
<td>15</td>
<td>Registered Nurse/Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Jodie</td>
<td>45</td>
<td>18</td>
<td>Clinical Nurse Specialist</td>
<td>Part time</td>
</tr>
<tr>
<td>Karin</td>
<td>41</td>
<td>18</td>
<td>Clinical Nurse Specialist/</td>
<td>Part time</td>
</tr>
<tr>
<td>Rose</td>
<td>53</td>
<td>&gt;19</td>
<td>Clinical Nurse Specialist</td>
<td>Full time</td>
</tr>
<tr>
<td>Neralie</td>
<td>37</td>
<td>20</td>
<td>Endorsed Enrolled Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Talia</td>
<td>45</td>
<td>20</td>
<td>Registered Nurse/Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Patrice</td>
<td>53</td>
<td>23</td>
<td>Endorsed Enrolled Nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>Lynette</td>
<td>51</td>
<td>31</td>
<td>Registered Nurse/Midwife</td>
<td>Part time</td>
</tr>
<tr>
<td>Marika</td>
<td>51</td>
<td>36</td>
<td>Clinical Nurse Specialist</td>
<td>Full time</td>
</tr>
</tbody>
</table>

Workplace adversity and its impact on the participants’ health and wellbeing and the influence on personal resilience are discussed in this chapter and Chapter 5. The two major categories that emerged from analysis were Workplace adversity: Pre-intervention and Workplace Adversity: Its Impact and Resolution Pre-intervention. Their sub-categories, themes and sub-themes are set out in Table 4.2.
Table 4.2: Overview of Pre-intervention findings

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
<th>THEMES</th>
</tr>
</thead>
</table>
| Chapter 4: Findings Chapter Workplace Adversity: Its Presence Pre-intervention | Difficult interactions in the workplace | Difficult interactions with colleagues:  
- Lack of team work  
- Bullying  
- Nursing hierarchy  
- Lack of interpersonal communication skills  
- Ineffective conflict resolution |
| | | Difficult interactions with management:  
- Difficult interactions with the NUM  
- Interactions from management decisions |
| | | Difficult interactions with clients |
| | Lack of support and recognition from colleagues, management and ‘outside’ | Lack of support/recognition from colleagues  
- Management’s lack of support for nurses and midwives as clinicians and workers  
- Lack of support/recognition from ‘outside influences’ |
| | Workload and work pressure | Aspects of workload  
- Aspects of work pressure  
- Dissatisfaction with quality of care |
| | Work/life imbalance | Being out of balance  
- Accepting imbalance |
| Chapter 5: Findings Chapter Workplace Adversity: Its Impact and Resolution Pre-intervention | The Impact of Workplace Adversity Pre-intervention | The impact of exhaustion and shift work  
- The impact of emotional labour on relationships with colleagues and clients  
- The impact of stress  
- The impact on general health, diet and exercise  
- The impact on fulfillment and commitment to stay |
| | The Resolution of Workplace Adversity Pre-intervention | Organisational initiative for resilience  
- Collegial support and resilience  
- Personal initiatives for resilience |
4.3. **Difficult interactions with colleagues, managements and clients**

Difficult interactions in the workplace were a major factor associated with workplace adversity. The conflicting perspectives and interests of individuals and groups within the collective case, primarily related to professional knowledge and clinical experience, were the chief cause. Participants reported that their workplace was often an environment characterised by hostility and negative emotions. Workplace relations were a major cause of stress and anxiety, expressed as feelings of stress, fear, and worry about future negative experiences at work. Coping strategies consisted of emotional distancing and impassivity, or hiding one’s authentic self from colleagues out of distrust and fear. These findings will be discussed under three themes: Difficult interactions with colleagues, Difficult interactions with management and Difficult interactions with clients, as shown in Table 4.3.

**Table 4.3: Themes of difficult interactions in the workplace**

<table>
<thead>
<tr>
<th>Difficult interactions in the workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Difficult interactions with colleagues</td>
</tr>
<tr>
<td>• Difficult interactions with management</td>
</tr>
<tr>
<td>• Difficult interactions with clients</td>
</tr>
</tbody>
</table>

In the interests of clarity, the following terms will be used to denote the number of participants who reported the experience being discussed: ‘few’ = less than 5, ‘some’ or ‘several’ = 5-10 and ‘many’ or ‘most’ = 11-14.

4.3.1. **Difficult interactions with colleagues**

The majority of difficult interactions in the workplace were reportedly between colleagues in the unit, whether other nurses and midwives or physicians. The stories told by the participants outlined the outcomes of negative interpersonal relations: distrust, criticism, gossip, exclusion and harassment. Negative interactions hindered appropriate and effective workplace communication. They also caused harmful individual responses
such as distress, worry, fear, frustration, anger and stress that affected personal wellbeing and fulfilment. In addition, a negative work atmosphere was created that was counter-productive to good morale, or the positive perception of one’s work and that of others. It affected their ability to resolve conflicts and work collectively towards positive outcomes for themselves and clients. The following verbatim excerpt revealed one participant case’s perception of the interactions taking place between colleagues in the workplace:

There seems to be a lot of talking about things behind their back, and you know, putting people down in front of other people and that kind of thing. I try to stand up to it where I can, and I try to stay out of it as well...but I will speak up if I don’t agree with something, and that doesn’t go down too well sometimes...Just no-one wants to rock the boat there. Yet they’re all sort of bitching behind backs...passive aggressive, I think. That kind of explains it in a nutshell [Lucinda].

There was a view that negative workplace interactions occurred in a minimum of instances and with a minority of protagonists. A few participant cases believed it was the few - rather than the many- at fault. However, the effects of those few individuals and the negative incidents they engendered were strong and enduring for those participant cases that reported them. Some disclosed they did not know how to deal with such unsupportive interactions with colleagues.

4.3.1.1. Lack of teamwork

One of the main reasons put forward for difficult interactions was a lack of teamwork; a diminished commitment to working together in a manner that required trust and effective communication. Although a policy of team nursing was in place and reportedly reinforced at hand-over meetings, some participants reported they often encountered co-workers who were unwilling to participate. As a result, they felt frustrated by the unprofessional, inefficient work environment that was created. They believed teamwork was an important element of positive patient outcomes and for smooth, effective operation of the unit. Managing their own workload became more pressured when colleagues did not engage in teamwork, as Alice’s comment suggests:

A lot of the staff there don’t know how to team-work. Sometimes an off-sider won’t team-work with me, and I find that really annoying...teamwork is you work together, you communicate, you work alongside each other, you know, I’ll answer your buzzers and you answer my buzzers...a lot of the staff members don’t want to do it, and that’s where the problem is [Alice].
Poor interpersonal communication and unsupportive relationships between colleagues in the workplace influenced attitudes and behaviour towards teamwork. Participants reported some co-workers, depending on the shift, were so unfriendly or avoidant that they felt compelled to work alone or ‘around’ them. The situation is reflected in Gillian’s rationale for her avoidant approach to teamwork; her comment shows that she was not committing to teamwork at work:

*There are times when I just look at someone and I get this negative feedback. I tend to just step away or walk away…if it’s already that way I tend to stay away from her because I won’t be productive, I might just be getting into trouble…If I hear who I’m working with and they are people that I don’t want to work with, well, I just can’t deal with it, I just go on with my own work [Gillian].*

**4.3.1.2. Bullying**

Some of the most difficult interactions centred on the issue of workplace bullying. The hospital management was putting initiatives in place to raise awareness of the issue with compulsory staff education sessions. It was a sensitive issue because of destabilising outcomes connected to past investigations of bullying in the unit. However, the fact was that similar complaints still dogged the unit and there were lingering difficulties with filling staff vacancies. Vicky described her understanding of the current workplace initiatives in light of the recent past:

*Bullying. That’s what’s going around at the moment. We’re all getting lectured on it, aren’t we…we have to learn to support each other, and be nice to each other and not gossip about anyone…it used to be that the midwives were always being mean to the ENs [enrolled nurses], but now apparently everybody’s being mean to everybody [Vicky].*

Some participants believed the bullying seminars highlighted the poor attitudes that uncooperative colleagues displayed towards bullying and collaborative work practices. They felt the sessions were being used by some of the nursing staff to empower themselves and induce others to use bullying tactics as part of a group membership dynamic.

*We did have a talk recently on bullying in the workplace and it was quite inspirational. I thought oh this is good, you know, this is where we need to be going…and yet I walked past the tearoom and they were all like “what a load of crap” Then they [said], “Oh that was bullying! You were bullying me!” you know, that kind of thing. And I thought okay. [The educator] said in this talk, “if you notice any bullying or talking about other midwives in the tearoom, you should just get up and walk out and say “I don’t agree with this,” which I’m happy to do. And luckily that hasn’t happened to me yet but I*
know it does happen. But you know, again, there was a send-up of that, “I’m walking out now because you’re bullying me” all this sort of stuff. So it does make it hard for you to actually act on doing that when it’s being made a joke of [Lucinda].

Some participants reported that the nurses and midwives who were looking for positive change in the workplace felt even more disheartened when instances of group bullying occurred. Monica shared her view:

*If you have people bullying on a regular basis it’s very difficult...I then go back to the ward with the people that have been to the in-service [on workplace bullying], the people who bully think it’s funny that there’s a need for in-services on it. They don’t see it, and they’re like “Oh well, people should toughen up” and all this kind of stuff and the other half are like “Yeah, you know, this is me, I get bullied all the time.” I don’t think it’s achieving what it’s supposed to be* [Monica].

Gillian had also concluded that some difficulties were caused because newer staff had different understandings of what constituted workplace bullying. The implication was that she thought younger or less experienced nurses and midwives should tolerate some inappropriate interactions at work, such as harsh comments, as the idiosyncrasies of a more experienced colleague rather than as bullying. She believed staff members needed to have worked in the environment for at least a year to be able to correctly ascertain when actual bullying had taken place.

*It’s already happened to one of my workmates. She got in trouble and she was just teaching this first year grad the right thing and she was called a bully so I don’t know if they know what a bully, a real bully is...She was just telling the person the right step, get the result, if the result is that bad can you just double check it and then get the doctor and, you know, all the right things about accepted code...Because she [the graduate] was told of the right way and she [had only] seen it in one way, for me, my understanding of the first year grad [was] “I don’t want your opinion about it” with the tone of her voice...Yes, so she’s saying [she was bullied], but she hasn’t been in the workplace long enough to find out what is bullying* [Gillian].

These excerpts indicate that workplace bullying was a common problem in the case setting, and had directly affected several of the participants. These findings concur with the current literature that harassment and bullying, and especially horizontal violence between nurses and midwives and their colleagues, continues to be a serious concern in the nursing workplace.
4.3.1.3. Nursing hierarchy

A significant part of the difficult interactions and generally negative work relations in the workplace flowed from the disharmony between some midwives and endorsed enrolled nurses (ENs). A hierarchy that differentiated between the knowledge, professional standing and experience of registered nurses and midwives and that of enrolled nurses created division and conflict. Difficult interactions were present in the main because some midwives had a low opinion of the knowledge and skill of enrolled nurses, engendering criticism and exclusion of them. The enrolled nurses responded to their attitude with fear or hostility. There was also a general lack of clarity about the role of enrolled nurses in the workplace that caused confusion and misunderstandings. Because it emphasised the points of division between them, the presence of the nursing hierarchy in the unit was an evident cause of tension and distrust between work colleagues. An enrolled nurse described the workplace environment:

*There's an environment of blame on the ward. We coped a lot of blame from other staff. They just do it. Whether or not it's based on fact, its positional, its hierarchy...so the [registered] nurses are up in the pecking order, it must be their [the ENs] fault!.... The midwives would start saying “Well what are they doing here?” And we say, “Well, you know, I'm a valid member of this team,” and they make comments like, “You're a helper” and so that all kind of impacts on how you feel about your work* [Patrice].

There were three enrolled nurse participants in the study. They all held the shared perspective that their most difficult workplace interactions were with midwives. All three reported experiencing frequent verbal criticism directly from midwives, or hearing demeaning comments made about them by midwives. Lauren, an enrolled nurse, had worked in many other settings in the hospital and not previously encountered the same culture of blame and criticism of enrolled nurses.

The effects of difficult interactions with midwives were serious for the three enrolled nurse participants. They disclosed feeling stressed, vulnerable, tearful, angry and frustrated in the workplace. The incident described in the following quote highlighted the blaming and unsupportive interactions that were occurring between colleagues and the effects on those involved or witnessing these events. The impact of criticism was described by Patrice in this way:
If somebody’s very critical of me that will stop me. I will feel it, burst into tears, or feel challenged. Sometimes you do cry when it’s too much. There was an incident where I felt criticised by some of the midwives and then I heard they talked about it…everybody was making judgements [about me] “She didn’t take a sick baby down to NICU” so I felt professionally challenged…The doctor was there, you know, I’m a nurse [but] I’ve taken the responsibility [for the incident]. That environment of talking behind your back makes me anxious … overwhelmed or unhappy in my job...because my feeling is that there’s no point in people talking like that behind your back. How can you learn from that? [Patrice].

The enrolled nurse participants indicated they were excluded in the workplace due to a persistent belief that enrolled nurses were under-qualified and therefore not true members of the nursing team. This was despite some formal managerial efforts to instil a more positive view of their contribution to the workplace. They felt the view was most intensely held by younger and less experienced midwives, who perhaps had not yet learned the value of their years of experience, as perhaps the more experienced midwives had:

Oh yes, there’s a big class distinction with some of them. Some of them are fantastic, it’s usually the newly trained midwives that are more against us. The older ones are usually better...so maybe they [the younger ones] are thinking, “Well we don’t have the experience, the only thing I have to bring to the job is my qualification.”...You’re always identified. Even the other day, one of the girls who’s very anti-EN, the two of us got the medication, went to the bedside, and I’ll always start by identifying myself, “I’m Lauren, I’m one of the nurses looking after you.” I never say midwife. We went to give the patient the drugs and then the midwife said, “I’m the midwife and this is Lauren, she’s just the enrolled nurse,” and I thought “Yes, that’s it” [Lauren].

This quote indicated the apprehension reportedly felt by the enrolled nurses about the response from some midwives if clients did not realise the distinction between the qualifications of the nurses looking after them. The enrolled nurses reported they felt they needed to appease these midwives during their verbal interactions with clients if that was the case. The function of these interactions seemed to be to disguise the fact that enrolled nurses possessed nursing knowledge and skills. They also experienced the humiliation of derisory comments made to clients about their skills, by such references to them as being “just” enrolled nurses.

Neralie, who had worked in the selected hospital for 20 years and endured exclusionary behaviour from midwives, described the deep hurt and humiliation that she felt as a result:
We’ve come through all that “we-hate-you-people-I-can’t-believe-you-ENs-breathe-the-same-air-we-do” kind of thing; not getting hand-over from them. They wouldn’t even sit with you in the tea-room and have a cup of tea. We’ve been there, done that. It hurts, but we know what we’re capable of. We know that we have got brains above that of a lamington [Neralie].

Because the enrolled nurses were aware that some midwives did not approve their presence or value their contribution, they felt insecure - as though they must continue to justify their place in the workplace. This made some interactions with midwives take on a crucial nature that was most difficult and stressful to withstand,

She [midwife] said, “Well what should we call you?” I said, “We’re nurses, we’re enrolled nurses. That’s what our title is. Use it,” and she apologised but…well, it’s not necessary, that’s the thing [Lauren].

Opposing views of midwives over the place and responsibilities of enrolled nurses in the unit sometimes made them the crux of a conflict between midwives, which intensified the difficulty of their position. In their view, the ‘problematic’ midwives disapproved of other midwives showing the enrolled nurses additional clinical skills that made them, in Neralie’s words, “more worthwhile on the ward and more able to understand why we do things.” She believed some midwives found this practice threatening to their job security potential in the future:

They were not happy with us because they, well, you’re not midwives, you haven’t been trained…I think the midwives were fuming that we were going to take over their roles and that they [the organisation] were going to replace them with us [Neralie].

Some difficult interactions between midwives and enrolled nurses were said to be due to conflicting ideas about the expected skills and knowledge of enrolled nurses. The blaming culture made the enrolled nurse participants wary of undertaking tasks that could be viewed as outside their official scope of practice, yet they faced pressure from over-worked colleagues to do so, in order to get the work done. A lack of confidence in their skills and clarity about their role and duties caused difficult interactions, as in this incident recounted by Lauren:

I’d refused to give a Hep B injection because I hadn’t had the training and I was a bit nervous about giving babies medications. This midwife took me to task about it at a meeting. She just felt she had to attack me. I said, “Well, I’d like an in-service,” and the boss said, “Yes, we’ll get you an in-service. It’s not a problem, we’ll have one for all the ENs.” Anyway, that afternoon I had to relieve [the same midwife] in the special nursery and then she started going on about it, and I said, ‘Look, we’re having the in-service, what’s the
problem? I’ve had crap from you midwives for the last three years. I’ve just about had it” and I walked out of the ward, went down to the (...) ward and was talking to one of my friends and crying. I went back about 3:30 and all I said to the woman was “You can go home now, I’m here to take over” and she took offence to me saying she could go home and made a complaint about me [Lauren].

Conflicting perceptions of the nurses and midwives about the enrolled nurse role and responsibilities were complicated by ongoing organisational changes to it. The work expectations and assumed work responsibilities of enrolled nurses’ had changed with the introduction of each new NUM or policy change related to the general re-structuring within the health service in recent years. As one participant commented below, this factor added to their ongoing sense of insecurity and anxiety in the workplace:

“What role? What role?” It’s a major discussion topic. “Why and what do you want us to do?” Three of us have admitted we have gone home crying and that’s only because we are the three that know about [proposed changes to their rotation] at the moment [Neralie].

Despite their negative workplace experiences, the enrolled nurse participants attributed part of the inappropriate behaviour of some midwives to experiences they had in common in the workplace: heavy workloads and responsibilities, daily pressures and low job satisfaction - rather than antagonism towards individuals. Lauren said she often spoke to other enrolled nurses about not internalising offensive comments made by midwives. She clearly supported a demarcation between her role and that of a midwife; believing organisational mis-handling of human resource issues was at fault,

We don’t have that base knowledge. We might have worked there for a long time but still, I don’t want to be a [midwife], we’re not allowed to do it...She [previous manager] wanted us to be miniature midwives... brought in all these new enrolled nurses, well now they’re saying that’s what the problem is – the proportion of ENs is too high – and they want to move us because of this [Lauren].

The registered nurse/midwife participants tended to attribute difficult workplace interactions between colleagues to other causes than a hierarchy between nurses. Most common explanations put forward for explaining “difficult” interactions were a lack of knowledge of workplace processes and informal networks, personality clash between individuals, or a power play. These participants did not qualify whether or
not the colleagues they were referring to were registered or enrolled nurses or midwives.

There’s a few people that don’t feed back information and you’ve really got to drag it out of them, whereas other people will just come and say, “Listen, so and so is having this”...I think its something to do with their lack of knowledge, might be personality clash...and some people I guess it can be a power thing, “my patient – I’m not letting it go to anyone else” [Rose].

The majority of midwife participants thought that a high proportion of enrolled nurses on a shift caused problems for the registered nurses and midwives because a heavier workload fell onto them. A few midwives conveyed positive opinions of some of the enrolled nurses with whom they worked. This excerpt shows that Rose valued enrolled nurses as individuals and members of the nursing team:

She’s an excellent person, you know. In fact she’s an enrolled nurse and I’d rather have her working beside me than some of the midwives. There’s a couple of enrolled nurses, I would rather work with them because you can trust them. They’ll feed you back information and you know that the jobs that you’ve given them to do, they’ll be done and done well [Rose].

Another perspective of the hierarchical atmosphere at work depended on the permanency and stability of the relationships the nurses and midwives had built together; so that over time a harmonious work environment with more supportive interactions between colleagues developed, as had occurred with the long-time night shift workers.

I think the whole night shift is more supportive of each other than the day shifts, because there are a lot of part-time people [on days] and you don’t know a lot of them as closely, whereas if you’ve been working night shift for some time then everybody knows each other and they are, I feel, more supportive...there is not the hierarchy as well happening during the night [Vicky].

However, as Vicky had worked night shift for some time, it is possible that, as an accepted member of the established social network, she was unaware of difficult interactions that other nurses and midwives might have encountered.

Participants also understood difficult interactions between colleagues as the result of a division between ‘new’ and ‘old’ nursing staff. Some established participants believed most difficulties arose because certain ‘new’ nursing staff, whether casual, agency or rotational, were not open to instruction about the workplace processes and networks. They proposed that frustration and hostilities occurred when some ‘new’ colleagues were unable
to receive workplace-specific information appropriately from more senior, permanent or established staff members:

“We have casual, we have rotation and we have permanent, the ratio of those is we’re getting more rotational people and we’re getting more casual...The people that are not permanent should try to be more sensitive to those who know the place...they just need to be set down a little bit...to work out that this is where you work at the moment and you have to watch...they’re still hanging on to their procedures or whatever, their beliefs from wherever they were” [Gillian].

Alice, who reported a belief that she was still considered a ‘new’ employee in the workplace after three years in the unit, recounted her experience of wishing to add her insights about the workplace systems to her colleagues when she first arrived:

“I’d [suggest] something and they’d say, “Oh well, it can’t happen because it’s never happened,” and you think, “Okay, [I’ll] just sit back.” They are not willing to know your previous experience of other places that you’ve worked at that could benefit the work environment here” [Alice].

Alice’s perception that some of the more established staff members were not open to considering the ideas and expertise of new staff seemed confirmed by Gillian, who had worked in the unit for eight years and portrayed a more established sense of belonging in the workplace during her interview. Gillian reported that she did not give suggestions made or critique given about the workplace by new staff much credence, because she believed they did not have the actual experience in the unit to understand the problems it faced properly. The quote below indicated that Gillian felt apathetic and frustrated by new staff members who attempted to change aspects of the workplace:

“Some [new] staff think that they own the place but actually they don’t. Most of the time they don’t know what the [problem] is and how to deal with it” [Gillian].

Monica, a graduate midwife, commented on an additional aspect of the hierarchy present in the unit. Monica was positioned as a midwife, but she was also one of the first graduates of a new degree course. She reported she was subjected to bullying from other midwives who did not value her qualification. She believed the hierarchy differentiated between new graduates coming into the workplace and more established nurses and midwives. Her experiences indicate that power dynamics were operating between midwives on the same tier of the hierarchy:

“Sometimes you’ll come across it from people that have been maybe three or four years out, so they get a little bit of power rush because they were at the
bottom of the pecking order, but then when we come in it boosts them up. [Monica]

The socialisation process of new members of staff into the workplace culture was reportedly another source of stress for some participants; several recounted incidents they experienced that had included difficult interactions. These participants indicated the difficult interactions they experienced with colleagues when they entered the workplace were mostly related to oppressive behaviour and attitudes:

*It kind of reminds me of that old high school stuff, you know, when you’re desperately trying to be part of the group, and heaven forbid that you will become an outsider. It kind of feels like that to me, you feel like as a new person coming in you are an outsider, you’ve got to prove yourself to be part of the group, and then when you’re in the group it’s like everybody’s trying to stay in the group and not become the person to blame, and I think that is, I don’t know if that’s in all hospitals, maybe it’s in every workplace environment…it seems to be very symptomatic of nursing* [Patrice].

Most participants described struggling to be accepted by colleagues as new members of staff, even when they had moved into midwifery with extensive nursing experience from other settings. Lisa told the story of her recent socialisation experience, emphasising that acceptance from her colleagues was slowly occurring for her, reportedly due to her careful strategies of ‘fitting in’ with her colleagues by avoiding attention and not seeking support from others at work. However, she believed it would not be the same for another member of the nursing staff she knew, who had started working in the unit around the same time, and who had not been as successful in proving herself to her colleagues:

*I’d have to say that I found it very difficult. The unit’s fairly top-heavy with people who’ve been there fifteen years or, who’ve known each other fairly well and who’ve worked together for a long time. So to come in as a new person to be accepted…it was difficult. I found it tough. They’re not particularly interested in me as a person. They’re wanting to see how you go and then if you’re acceptable they might be more interested…There’s one person in particular I know who’s in that category [of being tested], that person doesn’t know what’s going on. I mean she knows she’s not accepted, but she doesn’t know why. (…) did mention it to me that that’s what’s going on, but it’s certainly not openly talked about. I did talk to (…) and she said that this other girl has had a terrible time because she’s more or less excluded, so there’s different levels of exclusion. There might be exclusion where they’re not sure about you; or...where they absolutely have made up their mind [that you are not acceptable] [Lisa].*
4.3.1.4. **Difficult interactions with physicians**

A few participants reported that interactions with some of the physicians working in the unit were amongst the most difficult they encountered. Hostility and disrespect conveyed by a few individual physicians caused the participants to respond with fear and avoidance. An environment of unequal power relations between physicians and nurses and midwives worsened some communication difficulties with physicians. Lucinda believed the placatory behaviour of the midwives enabled physicians to be arrogant and coercive towards them, and recounted the story of how a midwife colleague asked her to do a time-consuming administrative task for a physician that she considered demeaning and unnecessary. When she expressed her opinion the colleague was unsupportive and told her that the other midwives ‘played along’ with the physician’s wishes for the smooth operation of the unit, even though they did not agree with the practice. Lucinda reported being embroiled in difficult interactions with the midwife, the physician and her nursing unit manager, all of whom responded in unacceptable ways, in her view:

> Unfortunately, they’ve created a situation there where I think the midwives are quite subservient to the doctors and so that grates me...we clean their speculums, open up the rooms, set up the computers for them, make the beds, clean the beds at the end of the day, all that sort of stuff. I can bear that slightly but this [additional requirement] was just, for me, I thought I just can’t do it. And it might sound like I’m being really obstructive, but I just feel like you’ve got to have some sense of self, and...I spoke up to him and he attacked me personally [Lucinda].

Difficult interactions also occurred because some physicians in the unit did not accept the credibility of certain recent midwifery qualifications. They expressed disapproval and excluded new graduates based on this belief, as Monica explained:

> I have a really hard time with the doctors, and I got told off again this morning for something I hadn’t even done. They’ve been quite outspoken that to them our degree’s a useless waste of time, we should never be allowed in...[Monica].

4.3.1.5. **Lack of interpersonal communication skills**

Although the majority of participants initially stated there was good interpersonal communication in their workplace, the communication difficulties they recounted during interactions with other individuals or during incidents caused negative effects on the people
involved and those around them. Workplace interactions were made more difficult by the way individuals approached personal communication, interpreted them or responded to different communication styles. Jodie confirmed this view:

I think some people can be very intimidating and over-ride people...I think that most staff are fairly professional but some people, they’ve got to be involved in everything. They can’t let go of stuff [Jodie].

Some participants’ own responses to colleagues heightened their stress or anxiety. They reported reacting negatively to sarcasm, responding harshly when angry and being inclined to listen to or take part in gossip about colleagues. Alice thought her assertive communication style was sometimes confronting to colleagues; Marika believed she was vulnerable to difficult interactions because of her sensitive nature:

I’m a very forward person, and I like to speak my mind and if I see something wrong I just sort of say to people...I don’t go around peoples' back and talk...I just tell them right there and then, and a lot of people find that very intimidating. [Alice]

I do have times when I’m not very strong; people say that I’m too sensitive with my workmates. [Marika]

Tina recounted that her difficulties with relating to colleagues occurred because of her unfamiliarity with Australian society “because I’m coming from another country and the culture here is different” [Tina]. She reported that social interaction in the context of an Australian workplace was very different. She revealed that she sometimes found herself thinking over and over about some interactions with colleagues, becoming tearful, worried and less confident of her nursing capacity.

4.3.1.6. Ineffective conflict resolution

Ineffective conflict resolution methods increased the incidence of difficult workplace interactions. Some participants reported feeling uncertain, when a difference of opinion arose, about whether or not a collaborative attitude towards the conflict would prevail with some colleagues, and what may happen if a disagreement escalated through open dialogue:

We’ve had incidences where people talk to each other [about a conflict] and then the person that was trying to approach and deal with the situation has actually been hauled over the coals and accused of [saying negative] things that didn’t actually happen. So now we’ve all got to be really careful. Like, you don’t like to say things [confront a colleague with a problem] in front of
other people, but now you’re kind of a bit wary about saying something to people just on a one-on-one basis… [Jodie].

Other participants had no doubts that some colleagues would react negatively if contentious issues were raised openly. They distrusted the responses of both individuals and groups in the workplace if they were to affirmatively raise a problem in their unsupportive work environment. They had concluded that avoidance was the safest way to protect themselves from conflict with colleagues, but they were also isolated because of it.

There’s quite a few trust issues. There’s a lot of socialising with the NUM and I can see that’s a positive thing, but if I have an issue with someone or something I’m not sure where that information is going to go. So I have to be a little bit careful [Talia].

Several participants discussed how they routinely coped with conflict resolution by placating, withdrawing and working around a colleague, carrying out tasks independently and avoiding potentially difficult interactions:

I think a lot of people just placate and say what that person wants to hear and then they just go and do what they want to do anyway [Jodie].

These kinds of unhelpful reactions to the difficult interactions occurring between work colleagues were contributing to the interpersonal communication problems present in the setting.

4.3.2. Difficult interactions with management

Another significant source of workplace adversity for the participants was difficult interactions with management. These interactions could hold high stakes as they often surrounded issues of conflict resolution in a workplace environment of blame and supervisors, but the participants’ attitudes towards the organisation as a whole were often characterised by frustration and dissatisfaction as a result of low morale and constant change.

Table 4.4: Themes of Difficult interactions with management

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<th>Difficult interactions with management</th>
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<td>• Difficult interactions with the NUM</td>
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<td>• Interactions from management decisions</td>
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4.3.2.1. **Difficult interactions with the NUM**

A substantial number of the difficult interactions of participants were reported as having to do with their nursing unit manager. These ranged from conflict resolution problems for the participants and others to poor communication or leadership style from the manager. Some participants did not experience mutual respect and support in their relationship with their NUM,

*You can do a really good job and think “This was a good day. Everything went well.” Anda then the NUM will come back and say, “This [alleged error] happened on this day.” And for me it kind of, it can really take the goodness out of the whole day…Our NUM is very, very pedantic and strict. If there’s any mistake it’s picked up straight away and you’re given a talking to and you’re told very clearly that that’s not to happen again. So that can make me quite nervous, in a way that is not good for you, to know you’re going to get [verbal criticism] if you do something wrong* [Lisa].

Other participants had experienced even more adversarial interactions with their NUMs that seriously affected their self-esteem, well-being and confidence in their own capabilities. Marika’s experience revealed that difficult interactions were sometimes part of deep and consistent conflicts between participants and their managers. Marika revealed a sense of remembered pain at the public humiliation she experienced during these incidents in the workplace:

*When I first started… the acting NUM at the time was very mean to me…It was terrible. She would reprimand me in front of other people and make out I wasn’t doing things right. Stuff like that is so silly, that can undermine a person, but I knew I wasn’t. Everyone else knew I wasn’t… everyone could see the problem, she caused a lot of others trouble but they were too scared to take it on, and so we existed around her* [Marika].

4.3.2.2. **Interactions from management decisions**

Elements of the conflict resolution procedure were reported to compound initial difficulties between colleagues, which intensified the problem and made staff reluctant to seek resolution from supervisors. A few participants mentioned deep dissatisfaction with the management’s insistence on written complaints against colleagues before action would be taken. They felt the process usually only served to heighten the problem and exacerbate their distress. They also believed it was an attempt to avoid resolving communication
problems between colleagues, in the hope that the complainant would not have time or energy to fill out the forms. They found filling out the forms time-consuming when already under stress and extreme time pressure, and that this time was potentially wasted if complaints did not eventuate in action. Participants preferred not to focus official attention upon the difficulties they were experiencing with a colleague; and often they did not want to get their co-worker into a great degree of trouble. Instead, they wanted their NUM to assist in mediating more assertive and effective communication between colleagues and resolve problems in a face-to-face, unofficial and less threatening way. Gillian indicated she had given up on the conflict resolution process and withdrawn from engaging with colleagues in difficult situations.

*I speak to my manager about it, nothing has been done, so...* She said that she will stop the person or if it’s that severe or that important to you, you must put it in writing so we can deal with it, but I don’t want that person to be in such trouble... I just want her to know what she did and how it affected me...most of the time I just want to go home when nothing happens; you know what I mean, with my patients still breathing  [Gillian].

The perceived failure of management to make wise decisions and safeguard communication between departments also caused a few participants to distrust management. The rationale for changes that affected nurses and midwives significantly were not given; nor were they consulted before or after changes. Patrice, acting on her own initiative, had put up wall posters with positive images of mothering in the special nursery and played gentle music on a compact disc player, all designed to create a more relaxing atmosphere for the mothers and their babies:

*My feeling was that I try and change it...make it quieter, softer light, put lovely music on. You know, there’s a lot of babies and mothers, put posters up that reflected mothers and babies rather than clinical stuff. But then I went away...*[Patrice].

She found, to her great disappointment upon returning from leave, that her additions had been removed and the compact discs placed in the bin during an inspection by Infection Control staff. She felt dismayed at the absence of communication and collaboration around their decision, and that her manager had not taken on a sense of ownership of the changes in her absence. This experience underscored for her the low priority given to staff initiatives in the hospital and the unit:

*I should really resolve that with Infection Control as a nurse. What is the rationale and is there anything I can bring in, like an MP3 player, could that be plugged in? You know to what extent you could create, so I’ve got that...*
reasonable [resolution]...I guess there’s another part of me that thought there was nobody [else] protecting that, and I wondered if it’s too much for some people too. Somebody mightn’t like it, but in that environment you just don’t know [Patrice].

4.3.3. Difficult interactions with clients

Interactions with clients were overwhelmingly beneficial for the participants in the study. Engaging and interacting with clients was their main interest, recompense and means of job satisfaction. However, the difficulty of some interactions with clients was seen as a source of workplace adversity. Participants felt there were increased instances of hostility and conflict from clients; one participant felt the risk of personal harm from clients was increasing. Others spoke about the emotional effects of receiving verbal abuse and threats from clients. Participants felt that the high number of women with a low socio-economic profile that presented to the health service influenced the number and degree of difficult interactions that occurred. A significant percentage of the client population had complex social and health needs resulting from a variety of chronic health problems, alcohol and substance addiction, domestic violence, childhood sexual abuse and learning and developmental disabilities. Some participants reported that many of their clients were experiencing financial difficulties or emotional problems and this caused stress, anxiety and low mood that precipitated difficult interactions.

Some mothers are a bit cross, it’s very hard to talk to mum. When there’s [domestic] violence sometimes. I think I’m dealing okay with that case, like if I’m kind to mum, I speak softly to mum...[then] she’s alright. Some people will complain and say, “That midwife is too rude to me and I don’t want her” [Tina].

Difficult interactions were also encountered because clients were at an extremely stressful point in their lives, pregnancy and raising young children, and sometimes adverse clinical and social outcomes were unfolding. Often clients were separated from their usual support networks, particularly if they had been brought to the hospital from distant parts of the state. Lisa recounted the conflicts she experienced with clients often stemmed from the opposing perspectives of parents and nursing staff concerning medical interventions on babies:

They’re looking at the child from a mother’s point of view, whereas we have a duty of care from a nursing point of view to do certain things like take blood
samples, or say you know, the baby needs to go back to bed now whereas they probably prefer to have the baby awake. So you’re sort of, in a way, you’re going against what they would naturally choose to do [with their baby]. So that’s quite difficult at times… [Lisa].

The depth and range of critical experiences that the participants faced alongside their clients also caused difficult interactions. One participant proposed that because great flexibility was required in the responses of the nurses and midwives to meet the varied needs of clients, some were not able to adequately provide the required level of empathic nursing expertise, and so difficult interactions occurred:

We have a diverse overall lot of patients as well. Like we have patients that are well on in their pregnancies, part way through their pregnancies and are coming in because they’re vomiting all the time. We have patients that have UTIs; we have patients that are losing babies; we have patients that are having babies terminated; we have women that have had still births; we have gynae women; it’s a very diverse area….A few weeks ago we had six babies die in a week and you’re having to go from that to looking after a woman that’s got a baby and its alive, you know, and you’re going backwards and forwards [Rose].

At times the nurses and midwives reported that they felt they were not able to respond in the appropriate manner at the required time. Participants disclosed when they were shocked, scared, angry or stressed themselves they sometimes did not engage in difficult interactions with clients appropriately or therapeutically. Gillian’s reported experiences surrounding a recent maternal death in the unit demonstrated the magnitude of the events that the participants were dealing with, often without adequate debriefing, and the grief responses to trauma exhibited by the nursing staff:

We had an accident in the ward where there was a maternal death. And that’s when everything crashed and now it’s just deciding to move on with it but there are times that it will, you know, come back into your mind. It was very traumatising, especially to the staff who actually dealt with it on that day, and I won’t forget that day because it was gloomy and thinking what happened, you know, it was so uneasy [Gillian].

Negative environmental elements that impacted on nursing practice also contributed to difficult interactions with clients. Some participants disclosed that, due to the heavy and ubiquitous workload, sometimes negative emotions like agitation and frustration emerged in their responses during client interactions:
When you’re at work you tend to be cranky with your patients and you don’t deal in a way that you know [you should]…you tend to, to tell them what to do instead of listen to your patients. And it’s not helping because these are mums with stress on them, probably first baby, doesn’t make it easy. Or they enter the blues, the blues comes in so…and they can read your tone [Gillian].

These excerpts evidence the large number of difficult workplace interactions taking place in the setting. These interactions were found throughout the hierarchical structure of nurses and midwives. They demonstrated the incidence of workplace bullying and ineffective conflict resolution; the lack of teamwork and poor communication that characterised the nurses and midwives and their workplace.

4.4 Lack of support and recognition

The collective case was characterised by another important factor associated with the phenomenon of workplace adversity, lack of support and recognition. In this context, the term of ‘recognition’ was used to describe the participants’ perception that they were not appreciated by others in the workplace and their belief that their work was not recognised enough as being exceptional or sustained. Participants believed there was an absence, on the part of the organisational management, of extending support and recognition for the valuable contribution made by the nurses and midwives. Many of the current communication problems were viewed as an outward sign of the lack of support and recognition that existed. The results for those participants affected were feelings of vulnerability, isolation and loss of confidence. These participants felt unsupported and unrecognised by colleagues, the organisation in general and by outside influences, such as the local media. These three main sources form the themes of the discussion: Lack of support/recognition from colleagues, Lack of support/recognition from management and Lack of support/recognition from ‘outside.’ They are presented in Table 4.5.
Table 4.5 : Themes of lack of support and recognition

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<td>• Lack of support/recognition from colleagues</td>
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<td>• Management’s lack of support for nurses and midwives as clinicians and workers</td>
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<td>• Lack of support/recognition from ‘outside’</td>
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4.4.1 Lack of support/recognition from colleagues

This theme related to participants’ perceptions that they, and their work, were not noticed and valued by others around them in the workplace or within the organisation. An absence of the desired support and recognition between colleagues was a frequently reported experience. Participants identified it as a workplace problem and believed greater support would lead to greater sharing of the workload and a more collegial atmosphere at work. This absence resulted in respondents having a sense of having been rejected by colleagues and frustrated by their thwarted efforts to work more collaboratively. Ultimately it caused some participants to feel less satisfied with the job and their performance of it. One participant stated the workplace changes she thought were necessary:

[We need] more workplace support, definitely, and [to be] more supportive rather than bitching. There’s a lot of putting down and negativity instead of acknowledging [Talia].

The NUM was seen by most participants as an important source of everyday support and recognition for a job well done. The nurses and midwives looked for confirmation that their efforts were observed and appreciated by supervisors, especially in view of the difficult conditions they worked under. Because of the arduous elements of their work, such as chronic staff shortages that led to overload and typically decreased job satisfaction, the participants felt they deserved managers that were responsive to their need for recognition and support. Some of the participants believed they did not receive enough support and recognition to maintain a sense of well-being on the job:

It can be disappointing to your self-esteem, because you want to be good at what you do. So it can be hard to keep going, and doing the same thing all the time with no recognition as to what you’ve achieved [Lisa].
There was a lack of support and collegial respect in the unit based on the hierarchy that existed between midwives and enrolled nurses, which caused added sensitivities to everyday work events and processes. Several participants believed they were not given due recognition for the extent to which they managed the workload:

_The other day there were no [babies] in the nursery so I was just helping everybody, and I couldn’t stop. At no point did anybody recognise what my day was like and that’s very hard. Because as soon as you sit down to have a drink of water, they see you there: “Oh, Patrice, can you, can you, can you…?” And it’s like there’s no recognition…sometimes you need to sit down, have a drink of water, or look at your sheet and see where you’re up to in your own work, and it’s almost like nurses aren’t allowed to do that. What’s that nurse doing sitting down?”_ [Patrice]

The experience of feeling unsupported, isolated and alone in the workplace began when nurses and midwives first came to work at the hospital. Lisa told her story of joining an environment of mostly senior nurses and midwives. They were selective in providing support to colleagues; only extending it to those they had long associations with. There was an environment of distrust between colleagues that Lisa found had not been broken down after more than a year of working there:

_I think it would have been helpful to me to talk to someone but no, that wasn’t available. I found in that section the senior people help their friends. They don’t help the new person, whereas it’s actually the new person who needs their help. Not their friends. But they look after their friends. But as I’ve been there longer and I’m more accepted I am getting more help… So that’s a really difficult thing. Because the more you need it, the less likely you’re going to get it. And if you say anything about it you’re really less likely to get it…It’s a harsh judgment, I think. I think part of it is they don’t want to work with someone who can’t cope, so you have to be able to cope or you won’t be accepted…You just have to figure out by yourself how you’re going to cope with it_ [Lisa].

Finding support for themselves and extending support to colleagues was made more difficult by the frantic work pace and constantly changing workforce. Some participants had found it impossible to build relationships with colleagues that would potentially become a network of support due to staff turnover and shift work. In any case, they believed there was little opportunity to talk over important concerns; so support from colleagues was perceived to be limited and tended to be intermittent, somewhat superficial and not available when needed. However, even in the difficult circumstances described collegial support was not impossible. Most participants reported that even their scarce experiences of support from their colleagues were beneficial.
4.4.2 Management’s lack of support for nurses and midwives as clinicians and workers

There was a perception by the participants that the executive management, especially above the level of nursing unit manager, did not effectively support and recognise the nurses and midwives. The workplace culture was one of persistent suspicion and blame of the nurses and midwives, despite the existence of a formal no-blame policy. Participants felt their managers routinely blamed them for adverse events rather than managing them appropriately to work towards positive future outcomes. A few found the attitude of management particularly objectionable because it continued alongside the official promotion of a non-blame culture, supposedly supporting reflective practices to assist staff to continue their education and development. Vicky expressed her cynicism of the hegemonic behaviour of some in positions of leadership:

[The official policy is] “No blame – it’s about education!” That is a big fat total fib! And they [management] are always looking to blame the nursing staff from where I’m looking. They are looking to blame the nursing staff who were involved in any incident at all, whether it’s someone bleeding, someone’s blood pressures going off, anything, they are always looking for somewhere they can lay the blame. It’s reasonable…but it’s a bit more vicious than it needs to be, I think… I really do feel…brought undone, by the fact that there are signs everywhere saying “There is no blame” and then... it appears that it’s totally the other way and they’re doing their utmost to pin it on anyone that’s done anything wrong [Vicky].

Although appreciative of the no blame policy’s existence and the management’s initiatives to raise awareness of workplace issues, a few participants believed they were failing to change behaviour because they did not effectively enforce the guidelines:

I think the blaming thing is the worst thing because thinking back to that [adverse] incident, my God, the thing that made me also really upset was that they [management] wanted to blame the team leader, who is blamed many times, a particular person…she’s quite a weak member of the team, and she’s just everybody’s scapegoat and I find it really uncomfortable, like although there are limits of her skills, to me that’s not the solution. Like even the younger students coming in and they get into it as well. To see the manager do that was really dreadful [Patrice].

The management was also seen as inflexible towards diverse beliefs and approaches to ethical decisions or practice positions. The participants were bound to consider issues and make decisions on the basis of ethical principles during their everyday work. Rose articulated her view of the management’s failure to support and value the nurses and
midwives with the example of how the nurses and midwives organised their own work around terminations of pregnancy. She reported that sometimes the nurses and midwives were forced to work around the management in such cases, because the response from management was impersonal and coercive. Rose believed the behaviour of the nursing staff in these instances was a positive aspect of the workplace, where the nurses and midwives exhibited collegial collaboration, respecting each other’s personal beliefs and supporting the ethical positions of others during these events:

Some people can’t cope with looking after people that are having a termination and I think if that’s the case and there’s someone else who can look after her, why not?...[The administration says] you’re employed here, do it!...I know there’s one person who works here doesn’t like doing terminations and the other girls will do them for her, she doesn’t mind looking after the woman after she’s delivered and things like that ...the administration mightn’t be, but the staff are supportive of each other [Rose].

The organisation was also perceived as failing to recognise or reward individual attempts to assess and improve gaps in nursing practice, staff procedures or patient experiences. Patrice told her story of feeling totally unsupported by the organisation in her attempt to improve the experiences of mothers and babies spending time in the special nursery. She believed the management did not value her or support her position when there was a conflict with hospital policies.

I’ve come back and it’s all changed back. I think that was pathetic...I understand that if some poor baby was at risk because I had a CD there, no I wouldn’t want that, and my thinking was, “So what’s the difference with washing your hands when you’re going to put a CD on, and then washing my hands to go back to attendance”...You couldn’t create that environment without the music. [Posters of] pathways for a baby that’s got jaundice or respiratory distress can stay up on the wall but pictures of women breastfeeding can’t! Why didn’t it all come down? [Patrice].

There was also a perceived lack of recognition by management of the value of nurses and midwives to the organisation. The organisational attitude towards the nurses and midwives was seen as impersonal and dehumanising. Some perceived they were treated as “cogs in the wheel” by management, fulfilling a need wherever and whenever it was felt. Several participants did not think the organisation viewed them as individuals with unique sets of circumstances that they brought with them into the work environment each day. Rose believed, although the nurses and midwives carried out the real work of the hospital, that greater value was placed on administrative roles:
I think that nurses feel that they’re the bottom of the ladder and I think there should be a lot more done for us within the organisation. Like sometimes there’s so many people up on Level (...) in that building you feel like it’s crashing down on top of you at times…the real workers are the nurses. If you didn’t have nurses you wouldn’t have the hospital. But organisation wise, as I said, we’re just numbers, we’re numbers, we’re numbers. Maybe I’m committed to my job but I can’t say that I’m committed to the organisation [Rose].

Through their narratives, it was evident that the participants’ felt they were under-valued and largely unappreciated by the management.

The lack of support and recognition was shown strongly through aspects of the participants’ working conditions. The roster system in place seriously restricted autonomy over shifts and overtime. There was a lack of consideration for long-term commitment to the organisation or the health effects of longevity in the job. For example, Vicky believed she had earned seniority when rosters were being made up, as a senior midwife nearing retirement, but reported the management were not considering additional strategies to assist her health and well-being so that she could stay longer in her job. Other participants felt similarly that the demands and stress of the position were not fairly remunerated.

The workload is really, really high. For the amount of money I don’t know of any other profession that gets that workload with that level of responsibility, and you know, something goes wrong, or there’s a death of a baby, it’s just a horrible thing to have to live with. For what, thirty-two dollars an hour? [Talia].

The organisation did not recognise or reward commitment to excellence or working over and above job requirements. Lauren reported she had experienced a growing awareness that her hard-working approach to her job was leading her towards burnout and jeopardising her ability to survive indefinitely in the workplace. In any case, she felt increasingly disillusioned because she perceived that her extra efforts were not recognised or properly remunerated by the organisation:

That is a way of surviving, isn’t it? Just thinking, “Well the only way I can, well wake up and survive here longer is not to invest too much time and too much energy”... You never get off on time, you always get off late, and they [organisation] don’t care. They very rarely give you any overtime [Lauren].

The participants reported that the organisation made workplace decisions that directly and significantly impacted upon the lives of nurses and midwives without understanding the reality of the consequences for those working in the wards. A few felt the decision-making
process was flawed and no real value was placed on the views and comments of nursing staff. Participants claimed there was only an “appearance” of an inclusive process, which caused them to feel both betrayed and excluded. Patrice was passionate about her nursing role in the special nursery area and was worried about potential changes she heard the management was planning:

*I think [how] they make decisions is the NUMs will go, the managers will go, the ward NUM will go to a meeting and then they make decisions. It seems to me, for staff on their behalf without really true representation. I’m hearing a lot of snippets that my role may change, that’s only just little whispers. But knowing how it’s gone before - usually there’s a reason why people are whispering it - because somebody’s been talking. They [management] say…they welcome suggestions, but I don’t know*  

[Patrice].

Other participants felt unsupported by the organisation when adverse outcomes or stressful events occurred. A few believed the organisation had not cared adequately for the nurses and midwives affected by a recent post partum maternal death, and were still coping with resentment of the management:

*Initially, counselling wasn’t offered. We all came back the next day, we all drove home that day. We were offered counselling apparently, but [months] later on with the psych counsellor here and only in a time that she was available. [The incident] was on a night shift and a lot of people on night shift are on permanent night shift, so they can’t come in [at other times]. People work on night shift for a reason. It should have been offered on nights that we’re free. They should have had the option of that, [the organisation] should have the ability*  

[Neralie].

A few participants believed the organisational agenda after the incident was to deal only with the legal and political aftermath and to ensure that clinical changes were in place; rather than act sensitively and responsibly to ensure their employees’ recovery and ongoing wellbeing after a traumatic event. Neralie felt uncared for by the organisation, that no one had considered that she and her colleagues may still be experiencing negative emotional effects from the patient’s death. She felt pressured to attend a staff meeting called by management six months after and was worried about being re-traumatised by having to recall the incident. Neralie was disenchanted with the organisation’s perceived failure to provide effective support for her and some of her colleagues.

*That was our counselling, yes this is what happened and these are the findings and blah, blah, blah. I just went home at the end of that day and I thought oh, my God what are they doing? A couple of us didn’t want to come in because it was rehearsing stuff, it was going over it again but you felt like you had to come in to do it. I thought if I hadn’t gone to that*
meeting how would that have looked and I felt the pressure to come in. They told me you’re being paid overtime for it, but that’s not quite the point really… I found out what the actual Coroners findings were in the last ten minutes. It had been two hours of shit to get the ten minutes of fact [Neralie].

4.4.3. Lack of support/recognition from ‘outside influences’

Some participants reported their concerns about the lack of support and recognition they believed nurses and midwives received from others outside the organisation. They believed they were being negatively portrayed by the local media and this was influencing the perceptions of potential clients and others in the community. A few participants disclosed how vulnerable they felt to the unhelpful and negative images the media was presenting about nurses and midwives in general, as well as judgements of their performance in relation to the specific death that had occurred in the unit. They felt attacked and found the experience demoralising and hurtful:

We get bashed by the media, and every second week in the paper you’ll read something about us, and how dreadful we are. The media go on about it and yet, you know, every day so many lives are saved, so many miracles, in the last half hour or whatever it is I’ve been here so many miracles have happened up in that main building up there that, you know, we’ll never be able to comprehend, but you’ll never hear anything, there’s probably nothing in tomorrow’s paper about what happened just now [Neralie].

This section examined the lack of support and recognition experienced by the nurses and midwives in their workplace. The participants perceived a lack of support from colleagues, management and from other sources in the outside community. They also felt that little value was placed upon them as professional nurses and midwives by the organisation, and even at times by their colleagues.

4.5 Workload and work pressure

The current workload and its incumbent pressures were revealed as another major source of workplace adversity. The heavy workload demanded that the nurses and midwives constantly worked quickly; and at times the pace resulted in fears that patient care would be compromised and important health indicators missed. Work pressures were mainly experienced as a sense of greater personal responsibility for the wellbeing of others, especially by the senior nurses and midwives with more experience in the unit:
The drowning part is the workload that we have and the expectations that are put on us every damn day that makes you go home and cry, that make you want to go home and have a drink. That’s the drowning part, the just surviving part [Neralie].

These comments demonstrate the very serious physical and emotional effects the workload and pressures of the environment were having on the participants. When participants had other responsibilities besides their work – like family caring, study or primary income provision, there was a further impact on their experience of workplace pressures. The excessive workload also carried an additional emotional load which detracted from the participants’ well-being. Work pressure was often increased because the unit was a chaotic environment that was not conducive to participants’ ideals of nursing and midwifery, or the way they wanted to practise.

In the workplace, intense work pressure grew out of the feeling of carrying heavy responsibilities, such as being the only registered nurse or midwife on a shift. Other sources of pressure reported came from a stress-producing teaching load of student midwives, and from prompting perceived unreliable or avoidant colleagues to increase their productivity. Some participants spoke about the pressure they felt to carry out their job in the allotted time or to the expected high standard in a harsh, judgmental and blaming workplace culture.

*People have difficulty fitting in what they have to do within the time…you can’t always meet that high standard [in the time allowed] – it can make me quite nervous* [Lisa].

*Half the time you leave your shift thinking that you haven’t done your [complete] workload…You have to rush a lot. And that’s unsatisfactory* [Alice].

The revealed themes that were contributory to the presence of workload and work pressures are presented in Table 4.8 as ‘Aspects of workload’ and ‘Aspects of work pressure.’
Table 4.6: Themes of workload and work pressure

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4.5.1. Aspects of workload

Without exception, the participants found the physical demands of their workload high. They experienced daily physical strain from lifting equipment, pushing heavy trolleys and stretching into uncomfortable positions when assisting women giving birth. The physical demands caused muscle pain and fatigue, especially if associated with irregular sleep patterns, shift work and the continually fast pace in the unit. The following quote from Jodie reveals some of the effects of working under such demanding workload and pressures, including the serious level of despondency that was developing:

> We are working under a lot, we’re busier and we’ve got the same amount of staff but its a heavier workload, we’re still managing to work but with the time we have we have to work more efficiently… you can probably cope with all those things if you had adequate staffing to give adequate care but a lot of the times you’re just skimming through and you’re doing the basics and you know, what we’ve been saying lately is “Oh well, no-one’s died so we’ve done okay” but I mean, that’s pretty sad… We just try to balance it out so everyone’s got a reasonably even workload but that doesn’t always work and um we just pitch in and help each other as we can… oh yes we’re working at dangerous levels [Jodie].

Chronic staff shortages and high patient ratios contributed to workload for some participants. Officially, a team of nine or ten nursing staff, three of whom were usually midwives, cared for approximately thirty patients; representing a workload of around 10 patients for each midwife. However, several participants pointed out that the official patient load did not reflect the real workload, because babies were not included in the patient numbers. These participants reported caring for babies was a significant part of their workload. Alice’s comment describes a participant view about the staff/patient ratio:

> If we’re only 3 midwives we have 10 patients each. And 10 patients for one person is a lot. And what happens if you have a sick baby? So, it just makes everything really hard. If you have fresh caesarian section ladies you’ve got to do your post-op every 2 hours or hour, you know, and if you’ve got 10 patients that are caesarian section, it takes up most of your time [Alice].
The uneven skill mix also influenced workload. Of the nine or ten nurses and midwives on any shift, five or six would likely have limited abilities to contribute to the core workload, either because they had additional ward responsibilities or because they had less professional agency and could not perform certain procedures. Therefore, any nursing team’s capacity to cope with the required workload of a shift depended on the skill and experience level of the individuals rostered on it:

*Numbers are great, but you need to look at what you’ve got in those numbers…*[Neralie].

*You have people that can only do certain things and then other people find that unfair and stuff and they’ve got to fill in, but then at the end of the day if you’ve got staff that are going to come to work, well that’s better than not*[Jodie].

The workload problem was intensified because of the pervasive view that enrolled nurses were not able to contribute to the workload. A few participants thought the argument about how much skill mix affected the workload was given more credibility by the midwives in the workplace than it deserved, although admittedly enrolled nurses were currently restricted to making less contribution to the workload than they had in the past. Several believed this factor of restricting the scope of practice for enrolled nurses had contributed to the workload tension between midwives and enrolled nurses.

*Years ago we had our own patients as enrolled nurses. We worked together [with midwives] but still had our own patients, we’re not allowed to do that now, we’re not even allowed to do the woman’s care plan - which is quite [exasperating] - so they [midwives] feel more pressured …they seem to think if there were more of them it wouldn’t be so hectic*[Lauren].

A few participants observed that a good deal of productivity was lost because some colleagues continually argued about their patient load and were overly vigilant about who did the work, rather than ensuring that the work was done. They believed some colleagues made the workload more intense by complaining about their perceived individual load rather than contributing to the overall workload. Lauren, also thought the chronic staff shortage, which affected the workload problem, was due to the unit’s reputation within the hospital as an unfriendly work environment so that nursing staff tended to avoid it.

*A lot of casual pool and nursing staff refuse to work there…going there can be very, very daunting*[Lauren].
4.5.2. Aspects of work pressure

There were also several aspects of work pressure that existed across the setting. The workplace environment was one of constant, conflicting and unrealistic pressures placed upon nurses and midwives. Some struggled to find effective strategies to cope. The unforeseeable way events unfolded over any shift also impacted on work pressure. Some participants reported encountering anxiety and worry about what they believed might eventuate; they were concerned about patient safety levels, for their colleagues and for their own ability to keep going safely. The following excerpt demonstrates some of the personal effects of pressure -- guilt, dissatisfaction and stress:

*I can’t, like it’s just impossible, it doesn’t matter how many years of experience you have and how good of a midwife you are, to do everything properly in ten hours. And if anyone there says that they do it’s impossible, you know. So you just give all you can but it’s just like, you know, it’s just like a ticking bomb. Things can happen because you can’t be everywhere all the time…You just have to rush a lot of things. That’s why I get this, sometimes, feeling that I haven’t done my work properly…*[Alice].

The additional emotional load associated with heavy work pressure was evident from the stories of participants, emanating from a sense of personal responsibility for the wellbeing of clients, colleagues or themselves. For example, one participant felt responsible for protecting her clients from the gossip and negative interactions that took place between the nurses and midwives in their hearing. Tina reported that she felt a sense of pressure that she might not be competent enough to advise her clients in some of the life circumstances they presented with:

*Sometimes I feel not confident in my work, when patients, they’ve got quite complicated social issues, and I feel like a bit hard for me to deal with that case, like it could be a domestic or some type issues or something like that. But I can get some [help]…if I don’t know I can ask someone else professional, but sometimes I still feel a bit hard to deal with that case*[Tina].

Another participant accounted for her need to leave every shift with little or no work outstanding for the nurses and midwives that followed as part of feeling responsible for colleagues:

*I do mull over work and I have been known to ring here and say, “Look, did I do that?” about a thousand things…*[At work] I leave myself a lot of post-it notes, I like to be really organised, so that I give a really good hand-over to whoever is
coming in in the afternoon and so I can go home with some kind of clear conscience. Go home…playing your CD in the car, do you know what I mean? That you left her [colleague] knowing that this, this, this, this and this has been done and that she’s going to have a good night. I would like to think that if I come after someone that I would get similar [behaviour] [Neralie].

Although this behaviour reduced Neralie’s stress about her own performance, when she was not able to meet that expectation, the sense of responsibility continued into her own time. She then experienced negative effects from feeling guilty and could not disengage emotionally from work.

Work pressure was particularly heavy when participants were responsible for earning the primary income for their families. This responsibility was usually in addition to multiple roles of parent, student or carer. These participants carried the responsibility of withstanding the demands of their jobs for financial reasons. They could not afford to gain a respite from the extreme load by dropping hours or taking time off, despite fatigue or illness, as some other participants were able to do. Vicky stated:

Well, I have hanging over me the fact that my husband has no income so I have the responsibility…actually that does, unfortunately, impact a bit at the moment, so that’s probably unfair, makes it kind of much more intense because you know well I can’t actually leave, either. And I can’t go and work in a plant nursery because, you know, I’ll only get half the amount [Vicky].

The increasing work pressure was also perceived as due to a rise in the number of surgical interventions taking place in the unit. Several participants believed that this factor added to their workload because patient care was becoming increasingly more labour-intensive. Neralie stated that this change required her to think and respond from both surgical and maternity nursing perspectives. There were also an increasing number of interventions with babies occurring, such as administering antibiotics, monitoring blood sugar levels and providing regimented feeds.

With the surgical delivery rate that we do now, it is becoming much more fast paced, it is a surgical ward now, a very high percentage, (…) evenings and (…) mornings were our [caesarian] section days and you would be mentally prepared for that, whereas now Monday to Friday - evenings, mornings [Neralie].

There was considerable pressure on participants that came with the responsibility of dealing competently with the significant number of difficult clients and complicated
medical cases presenting at the antenatal clinic. There was an ever-present threat of missing something important to their care and a sense that the participants held the responsibility alone. There was always the potential for adverse outcomes because of the vulnerability of unborn babies and infants, and the number of factors that could cause problems for pregnant women and their babies. The pressure of missing something, either from lack of knowledge or not enough time spent with clients, was well recognised amongst the participants, indeed it was a common experience. There were many emergencies in antenatal nursing, and the likelihood of experiencing sudden and stressful changes to a client’s health status often made the participants feel pressured and on edge:

  Sometimes I don’t feel like I have the knowledge. Research and things are changing all the time…it kind of scares me that I might be the only one they see through the entire pregnancy. So, I’ll go home, it might take me two days to go “Oh, it’s okay, I’ve done the right thing with that person”…I thought I’m not sure about what I’ve decided and I ran it by a doctor and what I decided was fine, but there’s still a bit of self-doubt there… There’s a lot of responsibility. It’s hard to deal with on a day to day level. If you’re preoccupied you can easily overlook something…lots of pressure to get [through quickly] - you know you’ve got people waiting for you in the waiting room [Talia].

Additional pressure was experienced regularly when the participants were obliged to deal with situations they were not adept to handle. Sometimes the scope of the medical event or problem was seen as more high-risk or complicated than they wanted to be involved in as nurses and midwives. There was pressure to stretch one’s nursing capacities, which caused worry about potential scenarios they might have to face, and anxiety about how they would cope. Others spoke about the pressures of mentoring student midwives, especially those they found it difficult to build rapport with. The increasing difficulty of university assignments meant students needed more of their time and support in order to succeed. One participant, Gillian, believed that there was constant pressure placed on the permanent nurses and midwives to teach and work at the same time. Another, Talia, felt pressured because her interest was not the high-interventionist midwifery that was increasingly required of her because of the number of clients presenting with high-risk pregnancies.

Two participants reported they were being placed under increased pressure to function at a higher level in the workplace, even though they lacked qualifications or experience, because of the constant shortfall of registered nurses and midwives. Alice recounted she
sometimes felt afraid of the consequences of this pressure in terms of patient safety. She shared how she often had to assertively remind her colleagues not to place more responsibility onto her than she should be expected to handle:

I said to them “I finished my midwifery [4 months ago]” and they think that I’ve been a midwife for like 10 years. And I think, “No, no! I’m just a new middy!”…They made that mistake because of all the years of experience [I’ve had previously] working in the [health] system I suppose. [Alice].

Those who carried onerous commitments outside work reported experiencing particularly hazardous effects from work pressures. Several participants revealed they had significant responsibilities of caring for children or parents with special health needs, lived in stressful domestic situations, or were completing external study courses. Participants who worked permanent night shifts seemed most constricted. They were usually working in that mode because, on the face of it, night shift provided the greatest flexibility for meeting family and financial needs, however, if there were changes or challenges to either home or work spheres the effects could be catastrophic in terms of managing the pressures they faced. The real toll reported, sometimes an invisible one, was the cost to participants themselves in reductions of their own health and wellbeing. This dilemma -- how to manage particular, stress-producing outside commitments, such as caring for a chronically ill child, while working permanent night shift -- often left them feeling stretched and unsatisfied with their performance in any sphere.

The pre-intervention interview was undertaken with Jodie while she was facing changes in the work sphere, an organisational crack-down on working set shifts, and she was feeling particularly pressured about how to continue managing her child’s preferred care. She also felt the pressure of potentially being asked to work extra shifts, as was happening to her colleagues. She felt trapped between the expectations on her to be the primary care-giver for her child, and those of her colleagues to share the workload around in times of staff shortage:

Last week there was an emergency right at the end of a shift, you can’t go, you’ve got to help….It depends on how [my child] wakes up to how [he/she] feels…I just rang up and said “I can’t take you to school, you’re going to have to go [by bus] or you wait until I get home and you’ll have to be there by yourself.” (…) won’t stay there [alone]. I just said “It’s your decision, I have to go.” But it’s not good. I mean if (…) was just the average kid I’d probably be able to deal with it but that’s a real stress factor…[If I’m late home] it’s always there in the back of [my]
mind and it depends on what the others [at home] are doing, like they don’t really want to pull their weight a lot of the time so that’s all impact [on me]. [Jodie].

Participants like Jodie were uncertain how they could deal more successfully with outside commitments in the future, or how the organisation might respond. The somewhat fatalistic tone of this response shows the ongoing uncertainty and insecurity of their position:

*It’s in the lap of the gods isn’t it, the NUM that’s there…she is pretty good but there’s particular nights of the week I just cannot work, it’s not safe or reasonable for me to do those nights. But um, there’s this thing now that you can’t have set shifts* [Jodie].

4.5.2.1. **Dissatisfaction with quality of care**

Caring for mothers and babies as individuals was the major reason for the participants’ commitment to their job, and what gave them moments during the working day that were meaningful and fulfilling. They believed individualised care was the essence of nursing and midwifery and were committed to providing quality care for their patients. This element of their work sharply influenced their degree of job satisfaction.

*It’s actually [about] giving individual care or being there to give emotional support, being involved in helping, yeah helping make their experience more enjoyable… and if we’re unable to really do that…* [Jodie].

However, several participants spoke about their dissatisfaction with having significantly reduced time available to spend with patients. These essential caring tasks did not fit easily into the time management models they were expected to adhere to by the organisation. They believed they were losing the opportunity to provide the therapeutic care they most wanted to provide, such as assisting women to initiate breast feeding, because of the high proportion of time given to basic nursing and administrative tasks. In the following excerpts participants voiced their frustration and dissatisfaction with not being able to provide their ideals of optimum care.

*I love being a midwife. Just the frustration…of seeing someone every fifteen minutes doesn’t match with that sort of productive outcome. I’d like to give more* [Talia].
It’s about not giving these poor new mothers the time, because there’s just a push, the only time you spend with the patient is arranging the doctor’s visit book and arranging the discharge. You can’t spend any time with them because you’re just forced to get patients out which I disagree with. I know there’s more ladies having babies but management want the women to go home on day one, well, you know, that’s not going to [work], if she’s a first time breast feeder she’s not going to be able to learn the whole thing in one day. So yes, that’s what I hate… [Lauren].

You [want to] go in and hold the baby and meet the family and the husband that’s supporting them, and you can have a really good look at what’s reality for her, rather than running and getting the machine and, “Oh, can I take your temperature;” and, you know, running back to someone else [Patrice].

These excerpts emphasise how the participants’ feelings of dissatisfaction with their ability to provide what they perceived to be quality care strongly affected their perspectives on the workload and pressures they had to contend with. Participants felt that doing satisfying and worthwhile work was the reward for the heavy nature of their work, and that reward was being curtailed more and more.

4.6. Work/life imbalance

Work/life imbalance was another significant factor of workplace adversity present across the case. Some participants perceived their life experiences – and those of their families – were suffering due to the overwhelming demands and negative effects of their work. Participants were predominantly concerned that their work situation made it difficult for them to maintain primary relationships with partners and children. The participants’ difficulties with managing work/life balance also influenced their attitude towards the organisation. There was resentment that the roster system forced them to arrange their social and family time far in advance. Some felt this meant they were already becoming increasingly isolated from people outside their work sphere, and from access to social opportunities.

Some participants stated that achieving greater work/life balance was a motivation for joining the study. They reported wanting information and useful strategies to assist them in coping with their work lives better so they could experience a higher level of satisfaction with other spheres of life.
I think with nursing you can become really kind of bogged in your work. Like it is very demanding on lots of levels and you can get a bit [into taking] work home or you need quite a push out of it to stop being a nurse...you’ve got to be careful, I think, that you don’t lose yourself [Patrice].

That’s 20 years of this that I’ve done, and what is appropriate and what level of sacrifice you’re meant to make at 17 is very different [to now] when you’re wanting children, you have a marriage to maintain and you have friendships which are important... I thought, I have [given] so many devotions to this, it’s starting to get like a bad marriage, I’m starting to hate [nursing] and I’m wanting out but I had no back-up [Neralie].

A few participants expressed concern that they were living simply to work and sleep -- with little scope for any fulfilling or enjoyable activities. In the pre-intervention phase there was an overall concern about how the participants could continue coping with workplace adversity without improving the sustainability of their work/life balance:

Finding ways to actually incorporate that in the real world, because...my mind [is] saying you know you need to do something for yourself, but I’ve just got to go and wash the dishes...it’s true of a lot of women isn’t it? I mean it’s just thinking you’ve got to stop and lie down and put the relaxation tape on or go to yoga class. That’s more important than the washing and I think it’s that stuff of how do you really make yourself that important? [Patrice].

Maintaining balance was most difficult for participants when partners or children were at critical stages in their own lives; for example building careers, full-time study or experiencing health crises. Additional burdens detracted from the support they could offer the participants. When family members were the participant case’s primary support with household and childcare responsibilities, work/life balance became more complex and difficult. In some instances the imbalance caused anxiety and guilt that their primary relationships were being stretched and potentially strained. Participants usually felt powerless in the present to relieve the situation they found themselves in.

Many participants spoke about the complex relationship between their work/life balance and their unique challenges to maintaining personal relationships. The circumstances they described showed clearly how difficult it was for them to create space for relationships with others, or time for themselves. Some participants spoke eloquently of how they felt overwhelmed by the complexity of their life circumstances and the many competing demands on them associated with work, family and study. The situation was interfering with their ability to cope and causing them to feel overloaded and inadequate:
When I started here I moved and got married all at the same time. I was sort of living in reasonable proximity to my sisters but they’re all working full-time, so…a lot so that support has gone. And the people I went to uni with, we were told…to keep in contact but we’re all doing different things now, it’s moved on so we don’t do that either…My partner and I have more than six children between us, so we’re kind of busy. I generally work on the weekends, and he’s at home with the kids [Lisa].

The development and maintenance of other significant relationships with friends was also limited by the degree to which a work/life balance could be struck. One participant described her social life as unrewarding and quite lonely; it was causing harmful effects on her wellbeing:

*Usually when I get days off, I just stay at home…sometimes like I don’t have much activities to do, so that’s another issue that I feel a bit stressed [about]. I don’t have many friends here to go and have a social life…I’m studying…and I’ll have a child [soon] [Tina].*

There were further perspectives of work/life imbalance outside work. Some participants experienced unrelenting work demands from the home sphere in addition to work. A few participants reported that even if there were household jobs to be done when they returned home from work they could focus on sleep or self-care:

*If I go home and the house is untidy I just go to sleep. I don’t worry about the house…I have to let some things go [Alice].*

However, other participants could not delay or delegate their household responsibilities. Their ability to bounce back was decreased as they tended to spend time on home duties instead of sleeping, and it also increased the likelihood of family conflicts:

*You stress at work and then you go home and I want things in order…you’re expecting it to be nice and tidy, nothing in the sink… it’s more stress and I tend to be more cranky and I shout [Gillian].*

The ‘double’ shift experience of having substantial work responsibilities at home as well as at work, affected the participants’ recovery and ability to bounce back between work shifts. The requirement of work in the home was exacerbated by the irregular hours spent away at work, especially due to shift rotations. Several participants told how the first days at home after working a number of shifts in a row, in particular, placed a strain on family life. They needed time to recoup and recover but found this collided with the needs and desire of family members:
Well, I work night duty so that adds another dimension to [work/life balance]...it just makes it easier for family and my husband works seven days a week and he can’t just stay away at the drop of a hat, so like its easier for me to have the weekends off. That’s the main reason I did night duty because at least even if I’m at home and sleeping I can still get up and do things and be there if I have to be... [But] family life doesn’t work very well  [Jodie].

The participants were employing a range of strategies to impose some kind of work/life balance, even if the effect was largely unsuccessful. They were attempting to keep up the activities they enjoyed and trying to make time for important relationships. They also talked about the importance of values about work, family, relationships and community to their understanding of life balance. It was evident their values and realities were incongruent and underpinned the problems they were experiencing; there was a schism between their ideals of work/life balance and the reality of their lives. Several other participants also attested to the problems they were finding in keeping their efforts at work/life balance going. They did not seem to hold any hope or expectation of the organisation to partner with them in their efforts. The following excerpt from Patrice tells of her strategies for maintaining work/life balance.

*Keeping up with things that I loved to do before, as much as possible....I think anything regular can be a bit hard to keep up with... I’ve got a very supportive network of friends but I can’t quite get to everything that everybody else can, I am working. I just have to say to everybody “If you want me to be there, or if it’s something special you’ve got to give me more notice, there’s no more ringing me up at the last minute saying we’re doing this. “...So that spontaneity, that’s what I mean about my social life has suffered. You kind of feel structured to the work...And I also have to give them [friends] the message that I’m still interested  [Patrice].

Other participants were currently considering future life changes that would be additional challenges to their work/life balance. Some related to personal aspirations, such as having their own baby and starting a family; others were to do with study and career opportunities, such as in Lisa’s case:

*Well at the moment I’m deciding whether to stay [in my current job] or whether to do midwifery. Yeah, it would mean a twelve, eighteen month commitment, and it would mean to work full-time, which I’m not sure if I want to do that at the moment...I guess somewhat it depends on my personal family dynamics, too [whether] I’m free to take on more study and more shifts. Because that’s what would be required... more of a commitment from me and I don’t know if I’m ready to do more at this stage  [Lisa].*
Organisational mishandling of work/life balance was also indicated. A practical desire from management to assist nursing staff by instituting and maintaining policies and procedures conducive to work/life balance was not evident. The procedure for organising work schedules suggested a hegemonic, obstructive view of the work/life balance needs of the nurses and midwives, rather than a proper understanding of the redress needed to workplace adversity they faced. One participant, Neralie, reflected on the extent of the problem for her:

*The work/life balance. I can’t speak for everybody, but it is everybody’s concern, that’s why most people work part time. We don’t have set shifts there, we get 4 requests a roster, we used to, if you work full time, get 6 to 8 requests a roster. Some people weren’t being fair with that. It would just leave everything short skilled or short staffed and so they [management] said “Right well we’re going to fix this problem, we’re going to halve your requests,” which makes it very, very hard. But also, we’re requesting shifts, right now, for [6 weeks time]. Once you’ve requested it that’s it and it’s a big no to everything else, and that makes you pretty down on your job [Neralie].*

There was an additional participant perspective about the inevitability of work/life imbalance for nurses and midwives. Two participants indicated that, although they experienced difficulties in coping with the level of imbalance in their lives, they accepted it as part of their decision to take up nursing and midwifery as a career. One participant believed it was necessary for career progression and to generate an adequate income but implied she would not continue to accept its strictures indefinitely:

*You can’t do nursing Monday to Friday normal shifts ‘cause you just don’t get paid enough. So you just can’t actually [achieve this], [its] the profession I suppose. It’s not like you have to do it for 50 years. You can do it for a couple of years and I suppose you can change. Once you’re where you want to be you can sort of slow down, you know [Alice].*

Another participant implied a more philosophical acceptance of her own experiences of exhaustion and inadequate working conditions that led to the impossibility of maintaining a work/life balance. She believed these factors were part of the “normal” experience of nurse and midwives:
I think [being out of balance is] the nature of the game. Because some shifts are just great and you think oh this is fabulous, especially when you're having a really rewarding two way [interaction with a client], and the next day it could be just work, after work, after work task, or something, drama, you know really, sort of geting filled up and exhausted and not getting off on time or getting a break, you know all that kind of stuff. I do think that’s the role [Patrice].

4.7. Summary

This chapter outlined the characteristics associated with workplace adversity experienced by the participants. The workplace adversity present in the setting caused several adverse effects on their physical and psychological health and wellbeing. The majority of participants were experiencing serious dissatisfaction associated with their workload, the quality of care and their capacity for work/life balance. There were also serious deficiencies in the workplace culture that led to difficulties between staff members and an unsupportive work environment. The next chapter will investigate the impact on participants of coping with these elements of workplace adversity. The subsequent chapter also reveals the presence of other factors that assisted some participants to resolve the negative effects of workplace adversity.
CHAPTER 5: Abstract

Chapter 5 is the second findings chapter from the pre-intervention phase of the study. The chapter presents the impact of workplace adversity experienced by the participants that was discussed in the previous chapter. These effects included exhaustion, emotional labour and stress. In addition, workplace adversity impacted on the health and wellbeing of the participants and their sense of fulfillment and commitment to stay. This chapter concludes with an exploration of the factors that affected some participants’ resolution of workplace adversity, even before the study intervention. Some of the content in this chapter has been published previously.
Chapter 5: Workplace Adversity: Its Impact and Resolution Pre-intervention

5.1 Introduction

Chapter 5 explores another primary focus of the research study: the investigation of the effects of workplace adversity on the participants’ health and well-being, sense of fulfillment and commitment to stay. The impact of workplace adversity was felt in some way by all the participants. Although a majority of participants experienced negative effects from being in their workplace, these experiences were not distributed evenly across the collective case. The chapter also deals with the differing levels of agreement reported by participants about the negative effects of workplace adversity under discussion.

It is important in collective case study research not to discount the views of participants that are different from those of the majority. Therefore, the chapter also explicates the means by which some participants achieved resolution, or partial resolution, of the impact of workplace adversity. In the collective case under investigation there were participants who did not believe they were negatively affected by workplace adversity, with some believing their health and wellbeing were positively influenced by factors associated with their workplace.

The impact of workplace adversity pre-intervention have been placed into themes of ‘The impact of exhaustion and shift work,’ ‘The impact of emotional labour on relationships,’ ‘The impact of stress,’ ‘The impact on general health, diet and exercise’ and ‘The impact on fulfilment and commitment to stay.’
Table 5.1: The Impact of Workplace Adversity Pre-intervention

<table>
<thead>
<tr>
<th>The Impact of Workplace Adversity Pre-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The impact of exhaustion and shift work</td>
</tr>
<tr>
<td>• The impact of emotional labour on relationships</td>
</tr>
<tr>
<td>• The impact of stress</td>
</tr>
<tr>
<td>• General health, diet and exercise</td>
</tr>
<tr>
<td>• Fulfilment and commitment to stay</td>
</tr>
</tbody>
</table>

5.2. The Impact of Workplace Adversity Pre-intervention

The impact of workplace adversity was significant for a majority of participants in the pre-intervention phase. Workplace adversity caused onerous personal and professional burdens for the participants, including losses to self-esteem, self-confidence, critical thinking and professional decision-making capacities. Participants experienced a range of negative health and wellbeing effects from working in their environment, such as constant fatigue, sleeplessness, chronic pain, stress and anxiety. As physical and socio-psychological health indicators were diminished their ability to engage in adequate self-care practices waned as well.

5.2.1 The impact of exhaustion and shift work

Exhaustion was a major consequence of the work adversity experienced by the participants. There were both physical and emotional dimensions of the exhaustion they experienced from their work. It resulted in a number of detrimental effects on health and wellbeing, such as fatigue, as Talia’s words show:

*I’m just really tired…it kind of plays into every aspect of my life. If I’m having a bad working week you know, I’m going home tired, I might snap at the kids, I don’t enjoy my days off as much, because I’m really tired, so I don’t want to do the things I love to do. So it kind of affects everything…* [Talia].

Physical exhaustion was common for the participants. Their descriptions of the experience included physical fatigue, muscle and joint soreness, and headaches. They found it difficult to maintain their energy levels to cope with the demands of work and
other activities. They reported it was most difficult to recover physically after the transition from one shift to another, and especially after night shifts.

*I can’t seem to get more strength and if I go to work it’s like here I am again… You can feel that your body, you want to do things but your body says, don’t move, I can’t anymore* [Gillian].

Three participants aged in their fifties mentioned ageing, arthritis and the effects of menopause as contributing to the physical exhaustion they experienced. One participant ‘case’ inferred her exhaustion was due to experiencing years of disrupted sleep cycles; another believed her exhaustion was due to her age, full-time work and a physical health problem, which she differentiated from exhaustion caused by depression or anxiety:

*I’m 63 years of age. You know, I’m allowed to be tired. I work full time…But I’m not tired because I’m depressed or anything like that…I’ve just got arthritis so it’s getting a bit sore at times* [Rose].

However, some participants reported they believed there was a relationship between physical and other forms of exhaustion. They reported being exhausted physically over an extended period of time increased the feeling of emotional overload, of coming to the absolute end of one’s endurance; a precursor to burnout. Several participants recognised they perhaps reached that point at times and believed emotional exhaustion was damaging to their health and wellbeing:

*It’s just a lot of information overload… at the end of the day I’m really – my head is full, I feel like a bit of a zombie…I used to feel physically tired. Now I’m just emotionally …so it’s not just the physical overload of your brain, it’s that emotional side as well* [Lucinda].

Sleep deprivation, resulting in chronic fatigue, was another major part of the exhaustion experienced by most of the participants. Most participants shared that they had problems sleeping due to stress and worry about work issues. This became a pattern of missed sleep or sleep disturbance that had serious health and social effects on them. The quote below gives a powerful indication of the trouble these participants had sleeping:

*I tend to [get to] sleep late, you know stress, it’s really hard…Sometimes I just have to sleep, I try not to take, you know, those over the counter drugs… It’s hard to go to sleep sometimes, like last night it was too hard because I went home [leaving] a sick patient…* [Gillian].
Shift work caused a feeling of never being properly rested; some participants regularly had to forgo sleep to take children to school, run errands, shop or pay bills. Several participants reported that working rotating shifts brought an extra dimension to the exhaustion they experienced. The permanent day shift participants commonly said they could not cope with the physical, mental or emotional fatigue of working rotating shifts, although some of them had done so in the past. The implication was their health and wellbeing had benefited from less shift work in the wards, causing less exhaustion and fatigue:

*I get tired because I work full-time ...but nothing like the tired I used to when I was on shifts* [Marika].

A common association reported was that between exhaustion and working night shift. Participants found that it caused a range of negative health effects, from inadequate and poor quality sleep, disrupted sleep, to being out of sync with the routines of most other people so they missed out on active pursuits and social opportunities. Some participants also reported they did not feel as competent working during night shifts as during the day. Vicky’s comment clearly showed the connection perceived between experiencing sleep difficulties and working permanent night shift:

*Sleeping gets to be a problem as you get older, and gets a problem when you do night shift...Because you’ve sort of got disrupted sleep cycles but if you’re wound up, it’s very difficult to wind down.... But I am feeling like, when I go to work night shifts I feel like a different person to when I go and work that evening shift. And I really feel that I’m probably not quite as safe on the night shifts. You’re a little bit more automatic. You miss things...If I’m working night shift I’m exhausted at the end of the shift anyway, physically, emotionally, every way* [Vicky].

Two participants worked permanently on night shift. They acknowledged their work was especially problematic; they believed long-term exhaustion set up a pattern of chronic sleep deprivation and disturbance, and even caused dangerous events like micro-sleeps from driving while exhausted. Jodie told how she had experienced micro-sleeps twice while driving, once after a first night back on shift and once while driving her child to school. She reported that in her six years of working night shifts she had known of a number of motor vehicle accidents involving colleagues that had occurred with loss of life. She attributed those accidents to fatigue and that increased her anxiety about her own safety when driving. Jodie seemed resigned to the difficulties she encountered trying
to achieve some quality of life for herself and manage her family caring role with such a disjointed sleeping routine:

Oh it goes through cycles, like um, well if you get past a certain time well then you can’t go to sleep and you’re wide awake or you might go to sleep and then you wake up and you’re wide awake, or you’re just exhausted and never feel as if you’ve had enough sleep. When I’m working it can vary, really I have from four to six hours, sometimes I might have seven, a lot of that’s split sleep - it’s not all solid, you go to bed and wake up and that’s it…I actually have to get the youngest one to school or take them all to school, or sometimes I’ve got things that I have to do, cause if I don’t get up through the day, well I won’t get it done, so yeah…[Jodie].

Working part-time was seen as a strategy of coping with the demands of shift work; it was in effect a method of dealing with the problem of not getting enough rest. The participants believed this protected them to some degree from the worst effects of continual exhaustion. Most found their part-time workload extremely tiring as it was; they could not envisage increasing their hours because of the negative effect on their health and wellbeing:

The week that I work three days I feel a wreck, and that’s only three days. I do not know how girls do it five days [Talia].

There was a perception held by some participants that being a part-time worker provided more autonomy over the number of shifts they were expected to work; as they believed they then had a valid reason for refusing extra shifts. Despite this perception, some part-time participants recounted stories where fatigue had not been accepted by managers as a reason for refusal to work. Jodie told how a part-time colleague of hers refused an additional night shift due to tiredness and was told by her NUM “Well, aren’t we all? Everyone’s tired.” Jodie felt dissatisfied with the management’s attitude and was concerned that demands on her could increase. Talia, another part-timer, recalled a similar episode of feeling harassed by her NUM to work additional shifts, and having to retreat to the toilets to try to avoid her supervisor’s pressure tactics:

She waited till I came out and said “I need you” and I said, “No” and she went off stamping her feet and I said to her, “How about you look at the extra shifts I’ve done this month…and just accept that I don’t want to do it.” I work part-time for a reason [Talia].

Being able to maintain better health and wellbeing was also attributed to working part-time by participants. They believed working part-time resulted in having more time to
exercise, pursue interests and maintain fulfilling personal relationships. Some participants also believed, because of the intense mental focus on their work when they were there, that having longer periods away from the work sphere gave them a healthier mental outlook.

Some participants reported that the most difficult aspect of their exhaustion was the burden of recovery time that was required. They experienced this problem most acutely after working a number of shifts in a row or when they transitioned from one shift to another. There was also an implication of self-reproach; these participants felt they should be able to bounce back more quickly and easily, causing feelings of guilt that they could not cope better with their work regime. Other participants viewed the recovery time as necessary, but as an ultimate waste of their valuable time. As the exhaustion they experienced was implacable they felt frustrated that they needed to rest when they would have preferred to use the time away from work in a more enjoyable way:

> Sometimes like if I’m on evening shift, and I swap to morning shift, very hard to get enough sleep. You have to get up very early, and if I have a few morning shifts going into night… the past two days, like, I took one sick day off, just wanted to get some sleep. I don’t like night shift. Yeah, I feel very exhausted after a night shift. It’s very hard for me to recover back to normal life [Tina].

The presence of shift work was indicative not only of exhaustion, but of less positive perceptions of health and wellbeing, workplace experiences and quality of life in general. The participants that worked regular daytime shifts with a core group of co-workers were the most satisfied with their workplace and spoke more positively about their physical, mental and emotional health than those that worked rotating shifts. This implies that their working conditions and environment afforded them greater protection against the effects of workplace adversity.

> I have managed not to do too much shift work, just by my own choosing of how I’m being employed, so that’s helped my health [Lucinda].

### 5.2.1.1 Coping with shift work

The participants that lived alone expressed less difficulties with shift work than those living in family situations with children at home. They felt this was due to having less
care-giving responsibilities and the potential for more time to themselves for leisure, and therefore greater scope for maintaining a work/life balance. This sub-group also reported less problems with sleep and minor health problems. However, it could also be suggested that the life experiences of these participants, who were long-term nurses and midwives, had been shaped by the shift work environment. Over time, rather than creating a work/life balance, they had been socialised to accept a limited lifestyle where other interests, and even relationships, were subsumed to the demands of work. In this case, their social networks tended to be small, or made up of family members; and often they had caring responsibilities for elderly parents as their siblings had moved away or formed their own families. While these participants perceived their family carer responsibilities with differing degrees of obligation and choice, their range of outside interests were diminished because of them. One participant, Marika, whose nursing career spanned several decades, described her life outside work in positive terms in the following quote, yet there was a sense she felt her scope of life was constricted. This suggested her life opportunities may have been minimised due to long-term shift work demands:

*Well I’m single, I’ve only got a cat, and I’ve got my mother who lives [40 minutes away] and I’ll sometimes go and spend the whole weekend with her…I ring my sister during the week and I’ve got another sister that I’m close to as well…I do water aerobics on Mondays and Wednesdays, and I have a friend who I go to the movies with. I’ve got good support, I never feel lonely* [Marika].

For a few participants, there was a ‘boom and bust’ cycle approach to coping with shift work, where they worked to the point of exhaustion and then took long periods of leave to recover. They spoke about these leave periods with specific reference to needing physical, mental and emotional recovery. Four participants took leave of six weeks or more during the study time-span; one of whom also spoke about a previous three month ‘escape’ from work:

*I felt before I went on holiday completely washed out. I was thinking oh, if it can go from that to that, you know? From feeling really centred and everything was going great to totally shattered because the work is hard, it’s full on* [Patrice].

At the time of her pre-intervention interview Patrice had just returned from two month’s leave and was feeling as though “I’m surviving well…that’s because I’ve had a distance of change and a real good break.” She described a cyclic way, similar to Neralie, of passing through different phases in her attitude to work. It began with feeling that work
was “fabulous,” to feeling her work was repetitive and was not being recognised, to feeling “overloaded and exhausted.” She then knew it was time she took extended leave to recover before beginning the cycle again. Her everyday role was characterised by often not getting breaks or off shift on time, and racing between clients or assisting midwives. Patrice seemed to have accepted the phases of diminishing health and wellbeing she passed through; intermittent escape was her solution to dealing with the difficulties she faced in the workplace. At the pre-intervention phase she did not seem aware of the potential for changes in her workplace or in herself that could possibly guard against the experience of overload she was describing.

The inflexibility of work rosters was often cited as a problem for those participants that worked rotating shifts on wards where self-rostering was not allowed. The lack of autonomy they experienced was seen as an indication of the uncaring attitude of the organisation towards them. They did not believe there was an equitable or adequate rostering system in place for work/life balance; for effective workload coverage or for quality care of patients. Several participants said they were frequently unhappy with the shifts they received but felt they had little autonomy over shift changes. They were allowed few changes per roster, they were required to find their own replacements and the nursing supervisor could refuse their request.

*With the rosters, I mean I know you can put in requests, but you’ve got to be six weeks ahead of yourself and I’m not usually that organised. And other people aren’t either. Maybe if there’s a big thing coming up, a wedding or something. But otherwise people aren’t. You say, “Oh what are you doing? I’ve got a day off in six week’s time? People look at you like, “Well, I don’t know what I’m doing. Ask me again in three weeks”* [Karin].

Shift work was believed by most participants to place specific pressures on personal relationships. Family and social events were missed due to work and this caused tension and upset with family and friends if they did not accept the participants’ lack of autonomy. Some participants spoke of the emotional dilemma they faced when they were refused a shift change to their roster for a significant personal event. They were left with two unpalatable choices, call in sick for a shift knowing that work colleagues were aware that they had tried to change that shift beforehand, or come to work and face disappointment or even anger from family and friends. They reported feeling guilty about taking sick leave under such circumstances, and some had experienced hostility from colleagues when they returned to work because of the added work pressure created by
their absence. Other participants disliked the deception involved and that they were not able to be authentic at work about social events taking place in their lives. However, if they had decided to miss out on the social or family event and come to work in those situations they experienced a sense of loss of quality of life and resentment towards the management’s rostering system processes:

*If you haven’t got what [shift] you want you’ve got to swap with somebody and that makes it harder, you know, when you’ve got to try and find somebody and persuade them to give up their Saturday night, and then there’s a risk then, that they will say, “You know you could take a sicky.” But you know, I could take a sicky, and somebody’s got to carry the work, so you have that responsibility, to make it to the ward and to your shift...if you’re ringing up going, “Oh I’m sick” when really you’re going to a 40th birthday party, it’s lying...and then the next day you can’t say, “Oh, had such a great night last night”* [Patrice].

### 5.2.2 The impact of emotional labour on relationships

The participants reported that emotional labour was a part of their experience at work, and one that impacted on their sense of wellbeing. Emotional labour was experienced most strongly in two kinds of workplace relationships; those with colleagues and those with clients.

Talia confirmed in her first interview that she often felt uncomfortable at work because she felt she did not fit in with her colleagues, the surrounding environment, culture or organisational style of the workplace. She believed her interests and ideals, about nursing and midwifery or in general, were not readily understood and supported in the workplace. She felt she had to hide her authentic self and did not volunteer information about herself at work:

*I think this area is very conservative...I’ve seen lots of different people living different ways of life, and I like having lots of different people around me...just that whole ‘very conservative’[attitude], and I come here and I may have done [something] on the weekend... and I don’t feel like I can share that* [Talia].

Several participants had experienced emotional labour when they had first started working in the unit. They had encountered reactions from their colleagues to suggest it was not safe for them to show their authentic selves for some period of time; they felt they had to conform to the projected ways of working and being by their colleagues in order to be
accepted. Two reported their colleagues were not interested in finding out more about them than the superficial opinions they had formed at the beginning. Lisa described this process as being ‘made passive,’ Patrice as ‘reinventing herself’ to be more acceptable to her coworkers. Both these participants commented about the experience of hiding and protecting their authentic personalities.

I just have to keep being, maybe submissive isn’t the right word, but that kind of…passive [for] a long time I think! A long time. I’ve had to think about it a lot and just go at it very slowly and try and work out what’s going on. I guess I wouldn’t like to think of myself as submissive, but certainly passive would be the way that I had go about it [Lisa].

When I went there I found – my self, my personality and my experience that I’d had before that - left behind. I had to reinvent myself in a way, so I felt a bit out of touch with my real self till I learned how to be in the environment, it was a bit of a shock too and my way of dealing with that was to try and humanise it [the ward] a little bit more…Going into it I didn’t feel I was myself for a long time. If somebody asked you what you thought of something you had to be very careful. If you’re sitting in a coffee room together, you know at lunch time, even a discussion about, oh I don’t know, the Iraqi war, or politics, you need to be careful of what you say and think because you’re trying to fit in, because they don’t know who you are, very subtle and yet very obvious things. And then you start to get reflected from the group what they think [about you]…The reflection that I got as I was working was that I was a wonderful, lovely person. They all started to get confidence with me that I was of the ideal. And I’ve still got this ideal - even when it’s stressful people would describe me as, “Oh you’re so calm!” I’ve got a really good emotional level, but inside of my self it doesn’t feel like that. You’re going home, it’s like, “Oh God! that was terrible, or sad,” or, you know, overwhelming or whatever…I have grown in confidence in being more myself, I definitely have, but that did take a long time [Patrice].

The comments suggest that these participants may have lost confidence in expressing themselves naturally in their workplace, causing them to doubt their own thoughts, words and behaviour around clients and colleagues.

Patrice had also observed emotional labour in her colleagues during a stressful event when officers of the Department of Community Services came to the special nursery and removed a baby from the care of its mother. Patrice’s emotional response to the incident had been a deep and immediate sense of distress when she realised that the baby’s mother had not been informed nor given the chance to see the baby again. One colleague had
encouraged Patrice to see her own response as an authentic one, which helped to reassure her that her response was a normal one and that she was coping. However, afterwards Patrice felt a mixture of emotions about the incident – shame and embarrassment that her distress had kept her from continuing her work at the time, resentment that other colleagues had found her response unhelpful, and disappointment with those colleagues who could not acknowledge the emotional labour she believed they were experiencing.

*When we were all talking I saw how other people [dealt with it], it was like “don’t really deal with the feelings then”, and I thought that I couldn’t really deal with it so healthy or so well. Like it really, really upset me seeing this little baby being taken away without its mother being able to say goodbye. Then somebody said to me going to see a counsellor was the best thing to do. So that to me, was like somebody with their experience had learned to deal with how I [was feeling]…it was almost like a permission for it as well…How they deal with this really huge emotional thing was to push it down and carry on with the work…They see that as resilience, pushing it down and getting on with it, whereas I don’t. I think that is just asking for trouble* [Patrice].

This story illustrates how emotional labour was being enacted by the nurses and midwives in the workplace and how the informal networks and behavioural norms were reinforcing its continuation.

Another aspect of emotional labour experienced by the participants that affected their health and wellbeing was when they were dealt with clients in stressful circumstances. Rose recounted how there was an additional burden for her when an adverse outcome occurred for a client and the nurses and midwives around her also became emotionally distressed. She felt she had to remain outwardly unaffected emotionally. In those circumstances she felt that she needed to support distressed clients, their families and the other members of staff, without allowing herself to show her true emotional state:

*You’re not only coping with the mother, you’re coping with the family, you’re coping with the father and the other relatives, you have a lot of people to cope with. Yes, and somebody might be looking after them and then they come out and they’re in tears so somebody else has to take over. You’ve not only got to support them [the nurse/midwife], you’ve got to go back and support the woman as well* [Rose].

Emotional labour was also engaged in when distressing personal histories were disclosed by clients to the nurses and midwives and they were required to seem unaffected. One participant ‘case’ spoke about distancing herself emotionally in order to perform her role
competently. However, there were times when the number of clients revealing distressing
events became overwhelming; and then she felt justified expressing her emotions in order
to keep a sense of humanity intact.

You have to do these psych-social assessments, asking people whether
they’ve had domestic violence, child abuse, all that sort of stuff about their
history, obviously that can open up a lot of stuff, so…dealing with that on a
regular basis as well…I can seem to distance myself, but you know, some
days if you just have a run of a few different women telling, you know,
bawling their eyes out about something, that’s got to get to you or otherwise
you’re not doing, you shouldn’t be doing your job, I don’t think! [Lucinda].

These participant excerpts reveal the significance of emotional labour in the
experience of workplace adversity in the workplace. The participants were enacting it
on a regular basis.

5.2.3. The impact of stress

The experience of feeling negative stress at work was also a common one for
participants. The effects upon their health and wellbeing were evident in the excerpts
that follow about stress from work events, work pressures and unexpected
organisational change.

Gillian decided to join the research study after her husband confronted her about the way
work was affecting her relationship with her son. She was worried about the prospect of
managing significant family relationships while coping with the delayed stress of working
in a challenging environment. This was causing her stress:

My husband just stopped me from what I’m doing and he talked to me and
said, “I think you have to lay low with your work because you’re bringing
it home and you’re taking it out on your son,” which he doesn’t like. He
doesn’t mind if I’m taking it out on him but not on the kids, which made
me realise that, “Yes, I am doing that and I don’t want my kids to be
suffering at all” [Gillian].

Gillian explained how her stress level had increased in keeping with expanding
responsibilities in the home sphere with a home and child to care for. She no longer had a
relatively stress-free environment to come home to after work which was her primary
stress-reduction strategy, so her general stress had increased. She felt unable to cope with the pressure in the same way as before she had a child.

*It was just stress, because I’m like the sort of person, I want things in order. At home, yes, I like my stuff in order and having a kid is not helping, plus I’m just married and before that I am really that kind of person, I tend to get organised and if things are not in their proper places, you know* [Gillian].

Two participants recounted remarkably similar experiences about how stress affected them at work. They described a sense of immediate overload when they needed to physically withdraw from the environment and process what was causing them to feel that way. At other times they could contain the feelings of being stressed and overwhelmed until they returned home afterwards:

*I notice with myself if I get really teary, I’m stressed…That’s a marker for me …like suddenly, you can be in work and suddenly you feel like you want to sit down and cry, or you go home and you feel it, you know what I mean? And then I tend to look to see what, what am I feeling, why am I feeling like this, and then I’ll have a really good cry, and then I’ll feel better* [Patrice].

*I tend to just sit down, I don’t want to cry and stuff like that but I just need to sit down and think about where it’s coming from* [Gillian].

The main stressors were reported to be related to the workplace environment. These included a stressful level of criticism from others, a sense of shame about others’ perceptions of their own performance, and the operation and events of the unit itself.

*The last few years we’ve had a lot of ups and downs up there, and the entire hospital is aware of what’s happening just on our little ward so you know that…has been a lot to deal with* [Neralie].

Another participant, Jodie, stated that sometimes she reached a peak of stress about her work situation feeling “I can’t function under this criticism…I’ve seen people go [leave], yeah, because they can’t cope with it anymore”. Other participants mentioned that they were stressed by conflictive relationships with colleagues, as shown by the comments below:
Some participants revealed that their stress was related to distressing events at work. For example, Vicky told how some of her colleagues were experiencing stress from the ongoing police involvement and official court proceedings associated with the maternal death. It was causing confusion and anxiety for the nurses and midwives involved that official consequences could still unravel in unknown ways:

_The police are interviewing again, over [the maternal death], and I’m not sure why. It’s really distressing for the girls that thought that it was all finished. Also I find it distressing that it goes on for this amount of time, they’d all done their interviews with the police and now it was all over again. I didn’t actually get to talk with the girl that I was working with that had an interview. I should have been supportive, but I wasn’t! I mean it was, it’s always an anxious place to be but now it’s very, very difficult_ [Vicky].

Another participant, Neralie, was involved in the same incident and recounted similar stress responses to those Vicky described. Neralie perceived her experience of being interviewed by police as stress-producing and humiliating, because the interview took place in the full view and hearing of clients and others in the unit:

_It was pretty horrific, we were all treated like criminals, you were made to feel like criminals by the police when they come in. You were interrogated, it was here on the ward, in the corridor_ [Neralie].

5.2.3.1. **Coping with stress**

The participants told disclosed a variety of ways they coped with stress caused by workplace adversity. These included thoughts, attitudes and behaviours they found helpful. Some participants reported that they did not always manage their stress appropriately, others were not consciously considering the impact of stress upon their lives. As Gillian said, “If I get stressed then I get stressed.”
Patrice had enacted a sort of cognitive coping method that reduced her stress. She reported she had learned to temper her reactions to frequent organisational changes that affected her job and her co-workers, and heightened the general level of stress felt in the workplace:

*When they [management] make a statement, like the other day in the meeting about changing things around, people started going “Oh the sky’s falling down, the sky’s falling down” in reaction to it, which is understandable. But I just feel now that I’m not going to do that again because I’ve seen how you can get yourself quite stressed, and worried about your job and what’s going to be the implications* [Patrice].

Several participants also reported that they felt stressed about work even when not at work, causing a range of deleterious physical and mental health outcomes. These included lack of sleep, feeling on edge and unable to relax and continually thinking about work issues. Some participants found it was useful to call work after they had left to allay their stress, they experienced stress when they could not check with colleagues about a particular matter. Others, like Talia, had learned it was important for them to restrict phone calls back to the ward after they had left work to relieve stress and switch off from their work day.

*I don’t let myself do that. I used to, but I don’t do that now* [Talia].

Two participants implied that they experienced stress as a positive force with beneficial outcomes; yet only one of the two admitted being stressed also had negative health outcomes:

*I seem to go better when I’m stressed or got a lot to do, better organised...Oh, every now and then I get a cold or something but, you know, or ulcers in the mouth, that’s the usual stress thing* [Lauren].

Alice’s comment suggests the stress she experienced at work was influenced by her own perceived internal locus of control. She believed that she could usually control events happening around her through prioritising her work, and thereby manage her stress level. However, this quote also implied that there were also times when she “had to” become stressed because the workload exceeded her control, and then she concentrated on patient and personal safety:

*I don’t get stressed unless I really have to. I just do what I can, and make sure I prioritise my work and make sure everybody’s safe and I’m safe* [Alice].
A third area that participants reported feeling stressed about was patient health outcomes, especially when they knew there was an adverse outcome for a client. Several of the participants revealed that they became stressed about what was happening with patients they were caring for:

At work I have a patient who is quite ill and we don’t know where it’s coming from and stuff like that, and that is the same situation what happened when that patient died. So, it’s naturally in my mind while I’m working, and I just well...I don’t want to go home, and when I get home I’m worried that she’s going to die. That kind of thing, I know it’s not helpful but yes, I was worried [Gillian].

5.2.4. The impact on general health, diet and exercise

Participants were asked in the pre-intervention phase whether they thought their health was affected by workplace adversity, and if so, in what ways. The general health problems most widely experienced by the participants were headaches, feeling run down, frequent colds, sleep difficulties, and back and knee pain. Although other participants responded they were dealing with minor health problems they did not perceive they were caused by workplace adversity.

Four participants did not believe that their general health status was affected negatively at all by their work. The majority of participants were unsure about whether their general health problems were associated with their work. Two participants felt their health was affected badly by their work. Gillian explained the two were linked in her case because she could not regain her health in her current work situation

I was sick often this year, like my flu doesn’t go away quickly. I’ve tried everything, antibiotics and stuff like that and even my doctor said, “What’s wrong with you? I think you just need to have an annual leave.” I said, “Oh I can’t afford to have annual leave at the moment” [Gillian].

Talia’s perception was that her job had caused her to develop a chronic health problem, and even though she had corrected the symptoms through lifestyle change, the perception that her work environment was unhealthy persisted:

When I got diagnosed with this [the doctor] actually said to me “your job is extremely unhealthy for your body. You should not work in a hospital.” He said I had really high antibiotics in my bloods, and I said “I haven’t had an antibiotic since I had a middle ear infection [as a child]”. And he
said that it was air-borne and that it was entering my body. ‘Cause I was working on (...)[ward] and I was doing lots of IV antibiotics. It was affecting my health. [Talia].

Lucinda also considered her working conditions could be influencing her health status. She suffered frequent headaches but considered they were likely caused by work stress or eye strain from working on computers. However, she accepted the prospect that her workplace may be unhealthy:

Sometimes I do wonder if I had a different career that wasn’t just coming to some big concrete building every day, with very little natural light…and you’ve got all the bugs of a hospital around you…My health is affected by workplace adversity only slightly I’d say, but it could potentially be better in a different environment [Lucinda].

There was a suggestion that the participants’ health and wellbeing were being compromised by workplace adversity. However, the majority of participants did not definitely agree with that premise, and they did not consider managing the impact of workplace adversity as a part of maintaining their health.

The relationship between work and good health through diet and exercise was significant to the participants. Shift work made maintaining healthy eating and exercise patterns difficult. Fluctuating weight levels were linked to how well one coped with their current place in the shift rotation; sometimes eating more was a response to workplace stress. Shift work affected the type of foods eaten; with a tendency to eat whatever was most convenient and accessible. Shift work also required having irregular meal times so normal eating patterns were difficult to maintain. One participant ‘case’ expressed it as:

I’ve gained a bit of weight because I drink when I get home and then comfort eat. I feel like I’m getting caught, there’s like a negative spiral [Monica].

I think we are terrible, nurses, at eating well, so we’re in a health profession but we don’t eat well or drink well. We eat quick fix, chocolate, lollies, all that ‘keep going stuff.’ We all know about what it is, blood sugar and, you know. We all know it but we’re all doing it [Patrice].

The experience of shift work also caused feelings of powerlessness and frustration regarding personal fitness and exercise. Even when the mental and physical benefits of
maintaining an exercise regime were recognised and desired, maintaining it as a regular activity was often frustrated. Although this is a common experience for many in society and was likely also related to personal motivation, some participants perceived that their ability to incorporate healthy exercise levels into their lives was disrupted by continual fatigue associated with work:

_I keep thinking I should start getting into that regime. But I have one day a fortnight to myself and so I treasure that, and make sure I don’t do much…if I don’t feel like leaving the house I’m just flopping_ [Lucinda].

The difficulties the participants encountered with maintaining the principles of good nutrition and healthy exercise plans can be viewed as a part of the impact of workplace adversity.

5.2.5 The impact on fulfillment and commitment to stay

The participants were unanimous in stating there were opportunities for fulfillment and reward in their work, mainly through the personal connections they made with their clients and through caring for mothers and babies. However, there were several aspects of their workplace environment and its problems that impacted on their personal enjoyment of their work. The degree of fulfillment covered a range -- from those who enjoyed most aspects of their work and environment, to those who found little fulfillment and were currently motivated to stay primarily because of convenience, income, or a sense that they would not be able to get alternative comparable employment.

Environmental issues had the most significant influence on the sense of fulfillment. Those with low satisfaction stated it was influenced by a complex set of difficulties they encountered. For example, Talia reported feeling unsupported, not at ease with most of her colleagues and not coping with fatigue. To improve her sense of satisfaction she had broached her manager about an idea she had to introduce an antenatal educational program into her practice, similar to one operating at another hospital. She had also suggested starting a gentle exercise class for staff to increase health and wellbeing. However, both ideas had been rejected by colleagues and the organisation and she felt quite dejected about continuing to work there:
At the moment it’s convenient to work where I’m working. I sometimes like it - I’m not really happy where I work. And I’ve worked on both the wards as well and I’m not happy there. So I’m in this thing of what do I do, do I have a total career change? I don’t want to change my career, I just want a bit more satisfaction in my work...I actually said in the tea room “Would anyone be open to coming in early for a class before a workday?” (...) said “Yeah! Me,” everyone else said “Hm. Come to work early? No” [Talia].

Some participants were inured to experiencing little fulfillment because of the restrictions placed upon their scope of practice, unrelenting workload and belief that their work was not recognised and valued,

I think the general consensus like, most people are thinking, well why are we here? Why are we doing this stuff, you know [Jodie].

A few participants felt dissatisfied because of the perceived inability of some nursing unit managers to lead their areas in an inspirational and consistent way. They expressed doubt about the health organisation’s ability to place appropriate people in management roles, based on their past performance. Two participants referred to an incident where they believed a manager, who had been a successful acting NUM for over a year, had been passed over and replaced by another person, whom they found very difficult to work with:

I think what happens to staff is that people stop trusting...the managing structure, so people become very insecure with that, and then when they see somebody who they felt was doing a great job [getting passed over] I think they sort of wonder what’s going on? And I don’t quite trust...the support that they offer on the level of management to the staff...So you still get that impression there’s a lot of people in the job that have got a different agenda that you don’t quite trust [Patrice].

Patrice spoke at length in her pre-intervention interview about her dissatisfaction with the organisation’s lack of transparency in communicating the rationales for decisions made, especially those that decreased the job satisfaction of the enrolled nurses. She reported feeling powerless and frustrated that the views of enrolled nurses about the proposed changes were not valued by the organisation executive. Patrice felt the management minimised or “dumbed down” their role.

The enrolled nurses’ dissatisfaction with the proposed organisational changes centred upon two chief concerns. Firstly, that quality of patient care would be reduced, as they
considered the current workplace environment and demands required enrolled nurses who were acclimatised to the unit and understood the processes, procedures and informal networks in operation. Secondly, they were concerned about the potential for staff losses due to the stress and overload that could occur from bringing in nurses who were unfamiliar with the unit. This concern was based on a previous attempt by the organisation to introduce a group of Reconnect midwives, those returning to the workplace after some time out of nursing and midwifery. That recruitment initiative had been unsuccessful in attracting long-term employees, due to the unexpectedly heavy workload and other types of workplace adversity. These concerns, while they indicate these participants’ sense of commitment to their workplace, were believed to be the result of previous failures in organisational decision-making and staff communication:

We’re concerned when we go on this rotation that they’re [management] going to get goodness-knows-what people coming in who are not going to know anything about anything, policies and procedures, and things are going to get missed and that this woman [who died] may not be a one off, and that’s our concern…we just feel that we’ve got this scope of knowledge, we know that the policies and procedures are different now but [management is not] looking at…what we’ve achieved, look at what we do and look at what you’re going to do with us and what you’re going to replace us [enrolled nurses] with…because its only in the ward’s interest [Neralie].

The aftermath of the recent maternal death in the unit also appeared to have de-stabilised perceptions about the organisation and sharply affected enjoyment of work. Some participants were unhappy about the introduction of work changes without adequate communication and thought the organisation lacked visible care and consideration for the nurses and midwives after the incident. Management was seen as attempting to distance itself from a tragic patient outcome at the expense of the well-being and support of the nurses and midwives.

After that [death] we kept silent and things were passed on for us to do [from management], quick changes that they can’t even think the rationale of doing…in fact it’s just adding on to your workload. We just do it but there is half of us thinking, this is quite nonsense…At the end of it, it was the nurses who got blamed. After that we don’t talk about it, nothing has come back to us in regards to how you are now, you know, what did you get from that situation, did you learn anything or what, there’s nothing at all [Gillian].
Another source of discontent was a lack of regular debriefing between colleagues about shared workplace interests and issues. There was no effective forum where opinions, ideas and recommendations could be discussed by the nurses and midwives with each other or with management. The current debriefing meeting, termed “the staff meeting”, was dissatisfying for several participants. It was generally reported that only administrative and organisational issues were discussed. There was no reflection on practice or pastoral care of the nurses and midwives. Participants also commented that most staff did not feel the meetings were a safe environment to raise issues and concerns. Gillian was especially disappointed by the managers’ tendency to discourage and fob off questions from staff, and their lack of responsiveness to questions and concerns about work or nursing skills and knowledge. She believed their attitude was due to the overall communication problems in the unit:

*You don’t get the answers that you want anyway, they tend to answer with a question, which I think is not enough, because it won’t actually help me to change my attitude to work or the way I work* [Gillian].

Most participants reported they were experiencing at least some enjoyment of their work, although there was a marked range in their level of overall fulfillment. For some the experience could be just a moment during a shift when they gained a sense of achievement and self-worth.

In the pre-intervention phase some participants were considering options for change in the immediate to mid-term future. Others were experiencing enough job fulfilment to keep them working at their jobs:

*In all honesty I couldn’t imagine really doing anything else, and I have thought about it. I wouldn’t probably get the satisfaction, that I do. There’s something keeping me there and I am in an area that I always wanted to be in now, so that keeps it good too* [Neralie].

Enjoyment of work was also dependent on the depth of client interaction the nurses and midwives were able to give and receive. Participants were more likely to feel fulfilled if they had time to form therapeutic relationships with the women they cared for and follow their hospital journey through to a satisfactory conclusion for them and their babies:
We’ve got women that are there for long periods of time, we had a girl that went home just a couple of weeks ago with her baby that had been there since she was 22 weeks and she got to 36 weeks, they become members of your family while they’re there [Rose].

In the pre-intervention phase most participants did not contend that they were staying in their jobs despite the presence of workplace adversity. However, most readily agreed that there were several factors that suggested to them they should consider leaving their current work situation for their own health and wellbeing. Several participants commented on the low retention rate in the unit over recent years. Some were unable to clarify any other aspects that kept them in their jobs than the rewarding moments with clients they experienced.

In the pre-intervention phase, four participants reported they were currently considering their career options and whether or not they would stay in their current positions. Two participants were considering leaving nursing in the future to study medicine or other health-related disciplines. The participant excerpts below suggest that workplace adversity was influencing both their current opinions of their job and the decision-making process about future retention prospects in the unit:

*It appears to be an easy job, because people [think], “Oh it would be great just to feed babies”...[but] it’s a really difficult job and I still have to think whether it’s the right job for me or not. [My NUM] said for me to come back in a few months and let her know what I’ve decided, whether I’m going to stay or whether I’m going to look for something else* [Lisa].

*I think I’m in between, yeah... I’m half and half I think...because I’ve been nursing previously in general [nursing] and I’ve done other different nursing I’m just finding that midwifery doesn’t give me the satisfaction. So, I’m just sort of in the middle, I said to myself that I’d give myself a year or [so] before I decide whether to go back to general nursing or stay* [Alice].

It is important to note that the majority of participants who stated their ultimate aim was to move out of their current positions were still considering other nursing contexts rather than leaving nursing and midwifery entirely.
I eventually want to become an educator or maybe even as I get older and have years of experience obviously, you know, I wouldn’t mind working in the community, or…[as] a health care worker or something [Alice].

Two participants were contemplating retirement in the medium term after long and rewarding nursing careers. Vicky approached retirement with a sense of relief; the other, Rose, was less ready:

First of all I was going to retire when I was 55, then I was going to retire when I was 58, then I was going to retire when I was 60, which is pretty damn close. And that doesn’t look possible now, so I’ll probably have to work until I’m 65 and sometimes that hangs over me like a big, black cloud, but other times actually being able to go to work, and being a person who is still alive, and still healthy enough to be able to go to work, and to go to a job that is interesting, and challenging, I’m lucky! I have resolved that I may be working until I am 65, and that if I am healthy, as I am now, then that’s probably good for me and just what I need [Vicky].

Retire? Oh no, not yet. I’m happy with what I’ve done and what I’ve achieved in nursing, yes, I don’t want to be management or anything like that, I can do without that…[but retirement] is just off in the distance. I’m not ready yet [Rose].

5.3. The Resolution of Workplace Adversity Pre-intervention

The collective case also included some participants who were coping well despite the workplace adversity that surrounded them. They attributed their own survival, and ability to thrive, to a variety of factors. Those participants who considered they were thriving at their interviews were also experienced nurses and midwives who had been employed at the hospital for many years. They had built their careers, forged support networks and become familiar with organisational policies and processes, within the selected hospital. They reported that their years of experience had taught them many ways to stay strong enough to survive and withstand, even thrive, amidst workplace adversity. This category is discussed under themes of ‘Organisational initiatives for resilience,’ ‘Collegial support and resilience’ and ‘Personal initiatives for resilience.’
Table 5.2: Themes of the Resolution of Workplace Adversity Pre-intervention

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5.3.1 Organisational initiatives for resilience

There was universal agreement about the abundance of staff education and development courses provided by the organisation. In fact, the number of in-service opportunities confirmed for some participants that the organisation valued the professional development of the nursing staff, and indeed provided support for them to increase their nursing knowledge and skills. Part-time participants across all levels of nursing shared the opinion that education and training support offered was more than adequate. One participant commented that it meant the part-timers were not left behind in their career progression. She believed the organisation was supportive of her career aspirations:

> *I had a staff appraisal and I’m being encouraged to carry on studying, I think there would be support there for me to do it ‘cause I think there’s a lot of courses, internal training, there’s a lot that you can do if you choose to* [Patrice].

5.3.1.1 Autonomy

A few participants responded that increasing autonomy by specialising in areas of their jobs helped them to cope with their jobs. These specialist roles took them away from the frenetic pace of the ward or the harsh judgment of colleagues, and allowed them to concentrate on a focussed element of their practice; on the mothers or on the babies. These positive experiences presented them with greater capacity to experience job satisfaction. Because they had a sense of ownership and control in their work at those times, they felt competent and enjoyed their work. The knowledge of heightened satisfaction that came from opportunities to be autonomous, if only for a proportion of the time they worked, helped motivate them to better withstand the detrimental effects of workplace adversity when they were engaged in work with little or no autonomy.
When I have my own clinic I have autonomy and it’s great. Yeah, that’s why I keep doing that...if I’m doing my own clinic, I’m thriving. You know, because I get lots of positive feedback from the people that I see, and I know I do a good job [Lucinda].

5.3.1.2. Nature of work

The thriving participants unanimously stated that they loved the work they were doing, that it was interesting, stimulating and rewarding. Their work gave them a sense of purpose and they believed they were a useful help to others. The nature of their work also had positive benefits for those who were not thriving as well; they too often stated it was the best aspect of their work. One participant, Lisa, enjoyed caring for the most disadvantaged clients that presented to the unit, such as the women from a local correctional facility who attended the unit for medical care. The scope for change and variety was also valued; participants enjoyed working at different elements of their practice throughout the day or week:

There’s variety. Sometimes I do get something back from the job. I guess my special interest is talking to those mums who have difficult circumstances...my interest is trying to be as supportive as I can to those people...I think that I’m lucky to have a job where I can look after babies because I like doing that, and we get to nurse the baby and talk to it and feed it and all that even if it’s only for a minute at a time [Lisa].

I enjoy the work. It’s stimulating because there are the three different areas [antenatal, delivery suite and postnatal], and because we’re a teaching hospital and a main referral hospital, then we get all the interesting cases that are referred onto us from the country and yeah, so it’s always very interesting. This job still is challenging. It’s rewarding. Knowing that you are helping, even if the people you’re helping don’t know! The best thing is the variety...[Vicky].

We do something different each half day, like this morning I was team leader and then tomorrow morning I’ll have clinic, the next day...so we don’t do the same things all the time every day. It’s a good job [Marika].
5.3.2. Collegial support and resilience

The most significant way of overcoming workplace adversity for some participants was through experiencing effective collegial support. Three participants who categorised themselves as thriving in the pre-intervention phase stated that the support they received from their colleagues was very beneficial and helped them cope with negative outcomes better than they would have otherwise. Those participants who were not coping as well also referred to the support between colleagues as significant. Three who were thriving in the workplace also nominated support from their NUM as very important to their sense of coping and wellbeing at work. Lynette reported:

*We [the nursing team] find that we talk with each other a lot anyway at work, and because we always have time to talk with each other and we generally have lunch together and throughout the day we mix and have morning tea with each other... that's a good way to download, and if we have any problems we can go and follow one of the other girls up and just say look, you know, this is what is happening and what do you suggest?...There’s always our NUM too, she’s always really approachable. I suppose just talking to someone about it is, I think, a really important thing, and for them to encourage you...And I think our thing too is we’re just very supportive of each other. And I find that’s fairly important and it would be hard to cope if you didn’t have someone else to talk with. I work part time. I really enjoy the work environment that I work in. I get on really well with my co-workers. And our NUM is brilliant, she’s a great manager [Lynette].*

Positive communication processes were also important to maintaining resilience in the workplace. Affirmative relationships with colleagues were often viewed as one of the most rewarding aspects of working in their challenging environment, and for those who thought they were just surviving, or not even that. Being able to talk over workplace events or issues with those who knew and understood the way things stood was very valuable in helping participants to overcome their feelings of isolation and low self-confidence. A few participants remarked that positive support received from colleagues was also beneficial after they had experienced stressful events or adverse outcomes or began to doubt their nursing capacities. Lynette recounted her experience of talking to her colleagues about her role in an adverse patient outcome:
I should have known what I was looking at and been able to interpret the results, it was [the] sort of thing you’d wake up and think oh, this happened yesterday and I feel really badly about it, and then you’d sort of think about it all day. Eventually, talking to other people, getting their positive feedback, reflecting basically on what happened and different ways of maybe responding or whatever, and looking at how I can improve in the future, and then it just sort of gradually faded away [Lynette].

Some participants enacted their own informal support networks with colleagues, for example, car pooling to and from work. They used this time and space to debrief about the events of the day and ongoing issues before they moved into the home sphere. The important element of these support networks was that colleagues shared ‘insider’ knowledge of the work and workplace and understood the subtleties of the relationship dynamics of the unit:

I talk to […][colleague] a bit, because I give her a lift to work, to and from…so we kind of both offload in, you know, half an hour. It’s funny actually because they know what you’re talking about…yeah, and everyone’s been there [Talia].

Other participants felt very confident in seeking support from colleagues in the workplace during working hours. They felt very satisfied with the level of support present from their colleagues and managers, should the need arise:

[We] talk to each other, we help each other. [If there’s a problem] you’d probably be better, I think, probably people would go and talk casually themselves on their own…[The NUM’s] door is always open if you’re stressed about something, you can always go and knock on her door and sit down in her office and go through it [Rose].

5.3.3. Personal initiatives for resilience

Another area of findings relating to the participants who reported they felt they were thriving in the workplace despite the presence of workplace adversity was the personal strategies they utilised to maintain their own factors of personal resilience. These included drawing comfort and strength from supportive relationships they were involved in, and therapeutic activities that helped them to care for themselves, to relax or distract themselves from the negative elements of their workplace.
5.3.3.1. **Support from significant others**

An important personal factor that assisted the participants to cope with the workplace adversity of their environment was the support they received from their family members and friends. Mothers, sisters, husbands, partners, friends and neighbours were listed as effective support people for the participants. Participants valued these relationships as they provided a range of effective forms of support, from sharing the load of responsibilities, offering an objective opinion, being a sounding board, a venting partner, a passionate ally and a solid source of emotional support and security, as the situation required.

_I also have a very supportive husband so he’s, you know, good to talk to and he helps a lot. He does a lot more than me, probably, on the home front. He cooks more than I do and we both share the cleaning and he now looks after the children a few days of a week! I [also] go to a Mothers Group…they’re a really great support network and our children are similar ages and stages, so, that’s really nice. And we also have girls’ nights out without the children… that’s what’s nice!_ [Lucinda].

5.3.3.2. **Self-care**

Only two participants reported that they were aware of the need for self-care in their workplace, and were motivated to make it part of their practice at work. They believed their attitude was not a common one amongst their colleagues. They thought the idea of self-care at work was not much used or supported in their workplace:

_I always make a point of going [on my break] because a lot of staff just work through their breaks because they think they’re the only person that can look after that patient, and I say, ‘Well you shouldn’t be too busy, just say to your patient I’m just going for a drink, a cup of tea,’ cause you have to look after yourself’_ [Lauren].

_I make sure I have my breaks. Even if it’s becoming busy and even if it’s for 15 minutes I go and have a break. I think your meal breaks are important and that’s why I try and educate some of the staff there that don’t have their meal breaks. I say to them, ‘You should really have your meal breaks, it’s called self-care.’ And then they just look at me! And say, “Okay.” Martyrting doesn’t get you anywhere. It doesn’t help, you don’t achieve anything by being a martyr_ [Alice].
However, the participants who reported they consistently practised self-care strategies did not consider they were thriving. This finding suggests the effect of self-care practices, although no doubt beneficial, was not enough to mediate or change the effects of workplace adversity.

Cognitive tools, such as positive affirmations and self-talk were used by some participants to neutralise the harsh effects of the workplace. One participant believed she rationalised elements of her practice that could otherwise be stressful and de-personalised her negative experiences, which allowed her to continue working and not experience more harmful effects. It also suggests a potential lack of awareness of emotional labour that could be operating:

*I look at it my way, [how] I deal with it is I can make that woman’s stay as pleasant as possible, well I know I’ve done a good job and if I’ve done a good job well, I, I guess, if it doesn’t belong to you it doesn’t hurt you as much. I’ve learnt these strategies over the years and it’s only experience that gives it to you* [Rose].

The concept of self-care outside work was more widely understood and prevalent. Participants reported using a range of therapeutic activities to help them deal with the demands of their work, including relaxing activities like gardening, listening to music, yoga, dancing, reading, journal writing and having a professional massage. Interactive activities were also helpful for some participants; they socialised with groups of friends and attended various interest groups. Other participants cared for themselves through practices like reading self-help books or consulting professional counselors. Alice spoke of her self-care strategies:

*I listen to music a lot. I find music is fairly relaxing. Or gardening. I love gardening...I'd just go home and put some music on and if it's nice I'll go and do some gardening and start digging away! Do some pruning, cut all my trees down! And I do reflect* [Alice].

Lisa stated she had become more self-aware of the need to conserve energy levels outside working hours by paying attention to living the kind of lifestyle that would protect her from the harshest effects of workplace adversity.

*I realised that I have a tendency to do more than I should, but then I know that I have to rest, so I’m just careful about what I do because I know that I*
have to come to work and want to come to work, so that’s a priority. I have to be aware of the limits because I don’t want to do anything that’s going to prevent me from continuing [Lisa].

The role played by solitude was an interesting aspect of self-care. Several participants found it important to disengage completely from other people in order to be refreshed and replenished. They used activities such as swimming laps of a pool, running alone, or using a gym treadmill with headphones on, seeing a movie alone or having a regular day to themselves in the home:

I have a gym where I go and do some of my best thinking on the treadmill. Going for a run is very therapeutic. I love it, the endorphins at the end are a nice little sideline. They’ve got music video screens in the gym and so, as they say, you’ll just zone out of what’s happening. And you’ll not be aware that anyone else is actually beside you, you’re just zoned out and in this completely other place and it’s not a bad place to be for an hour and a half [Neralie].

When they had the capacity to reflect on their current circumstances and future goals, and considered that they could personally enact changes that could increase their wellbeing and prospects, the participants felt they were more resistant to workplace adversity. Some participants were able to view their workplace environment as one that provided opportunities to develop their professional skills or develop aspects of their personal growth. Two participants claimed they maintained their interest and motivation by gaining knowledge and skills at work. This provided a sense of wellbeing and hardiness, and consequently they enjoyed their work more.

Getting out of (...) [ward] was really a good experience because I was suppressed, it was very rigid, pedantic with everything, a retiring management…I didn’t develop at all. Then I moved on and pushed myself out of that place…because I wanted to work as the most things that I can, in terms of education [Gillian].

Just keeping myself educated, up with current methods; I’m always interested in finding out different new things that are going on, like I have been interested in the gynaecological side of things. So I do gynae-clinics; making sure I’m giving the women the best information that’s available for them, and as I said, just keeping myself on top of things in the current way of thinking…I love my job [Lynette].
Other character attributes were seen as helpful for overcoming workplace adversity. These included personal traits such as loyalty, flexibility and the tendency to keep on looking for solutions to problems. Individual determination to have a positive outlook on work issues and the workplace was another way that participants were able to counteract the harmful effects of workplace adversity. The examples below describe the advantages provided by certain character traits. These participants believed their personal character attributes made them more resilient to the workplace adversities that faced all the nurses and midwives.

You often go in a completely different work bay [each shift], and a lot of people don’t like that at all. It doesn’t really bother me. I think I’m more adaptable because you can kind of learn more by moving around, so…it doesn’t bother me that much. [Lisa]

The loyalty is still there. I still do give a damn that things run properly. I do care and it sends you mental sometimes…but I think that commitment then makes you strive to have that little bit of excellence and that wanting to learn, I think that kind of correlates with all of the other qualities that make a half thinking employee, you know, and a half decent workmate [Neralie]

Some participants also exhibited hardiness that enabled them to take personal steps to increase their enjoyment of work. For those participants, overcoming workplace adversity depended on whether or not the participants could transfer their sometimes meager job fulfillment into an intrinsic reward that gave them strength and vitality, and made up for the failures in that regard caused by other aspects of their work. One participant did not find much intrinsic reward in many aspects of her job in the unit, however she had responded to the challenges of her work environment by acting on a determination to follow up on clients after they have had passed out of her care. She did not expect recognition from her superiors for the practice; rather she viewed this as a proactive way of extending her sense of fulfillment for herself.

Seeing the women right through and actually getting them to the birth stage well-educated, well-informed. Having a great labour and birth! Yeah, that’s very rewarding. If I don’t get to see them up on the ward, and it’s very hard to find the time to do that, I actually make follow-up phone calls and speak to them at home. In between [appointments]. So it could be just five minutes, just touching base. I look up on the computer, see what their birth was like, see how everything went, and then just give a quick phone call. I think you can make a difference. I think if everyone just does one little thing
that's a little bit different, it can make a difference. You know, the ripple thing [Talia].

5.4 Summary of the Pre-intervention Phase

At the outset of the study the setting was beset by various unhelpful conditions and difficulties that had created a work environment that was characterised by distrust and blame. The collective case was characterised by communication problems, lack of support and recognition, heavy workloads and pressure, and little work/life balance. The experience of work was largely burdensome both physically and mentally, with intermittent episodes of fulfillment and pleasure from positive interactions with colleagues or clients. However, overall, the factors of workplace adversity caused many of the nurses and midwives to feel isolated and vulnerable to verbal or emotional attack from colleagues and management.

The conflict and difficult relations present in the workplace should be examined in light of, at least in part, specific environmental factors and historical events of the unit. There had been a widely publicised unfavourable Coroners Report relating to a maternal death that occurred in the unit. The unit had experienced a degree of instability in leadership over the previous four years, with several management changes, acting-NUMs in place for long periods, and a reportedly popular acting-NUM passed over for the role. Further instability had stemmed from two investigations into workplace bullying in the unit, one resulting in the removal of a NUM; and the loss of twenty-three members of staff over a short period of time.

The unit had gained a reputation for being a daunting and problematic workplace with the potential for adverse events, high patient turnover and a lack of cohesion amongst workers so that it was increasingly difficult to attract new staff, even casual or agency staff. This caused a long-term shortfall in qualified nursing and midwifery staff, and there was generally low morale amongst those that worked there.

The utilisation and role of the enrolled nurses of the unit was also problematic. There had been a high proportion of enrolled nurses employed in the unit some years earlier
to counter the staff shortages. However, that initiative had created tension around the dimensions and enactment of the EN role under different leaders, and protective behaviours and attitudes by some registered nurses and midwives who saw enrolled nurses extending into more clinical areas of midwifery as a threat to their professional standing. Over time enrolled nurses had been removed from some parts of the unit including delivery suite, but they still rotated around some of the other areas. This situation had caused a backlash by some nurses and midwives against enrolled nurses.

The enrolled nurses reported they were also ambivalent about their role due to the changes they had experienced. At times they reported they were split between those that looked to develop their scope of practice and those that agitated against being asked to bear more responsibility by management. By the time of the pre-intervention phase the management were again planning to rotate enrolled nurses across more areas relevant to the current study, including children’s ward, neonatal intensive care unit (NICU), antenatal and delivery suite.

In such an environment the alliances between colleagues that had been built, usually from long-term work-based proximity or social connection, became a significant source of support for those participating in them. However, these factors could also serve as an exclusionary force for others. The preliminary data revealed that it was usually difficult for new staff members to feel welcome or supported in the unit because collegial interest and assistance was sometimes perceived to be withheld, as a method of testing out new employees. This overall situation led to a workplace culture where some nurses and midwives, especially newer employees, felt unable to express themselves authentically at work, and believed that it was unsafe to discuss personal experiences, beliefs and ideas with work colleagues.

This chapter presented a range of serious and negative effects of workplace adversity on the participants. The effects were manifested through the efforts of the participants to cope with exhaustion and shift work, emotional labour and stress. As the data show, the most common methods of coping were not healthy ones, and included strategies such as further withdrawal, which intensified the general milieu of isolation and non-cooperation. There were also notable effects on the participants’ general health and
wellbeing. Their experiences impacted strongly on their sense of fulfillment and commitment to stay in nursing and midwifery.

This chapter also proposed that some participants had been more successful than others at using protective mechanisms to limit the harmful effects of their everyday work. Some participants utilized organisational initiatives, collegial support networks and their own strategies for personal resilience. The following chapter will deal with the development and implementation of the study intervention. Various theoretical and practical considerations were necessary in order to devise an effective intervention program, in light of the findings from the pre-intervention phase.
CHAPTER 6: Abstract

The intervention consisted of six day-long resilience workshops and a mentoring program. This chapter comprehensively elucidates the study intervention, from its development to its implementation. Great care and consideration was given to the task of ensuring the participants were provided with a positive learning experience, one that effectively communicated both the concerns of workplace adversity and the benefits to be found from developing and maintaining personal resilience. The andragogical approach and theoretical underpinnings of the workshops are presented in this chapter, along with the details of the format, content, materials and learning activities. Information about the recruitment and facilitation of mentors is presented, as well as the evaluative reflections of the mentoring program by participants and mentors. The chapter concludes by highlighting the major challenges of the intervention and providing recommendations. Parts of this chapter are presented in first person.
CHAPTER 6: The Intervention: Development and Implementation

6.1 Introduction

A specific intervention was designed for this study. It consisted of a series of six one-day workshops attended by the participants and a facilitated mentoring program that established mentoring partnerships between the participants and mentors who were senior or retired nurses and midwives. The intervention phase for Cycle 1 took place from August 2007 to February 2008, and from July to December 2008 for Cycle 2.

6.2 Development of the Workshops

The workshops aimed to emphasise the role of self – self-awareness, self-development and self-care – in developing, improving and maintaining resilience. The ‘self’ was understood to be “a person’s view of her own unique being” made up of mind, body, sensory perceptions and interactions with others (Porritt 1990: 47). The rationale for the chosen aspects of resilience explored in the workshops was determined from the research literature on both resilience and the nature of nursing work in its current contexts of increased demands and workplace adversity. As discussed in Chapter 2 there were several characteristics of personal resilience identified in the literature. These characteristics informed the key areas to be explored in the workshops.

Every workshop was held over a whole day and made up of two broad resilience topics. The sessions on each topic, an attribute associated with resilience from the literature, were planned to run for approximately half the day’s duration. The workshops were held within the hospital campus. Attendance was considered work time and so all participants were paid for the time they spent taking part. In the second cycle opportunities were added for the mentors to attend some of the workshops in order to increase the amount of time spent with their participants. The workshops were entitled as follows:
Workshop 1: Mentoring Relationships (combined mentors and participants) and Establishing positive nurturing relationships and networks

Workshop 2: Building Hardiness and Maintaining a Positive Outlook

Workshop 3: Intellectual Flexibility and Emotional Intelligence

Workshop 4: Achieving a Life Work Balance and Enabling Spirituality

Workshop 5: Reflective and Critical Thinking

Workshop 6: Moving Forward and Planning for the Future

6.3 Learning goals and outcomes

In light of the pre-intervention findings about the case, the intervention required the development of a customised learning program that would ultimately achieve a participatory, collaborative learning group. The learning goals of the program were informed by elements of social learning theory, which viewed self-efficacy as a substantial influence on behavioural change (Bandura 1989). Because of the importance of the link between self-perception and personal performance, the idea was to potentially strengthen and support the participants’ performance through the positive educational initiatives of the intervention. It was thought that their performance mastery would potentially rise through acknowledging barriers to success, strengthening peer support and modeling, and using persuasive educational development. The specific learning goals of the intervention were that the participants would be able to:

- identify the factors associated with workplace adversity and their effects on them as individuals,
- identify the attributes and processes associated with personal resilience,
- review their current strategies for developing, building and maintaining their own personal resilience and
- learn additional individual strategies for personal resilience and demonstrate their application.

The workshops each covered two related elements of personal resilience; identified in a literature review that sought to identify the chief characteristics associated with
personal resilience (Jackson et al 2007). These characteristics were positive personal relationships and networks, personality hardiness and positive outlook, intellectual flexibility and emotional intelligence, spirituality and life balance and reflective and critical thinking (Jackson et al 2007). Learning activities were designed to achieve the learning outcomes developed for each session.

In addition, the workshops were conceptualised as learning programs that would provide current, clear and comprehensive information, be appropriate and flexible, match the current competencies of the participants and meet their language, literacy and numeracy skill needs. Table 6.1 presents an overview of the workshops’ aims:
<table>
<thead>
<tr>
<th>Workshop</th>
<th>Program content</th>
<th>Session Aims</th>
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</table>
| **Workshop 1: Mentoring Relationships (for participants)** | Overview of project and workshop series  
Mentoring in Nursing  
Creating a Mentoring Partnership  
Knowledge and Skills for Success  
Mentoring as a learning activity | Provide an overview of the research study  
Introduce concepts of mentoring partnerships  
Explore benefits and opportunities for mentoring partnerships in health care context  
Identify roles and responsibilities associated with mentoring partnerships  
Consider styles and strategies of mentoring partnerships  
Identify common pitfalls associated with mentoring  
Link the concepts of mentoring to personal and organisational learning |
| **Establishing positive nurturing relationships and networks** | Nurturing personal relationships  
Relationships that encourage and motivate  
Crucial conversations for healthcare work | Focus on protective aspects of positive relationships and networks on the effects of workplace adversity                                                                                                    |
| **Mentoring Information Day (for mentors)**     | Overview of mentoring program  
Key goals and outcomes of a mentoring partnership  
Roles and expectations of people in the partnership  
Evaluation of the partnership  
Accountability of the partnership  
Facilitating the partnership  
Mentoring in Nursing  
Creating a Mentoring Partnership  
Knowledge and skills for Success | Provide a brief overview of research study  
Foci of mentoring program, mentors’ roles and expectations, issues of accountability  
Promote reflection on past mentoring experiences, current skills and aptitudes |
| Workshop 2: Building Hardiness | ▪ Mentoring experiences  
▪ Defining positive outlook and personal hardiness  
▪ What is already known about hardiness in the workplace  
▪ Strategies for Success:  
  o Prioritising activities in a time-pressed environment | ▪ Identify the elements of a positive outlook and personality hardiness related to nursing and midwifery  
▪ Demonstrate the benefits of maintaining a positive outlook and developing hardiness for job satisfaction and health and wellbeing  
▪ Define the principles of self-care in a time pressured environment by prioritising activities and using assertive communication  
▪ Interpret strategies that have been shown to promote a positive outlook and hardiness in the workplace  
▪ Formulate individual strategies for improving and maintaining a positive outlook and hardiness |
| Maintaining a Positive Outlook | ▪ Learned Optimism  
▪ Assertive communication (Guest presenter)  
▪ An authentic life  
▪ Self-esteem  
▪ Self – awareness: past, present, future | |
| Workshop 3: Intellectual Flexibility | ▪ Intellectual Flexibility: Definitions and Characteristics  
▪ More characteristics of IF  
▪ Links to nursing research and resilience | ▪ Define the principles of intellectual flexibility (IF) and emotional intelligence (EI)  
▪ Define significant existing research findings regarding IF and EI as they relate to nursing  
▪ Evaluate the advantages of applying elements of IF and EI to nursing/midwifery practice  
▪ Reflect on a variety of strategies to assist creative and critical thinking capabilities |
| Emotional Intelligence | ▪ Dimensions of Emotional Intelligence  
▪ Emotional labour  
▪ Strategies for success:  
  o Expand your thinking  
  o Creative Thinking  
  o Self-monitoring  
▪ Expressing emotion creatively | |
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<td>Envisioning work/life balance</td>
<td>Demonstrate at least two strategies for improving work/life balance</td>
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<td>Australian families today</td>
<td>Formulate an historical/political background of women’s roles in caring and other work</td>
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<td>o Historical, gender and power contexts</td>
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<td>o Assumptions about “juggling”</td>
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<td>Strategies for Success:</td>
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<td>o Adding new things to life</td>
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<tr>
<th>Enabling Spirituality</th>
<th>Enabling Spirituality: Definition</th>
<th>Explore some aspects of spiritually responsive nursing care available to them</th>
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<td>4 basic tenets</td>
<td>Explore personal perspectives on individual spirituality and its relationship to contemporary lifestyles and communities</td>
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<td>Spirituality and nursing care</td>
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<td>Strategies for Success:</td>
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<td>o In our Sacred Garden</td>
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<td>Walkabout in the Suburbs (Guest presenter)</td>
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<tr>
<th>Workshop 5: Reflective and Critical Thinking</th>
<th>What is reflection?</th>
<th>Identify the importance of the therapeutic use of the self and reflection in expert practice</th>
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<tbody>
<tr>
<td></td>
<td>Making meaning of experience</td>
<td>Demonstrate an understanding of the benefits of the reflective process to individual nursing practice and its underlying knowledge, influences, and motivations</td>
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<td>Moving from description to reflection</td>
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<td>Understanding reflection</td>
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<td>Therapeutic use of self</td>
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<td>Workshop 6: Moving Forward &amp; Planning for the Future</td>
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<td>Reflective action</td>
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<td>Reflection and expert practice</td>
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<td>Strategies for success:</td>
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<td>• Thinking critically</td>
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<td>• Reflection Circuit</td>
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<td>Define a model of reflection that have been shown to increase critical thinking skills and develop reflective practice</td>
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<td>Analyse individual strategies to creatively access and explore the reflection process</td>
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<th>Workshop 6: Moving Forward &amp; Planning for the Future</th>
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<tr>
<td>Resilience Re-cap Brainstorm: Things I Remember – Workshops 1,2,3,4,5</td>
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<tr>
<td>Group poster activity: Take home messages</td>
</tr>
<tr>
<td>Exhibition and participant presentations</td>
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<tr>
<td>Certificate presentation to ppts</td>
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<tr>
<td>Moving Forward – Creative movement (Guest presenter)</td>
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<td>Connections exercise</td>
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<tr>
<td>Planning for the Future</td>
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<td>• Goal-setting exercise</td>
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<td>Afternoon Tea and Farewell</td>
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<td>Identify the features of a resilient person and relate them to individual experiences</td>
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<tr>
<td>Formulate individual strategies for continuation and permanency of resilient beliefs and behaviours</td>
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<tr>
<td>Demonstrate an understanding of the ongoing process of resilience and the protective benefits of committing to long-term maintenance of personal wellbeing.</td>
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<tr>
<td>Present a creative piece from a range of expressive mediums that exhibits personal growth in one or more of the targeted areas of resilience</td>
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</table>
6.4 Adult Education Philosophies

A crucial requirement of the research study was to provide an effective workplace learning tool. Therefore, the intervention also incorporated the principles of adult education. It was decided that educational theories, actions, strategies and outcomes should be the underpinning concepts used to structure the learning outcomes of the program. Improved resilience could then be indicated by positive changes in confidence, self-awareness, communication skills, stress and anxiety, problem-solving skills, knowledge and insight, supportive relationships, and sense of fulfillment.

Understandings about learning were taken from the theories of key writers and works in the field, such as the affective domain of Bloom’s Taxonomy (1956), insights related to reflection (Boud 1985) and reflective activity (Dewey 1960), collaborative participation (Brookfield 2005), interests in learning (Habermas 1978), experiential learning model (Kolb 1984), andragogical practice (Knowles, Holton & Swanson 1998) and democratic group structure (Lewin 1973). The action sector was represented by competencies of critical reflection, experience-based learning, respect and recognition of self and others, valuing experience, and self-directed learning. The strategies that were decided to best affect transformational change were dialogue, debriefing, reflective journaling, role plays, creative expression, group interaction, feedback, metaphorical ‘post-mortem’ and didactic teaching.

6.4.1 Andragogical approach

The intervention was an opportunity to address participants’ understandings of personal resilience and extend them to incorporate new insights and strategies. The andragogical approach to the intervention was derived, not only from the need to present essential information about personal resilience, but from sensitivity to the learning needs and workplace experiences of the participants (Walker et al. 2006; Wieck 2007). The longevity of several study participants in the workplace was evidence in itself that they already possessed certain abilities to survive under difficult conditions. Therefore, as well as didactic approaches, it was important learning was approached as an exploration of the participants’ current knowledge and expertise in
using the concepts of resilience to enhance their lives and practice to date. However, it was also imperative that group members’ held these personal experiences open to critical reflection as well (Darbyshire 1994).

The group included those with different language, culture and educational backgrounds and so those aspects had to be considered andragogically. The groups possessed rich depths of alternate ways of knowing and being, although the level of taken-for-granted knowledge also ensured the need to challenge explanations and open up other interpretations. The information collected during the pre-intervention phase revealed the participants’ ideas about potential topics and learning activities of interest and their expectations of the workshops. This information was useful in forming points of common ground between participants and with the facilitator, rather than difference. A light touch to the facilitation approach, that emphasised the inclusive and exploratory nature of the preferred learning in the group, was also useful. It was necessary to provide an intervention that engaged and supported the participants, and attempted to compensate for some of the effects of workplace adversity they had experienced.

6.5 Learning Materials

The question of how the participants would learn the essential skills and knowledge to achieve the desired outcomes was a further consideration. An important part of planning the intervention workshops was developing high quality learning materials. These took the form of work booklets, referred to as the Reflect and Write booklet, with content, activities and tasks for each workshop. The booklets required the participants to read, write, discuss and demonstrate their understanding to others in the group. There was also an oral presentation with slides to guide discussions and activities in each workshop. Background reading materials, documents and handouts were also provided to the participants. At each workshop a related book for further reading was briefly reviewed and offered to participants to borrow until the next workshop.
6.6 **Learning Activities**

The main foci of learning activities were encouraging collaborative, self-reflective, creative and therapeutic learning processes within the group. The activities allowed the participants to process and practise the new skills and knowledge being presented (Kemeny et al. 2006). They took various forms and were structured to suit the participants; what was known about them and their work environment, as well as the learning goals and anticipated outcomes of the program. The activities and tasks developed for use included presentations and activities facilitated by guest experts, workplace scenario simulations, case studies, paired and group discussion and brainstorm exercises.

6.6.1 **Collaborative Learning Activities**

Collaborative learning activities made up an important component of the workshops due to the lack of opportunities the participants had to get to know each other in the normal course of working together. The collaborative activities concentrated on encouraging participants to interact with each other through listening, sharing personal insights, and forming skills and practice around common problems through the group ‘knowledge’ of surviving and thriving as nurses and midwives (Fenwick 2000). The collaborative learning activities were informed by the notion that people may use knowledge at work that is acquired through other, broader life-experiences and transferred to their workplaces (Gerber 2001; Larsson 2000). This view sees learners as conscious of making choices to use such knowledge in their workplace to improve the efficacy of teamwork and collegial interactions. Commonalities amongst the group were used to facilitate safe, trusting relationships between participants, and between participants and the facilitator. The activities modeled respect for diverse opinions, as these considerations were important for the achievement of many of the learning objectives. They required the participants to have strong self-ideation and the capacity to build positive relationships with others.
6.6.2 Self-reflective Learning Activities

Self-reflective learning activities were those that encouraged the participants to focus their attention on their own personal development and increase their situational awareness of their experiences, both current and in the past, that affected their feelings, attitudes and behaviours in the workplace and in their personal lives (Boud 1985, Pierson 1998). Reflective activities were used to introduce the learners to various concepts of the self and the relationship between self-development and increasing personal resilience. The aim of the reflective process is to proceed towards harmony and balance of mind, body and spirit (Becker Hentz & Lauterbach 2005). Reflection has also been shown to have a place in transformational learning as a means of developing competence and confidence with new concepts (Mezirow 1994; Stupans & Owen 2010). These activities were an engaging and pleasant access point to sometimes complex or sensitive material being presented, and this allowed the participants to more easily explore their own responses and communicate them to others when appropriate.

6.6.3 Creative Learning Activities

Other participant activities and tasks were designed to allow participants to practice applying the content in a setting other than their current one to facilitate cognitive processing. Interpretive activities using art and literature have previously been found to effectively engage nursing students in analyzing and discussing human experiences and caring responses (Darbyshire 1994; Turkel & Ray 2005). Learning opportunities were provided for this other setting to be a creative one, where the participants could experiment and explore their own cognitive process in a freely expressive and tactile way. The learning incentive was that they may then apply the new skill or knowledge to their own life-world or individual situation more readily, whether applicable at work or in another environment. Creative expression was also used to explore the participants’ personal meanings of abstract constructs that may be difficult to express adequately in words alone (Collie, Bottorff & Long 2006; Stuckey & Tisdell 2009). The creative activities also allowed the participants to share the symbolic meanings of their art pieces with each other, which had the potential to build connections between them (Anderson & Gold 1998). The activities used in this regard included drawing,
painting, collage, interpreting artworks and photography, creative writing and creative movement.

6.6.4 Therapeutic Learning Activities

Pre-intervention interviews also revealed some potential obstacles to learning in the collective case such as educational background, dislike of group work, communication problems, fear of failure, level of confidence and nervousness, finding the topic difficult to understand and attitude to organisational change initiatives. Therefore, learning activities that emphasised a therapeutic value to the participants were also incorporated. These activities included elements of relaxation exercises, guided visualisation, aromatherapy, music and hand massage. They were included because of their anticipated effect on the participants’ wellbeing in the learning environment and potential to facilitate positive learning experiences (Bost & Wallis 2006). Some of the learning activities and the rationale for their use are set out in Table 6.2:
Table 6.2: Learning Activities of the Intervention

<table>
<thead>
<tr>
<th>Workshop Topics</th>
<th>Learning Activities</th>
</tr>
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| Workshop 1: Mentoring relationships                  | **Collaborative:**  
|                                                      | **Systems ball game:** Participants stand in a circle facing each other. Facilitator throws a small, soft ball to someone saying their name out loud, that person throws the ball to another saying their name etc. until a pattern of the ball’s movement is established and everyone is included. After a few complete circulations of the same pattern a second ball is introduced and moves in the same pattern. After another few circulations of two balls around the group a third ball is introduced to the pattern. The activity ends as people begin breaking the pattern.  
|                                                      | **Aim:** to mimic experience of working in systems/processes under increasing pressure, to engage participants in discussing role of individuals and teams and relate to workplace setting.  
|                                                      | **Self-reflective:**  
|                                                      | **Reflect and write:** Participants are asked to record their reasons for undertaking the workshop series. These are collected by the facilitator for use in a later workshop.  
|                                                      | **Aim:** Establish learner needs, encourage learners to self-awareness of personal/professional issues regarding resilience  
|                                                      | **Creative:**  
|                                                      | **Mandala drawing:** Participants draw a large circle onto their choice of coloured paper. They are guided into a relaxed state by the facilitator using a guided visualisation exercise, then asked to draw whatever represents their past self in one half of the circle and their future self in the other using chalk, markers, coloured pencils.  
|                                                      | **Aim:** Activity used to foster creative expression, engaging with self-awareness and concepts of the self at points along the lifespan, encouraging a positive view of the future.  
|                                                      | **Therapeutic:**  
|                                                      | **Networks Activity:** Participants are given a handout of an archer’s target image (circles decreasing in size within a circle). They are asked to listen to the facilitator read aloud a description of the kinds of personal relationships that belong in each circle. The participants fill in the relevant initials or names of people who fit in that space for them. Activity takes place with gentle, relaxing music and using aromatherapy candles.  
|                                                      | **Aim:** to foster relaxation, self-awareness of concepts of positive support, helpful unhelpful relationships  
| Establishing positive nurturing relationships and networks |                                                                                                                                                                                                                     |
| Workshop 2: Maintaining a positive outlook | Collaborative: Guest presenter facilitated a group discussion around the difficulties of workplace communication. Participants were presented with information about using personal boundaries in assertive communication, using an analogy of an invisible monkey on the back of work colleagues, as “the problem” that everyone tries to unload onto others.  
Aim: Present major concepts of assertive workplace communication  

Self-reflective:  
Personal Treasure Hunt: Participants are asked to reflect on and chart their specific personal/professional competencies and convert their abilities into a positive global self-concept.  

Creative:  
Uncovering your Authenticity with Michaelangelo: Participants are asked to view and comment on aspects of photographs of Michaelangelo’s “David” and his artistic process of disegno, uncovering the sculpture already in the stone. Group participates in discussion on uncovering their own authenticity and its relationship to hardiness and positive outlook.  
Aim: Encourage concepts of creativity and authenticity through art critiquing and appreciation  

| Workshop 3: Developing intellectual flexibility | Collaborative:  
Art Gallery: Participants view a “gallery exhibit” of several artistic depictions that may resonate with concepts of resilience. They are asked to stand in front of the one most significant to them and share their ideas with the group.  
What image best represents your ideas about your personal resilience, and its importance to your work at this point?  
Aim: Encourage listening and discussion, group cohesion, respect for different perspectives  

Self-reflective:  
Sensory Awareness Inventory: Participants identify what experiences give them pleasure through each of the 5 senses then assess what sensory experiences they should try to incorporate more into their life.  
Aim: Foster self-awareness, self-examination and strategies for sensory perception  

Creative:  
Moominland Activity: Participants are asked to respond to a sketch portrait of the character Tooticky and an excerpt from “Winter in Moominland” by feminist cartoonist Tove Jansson. Discussion around concept of intellectual flexibility from Tooticky’s quote, “All is very uncertain and it’s this that makes me feel safe.” |
| Workshop 4: Achieving a life balance | Collaborative:  
‘My Country, My Dreaming:’ Participants sit in a circle and share their stories about where their “dreaming” and “country” are.  
**Aim:** Encourage listening and discussion, group cohesion, respect for different perspectives |

| Enabling spirituality | Self-reflective:  
**My Sacred Garden:** Participants are asked to find a quiet spot either in the room or outside to visualise an imaginary garden that represents their ideas about spirituality. They are asked to create a ‘virtual’ garden, using key questions eg: how do you enter, what is growing there, what tools do you use, what knowledge do you need, what practices do you cultivate? After reflecting, writing or sketching their garden, ppts are asked to write a journal entry about what concepts of creating and maintaining the garden apply to their insights and practice of spirituality.  
**Aim:** Self-reflection of spirituality and application to lifestyle and nursing practice |

| Workshop 5: Encouraging reflective and critical thinking | Collaborative:  
**Sacred Symbols:** Participants are asked to select one of a selection of everyday items symbolising the concept of ‘the sacred’ to them personally, and share a sentence of two about why to the rest of the group. Various items are displayed on a table eg: rose stem, book, teacup and saucer, prayer rug, Eastern jug.  
**Aim:** Use creative activity to approach potentially negative concepts of workplace adversity. |

**Aim:** Encourage creativity and reflection of abstract concept of resilience

**Expressing Emotions Creatively:** Participants view an emotive art work, Broken Column by Frida Kahlo and discuss the emotions portrayed. Participants are then asked to choose an emotion and reflect on its visual aspects using trigger questions eg: what colour is this emotion, what animal, flower, food is it like? Participants are asked to move quickly to expressing the emotion on paper with paint using their fingers.

**Aim:** Using experience of common emotions via various physical senses to encourage insight and self-perception.
| Workshop 5: Encouraging reflective and critical thinking | mini-globe, ball of string, scales, glass of water, shell, garden tool, hand held mirror.  
Aim: Encourage listening and discussion, group cohesion, respect for different perspectives  
Finding your flock activity: Facilitator whispers to each person what farm animal they are, either sheep, cow or duck so that there are equal numbers of each in the group. The participants spread out, close their eyes and move around making their animal noise continually until they find their group by listening to the sound.  
Aim: Encourage teamwork, trusting others, insights on personal behaviour in groups  
Self-reflective:  
Road Map of Life Reflection: Participants use a handout of road map to reflect upon the important events, turning points, choices and decisions in their lives to date  
Aim: Life course reflection, role of resilience  
Dialogue with the self: Participants choose a part of the physical body, reflective mind, emotional or spiritual self from the body tracing relaxation and engage in a dialogue with that aspect about its perceptions of a real-life issue eg: feet speaking about being fatigued.  
Aim: Gain insights into body/mind/emotions connection for health and wellbeing  
Creative:  
Personal shield Activity: Participants select from various shields pre-cut from paper. Art and collage materials are provided to represent participants’ sources of strength, comfort, personal/family values, guiding beliefs or life purpose. Participants make a journal entry about their experiences and insights.  
Aim: Gain insights on personal attributes of resilience and compare and contrast with others.  
Therapeutic  
Hand massage: Participants were given a personal relaxation hand massage with the use of warm water, heated cloths and scented massage oil.  
Aim: Relaxation, rejuvenation  
Reflection circuit: A selection of reflective journaling activities are set up at different locations around the room. Participants move from one activity to the next until all are completed. |
**Body tracing reflection** – Participants lie on butcher’s paper on the floor and their body outline is traced. Participants then listen with closed eyes to an audio-taped guided relaxation exercise. Afterwards they are asked to write insights or reflections directly onto the body outline with coloured markers. This activity was adapted to outlining the hands only if participants could not lie prone.

**Aim:** Gain insights on personal attributes of one’s body/mind/emotions and impact on personal resilience, compare and contrast with others.

**Workshop 6: Moving forward and planning for the future**

**Collaborative:**

**Connections activity:** Participants stand in a circle facing each other. Facilitator asks group to think of a connection they have made with another group member. Facilitator throws a ball of twine to a participant saying the connection aloud and holding the end of the twine tightly. As the activity continues the participants must hold their twine taut to create a cobweb effect in the centre. Activity ends when there is a good spread of connections between participants. Facilitator can then lead discussion of group cohesiveness, support and recognition of group members, their contribution to the group and potential for support network to extend after the group concludes.

**Aim:** Express group values, cohesion, respect and recognition, in context of separation

**Group Poster:** Small groups work on creating a poster to advertise one of the previous 5 workshops emphasising the significant resilience concept of that workshop.

**Aim:** Express group learning, discussion and listening

**Self-reflective:**

**Personal Resilience Care Plan:** Participants fill in a chart of 4 specific resilience goals for the future based on workshop content. The exercise asks them to consider necessary steps, resources, support people, time etc. to achieve the goal, and note date of when they will review and evaluate their achievements.

**Aim:** Self-reflection of potential strategies for self-care

**Creative:**

**Exhibition and Presentation of Work:** Participants display one or more of their creative works from the workshops and make an oral presentation to the group about their insights from creating the work.

**Aim:** Express and enjoy group’s creativity
6.7 Implementation of the Workshops

At each of the workshops, clear definitions of the resilience characteristics were presented and placed within the context of a nursing and midwifery discipline. Recent research was presented to demonstrate what was already known about the topic. This knowledge was built upon to facilitate the participants making their own sense of each of the concepts and how they applied to their own experiences, attitudes and behaviour. Group exercises and activities were included to encourage participants to reflect on how they currently understood and applied the characteristics to their personal and work life. New or additional strategies were then presented that could be explored and adopted; selected as interesting, therapeutic, inexpensive, having differing degrees of difficulty and catering to different learning styles. Creative and complementary therapies were incorporated into activities and used to access new concepts by creative means, develop the participants’ creative expression, and support the concept of improving resilience through self-care.

In addition to the curricula and activities of the workshops, it was also important that the participants felt they were receiving a positive experience in order to maintain their attendance and participation. Just as importantly, I wanted to convey to the participants in the workshops the same aspects of morale-boosting that the mentoring partnerships aimed to do. I wanted the participants to have a therapeutic experience and engage with the teaching and learning of the group. I hoped they could come to greater recognition of their intrinsic value as people and as nurses and midwives. To do this, I used as many ways as possible to increase the sensory and aesthetic appeal of the experiences offered in the workshops. These ranged from the room set-up and decorations, music selection, surprise treats and small personal gifts, and the refreshments and food -- such as a special ‘Christmas feast’ lunch in December with bon bons and fruit punch. I hand-made each participant’s name tag with a different colour theme and illustration. The participants were also given resources to assist them with continuing their own experimentation with the creative activities used in the workshops, such as reflection journals, sketch books, art pencils and crayons. They were also given relevant and interesting poems, newspaper articles and short stories to read at home. Each month a book selection, such as Ingrid Poulson’s
“Rise,” (2008), was briefly reviewed and loaned to an interested participant to take home. Sometimes the learning activities gave rise to opportunities to act on a participant’s interest so they felt noticed and significant; for example, when a participant chose the single-stemmed rose during the exercise on sacred items, I gave it to her.

6.7.1 Participation Rate

There was generally a high rate of attendance at the intervention workshops in both cycles. In Cycle 1, three workshops had full attendance. Three participants were absent for a workshop and one participant was absent for two. In Cycle 2, there was full attendance at five workshops, with only one instance of absence. Participants were absent due to illness, an overseas holiday and the death of a family member. Some participants attended the workshops even when they were on holiday leave.

6.7.2 Format and Content of the Workshops

The workshops were held in group learning venues around the hospital site and were held over a whole day. Participants were permitted to attend in working hours and paid at the normal rate. Although the format was designed to be free-flowing and flexible to take advantage of group learning processes, there was an organisational structure within each workshop. Each workshop contained 3 or 4 sessions of approximately 90 minutes, covering aspects of one -- or two related -- characteristics of personal resilience. Each workshop made use of:

- Introduction to the topic: introductory remarks about the major learning concepts leading into exploration of individual and group knowledge and competency with the material
- Oral/Powerpoint presentation: providing current understanding and approaches to the topic, especially from a nursing and midwifery world-view
- Reflect and Write booklet: individual and small group tasks, questions and activities used in conjunction with the oral presentation of learning material and used to lead discussion about the participants’ previous and current experiences and insights. There was an exploration of contrasting ideas and
attitudes amongst the participants and group definitions and understandings were formed where appropriate.

- Strategies for success: a session that contemplated various ways of developing, strengthening and maintaining the particular resilience characteristic under investigation, giving further opportunity for the group to share insights and expertise from within their own knowledge and skills, or add to their personal and professional repertoire.

- Participatory, creative learning activity: an afternoon session that built upon the learning concepts of the workshop and encouraged individual reviewing and application processes and creative self-expression.

- Concluding session: which brought threads of understandings together to formulate a ‘take-home message’ and evaluated learning about the workshop topic.

6.8 Forming the group

In forming the group, it was necessary to adequately communicate to the participants the potential benefits of developing further personal resilience. Due to the significant level of distrust in organisational staff initiatives in the setting, it was essential that time was spent in establishing trust, both with me (as group facilitator) and among the participants, many of whom had experienced interpersonal problems with their colleagues, and a few even reported past problems with other study participants. Therefore, some of the workshop content was introduced from a non-nursing/midwifery perspective and was selected to be stimulating, playful and relaxed, and aimed to increase participant engagement. An example of an activity with this rationale is the survival game activity in Workshop 4, where the participants were required to discuss as teams what equipment they would choose for survival after a shipwreck.

The initial interactions between the group members reflected the entrenched hierarchical structure in the workplace. They were initially reluctant to engage with co-participants who had different qualifications than theirs, especially in the pairs activities during the workshops, when the participants were encouraged to work with a different
person each time. Once this issue was observed and the reasons for it identified, there was a need to address the situation immediately so that the group would begin building rapport and greater trust. Group cohesion was crucial for the study participants to form an effective learning group. An early entry in my reflective journal revealed the perception that the participants were unsure about how to interact with colleagues in the setting of the workshops, where there were behavioural expectations of the group members to be respectful and inclusive, rather than the participants’ usual workplace norms of behaviour:

*There seemed to be some apprehension within the group with each other. They seemed ill at ease with each other, so not sure yet how closely they work together, although they all said they mostly knew each other. There is a group of three who seem very comfortable with each other and are used to being influential. I think group discussions may take some time to warm up.* [G. McD, journal entry]

At the second workshop I became aware that the participants were sitting in the room in ‘clusters’ based on qualification: registered midwives, registered nurses and enrolled nurses. This accounted for the apprehension that some of the participants had inadvertently displayed when asked to participate in pairs tasks during the workshop, and also when the first group discussion with real expressions of deeply-felt emotions and opinions occurred:

*Realised halfway through the day that they were seated by qualification roles, showing the distinction in their minds between ENs, RNs and midwives. Midwife participants sometimes betrayed opinions of superiority over ENs, “only have one qualified staff on shift” which brought some heat from Patrice and Lauren. Lauren spoke openly about her own negativity. Jodie was open about dissatisfaction with colleagues’ lack of recognition or value for night workers. So, there is a jostling of different interests and groups within the group, but all too polite to really become too heated in discussions, it is more hinted at verbally. The atmosphere is loaded though.* [G McD, journal entry]

I continued to monitor the group dynamic for the rest of the day, finally reflecting that the purposeful pairing of participants from different ‘groups’ should be continued during the workshops because the strategy was proving successful in causing different group members to interact with each other. However, I had to be sure to reinforce respect and safety for each comment and contribution made to the group. I recorded another event later in the day during the creative learning activity that also seemed to
further overcome the participants’ reticence to make personal disclosures in the group and trust that I, as group facilitator, would uphold safe disclosure:

_The last activity was the mandala [a schematic representation of the past/future] which most seemed to enjoy and relate to. Lynette screwed hers up in a ball and threw it into the centre of the table. Everyone else seemed surprised and embarrassed. I was happy with how calmly and neutrally I responded, “Well even that is a response and that is what we are aiming for here.” It was as though everyone breathed a hidden sigh of relief. As a group we could talk about personal perspectives, feeling outside the comfort zone, allowing for differences between us. Lynette was frustrated by the activity, “I just don’t see the point. It doesn’t mean anything to me.” I had a sense that she was more scared about it than anger directed at myself or the others. I deliberately placed myself in a “no offence” stance to model to her and the others that it was ok._ [G McD, journal entry]

This incident sparked one of the earliest evidences that the group was beginning to become more defined and cohesive. I was able to reinforce the idea with the group that the creative work they produced was not the major outcome of the creative learning sessions, but that self-exploration and playfulness was the desired focus. At that time the participants could see and understand more practically how they could approach the workshop activities in an experimental fashion, with no prior expectations from me, and hopefully from the other participants, about the results. This prompted a spontaneous discussion between the other participants about their fears of not possessing the assumed expectation of artistic abilities in the workshops, and supportive comments were made by participants to Lynette and one another.

Building trust in the group also concerned the relationship between the participants and I as the ‘outsider’ and the facilitator, the dichotomous tension present between the researcher and the researched (Borbasi, Jackson & Langford 2008). After the first workshop I reflected in my journal that,

_Rose, Marika and Lynette are reserving judgement, Lynette sometimes disparaging to me. They are not as accepting of my facilitation abilities or credibility._ [G McD, journal entry]

At the second workshop I recognised the need to address the trust issues between myself and the participants as well. I decided to emphasise the suggestion that the participants were all ‘experts’ of their own experiences; that they were valuable as people, nurses/midwives, and important to me and the success of the study. I
monitored the use of inclusive language; I considered how each part of the workshop enhanced their well-being, self-esteem and sense of empowerment. I used whatever personal attributes and interpersonal skills I could to make the participants feel comfortable and safe within the workshops.

An appropriate level of self-disclosure was used in workshop discussions to authentically “walk the talk” and model sharing personal insights and creative work with other group members to the participants. Therefore, at times I purposefully disclosed my own experiments with creativity for critical reflection by the group, for example, presenting a poem written about the group experience of the intervention in Cycle 1. The poem ‘Resilience Journey’ (see Appendix H) was based on a written response from the participants in Workshop 1 about their expectations and desires for the program.

It became evident that one participant held an esteemed position within the group and I felt the other participants often took their lead from her regarding my credibility. She was a senior, highly experienced staff member who tended to be somewhat maternal to the other participants and an advocate for their welfare in the workplace. As I was already conscious of making the workshops as nurturing as possible, given the demands, overload and stress the participants usually faced every day, I could draw on the common perspective of taking care of the group members that this participant and I shared. I was confident that I had begun to gain credibility with her and trust as a facilitator when I recorded in my research journal after Workshop 2,

Rose is more accepting, she seems to hold the alpha female position so I am conscious of winning her over. She seems impressed by the care I am taking of them all, the food, little rewards and treats, so will keep on being as caring as possible. Not hard – they are good people. [G McD, journal entry]

The importance of building trusting relationships with the participants was reiterated further on in the intervention phase when there was a need to facilitate a slight issue that arose for a participant with her mentor. I needed to make sure that all the participants understood that I was available and open to hearing their real concerns about their mentors, while at the same time encouraging some to sustain or increase their effort or sense of responsibility with the mentoring program. One participant
disclosed a communication difficulty with her mentor and reported their contact was becoming patchy. We spoke candidly during breaks in the workshop about how she could manage conversations with her mentor, moving forward on some of their agreed goals but not others. Unfortunately, soon after the mentor was forced to stop her participation when she became seriously ill, and subsequently she passed away. My research journal noted my thoughts at the time about appropriate disclosure to the participant:

*Phyllis [mentor] rang to let me know Carol [mentor] had died. I was horrified as I was not expecting it. Carol herself was positive when I last spoke with her. My first thought was whether Lisa [participant] would know about it yet, probably not. Arranging a meeting with Lisa proved impossible as she was not working at the hospital at present. I didn’t want to leave a voice mail about it. I finally got on to her but I had to inform her over the phone. I felt quite nervous but there was no other way. She was upset at the news but okay. It could have been awkward because of what we had talked about before Christmas, when she was having difficulties. I’m so glad now that we had those conversations because it made it easier now. We really knew how the other felt about Carol. I think Lisa will remember her with much fondness, as I will.*  

[G McD, journal entry]

### 6.9 Participant Reflections on the Intervention

Discovering how the participants themselves assessed their growth or changes in response to the intervention was a critical part of the evaluation process. Participant reports have been considered the best source of feedback for programs engaged in achieving transformational and preventative outcomes (Daponte 2008). Participants were asked to give their written evaluation of each workshop by completing an evaluation sheet at the end of each workshop (see Appendix I). The participants were not asked to identify themselves on their form. They were asked what they thought were the strengths of each day; the elements of the workshop that went well. They were also asked about any aspects that they thought could be added to or improved; if there were any weaknesses to the sessions in their opinion. Finally, the participants were asked to rate their experience at the workshop by circling an emoticon, to allow the facilitator to monitor the general wellbeing of the participants over the duration of the intervention.
At the end of the final workshop in the series the participants were asked to comment on the resilience workshop series as a whole. The final evaluation sought general information about the course, the course content and the course facilitator. Participants were given the choice of identifying themselves. Some of the participants’ reflections on their learning experiences are stated below:

*Positive thinking was good, the ability to say no – and not to accept other people’s “monkeys.” Loved mandala relaxation session* [Anonymous, Workshop 2]

*The painting session reminded me to include creativity in life. Reflection on self/reaction to workplace dramas went well* [Anonymous, Workshop 2]

*Interesting to know the difference between intellectual and emotional flexibility, making you realise that this is what we do all the time. Now it has a name* [Anonymous, Workshop 3]

*Very good day. It made me think about both sides of arguments as I can be a bit one minded at times.* [Anonymous, Workshop 3]

*Very interesting. I was amazed to myself – finding a new area of my personality* [Anonymous, Workshop 4]

*The review of the last 6 months demonstrates the resilience that we had initially has grown immensely under gentle nurturing* [Anonymous, Workshop 6]

*Nurturing, insightful and relaxing. The ladder of conversations, the mandala and the “monkey” of assertive conversations were new information to me.* [Lucinda, series evaluation]

*I think resilience is a wonderful topic to explore and very important. Glenda has expanded the topic to encompass lots of aspects of how to capture, analyse, measure and promote resilience* [Anonymous, series evaluation]

These comments reflect the wide variety of outcomes that the participants experienced from the workshop series, what different segments they enjoyed and found enriching. The comments also show that the participants were satisfied that the intervention workshops had been successful in assisting them to engage with several of the key subjects, namely creativity, self-care, assertiveness, positive communication and optimism. The final comment suggests that a participant had found the workshops helpful in stimulating her to explore and appreciate personal resilience and consider it an important part of her personal and professional life.
6.10 Development of the Mentoring Program

The facilitated mentoring program was an integral part of the intervention. Each participant was provided with an experienced and knowledgeable mentor to assist and support them during the intervention phase of the study. It was crucial for successful learning outcomes that participants experienced establishing a network of support. It was hoped that each mentoring partnership would continue for at least six months, and even indefinitely. The rationale for the provision of mentors was that they would act as partners in a developing relationship focused on achieving the participants’ goals and objectives (Zachary 2005). The partnerships provided an opportunity for the participants to practise positive professional relationship formation and experience the benefits of having a ‘critical friend.’

While the workshops focused on forming support networks between participants and encouraged reflection on finding natural mentors from inside their organisation, the mentoring program focused on placing each participant with a highly skilled mentor who was outside the organisation structure and hierarchy. The mentors brought a diverse range of knowledge and experience from other nursing contexts to the participants that facilitated the expansion of their ideas about their circumstances.

The program called for the mentors and participants to meet face to face or via telephone at least twice each month, seen as the appropriate frequency. The partners were given a mentoring agreement to complete together and sign at the beginning of their partnership (see Appendix J). This encouraged them to focus on the objectives of their mentoring relationship, their expectations of each other, and possible problems. They were expected to make joint decisions about how the partnership would be managed, such as confidentiality, feedback, schedules, logistics, limits and preferences.

6.11 Mentors

The success of the program depended on finding the high quality study mentors required. It was decided that the mentors would ideally have retired within the past
five years, and not be currently connected with the selected hospital. This was the only exclusion criterion, so the mentors were completely outside the organisation where the participants worked. Mentors were chosen who had previous experience in similar fields of nursing and midwifery to the participants, had prolific industry knowledge and experience and who were positive about their life experiences as a result of nursing. The selection of mentor criteria was guided by research literature suggesting the quality of mentoring was crucial in the success of previous programs (McKinley et al. 2004; Wagner & Seymour 2007; Grindel & Hagerstrom 2009).

To assist the selection process a demographic form was devised for retired or senior nurse/midwife mentors (see Appendix K). As well as obtaining contact information, availability and nursing/midwifery background for each applicant, potential mentors were asked to reflect on their skills, knowledge and experience and respond in writing to some central questions. In order to select the right applicants, the research team wanted to know about the applicant’s current nursing and midwifery profile and involvement, even if they were retired. They were asked to write about the kinds of support they thought nurses and midwives needed, why they considered becoming mentors in the program, and what were the best qualities they brought to the mentoring role. We also asked for their opinions of the current approaches in nursing education, as we envisaged that participants may well be continuing students, and we were mindful of the broad changes to nursing education over the lifespan of nurses and midwives of retirement age. In general, we were seeking people with a positive attitude in life and their careers, mentors who could authentically model their passion for nursing and midwifery and the satisfaction that their efforts had provided them.

Some of the following responses from the mentors about their motivation to join the study demonstrate the positive approach they took to their role as mentors:

*If I can help just one individual to achieve personal goals it would be worthwhile. My 50 years of nursing have been very satisfying and I would do the same again*  [Carol].

*Having been a mature age student I have an understanding of students’ situation. They need emotional and moral support and constructive criticism which has a positive outcome*  [Maureen].
I wish to encourage nurses to stay. I am relaxed, mature and enjoy my nursing profession. I have always juggled personal, family, work and educational life and consider life as a continual learning experience [Helen].

6.11.1 Recruitment of Mentors: Study mentors were recruited by publicising the study and calling for volunteers in local print media. These included local community newspapers across the regions surrounding the site and the online staff news service of the relevant area health service. Various other recruitment methods were used, including snowball technique, dissemination of study flyers and liaising with a retired nurses and midwives association. Potential mentors were asked to contact the researchers by telephone for further information. Anyone who contacted the researcher was questioned over the phone or sent a form about their age, qualifications, experience and reasons for wanting to become a mentor (see Appendix J). The potential mentors were informed of their rights to privacy and confidentiality, and that they could withdraw their participation at any time. They were told that all information they provided would be de-identified and they would be given pseudonyms. Information about the expectations of study mentors in the study was provided – attendance at a training day and availability to have either face to face or telephone contact with participants at least twice a month for at least six months.

They were also asked to take part in an audio-taped interview after the intervention phase was completed. The potential mentors were offered ongoing support by the research team and the opportunity to meet with other study mentors regularly during the intervention phase if they wished.

If the potential mentor was agreeable, an information package was sent to them including a participant information sheet, media release about the study, a demographic form and consent form (see Appendix J). They were asked to read through the documents at their convenience and sign and return the consent form and demographic form if they wanted to proceed. Once informed consent was gained, an invitation to attend a Mentor’s Information Day was sent to the mentors. This was held onsite at the selected hospital and combined in part with the first intervention workshop so that mentors and participants could meet each other over lunch and chat.
The snowball technique was also used to recruit mentors (Denzin & Lincoln 2000). Each recruited mentor was asked to speak to other retired or senior nursing colleagues about their participation in the study, or to propose other potential mentors for the researchers to contact by letter. Other mentors were recruited purposively by the research team members, who nominated people from their own networks in the nursing and midwifery field. A letter was then sent to them inviting them to participate in the study.

A recruitment flyer for mentors was also posted on notice-boards in Schools of Nursing at two university campuses near the selected hospital (see Appendix M). The flyer outlined the general aims of the study and mentoring program, and set out the expected role and commitments of study mentors. It was hoped that retired or senior nursing or midwifery associates of academic staff could be recruited in this way. Information packs containing a letter of invitation, media release, participant information sheet, consent form, and a demographic information form were also sent to nursing unit managers at seventeen of the nearest community health centres and early childhood health centres (see Appendix M).

Two executive members of the retired nurse and midwife association of the selected hospital were contacted by telephone and sent information about the study. Permission was asked to use their database of retired nurses previously associated with the health service so that they could be contacted as potential mentors. They agreed to contact members that lived in the area and canvass their interest in becoming study mentors to ensure members’ privacy and confidentiality. Those interested gave permission for their names and telephone numbers to be given to the researcher so that direct contact could be made. Permission was also granted for recruitment flyers to be placed at the registration table of the annual dinner of the retired nurses’ association.

6.11.2 Cycle 1 Mentors: There were eight retired or senior nurse mentors recruited into Cycle 1. Mentor recruitment for Cycle 1 came from two main areas: nursing academics at a university and retired nurses and midwives in the regional community. There were seven female and two male mentors, ranging in age from 40 years to 66 years. Two were retired nurses or midwives; the remaining six were all
employed as university academics in a variety of nursing education or adjunct research positions. The mentors brought varied nursing experience, including midwifery, women’s and children’s health, community nursing, intensive care and accident and emergency.

### Table 6.3: Cycle 1 Mentors

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Years in Nursing</th>
<th>Main Career Position</th>
<th>Employment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phyllis</td>
<td>66</td>
<td>28</td>
<td>Nursing Manager</td>
<td>5 yrs retired</td>
</tr>
<tr>
<td>Louise</td>
<td>&gt;60</td>
<td>&gt;40</td>
<td>Child/Family Health Nurse</td>
<td>4 yrs retired</td>
</tr>
<tr>
<td>Ana</td>
<td>50</td>
<td>32</td>
<td>Senior Lecturer</td>
<td>Full-time work</td>
</tr>
<tr>
<td>Penelope</td>
<td>50</td>
<td>30</td>
<td>Assoc Professor</td>
<td>Full-time work</td>
</tr>
<tr>
<td>Brent</td>
<td>50</td>
<td>&gt;20</td>
<td>Manager Aged Care</td>
<td>Full-time work</td>
</tr>
<tr>
<td>Nick</td>
<td>47</td>
<td>23</td>
<td>Lecturer</td>
<td>Full-time work</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>45</td>
<td>&gt;20</td>
<td>Senior Lecturer</td>
<td>Full-time work</td>
</tr>
<tr>
<td>Mary</td>
<td>40</td>
<td>&gt;20</td>
<td>Lecturer</td>
<td>Full-time work</td>
</tr>
</tbody>
</table>

6.11.3 **Cycle 2 Mentors:** The retired mentors were aged between 55 and 68 years. They were all female and had been retired from nursing for a period of six months extending to 5 years. Their professional qualifications were extensive and from a range of nursing fields, including midwifery and family and community nursing. There was one semi-retired mentor who currently worked part-time in general practice nursing.

### Table 6.4: Cycle 2 Mentors

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Years in Nursing</th>
<th>Main Career Position</th>
<th>Employment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carol</td>
<td>68</td>
<td>50</td>
<td>Clinical Education Coordinator</td>
<td>0.5 yrs retired</td>
</tr>
<tr>
<td>Maureen</td>
<td>68</td>
<td>30</td>
<td>Neonatal Nurse Specialist</td>
<td>2 yrs retired</td>
</tr>
<tr>
<td>Phyllis</td>
<td>67</td>
<td>28</td>
<td>Nursing Manager</td>
<td>5 yrs retired</td>
</tr>
<tr>
<td>Barbara</td>
<td>62</td>
<td>44</td>
<td>Health Care Consultant</td>
<td>1.5 yrs</td>
</tr>
<tr>
<td>Helen</td>
<td>55</td>
<td>32</td>
<td>Lead Registered Nurse (General Practice)</td>
<td>4.5 yrs (semi-retired)</td>
</tr>
</tbody>
</table>
6.12 Mentors Information Day

The concept of mentoring in this intervention was based on commitment to the mutual benefits of both partners through a process of exchanging and sharing ideas, growing together and mutual support (Al Huang & Lynch 1995). It was important that all the mentors were equipped with the necessary knowledge about the research study and the mentoring program, were well-prepared, and confident in their abilities to act as effective mentors once the mentoring program was underway. Therefore an information day for mentors was held at the hospital site. After feedback from the mentors in Cycle 1, an informal coffee event was held a week before the information day in Cycle 2 so that the mentors could meet each other before the Information Day.

The mentoring information day was held in conjunction with the first workshop, giving the participants and mentors the opportunity to meet each other and the members of the research team. There were some ‘mentor only’ sessions and some combined sessions with potential participants. The ‘mentor only’ sessions provided information about the knowledge, skills and attitudes required for successfully negotiating the mentor role. The mentors were also able to exchange ideas and reflect on their experiences and views about mentoring in the past.

Mentors were provided with an information pack with handouts and documents they would need to begin carrying out their mentoring tasks, such as a mentoring contract. Introductory sessions gave a brief overview of the research project, the key goals and expectations of mentors, the opportunity for providing feedback at the program’s end, accountability and contact issues. Members of the research team delivered the information sessions.

A mentoring seminar developed by the research team’s primary investigator was used to promote mentoring as a pathway for professional and personal growth, and leadership development. Handouts were provided that supported the material presented, with A Reflect and write booklet similar to that used in the participant workshops used to intersperse questions throughout the session. There were opportunities for the mentors to reflect on and discuss their own mentoring
experiences and re-cap the core competencies of being a successful mentor. The session also provided opportunities for practising mentoring skills, such as active listening and effective communication, and the chance to begin forming a support network for themselves as study mentors. The mentors were joined for lunch and afternoon tea by the participants so that they could meet and gain first impressions of each other. The session program for the Mentors Information Day is included in Appendix N.

6.13 Matching Mentoring Partners

A challenging aspect of the program’s success was the selection process for the mentoring partnerships. Mentoring partners needed to be matched in an appropriate, sensitive way (Benard & Marshall 2001). They also needed to receive the best choice of partner within the existing choices, in order for them to be effective and productive. The selection criteria considered in matching the partners were preference, age, gender, educational background and previous association. Partner preferences were indicated by a voluntary selection form handed out to participants at the end of the information day. They were collected at the end of the first participant workshop.

My research journal recorded some of my thought processes just after the participants and mentors met for the first time at the Mentors Information Day:

  [Mentor] and Marika obviously knew each other well so will need to follow that up. Some people filled in the partner selection sheets, so my priority will be to give those participants the mentors they want as much as possible. Tina has asked for Phyllis and I think they’re a good match, Phyllis has worked as a community literacy tutor before so interested in people from other cultures. I have some tricky situations with matches, firstly gender - as there are two male mentors – so have tried to go with assertive but easy-going participants, hope that works out. Also age – as some of the participants are older than the mentors, can be a bit tricky when I have judged some participants, especially Lynette, to not really be all that keen on being mentored. It may not go down to have a younger academic as her mentor, so have chosen Louise. This was not pleasing to her because she wanted to mentor a young person having struggles. Also some of the participants studied at (...) and didn’t want to have past teachers as mentors, so have to give them retirees rather than academics. Therefore the ENs may in some cases end up with the academics so there is the ‘awe’ factor that could contribute to some avoidance on their part. So I am quite apprehensive about how it is all going to work out at present. [G McD, journal entry]
Ongoing Support of Mentors

During the intervention phase, ongoing support was provided to the study mentors by setting up group emails and arranging monthly meetings. Most of the mentors lived in two geographical areas so the meetings alternated between sites. The meetings were usually held the week preceding a workshop, in case there was a need for ongoing communication with participants by the facilitator about a mentoring issue. The mentors were also encouraged to arrange their meetings with their participants around these times, to maintain motivation to attend and facilitate good communication and feedback between mentors, participants and I. The meetings were informal and viewed as an opportunity to express any feedback or problems from the mentors. It was also hoped that they would foster a network of support between mentors during the intervention period.

At each meeting the mentors were provided with supplemental reading about mentoring topics, such as active listening or reflection, that were accessed from internet sites, newsletters or journal articles. The meetings were an opportunity for the mentors to listen to each other, ask questions and discuss their experiences. They were able to collectively problem solve and encourage each other in their responses to individual circumstances. Significant comments were noted and recorded later in field notes. At the first meeting the mentors decided to exchange email addresses for further contact between meetings. There was also a contrived ‘breathing space’ towards the end of each meeting when the researcher absented herself so that the mentors could speak with each other without the researcher listening or taking notes.

The potential success of the mentor meetings was reduced by the small numbers that were able to attend regularly; usually between 2 and 4 mentors. It was an effective method of getting to know each other and airing issues of mentoring for those who attended, but understandably the main impetus and energy was reserved for the mentoring partnerships. Over the intervention phase, the potency of the mentor’s group was reduced to mostly an opportunity for social interaction; however, the most established and successful partnerships proved to be those that involved those mentors who had formed supportive networks with each other.
6.15 Mentor Reflections

Although the mentors were not participants in the study, their perspectives were of interest, especially regarding the experiences and outcomes of the participants. Therefore they were also part of the evaluative process. At the immediate post-intervention phase, the mentors were asked to attend an audio-taped, semi-structured interview to discuss their evaluation of the mentoring program and their assessment of the outcomes for their mentee. Interviews were conducted at a convenient time for the mentors at the university campus closest to their home, the clinical nursing research at the hospital site, or by telephone if necessary. The interviews with retired mentors were carried out in pairs to increase the conversational flow and prompt additional insights between mentors. The audio-taped interviews were transcribed into written text and all identifying information was removed. All mentor interviews were analysed using content analysis (Borbasi et al 2008).

Some mentors stated they believed their mentees had gained various positive outcomes in their view. These mentors reported they believed their mentees had greater self-confidence to deal with workplace problems due to the program, and greater strength and independence to rely on to survive and even succeed because of the intervention.

We [last] spoke to each other in January but I also see that as a positive because she hasn’t had to call. We have probably given her skills within the workplace...She knows I am there if she needs me which is good...We got quite close I would say, it was a good match...I gave her a lot of strategies because there was so much bullying in the workplace. I was trying to discuss ways of letting it wash over you rather than holding it personally [Helen].

Other mentors believed the most important benefit their mentees received from the program was to recognise the importance of self-care. They had worked towards goals of better work/life balance to improve work-related stress and believed that these goals had been achieved in their partnerships:

It was sort of a revelation to [my participant] to think ‘We can go out and we can enjoy ourselves and do things as a family, and I don’t have to be working all the time’ and I thought ‘Wow, if nothing else that’s a big plus.’...The other thing that was important was being able to say...
Another mentor recalled that she thought her mentee had benefitted most from the career development and greater motivation to put plans and dreams into action. She believed her mentee exhibited more self-esteem at the end of the program:

In hindsight Karin was very grateful and she also realised that it wasn’t quite as complicated as she thought and she started [saying] “There’s other opportunities for me now”…and then a position came up so it was “I don’t know how to interview” so we talked a lot about that. And that had all come from I’m sure her [better] self-esteem… “Ok, I can do other things now too” and from that come that great expression: “I’ve had a great day at work!” [Phyllis].

Mentors also gave feedback about their own experiences of the mentoring program. Most commented that the experience was a worthwhile and enjoyable one that was personally rewarding for them:

I think it is an outstanding idea and I also think that it is really clever to choose [mentors] with a variety of skills because, well, there are different things that people need at different times…particularly people that have access to other informational recourses than the participant who may not have access to, may not even conceptualise…or they don’t have the self-esteem to access it [Elizabeth].

Being a mentor is a good thing. I think anything you can do to help out or lighten the load for someone else is always a feel good sort of thing. I think it gives you insights into what the clinical area is like as well…I was just absolutely gob-smacked at the stories that were coming out and I thought, “God, this is just awful”…So it was certainly an eye-opener…It sort of gives you a contact with the real world, I suppose…[Mary].

6.16 Challenges of the Intervention

There were several challenges to the success and effectiveness of the mentoring program that were revealed during the evaluative process. They included: failure of participants to establish contact and difficulties with maintaining contact, a failure or lack of commitment to participate in the mentoring program; and sabotage behaviour by participants. For example, one participant informed her mentor at their first meeting that she did not need a mentor. Another participant went on a month’s leave at the beginning of the program without informing the facilitator or her mentor.
The most telling problem for those participants who did not successfully establish a partnership with their mentor was the difficulties around making and maintaining adequate contact during the life of the intervention. Most problems had to do with naturally occurring life changes impacting on participants that are inevitable when studying a group of people for a length of time, such as illness, holiday leave or moving house. There were also problems related to this specific case, as perhaps for other similar populations – chaotic work schedules and heavy workloads. One mentor, Mary, whose mentee did not maintain regular contact with her, was very aware of her mentee’s need for a mentor because of the effects of workplace adversity:

*I did feel that with my participant...she could have really benefited from speaking to someone just on a regular basis about stuff. She seemed to be quite disempowered in the role and then getting quite angry about people’s reactions and because people didn’t listen to her. That all seemed to impact on patients and their care* [Mary].

A few participants were committed to the partnerships but felt there were personality mis-matches with their mentors. These dyads usually maintained contact for a few months and the participants still reported it a favourable experience. Three participants reported being overwhelmed by a sense of awe of nursing academia at their post-intervention interview, two felt uncomfortable about working closely with male mentors, and two were severely distracted by problems in their personal lives. Unfortunately, these participants and mentors did not fully disclose their difficulties with establishing or maintaining rapport until after the end of the program.

*It’s strange having a man as your mentor. It just didn’t sit well...the thought of meeting. I thought of this man as this Professor kind of man that I’m just so beneath...I thought with him, “Something’s going to come out of my mouth and I’m just going to completely embarrass myself, and he’s just going to say, “What are you thinking? How did you even get into nursing?” sort of thing. It’s even harder [because] it’s a bloke. It was almost like a doctor, I would not talk [openly] to a doctor or a professor* [Neralie].

There were a variety of reasons mentors were also unable to maintain contact adequately, such as serious illness and moving out of the area. In addition, a few mentors were de-motivated by their participant’s hesitation in making contact with
them. Unfortunately, in the first cycle one prospective mentor withdrew from the program before her mentee had developed the confidence and skills to negotiate contact. It should be noted that other dyads had initial problems in establishing contact, but because both partners were equally interested and committed to meeting often enough to build rapport with each other they had successful partnerships by the end of the intervention.

Whilst the majority of participant experiences from the workshops were reported to be positive, there were also some that were perceived as negative or confronting. A program which has at its core the development of self-awareness must in some way confront participants with aspects of themselves that were previously unknown. A few participants revealed in the post-intervention phase that they were exposed to some unsettling experiences during the workshops. Lauren summed up her experience as:

\[\text{A lot of stuff in the workshops makes you just look at yourself and how you cope with everything and your attitude towards people, and its not always a good thing } \text{ [Lauren].}\]

For example, a few participants felt confronted in an early workshop session led by a guest speaker who was unaware of the hierarchical nature of the group. Group members were asked to recall an experience of feeling lost as an introduction to the concept of one’s spiritual home or ‘country,’ a signifier of spiritual connection in Aboriginal culture. Two participants declined to participate in the activity and others gave feedback later that they had felt uncomfortable. Interestingly, two participants, although noting they had been challenged by the activity, found it highly engaging and impacting on their previously held notions of self.

Engaging with creative arts was another element of the workshops that challenged some participants. Because it focused on the affective domain, sensitive thoughts and emotions surfaced relating to their own past, future, relationships, health and wellbeing. Some also had to overcome barriers of judging and making negative assessments of their own artistic talents. For example, a few participants reacted negatively to their creative work, destroying them before starting again or deciding not to participate further in the activity. However, these experiences were also
opportunities for group discussion and broke through individual barriers, making them more powerful learning experiences.

6.17 Recommendations

Despite the successful outcomes already outlined, the intervention was a complex initiative with fairly modest, investigative aims. However, the process of evaluation reached several conclusions for ensuring greater effectiveness of subsequent implementations of the program and permanency of learning outcomes for the participants. A paid ‘maintenance’ day program every six months would be beneficial for continuing the major positive effect of the intervention: removing participants from their environment to focus on workplace issues and reflect on their professional and personal development. All participants were in favour of follow-up sessions to maintain the levels of health, well-being and personal resilience they achieved after the intervention. Neralie confirmed the recommendation in this way:

_That would be absolutely brilliant! Because things do get lost in the everyday; and while this is all fresh in our minds at the moment in 6 months time you may just get lost in the whole work situation again, which is really easy to do. I think that a day to step back and just remind yourself of it every 6 months would be really beneficial_ [Neralie].

The implementation of the mentoring program strongly revealed the need for much greater support and facilitation of participants during the establishment phase of the mentoring dyads, given the number and severity of barriers that participants encountered. Recommendations include giving serious consideration to the negative effect of workplace adversity on the self-esteem and confidence of participants when they begin the program and how difficult it may be for them to initiate contact with a mentor. This aim should be further supported with opportunities for mentoring partners to meet at the workplace for the first few months of the mentoring program, both in dyads and as a group. After that, opportunities every month to bring partners together in a group meeting to more formally re-establish any partnerships that have had difficulties meeting would be ideal. Participants should also be provided with profile information about the mentors in the program that includes
personal facts and interests to counteract the ‘awe’ factor from becoming a barrier to establishment.

Encouraging mentors to feel free to assess the situation within their partnership and take more responsibility for establishing and maintaining contact between the partners when appropriate, especially at the establishment stage, is also recommended. The intervention had a specific time span determined by the research design, however, in view of the time period necessary for the dyads to build rapport, extending the mentoring period is recommended. There is also a need to ensure mentors are self-mobile and prepared to travel or they live close to the workplace or participants’ homes to ensure adequate contact continues.

6.18 Summary

This chapter presented the learning goals, outcomes, format, content and andragogical approach to the intervention. The intervention’s learning activities were implemented in order to encourage collaborative, therapeutic, reflective and creative learning processes. The details of the mentoring program were also outlined including the selection and ongoing support procedures for mentors. The chapter concluded by discussing the challenges of the mentoring program and the recommendations for potential improvements for the use of this and similar interventions in the future.
CHAPTER 7: Abstract

This chapter presents the post-intervention findings regarding the development and maintenance of the participants’ personal resilience, and the perceived changes brought to their personal and professional lives. The benefits and challenges that were experienced from participation in the intervention are discussed. There was a range of benefits received from the mentoring program including increased confidence, assertiveness, self-esteem, new professional challenges and finding renewed passion for nursing and midwifery. The positive outcomes from the workshops, such as increased collaborative capital, supportive collegial relationships, self-care strategies and creative self-expression, are also discussed. Findings on the impact of resilience on health, wellbeing, sense of fulfilment and commitment to stay in the post-intervention phases are also reported. The chapter concludes with an examination of the meanings of resilience emerging from the study and how meaning was formed by the participants through creative expression. Some of the findings in this chapter have been previously published (see McDonald, Mohan, Jackson, Vickers & Wilkes 2010, in press).
CHAPTER 7: Post-intervention Findings

7.1 Introduction

This chapter reveals the findings of the post-intervention phases of the study. These findings relate to the ways resilience was built, strengthened and maintained within the collective case, and to what extent and how effectively these processes were improved by the study intervention. The contextual depth of personal resilience across the collective case is also illuminated, as revealed by the rich variety of meanings and outcomes for the participants. The intervention was designed to bring about positive changes to the participants by reducing the harmful effects associated with workplace adversity, identified in the pre-intervention phase.

These positive changes in the individuals impacted on the collective case, as they built relationships with co-participants that translated into broader support networks in the workplace. There were positive outcomes in the workplace as well, as participants’ recognised that its negative characteristics, in effect, heightened the likelihood for tension and conflict. The participants brought insights and skills they developed during the intervention back into their workplace, increasing the perceived level of collaborative capital so that the workplace as a whole was positively impacted.

Findings are based on the analysis of qualitative interviews with fourteen participants and twelve mentors; two less participants than in the pre-intervention phase. Those participants both left their positions before the intervention phase began. An overview of the chapter is presented in Table 7.1. These findings are discussed in sub-categories of ‘Building, strengthening and maintaining resilience,’ ‘Impact of resilience on health and well-being, fulfilment and commitment to stay’ and ‘Meanings of resilience.’
Table 7.1: Overview of Post-intervention Findings

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<tr>
<th>CATEGORIES</th>
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<tbody>
<tr>
<td>Chapter 6: Findings</td>
<td>Building, strengthening and maintaining resilience</td>
<td>Personal gains from the mentoring program</td>
<td>Confidence in problem-solving</td>
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<td>Chapter Post-intervention Phase</td>
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<td>Receiving support and friendship</td>
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<td>Personal gains from the mentoring program</td>
<td>Gaining a role model and confidential advisor</td>
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<td>Professional gains from the mentoring program</td>
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<td>Personal gains from the workshop program</td>
<td>Benefits for vulnerable nurses and midwives</td>
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<td>Professional gains from the workshop program</td>
<td>Mentoring and personal growth</td>
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<td>Personal resilience initiatives</td>
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<td>Greater professional networks</td>
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<td>Raised self-esteem and sense of value</td>
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<td>Renewed passion for nursing/midwifery</td>
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<td>Impact of resilience on health and wellbeing, fulfilment and commitment to stay</td>
<td>Resilience and health and wellbeing</td>
<td>An experiential learning opportunity</td>
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<td>Resilience and fulfilment</td>
<td>Creative self-expression</td>
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<td>Resilience and commitment to stay</td>
<td>Exposure to new ideas and strategies</td>
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<td>Meanings of resilience</td>
<td>Defining resilience</td>
<td>Increased assertiveness at work</td>
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<td>Making meanings of resilience through creative expression</td>
<td>Improved workplace relationships and communication</td>
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<td>Increased collaborative capital</td>
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<td>Understanding self-care</td>
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<td>Nurturing supportive relationships</td>
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<td>Contributing to the resilience of colleagues</td>
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<td>Re-defining resilience and setting new standards</td>
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<td>Awareness of self and resilience</td>
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7.2 Building, strengthening and maintaining resilience

A major area of findings related to the process of building and strengthening personal resilience during the intervention phase, and how well that process continued on into the post-intervention phases. The intervention afforded transformational experiences that required observation and reflection and led to the formation of understandings adaptable to other situations (Kolb 1984). Participants reported having deeper understandings of the nature and scope of resilience as a concept, and its importance for coping with the demands and difficulties of their work. As depicted in Table 7.1, the themes of this discussion are ‘Personal gains from the mentoring program,’ ‘Professional gains from the mentoring program,’ ‘Personal gains from the workshop program,’ ‘Professional gains from the workshop program’ and ‘Personal resilience initiatives.’

<table>
<thead>
<tr>
<th>Themes of building, strengthening and maintaining resilience</th>
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<td>• Personal gains from the mentoring program</td>
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<td>• Professional gains from the mentoring program</td>
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<td>• Personal gains from the workshop program</td>
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<td>• Professional gains from the workshop program</td>
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<td>• Personal resilience initiatives</td>
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7.3 The Mentoring Program

The intervention phase for each cycle took place over a six month period and consisted of a series of resilience workshops and a mentoring program. The mentoring program (see Chapter 6) consisted of establishing mentoring partnerships between the participants and their mentors, generally achieving a range of positive outcomes for both parties. Four dyads were not successfully established; the challenges and outcomes for this sub-group were discussed in Chapter 6.
7.4  Personal gains from the mentoring program

Most participants reported they had received benefits from the mentoring program, in both professional and personal areas. The primary benefit for them was receiving great support during discussions about a range of work and personal issues. In the personal sphere, the participants expressed positive gains from the friendship and common interests they found with their mentors. They also reported greater confidence in resolving workplace problems, and being motivated by the mentoring program to try out new ideas and take on new challenges in their careers. Findings also indicated that the mentoring experience was particularly beneficial to nurses and midwives currently facing adversity from both internal factors, such as stress and work pressure; and external factors like continuing study and work/life balance. Several participants stated a desire to stay in contact with their mentor indefinitely, as they considered them helpful and supportive allies. Sub-themes of personal gains from the mentoring program are presented below in Table 7.3.

Table 7.3: Sub-themes of Personal gains from mentoring program

<table>
<thead>
<tr>
<th>Personal gains from mentoring program</th>
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<tr>
<td>• Confidence in solving problems</td>
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<td>• Receiving support and friendship</td>
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<td>• Gaining a role model and confidential advisor</td>
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<td>• Withstanding workplace adversity</td>
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<td>• Benefits for vulnerable nurses and midwives</td>
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<td>• Mentoring and personal growth</td>
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7.4.1  Confidence in solving problems

A significant benefit of the mentoring relationships was the practical assistance participants received from discussing and dealing with workplace problems. This was an area of concern for most; they needed strategies that they could initiate immediately to relieve stressful situations they were experiencing. The participants talked over their personal work issues and concerns with their mentors who they considered had
experience and skills in interpersonal relationships and communication. Several reported they gained greater insights into resolving conflicts and issues with colleagues and managers than they had considered before:

*She’s got a lot of experience in nursing...She would know how to, sometimes she had more experience with dealing with my relationships with colleagues* [Tina].

*She was always very receptive...She was willing to be supportive with the work environment and had some strategies for...kind of work situations, she had good plans there* [Jodie].

Several participants reported significant discussions with their mentors. The mentors were prepared to listen and were able to grasp the complexity of the problems and could turn them into opportunities for reflection and discussion about options the participant could take. For example, the current staff rostering situation was an issue of concern and dissatisfaction across the collective case; one participant received an insight by listening to her mentor’s actual experience of resolving the same problem in her own former nursing career. In the past, the mentor had initiated a self-rostering system with the NUM’s co-operation. The participant became interested in the idea and after discussing it at length with her mentor decided to take the concept to a staff meeting.

### 7.4.2 Receiving support and friendship

Most participants enjoyed meeting their mentors and the time they spent with them. Some spoke about the sense of rapport and friendship they had built with their mentors. They found their mentors were approachable and easy to talk to. In some partnerships the mentors were introduced to the family members of the participant. Others found common interests outside nursing with their mentor, like sports or artistic pursuits. A few participants described their mentors as close friends, someone they were interested in talking with about a wide range of topics, including work, study and family. They intended to continue their relationships into the future.

*Well I would like to think that she would say the same -- that we really clicked. We are very different people on some levels but equally we seemed to have a shared sense of humour and even though she has been more career focused than me in her life, she is not sort of like career*
above all else, at the expense of everything else. I feel lucky that I was able to choose [her for] my mentor…[Lucinda].

She was probably just supportive and yes maybe reinforced your decisions…it was sort of a little bit like a surrogate mother was how I thought of it  [Karin].

7.4.3 Gaining a role model and confidential advisor

Most participants spoke positively of their mentor and considered them good role-models. They gave positive, in some cases glowing, evaluations of their mentors. They believed they were valuable because of the efforts they made to keep in contact or because of the insights they shared on work or personal subjects. Some thought the richness of their mentoring partnerships was because their mentors were energetic, dynamic individuals who were well-connected in the nursing community. Others thought the experiences they had in common with their mentor shed light on the journeys they were taking as nurses and midwives, sole parents or as working women, sometimes struggling to achieve personal satisfaction in their jobs while also fulfilling personal and family responsibilities.

The participants respected the mentors’ confidence and organisational skills and attributed these to their nursing experience. A few said they had high regard for their mentors and gave them an influential position with respect to the decisions these participants were making about their own careers and life-views:

She’s experienced a lot, she noticed all the bullying in the system and that is what led her to leave [hospital nursing]. She said that was the best decision for her and she has had lots of really interesting [life] stuff as well as career stuff. She is still studying in her career. I know she is amazing  [Talia].

I saw her and thought she would be really good, even talking to her for a few minutes she just seemed dynamic and she had knowledge and I thought I could get something out of this and her. I thought that is the sort of personality I need and as I say, she proved to be not only just someone that was inspiring professionally to help me get ideas for my career but also someone I could just talk to openly about all sorts of things in life and we had a laugh as well  [Lucinda].

The participants felt the mentors understood and, in some cases had experienced some of the difficulties they faced in the workplace, which was particularly valuable. In any
event, they were trustworthy and confidential listeners from outside the organisation, which also made it easier for some participants to disclose sensitive information about themselves and the problems they were encountering.

*It was good to have a chat to a stranger, that you could just spill your guts to. ‘Cause I did! I was starting the (...) job, you know, I was just taking on that. So I was stressed* [Marika].

*Well, I had (...) [mentor] who was fantastic. The day I met her I thought ‘I’d love to be her participant.’ Yeah, it was good talking to someone else who doesn’t kind of work here, thank goodness, and someone who lectures in nursing* [Lauren].

### 7.4.4 Withstanding workplace adversity

The mentoring partnerships were effective in helping the participants to see that the workplace adversity they were facing was a serious and complex concern. Their discussions with mentors highlighted a number of workplace issues that often had to be worked on concurrently, like workload, work pressure or work/life balance, depending on their individual circumstances. Several of the mentoring dyads set goals for improving the work/life balance of the participants as a priority. Two participants were able to reduce their workload by reaching career goals set with their mentors, through gaining extra accreditations that carried higher remuneration. This meant they felt less pressure to work extra shifts, and had more time to rest, recuperate, or spend time with families.

*I can now drop a shift a fortnight and actually for me that extra money - I just kind of find for me with my work at the moment, some days just the responsibility of it, just the buck stopping with me, just gets a bit too much...It has given me a new lease on life with work because I am here even less...Yes I get one day a fortnight with the kids and one day a fortnight without the kids. So at least I get that extra bit of time to myself which I needed and I just do mainly try and make that a day where I do something special like go to the movies or just hang out at home by myself and play my music...*[Lucinda].

Several other participants achieved their goals for improved work/life balance by the program’s end. Some mentors suggested plays, books and recreational ideas that participants acted upon. This aspect of the mentoring partnerships broadened the participants’ interests and promoted the idea of spending some of their personal time in
fulfilling recreational activities with families and friends. One participant, who was a fairly recent migrant to Australia, acted on her mentor’s advice to take a day each month with her family to explore and learn more about the city they lived in. Together they discovered sections of the city where there was a familiar cultural atmosphere for the participant and her family and where they could buy items the participant had previously thought were unavailable in Australia. The participant felt these activities with her mentor had increased her family’s wellbeing, sense of cohesion and comfort in their new country. The mentor was also able to introduce her to some aspects of Australian social life, and helped her to appreciate that there was a need for recreation to relieve stress and offset the demands of work and study.

_I think we will go out every month ...Sydney...Australia! We have been here for 3 years now and haven't even seen places_ [Tina].

Other participants responded that, in the process of meeting with their mentor, they had travelled outside their familiar surroundings as well; others had learned more about their own areas as they showed their mentor around.

### 7.4.5 Benefits for vulnerable nurses and midwives

There were particular benefits for participants who believed they were vulnerable members of the nursing workforce. A sub-group of participants particularly benefitted from exposure to the concepts of mentoring. Some had experienced hostility and workplace incivility, organisational changes and disruptive leadership for some years. Some participants had worked in the unit for long periods and been exposed to more sustained workplace adversity; others were dealing with other adverse circumstances in addition to the workplace. Although a few of these participants displayed hesitation in their commitment to the program because of general low morale and distrust of official initiatives, most had positive opinions about the value of the program and the potential for even greater benefits for themselves with mentoring opportunities in the future.

One mentor of an overseas-qualified participant acted as a cultural broker, assisting with orientating her into her new country. They worked together to develop a career and study plan that was suitable for both her personal goals and her family situation.
With no existing family support system, they negotiated arrangements for child care and parenting support services available in the community. Due to the mentor’s involvement in voluntary English literacy programs, the mentor was well placed to assist the participant’s family to also gain extra vocational support.

7.5 Professional gains from the mentoring program

There were several improvements to professional practice that came out of the mentoring program. There were perceived changes in a number of ways participants worked because of their experiences in the program; overall they reported they were more confident and effective in their roles. The sub-themes of professional gains are as presented in Table 7.4 that follows.

Table 7.4: Sub-themes of Professional gains from mentoring program

<table>
<thead>
<tr>
<th>Professional gains from the mentoring program</th>
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<tbody>
<tr>
<td>• Increased assertiveness</td>
</tr>
<tr>
<td>• Greater professional networks</td>
</tr>
<tr>
<td>• Raised self-esteem and sense of value</td>
</tr>
<tr>
<td>• Career development/progression</td>
</tr>
<tr>
<td>• Taking on new challenges in the workplace</td>
</tr>
<tr>
<td>• Renewed passion for nursing/midwifery</td>
</tr>
</tbody>
</table>

7.5.1 Increased assertiveness

Assertiveness at work improved after the participants experienced the individual support of their mentor. They felt they could speak up more confidently about problems they experienced at work, and use official complaints procedures to express dissatisfaction with working conditions and non-delivery of entitlements. The affirmative influence of the mentors was significant in this area. Several participants reported they spoke to their NUM or other superiors after the intervention to advocate for improved conditions or voice practice concerns, indicating the mentoring program
had succeeded in mirroring to the participants that they were worthy of fair treatment in
the workplace and could act to bring about positive change. One participant had moved
to another part of the unit since the intervention and confronted some relational
problems:

_"I had a real big clash with one or two to begin with. Just how they spoke
to me was unacceptable for me. I thought hello, excuse me, you’re like
grown women talking to me like [that]. Anyway I reacted strongly to that
and kind of made it known...I did resolve it though..." [Patrice]_

### 7.5.2. Greater professional networks

The mentoring program gave the participants an access point into the wider profession
of nursing and midwifery. Through exposure to their mentors, who modelled a
professional identity and were connected to professional associations and other
networks, they learned the practice of keeping up to date with new research trends and
innovations in the profession. They learned about the potential for sharing information
with other nurses and midwives in other hospitals and contexts of nursing. These
participants gained access to potentially useful contacts for future career progression.
They began to accept that these things were possible for them, just as they had been for
their mentors:

_[An interview with the Chief Nurse] was a really good opportunity...I was
a bit daunted and I told [my mentor] and she said just go and be yourself
and have a chat and see what your options are...[The Chief Nurse] said I
might want to come along to these working bees at the College of
Midwifery...where you can sit and listen to the meeting and then be part of
a bit of a talk, being able to pick people’s brains about how they run their
clinics and, you know, what sort of options I have or just making contacts
for future jobs. Well, I am going to give it a go... [Lucinda]_

New opportunities such as these showed the participants a fresh view of their potential to build a
more interesting and rewarding career in nursing and midwifery, and gave them hope for the
future.
7.5.3 **Raised self-esteem and sense of value**

Some participants said their mentoring partnerships helped them to assess themselves more positively as nurses and midwives. They were treated with respect and experienced being of consequence to their mentors, and by the existence of the program itself. The intervention gave them greater energy and motivation, and in some cases bolstered their courage, to make necessary changes in life and work. The mentors metaphorically held up a mirror to them that reflected a positive image of a person with a purpose and future direction. Four participants believed their self-esteem had risen due to the mentoring program because they had begun to see that others recognised their value and importance. This belief was transferred into an intrinsic belief in themselves as being important and worthy.

Working in partnership with mentors they found credible and authoritative also helped them recognise their own contribution to their workplace and increased its credibility. The mentors reinforced the correctness of the participants’ priorities – quality of treatment for patients and themselves - amidst the current threats to them in the workplace. The mentoring experience made the participants more certain of the importance of their role and the value of developing themselves further in personal and professional areas. They recognised that the value of mentoring would continue into the future and finding natural mentors was an important aim for them. In fact, the mentoring program boosted their confidence in their importance to the health service.

> Even though you may not think of it every day it’s still in the back of your mind. There’s a seed planted there and now you can’t get rid of it. And I think that’s a good thing, I really do. Okay, you have to look after your personal stuff but with the mentors, with work stuff which is the bulk of your life, go and chat to people who’ve been there and done that and are still here. Go and see what they do. People who you admire, people who you respect, people you should speak to. And then try and deal with it like them too [Neralie].

7.5.4 **Career development/progression**

The experience of having a mentor enabled the participants to consider their professional development more comprehensively than they had before. They began
taking a more serious approach to their future direction as well as the current opportunities for advancement. They were encouraged to take relatively small steps immediately that would make a difference to their everyday experience of the workplace, for example by removing themselves from the most stress-producing elements of their position, even if only for part of the time. Two participants were successful in decreasing time spent in stressful or unrewarding work, which increased feelings of well-being and fulfilment. Four participants also reported they benefitted from discussing new career roles with their mentors.

*I spoke with her [mentor] about this new position I’ve just got, how to approach that, seeing if I should go for it…I think I’ve become more resilient because of the fact that I’ve channelled my job into another direction…I’m better now because I’m responsible for my own time…and dealing with [the women] as a whole* [Rose].

Some participants benefitted from the professional advice of their mentors and the sense of accountability inherent in their mentoring partnerships. They made progress in aspects of their professional development; the mentoring experience provided them with added motivation to step up and reach goals they had only contemplated before:

*She [mentor] helped me with the position I was taking on, she gave me hints on how to cope with people higher up…because they don’t seem to want to give you any support sometimes* [Marika].

*Virtually a couple of days after we finished the course, I got my credit for [clinical specialist] which she [mentor] had encouraged me to go for…so that was really great for me professionally to be recognised for that and also on a personal note…She just said to me,”Come on you can do it and I know you will get it.” So probably knowing I was meeting up with her made me think, “Oh well she is going to want to know I am making progress with this.” You know so it kind of did get me to do it* [Lucinda].

Participants made professional gains from the positive attitude towards the future and scope of nursing that the mentors conveyed. A few participants mentioned that their outlook became more positive about their current work situation, as well as the potential for greater reward and satisfaction from a nursing career in the future. This helped them to feel stronger in their present circumstances and more hopeful that they could enact positive changes over time.

*I was saying to (…) [mentor] I can see my career going in three different paths - stay in this area of work, or if I don’t, completely change my career to either education or uni direction, or child/family health, community [nursing]…I suppose I just kind of know where I want to go*
and I’ll just sort of see where life takes me in terms of what is going to be the best option of those three  [Lucinda]

Because (…) [mentor] is about 10 years older than me and she is still working, I thought, “I have another career, I am still a registered nurse,” and I thought, “Maybe I won’t stay with midwifery if I don’t enjoy it and I don’t like where it is headed.” Yes I could do something else…[Talia]

Another participant felt grateful for her mentor’s advice about the further study she began as a mentoring goal during the intervention. The mentor gained further credibility for the participant when she discovered her mentor had already completed the course she wanted to do. Tina commented that her mentor’s advice was most helpful to her:

She helped me a lot. Like when we made the mentoring contract we just kept on the main aim to improve my professional career, so as a result I’m going to do the course which I want to do and she can help me a lot because she has lots of experience [with it] and I can talk to her about what it calls for and what will come next  [Tina].

7.5.5  Taking on new challenges in the workplace

A few participants reported they were motivated by their participation in the mentoring program to take on mentoring students themselves in future. They had reflected on several aspects of mentoring from other participant and mentor perspectives during the intervention and wanted to be effective mentors in the workplace. Lucinda reported she had successfully mentored her first participant in the workplace and believed it would be an ongoing process for her. She knew what she wanted to emulate from her own mentor’s example, and was also assured she could contact her if she needed advice about a challenging or difficult participant:

I do wonder to myself, “Gosh what happens when I get someone that I clash with or I think is really slack or that would be more of a challenge?” I can talk to (…) [mentor] about those sort of things  [Lucinda].

Rose, Lucinda and Lynette revealed that their experiences in the program had encouraged them to take on new leadership initiatives in the workplace. They were aware of the benefits of mentoring for them and transferred that approach to dealing with students in the unit. Several other participants recounted a similar process had
assisted them in interactions with colleagues as the senior nurse/midwife on their nursing team. Rose spoke about how she had applied her insights about mentoring to a workplace training project on team leadership. She also collected research findings on coping with an aspect of their work that she identified as significant for the nurses and midwives working in the unit and volunteered to lead an in-service on the topic.

Other participants were enthusiastic about taking up a challenging, new work opportunity in the unit, the introduction of case-load midwifery positions. This initiative proposed increased patient contact leading up to admission to delivery suite, during and after birth, and included a home visitation program. These participants realised the potential for greater satisfaction and autonomy although there were general reservations amongst their colleagues about the conditions and pay that would eventuate for these new positions. They professed themselves to be more motivated to step into the new roles than they would have been before the intervention.

7.5.6 Renewed passion for nursing/midwifery

The mentoring program had the effect of renewing the interest and passion of the participants for nursing and midwifery. It gave them an opportunity to reflect on the reasons they entered nursing and even now found satisfying about it, as they focused on themselves and talked to mentors. As the mentors exhibited their sustaining interest and energy for nursing and midwifery, and especially in the participants’ direct situation and future, they transferred a positive perspective of the participants’ prospects and future that they began to see for themselves:

She [mentor] brought me books and stuff. She gets [me] these articles and newspapers. It is interesting to read what is out there. [Talia]

I have joined the College of Midwives and I get their quarterly journal and just trying to get that passion back again. Because they [members] are all very passionate people and maybe I need to be a bit around that…I might be able to take some of these [ideas] back to the clinic and say, “Well you know such and such a hospital is trialling this, what about this?...It is keeping me motivated,...enough that I want things to be ticking over. [Lucinda]
7.6 The Workshop Program

The other aspect of the intervention was the workshop program (see Chapter 6). The workshops invited the participants to explore the concepts surrounding resilience for them and find meaningful strategies of enhancing it in their own lives. The holistic aim was to emphasise the self – self-awareness, self-development and self-care – in building, strengthening and maintaining resilience. The content of the workshops considered the current workplace context of the participants; pre-intervention findings had dictated that individual and small group exercises needed to engage the participants who were experiencing the effects of workplace adversity.

7.7 Personal gains from the workshop program

Analysis revealed there were several personal gains from participation in the resilience workshop program. Participants were able to focus on self-development in a more concerted way than before. They enjoyed the days away from the responsibilities of the wards, the quiet surroundings where they relaxed and got to know some of their colleagues. They enjoyed the therapeutic elements of the workshops, with the inclusion of several appealing stimuli for the senses – art, music, colour, food and massage. The sub-themes for the following discussion are presented in Table 7.5 below:

Table 7.5: Sub-themes of Personal gains from workshop program

<table>
<thead>
<tr>
<th>Personal gains from the workshop program</th>
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<tbody>
<tr>
<td>• An experiential learning opportunity</td>
</tr>
<tr>
<td>• Creative self-expression</td>
</tr>
<tr>
<td>• Exposure to new ideas and strategies</td>
</tr>
</tbody>
</table>

7.7.1 An experiential learning opportunity

All participants reported the workshops were relevant, experiential and enjoyable learning opportunities. They learned about the concepts of resilience and how to adapt
them to their own circumstances. Over the course of the workshops participants began discussing ‘real’ experiences openly with each other, as more supportive and trusting relationships were established. The opportunity to work collaboratively with colleagues in a safe learning environment outside the workplace, rather than in the usual busy, pressured clinical setting was an advantage of the program. This meant that participants could interact with each other in a more relaxed forum without the hierarchical divisions of the workplace and begin to build a positive group dynamic. Working together in pairs or triplets on simulated workplace scenarios gave them experiences in hearing others’ perspectives on common confrontational issues where objectivity was possible. This led onto deeper communication between participants and rapport was built between individuals and as a group. Neralie confirmed:

_This course has been really, really helpful to remind you of some things that you can’t change up there. We can’t make the workload any less. We can’t make more midwives come in. We can’t change people as people. But what you can do, you can try and bring into yourself some strategies to help you get through it and remind yourself at the end of the day what’s really important_ [Neralie].

### 7.7.2 Creative self-expression

The opportunity to express themselves creatively was demonstrated to aid participants in understanding themselves better. The creative works they produced enabled an internal dialogue to take place about unfavourable aspects of their current health and well-being and the recognition of their strengths. Working creatively in a focused way suggested ways for each of the participants to reduce stress, better develop the helpful characteristics of resilience and protect themselves against the harmful effects of workplace adversity. Workshop activities drew on various elements of the arts and humanities including painting, collage, mandalas, creative journaling, poetry writing, and creative movement. The participants reported experiencing therapeutic benefits from most workshop activities, such as relaxation and hand massage that provided a sense of well-being and reduced stress. Other elements such as visualisations and use of music helped participants feel relaxed and supported in their learning.

_‘I do have a creative side to me but it is more of a musical strain and so when we did the dance I was right in my element. I thought, “This feels comfortable” and I was loving it’_ [Lucinda].
Exposure to new ideas and strategies

Exposure to new ideas and opportunities to practise them in a safe environment was another benefit of the program. The intervention afforded the participants the time and space to reflect on their own lives, health and future directions through a learning program that sparked fresh thoughts, feelings and behaviours. Participants reported that many of the workshop activities were new experiences and some were surprised by the impact they made. For example, one participant found the body-scan reflection activity (see Table 6.1) most revealing and spoke at length to the group about the insights she gained from her body “speaking” to her. A few participants, Lauren, Lynette and Neralie found some activities somewhat confronting experiences, as they revealed life choices that were influencing their health and wellbeing. A few participants, Jodie, Neralie and Gillian, also reported unsettling but important insights were revealed about their primary relationships. Patrice realised a significant aspect of her cultural identity was missing during a session with a guest speaker about Aboriginal spirituality and the dimensions of personal resilience. The discussion centred on the concepts in Aboriginal spirituality of one’s ‘country’ and ‘dreaming place,’ (see Table 6.1) which resonated with her, as the search for her own physical and metaphorical ‘home space’ was concurrently taking place. By the six months post-intervention phase, these participants had resolved these issues and made important changes, by seeking professional counselling, changing lifestyle habits and, in one instance, changing citizenship.

Another new concept to most participants was that of building and maintaining an authentic self and creating a life that sustained their authenticity. Most participants said this concept was new to them, and that it was instrumental in letting them see themselves in healthier, more hopeful terms with prospects for the future. During the workshop many examples were given of women who used their creativity and resilience to overcome difficult life circumstances, express their authentic selves and reach their own unique achievements. At the last workshop, each participant was given an award named for a person whose experiences were associated with an aspect of resilience, such as hope, courage, or perseverance, and a decorative pin. An effort was made to link the award to the participants’ demonstrated abilities during the
intervention (see Appendix O). At the 6 months-post interview several participants reported wearing the pin at work.

As a result of participating in the workshops, there were also reports of improved self-esteem and confidence by the participants. Several participants stated they had strengthened their belief that they needed to consider their own needs and make positive changes in life and work to actively pursue their own health and happiness. Gillian commented this meant eschewing feelings of guilt about focusing on her needs as well as those of others. Others thought their improved self-esteem was shown in an increased appreciation of who they were as people, which enabled them to deal with situations they encountered more confidently.

I do have a higher self-esteem now. When my mum had a problem at work it gave me the confidence to actually help her, and tell her “You know it’s kind of bullying you” and I told her “You don’t take any crap.” And I guess if I don’t know myself and my strength I won’t be able to help Mum. I help myself in a way, you know. I built up my confidence, and found what I’m capable of when I use it. Cause it’s like my resilience has gone up, yeah at the moment it’s up [Gillian].

Vicky described her change in attitude as follows:

Overall I feel a lot more positive. So that I am better able to do all this [resilience] stuff generally...I am not ever going to be a really confident, outgoing, who knows everything sort of person. I am in fact all the opposite, but I do feel I learnt a lot from that. It was valuable, the feeling of support within the group and the interaction [Vicky].

### 7.8 Professional gains from the workshop program

Analysis revealed there were definite professional gains made by participants from the workshop program. These included a closer group dynamic, more supportive communication, greater assertiveness and confidence in the workplace. The sub-themes of these findings are listed in Table 7.6 below:
Table 7.6: Sub-themes of Professional gains from the workshop program

<table>
<thead>
<tr>
<th>Professional gains from the workshop program</th>
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<tbody>
<tr>
<td>• Increased assertiveness at work</td>
</tr>
<tr>
<td>• Improved workplace relationships and communication</td>
</tr>
<tr>
<td>• Increased collaborative capital</td>
</tr>
<tr>
<td>• Understanding self-care practices</td>
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</table>

7.8.1 Increased assertiveness at work

A major professional benefit of participation in the workshops was an increased sense of assertiveness in the workplace. Many participants reported they felt stronger and more confident in communicating their real thoughts about work issues, especially to supervisors. The effect was a positive one; their sense of autonomy was raised providing greater satisfaction and a more positive attitude to being in the work environment. Gillian confirmed this view:

Before [the workshops] it’s really hard to me to say no…as I told my boss the other day “If I say yes, I can do it. If I say no, I don’t” and she said, “Yes I can see that in you now.” It was just really good. Yeah, because before I was just a quiet type of person who, you know, alright then I’ll do it, if I can’t do it I’ll still do it, I’ll force myself to, you know. Not anymore… [Gillian].

Others believed they had also improved their ability to negotiate conflict resolution procedures with supervisors. Neralie had been contacted by her NUM at home the day after her shift about a potential medication error that had occurred. As a result of the intervention, she instigated an official meeting with her NUM and nurse educator to explain the rationale for her actions and was confident and assertive about her decision:

I am going to put this [intervention] so much into practice then. I am not going to get angry. I’m not going to cry, I’m going to focus…I’m going to be assertive, I’m going to put a lot of things I’ve learnt from this into practice…I’m going to go in [person] as opposed to over the phone. When I’ve got something in front of me that I can show them, it’s easier to [explain]…I know what I’ve done and I’m happy with what I’ve done. [I want] to ask, “Is there anything in your mind that you can tell me that would negate what I’m thinking?…then we’ve all learnt.” And I’m going to go into it, not angry as I was yesterday, I am more than prepared to discuss it, I don’t want problems later. To have this meeting today, it’s a real self-preservation thing  [Neralie]
Another participant, Jodie, had become more assertive about communicating her real distress and concern about the workplace to her colleagues after a particularly arduous shift. She recounted how she pulled her car over while travelling home after the shift and called her supervisor, thereby reducing her stress and taking positive action:

*I said to my NUM, “I’m telling you because I wasn’t happy with it, it wasn’t adequate care”…I said, “I’ve got to get it off my chest now before I get home”…Then I rang one of my co-workers and said, “I’ve let you down” and we had a chat about it….That’s different for me, I probably would have stewed on it whereas I addressed it and I felt “Yep, I’ve got to move on”…that’s something I have learnt too.* [Jodie]

Talia revealed that she had put in place behavioural boundaries in her relationship with a colleague who was frequently hostile at work and she felt, took advantage of her. She put a plan into action that she had discussed with both her mentor and other group members during discussions in the workshops. In the post-intervention phase she felt more in control around the colleague and less likely to be overwhelmed by her unsupportive behaviour:

*It is just her abruptness…I can see the nice side of her but it catches me off guard every time. I won’t be giving in to her, no doing favours you know, the way she treats me. I just say, “No I don’t want to do that anymore.” It is self-preservation.* [Talia]

7.8.2 Improved workplace relationships and communication

Participants believed themselves to be more professional in their outlook to workplace communication with colleagues in the post-intervention phase. They felt more confident that they were responding to altercations in an authentic, self-caring way. In some instances they reported staying quiet; they were not reacting emotionally to negative comments directed at them or unsettling situations as much as they would have previously:

*Someone said to me, “You sound really stern” and I thought, “Well I’m not,” and I just let it go* [Jodie].

*There’s been issues with the NUM at the moment, normally I’d just go and growl, but I’ve decided “No, I’ll hold back a little bit.” Anyway, she actually approached me and it’s been much better because I haven’t been in her face*  [Lauren].
In other instances, some participants believed they were pro-actively raising subjects of importance to them more often in the workplace. It was part of a change in attitude about the state of the work environment, the realisation that the workplace may not be changing as quickly as desired, but nevertheless they could enact their own personal changes. One participant told the story of placing signs around the hallways to encourage greater collegial respect and support for each other:

No, there’s no change because it’s such a negative atmosphere up there, they’re very disrespectful of each other. So you try and do things, I found this “Respect Each Other” sign off a website… I put them up when I was on night shift… there’s one particular staff member who’s been really victimised and it’s a cultural thing… I was with them the other day and I said, “Come on, it’s really nasty, didn’t you read the signs?” They all kind of looked at me and didn’t say any more and I thought some of them were kind of thinking, and so that was a good thing [Lauren].

7.8.3 Increased collaborative capital

Another significant outcome of the workshop program was an increase in the collaborative capital, the term used to refer to the human, intellectual, and structural capital of teams in knowledge-intensive industries such as nursing and midwifery (Koch 2005). Wider support networks were formed, especially for those participants who had felt isolated in the pre-intervention phase. Various workshop exercises emphasised group cohesion and building trust (see Table 6.1). Others focused on the value of listening and learning from each other when working on shared tasks. Over the duration of the intervention, several participants felt they were more comfortable sharing their workplace experiences, both positive and negative, with the colleagues they got to know at the intervention and were positively motivated to support them in future. Some stated they were more willing to support other nurses and midwives after they had learned about the processes and practices of other sections of the unit from other participants during the workshops. They realised there were similarities between them, but also, in some instances, very different concerns and pressures for their colleagues. Some heard about issues of participants that they had never encountered themselves:

Yes [there have been changed relationships with colleagues] as I said before, I became closer to quite a few of them and I gained friends. Because even though I don’t work with them I can still relate. There was one occasion where we had to do CPR and [another participant] was there...
and I said, “Do you have your pin?” and she said, “Yes I do,” and showed it on her collar, and the supervisors, everyone, was looking “What pin?” It’s like an identification for us, like who went into the [resilience] group [Gillian].

When I see those faces around [the hospital] it is just really nice and it makes you think about the course and checking with that person to see how they are going and having that knowledge that someone out there is looking out for you...with [another participant], we just say a really funny line, “Just focus on the dolphin, the dolphin dives into the waves” [a reference to an artwork she created in the workshop] and you can see the funnier side of things and get through [Lucinda].

The intervention had been the catalyst for increased collaborative capital between the participants, especially for those participants who were not already connected to a support network in the workplace. After the intervention, positive relationships between the participants continued and provided them with reciprocal support in the workplace.

7.8.4 Understanding self-care

Another important learning outcome from the workshops was the emergence of a developing sense of self-care strategies as an essential part of individual professional practice. Many participants commented in the post intervention phase that learning about self-care had been an important message for them, one they felt would greatly assist their longevity in nursing and midwifery. They believed that learning to adapt self-care principles to work and life was a practical way to build and strengthen their personal resilience. The concept of self-care was a catalyst for reflection and changed behaviours that incorporated personal resilience into their daily lives.

At the resilience course and while we were doing all that stuff I thought back to my twenties when I was married, I really didn’t look after myself. I did what he wanted me to when he wanted me to do it. I socialised with his friends and mine went, and my family. And I saw. At the time I couldn’t see it. I look back and think that it has affected how I was at work. I wasn’t very confident at work. [But] definitely you can learn and grow [Talia]

I think probably what I learned here [workshops] is that you’ve just got to keep that awareness, that it can slip away because you’re not paying
attention and then you think, “Uh-oh” it’s gone all the way back. Yes I’ve got to do things for me and I’ve got to change a few things for me [Jodie]

7.9 Personal resilience initiatives

A major aim of the workshops was to equip participants with resources and strategies that would enable them to build, strengthen and maintain their personal resilience into the future. The curricula suggested to the participants some personal initiatives that they could take up for themselves and adapt to their own circumstances. The resilience strategies developed from the workshops are discussed in sub-themes set out in Table 7.7:

Table 7.7: Sub-themes of personal initiatives for improved resilience

<table>
<thead>
<tr>
<th>Personal initiatives to improved resilience</th>
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<tbody>
<tr>
<td>• Letting harmful emotions go</td>
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<tr>
<td>• Nurturing supportive relationships</td>
</tr>
<tr>
<td>• Contributing to the resilience of colleagues</td>
</tr>
<tr>
<td>• Re-defining resilience and setting new standards</td>
</tr>
<tr>
<td>• Awareness of self and resilience</td>
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7.9.1 Letting harmful emotions go

One personal initiative to improve resilience was that of relaxing the intensity of emotions around workplace problems and difficulties, and in some instances, relinquishing damaging emotions when they arose. Participants described learning to use several methods of professional detachment: consciously letting stressful emotions go, using positive self-talk; and engaging in behaviours that lessened feelings of guilt and responsibility that previously increased harmful stress (see Table 6.1). Some participants stated improving their resilience meant changing their attitudes to work and the organisation, learning to be more relaxed and less worried about workplace problems. One participant felt this was a step forward for her in terms of feeling comfortable in her position and maintaining her resilience:
I think just the way you handle yourself sometimes you know, you’ll be just caught up in something and you think, “No, no, you know?” It’s no use worrying about certain things you can’t change. You’ve really just got to stick to what you [can do], not everything you are going to win, really...You want something sorted out, and you try to do it, but then you think your whole life doesn’t depend on that, really. It’s work, you know [Lauren].

Talia gave the example of a discussion she had with a colleague during the workshops about professional and private identities. After the discussion she decided to change her behaviour around disclosing personal information about herself as a strategy to increase her hardiness against feeling judged negatively by colleagues.

We were just talking in the course and [another participant] said to me, “Well I just don’t reveal that kind of information.” She said, “Why do you reveal it?” and I said, “It just comes up in conversation” and she said “No, no, people like that, I hold back.” I don’t want to be guarded. I don’t want to be careful about what I say. But I have noticed that is how most people survive. I have noticed a couple of people and thought so that is how they handle it. I will just keep some things to myself because, you know, they want the details of your life and then all the judgements come and I think that I am here to work not to be judged [Talia].

7.9.2 Nurturing supportive relationships

Several participants felt that a major outcome of the program for them had been the improvements in their personal relationships as a result of the awareness of the need for work/life balance. They were reminded that nurturing primary relationships was an important priority, and recognised the support that people close to them were providing. A few participants accepted that their personal relationships had become stretched due to their heavy workload and pressured routines, and that they needed to make healthier compromises from then on. One participant suffered a family bereavement during the intervention; she reported this event had clarified for her that she needed to nurture her family relationships and balance her work in order to do so. Improving resilience for others also meant changing their normal routines and re-establishing family relationships. Other participants took much-delayed leave and spent time re-connecting with the people with whom they wanted to stay close to:

Life is not work and running, and if it is then it’s very sad. You need to look at other things in your life that are more important. Because family
and friends will only tolerate things for so long…During the course of this [intervention] it was making me realise that, I need to get a relationship going there again. I hadn’t seen my family in 20 years. And my husband was there for all of that for me…and its not very good for me to repay him by doing all night shift here and then going running for 3 hours a day [Neralie]

7.9.3 Contributing to the resilience of colleagues

For some participants, the intervention also refreshed positive beliefs about transferring personal resilience to colleagues for some participants, which in turn improved their own well-being. Participants experienced the positive effect of building a supportive network of colleagues that could provide them with support as they supported others.

With increased awareness of the restorative effect of improving resilience came insights about the importance of making their own contributions to collaborative practices in the workplace that built resilience. One participant recounted how she had heard there was a quilt being made for a seriously ill staff member. She decided to create and donate a panel although she did not know the person closely, as a way of making a positive contribution to workplace relations. Other participants had also made conscious efforts to contribute to teamwork and support resilience in the workplace:

I am trying to be part of the team a bit more and not to view it so negatively…I just realised that there is a lot of people who are probably well into their fifties who are stuck in their ways and they are quite happy with how it is going. They are saying well we are happy so you are the one with the problem. When I first started I wanted to be this person who was going to come in and change everything for better but now I realise ok I can’t actually make them see what I am saying about midwifery. They don’t see any of that. That it’s just the way they have always worked and why would I change it?…I am trying to make an effort there, to be more of a team member [Lucinda].

I do listen and encourage and support people who appear to need certain support at times when they are going off and they just need to be held up, just any [colleague] that you come across…I try to support others so that they can have resilience or try to give them the means for resilience, support and confidence and appreciating them [Vicky].
Because of a growing awareness of their own resilience, the participants reported developing a greater awareness of colleagues, and even clients, who were existing on less than optimal levels of resilience. One participant told the story of how she comprehended the very low level of self-care a colleague was displaying and spoke to her about the implications for her physical and mental health and her long-term resilience. The participants knew more about how low resilience was manifested in everyday workplace experiences, how they could respond more effectively to those people, and this generally resulted in feelings of tolerance and compassion for them:

*There’s different ways of being resilient. And I guess people look at it in different ways...I have reformed my definition of just how people react and how they accept different things.*  [Lynette].

### 7.9.4 Re-defining resilience and setting new standards

Some participants recounted that they had learned there were more ways to think about resilience than they had previously considered. They now accepted the notion that people looked at resilience in different ways and there could be advantages to their considering perspectives other than their own. They believed this insight had assisted them in dealing more productively with colleagues and clients.

*I am thinking more now, appreciating that people are all so different and they are so different from each other and they are so different from me*  [Vicky].

The intervention prompted the awareness that the participants need not accept the resilience level they experienced before their participation. This influenced their beliefs about resilience training. Because of their own experiences during the intervention, the participants believed resilience could be effectively improved, as long as an individual was open-minded and flexible about learning and could adapt it to their own individual situation:

*They say that resilience, you can’t learn it. You definitely can learn it. You’ve got to have the awareness, like your insights about things [change] over a period of time because once you’re aware and you wake up it is like it sparks and I can live my life the way I want to live it. Yes there are kids and financial restrictions but I can still try and create whatever I want...even in the workplace I am clear that I want to come to work and have a good work day. I do a little thing, I say it as I walk through the*
door ‘50% energy for me and 50% for work and I get 100%’...it [was] in
the course[the intervention]...It is funny how it works  [Talia]

A few participants revealed their ideas about resilience had deepened to a realisation
that it was not always to do with hardiness, but could also be about becoming softer,
more open to their own feelings and acknowledging the emotional effects of their
experiences. Two participants, Lauren and Jodie, who characterised themselves as
resistant to adversities pre-intervention, realised that they were not receiving adequate
support because they were projecting images to others that they could cope in any
situation. After the intervention they had new insights about how important it was to
acknowledge their own stressors to themselves and potential support people, like
family, friends and health professionals. Lauren remarked that although she had
thought of herself as “tough” and “born resilient” in the pre-intervention phase, she had
learnt that by always being outwardly strong others didn’t recognise when you needed
help. She recognised that resilience could also be accepting one’s vulnerabilities:

Sometimes...people don’t think you need support, it can be detrimental.
Because you could be a really tough person all the time and really, you’re
crumbling underneath and people see you as this strong person. Yeah, I
think you need to learn to ask for help sometimes, which is really hard.
But that’s what it [resilience] is, to know when you need assistance, or just

support or whatever. And I’ve definitely gotten better at it...You have to
change your behaviour, like you can’t change other peoples’ behaviour so
you have to change the way you behave towards them. All those things
were reinforced to you through the workshop.  [Lauren]

Another participant recounted a conversation with a health professional she had since
completing the program, whilst advocating for additional support for herself as a
parent.

When you’re at crisis point and you go to a professional to get help and
they’re not acknowledging you, it isn’t very helpful. I’ve told [child’s
health specialist], “When I ask for help I need help.” I said, “I’m not
going to yell and shout at you, I’m not going to break down in tears,
because most of the time I have (...) [child] with me and I’m not teaching
the right way of dealing with things.” So I said, “If I say something I
really mean it.” And the person said “Oh ok.” I wouldn’t have been able
to do that [pre-intervention].  [Jodie]
7.9.5  Awareness of self and resilience

The development and growth of self-awareness was another outcome that was widespread across the collective case in the post-intervention phase. The occurrence of a deeper understanding and acceptance of oneself seemed connected with an increased understanding of the need for personal resilience. Participants spoke of being better able to observe the signs of declining resilience in themselves. They felt the intervention had influenced their growth in this area:

The more you know yourself the more you're able to cope with things and there's always going to be times where I'm always going to be challenged, but I kind of look at why I feel those ways now, and that's why even the other morning I was driving, I thought ‘Why am I feeling that way?’ and it was just, you know, it was more to do with what I was expecting of myself, and frustration with people that are incompetent and shouldn’t be in the position they’re in  [Jodie].

I am more aware now since doing this resilience program. I look for it more I suppose, I look for it more in myself…exactly, an awareness of needing to promote resilience in myself, thinking about things that will help my resilience and strengthen myself [Vicky].

7.10  Impact of resilience on health and wellbeing, fulfilment and commitment to stay

A significant area influenced by self-development and growth in personal resilience was that of improved health and wellbeing. There were overall rises in the participants’ perceptions of their general health and well-being in the post-intervention phase. The participants’ abilities to cope and their sense of well-being were continuing to be affected by minor health problems that nonetheless caused problems. However, some important positive changes had occurred in their attitude to maintaining their health that had come from an increased awareness of the relationship between health and wellbeing and resilience and what strategies worked for them.
7.11 Resilience and health and wellbeing

Participants who had struggled with headaches in the pre-intervention phase had initiated strategies to relieve their symptoms, such as turning off artificial lighting, opening blinds and using natural lighting during client appointments. Lucinda also conducted her client interviews differently so that she entered client information into the computer as quickly as possible and then focused on direct eye contact with the client for the rest of the time. This practice cut down on swivelling her head from the computer screen to the client repeatedly, avoiding eye and neck strain yet still engaging in therapeutic interactions. Other participants reported taking more preventative action with muscular aches and pains, seeking regular treatment by physiotherapists and massage therapists, as well as taking hot showers and applying heat packs after work.

Many participants reported they felt less stressed at work, and in general, than before the intervention. They were taking a more self-protective attitude to withstand the factors associated with workplace adversity. Participants had engaged in various methods of stress reduction, such as exercise and relaxation activities. Some were making an effort to engage in more leisure when possible, making sure they conserved enough energy outside work to cope with the acknowledged stress of the workplace when they returned. Some participants reported using the time straight after coming off shift to make a definite shift from the work sphere to the home sphere, by reading magazines and fictional novels, taking relaxation baths or browsing on the internet. They changed work schedules, for example, taking shifts in different areas of the unit to give them greater variety and scope in their work than before. Other participants noted they had begun using changed thought patterns and behaviours to reduce their stress, especially in relation to clients. For example, Gillian reported:

I am more laid back now! I don’t want to stress myself out. And it’s good, I haven’t had that discussion with my husband again in regards to that, I have felt relaxed...I just try to do whatever I can and prioritise, and I tell them [clients] “I’m really sorry if I can’t do much because that’s all I can do.” And I think they understand when you tell them in a nice way, but I’m still reassuring them that they can come to me and ask me questions, I’ll do whatever I can. Yeah, ‘cause I don’t want to take the worry home [Gillian].
Rose believed her good level of health and well-being was because she had learned to disengage from work as she left each day.

[I learned] you threw it back in the gate [of the workplace] as you walked out, and left it there and picked it up in the morning when you came back, and that’s what you’ve got to do. You can’t live your work 24 hours a day…it’s like if you’ve burned the candles at both ends you’re the one that suffers. Nobody else suffers. You’re the one that gets ill [Rose].

A few participants were conscious of making a greater effort with their diet than before the intervention. They were more readily aware of the need to maintain good nutrition to feel good, be able to keep going at the required level and perform in the way they wanted to. Even small changes had made a difference for some participants; Neralie made greater efforts to eat properly when not at work and took pleasure in cooking meals herself:

I look forward to when I’m not working too, so I can go home and have some decent food, go home and cook [Neralie].

Most participants were still finding it difficult in the post-intervention phase to maintain an exercise program due to their hectic schedules. Some participants felt they now had a more positive idea of the role of a healthy range of exercise in being resilient, which indicated a change in their awareness. For one participant this understanding meant restricting her normal exercise routine:

I was going [to exercise] today but I was beyond tired, and normally I’ll just go. But my body was aching, my joints were aching. I really didn’t want to get up, so I slept on...[Before] I would go regardless, through pain, through sickness, through all things...so I thought “I’ve got to stop because then, when I want to do something enjoyable I won’t have the energy” [Neralie].

Overall most participants reported that their attitude to maintaining adequate health and well-being levels had improved after the intervention and in the six months since, as they experienced the benefits of bringing more healthy practices to fruition:

I am always being careful because if you are run down you can’t do what you want to do. But I think I have sort of moved to a different level where I am not just keeping up, I am moving forward. So I think for me if I was run down before it would affect my mood more than now. I think it has helped to be feeling well and that has helped with my disposition. And just feeling generally a bit more on top of things even at work [Lisa].
I never want to go back to that where I am just swamped and I don’t even realise I am swamped. People are saying, “Wow, [with] your life how are you coping?”, and I just say I am, I am fine [Talia].

7.12 Resilience and fulfilment

In the post-intervention phase some of the environmental aspects of the workplace that caused problems for feelings of fulfilment previously had subsided over time, such as the dissatisfaction caused by critical incidents and the re-structuring of the ward to ward rotation system. However, endemic problems of the environment and working conditions continued to be experienced by participants, such as the unsatisfactory shift rostering system. Post-intervention, the participants had a greater understanding of the desirable facets of a job for optimal satisfaction, and they had reflected on how and what they needed individually to achieve fulfilment in their jobs. However, they were also aware that shortcomings in the current systems and processes were still barriers to enjoyment of their work. With their views about work/life balance reinforced by the intervention, it was difficult for them to contemplate making compromises between increasing their satisfaction and jeopardising other aspects of health and wellbeing, or other factors of resilience. Lucinda expressed her dilemma between progressing in her career and increasing her sense of fulfilment and reconciling that with some of the other ensuing disadvantages of the workplace:

I don’t particularly want to do shift work and that is a down-side for me of working in (...) [ward]. If I want to get that experience I have to be prepared to do night shift, evenings, not see my family much. I am not sure that I can do it. You know, that would be so great and it would probably rekindle my passion a bit more. But I just don’t know, it’s a bit conflicting, isn’t it? [Lucinda]

However, some organisational initiatives were positively influencing the sense of satisfaction experienced in the collective case. One initiative, case-load midwifery, had been introduced and some participants reported they felt it had potential for raising the intrinsic reward experienced in the workplace. The positions offered more time spent in direct contact with clients and this was an important element of fulfilment for the participants. Two participants were taking up these offers because they recognised the potential for greater personal reward. They were still somewhat dissatisfied with their perception of the organisation’s reasons for the change, as shown by this comment:
The main rationale is money. The idea is that hopefully it will be cheaper. There will be less service etcetera so it will be cheaper. But I also think a lot of the women, rather than just seeing whoever is on when they come into labour [ward], at least they are familiar with who they get so they can have more continuity...So certainly, hopefully you would get more out of it. I guess there are a lot of unknowns having that on-call [system]...and it is a nice team, you want to work with someone who works similar to the way you work, so I am fairly optimistic. [Karin]

Even so, it was the abilities of the participants to feel more optimistic about their situations and the prospects for the future that were significant. Reportedly, the sense of satisfaction had increased post-intervention through greater personal attempts by the participants to improve it. For example, one participant received an insight during the intervention that the workplace could not provide her with fulfilment at present, and that her sense of value was best coming from other more personally-motivated sources, such as the satisfaction of meeting the needs of clients.

Other participants stated they were more able to manage some of the most dissatisfying aspects of the workplace environment, which affected their general enjoyment of work. They believed the intervention had enabled them to strengthen themselves in several ways so that they were better able to cope. Lucinda reported feeling better at dealing with uncooperative or frustrating colleagues:

> Certain people irritate me but I find that I am coping better with them than I probably did at some of the other interviews last year. You know, they would really get to me at times and now I just think that is the way they are...When I do my work I can just go home and not take on board their laziness and that is how I seem to manage. [Lucinda].

### 7.13 Resilience and commitment to stay

At the six months post-intervention interview, there was a continuing array of attitudes towards retention. Some participants were still interested in changing jobs in the future, but only one was seriously considering it at that time. The majority of participants were more committed to their positions in the unit than previously. Most participants stated they were more satisfied than before because they felt more empowered through coping strategies and changed circumstances in work and life spheres. One participant felt unchanged in her commitment to her job since the pre-intervention phase; her enjoyment of work had remained high throughout the study.
Two participants were undertaking further full-time nursing and midwifery study to extend their qualifications; both were intending to return to the hospital and the unit. One was particularly looking forward to joining the area of several of the other participants and working more closely with them. Three participants had progressed to higher positions in the unit that brought them more money, variety and scope of work, or better suited other conditions in their lives. These factors had influenced their health and wellbeing, and enhanced their sense of fulfilment and commitment to stay. Three participants had made changes to their modes of work that had also increased their enjoyment of work and willingness to stay, by mixing night and day shifts, reducing shifts or taking up extra shifts in other parts of the unit. There were four participants that, although feeling more fulfilled than before, were still interested in changing their employment and would consider other options if they arose. Two of these participants wanted to change their employment within the next year or so to develop their careers and enhance their sense of satisfaction further, but were content to stay at present. Lauren and Marika were less secure in their commitment to their jobs, both these participants had particular stressful aspects of leadership in their roles at work:

*If I could find a better job, I would leave. If I could find a nice place to work I would leave in a flash...I always look...it's just I like the work. [But] it's just all the rubbish and politics* [Lauren].

*I was thinking there for a while that I was even going to leave...I thought about it and talked about it and thought that was silly, I was just running away. When I was on holidays I was having a good time but when I came back I thought, “No, you think that’s better over the hill, greener on the other side.” But it is not and I would have had a lot of stress if I had [left]...[Marika].*

Overall the cross-case perspectives indicated that improved personal resilience had influenced the collective case positively about current attitudes to the job, the organisation and the decision-making process related to future retention.
7.14 Meanings of resilience

While the participants experienced the same educative therapeutic intervention, the interpretations of the outcomes within the collective case were quite different. In the same way, the meanings of resilience differed across the collective case as individual circumstances differed. However, there were commonalities across the collective case about some of the changes improved resilience brought. Participants spoke of changed family dynamics and personal relationships, re-defined attitudes towards themselves and others, changes to their sense of independence and economic and career development factors. These changes came from a richer perspective of what personal resilience meant to them.

7.15 Defining resilience

In keeping with previous research findings (Jacelon 1997; Jackson et al. 2007; Rew et al. 2001), in the post-intervention phase some participants thought of resilience in terms of a combination of traits, and some in terms of a process of experience over time. Participants reported their personal definitions of the meaning of resilience had broadened and deepened during the intervention, as they realised the wide range of ideas associated with being a resilient person. There were those who believed resilience to be a set of different personality traits, such as assertiveness and positive outlook. Lucinda described her resilience as having peaked after the intervention, because she was now aware of her strengths: that she was assertive, calm and friendly in the workplace. Gillian reported a similar effect of learning about the attributes of resilience she possessed and could draw on from her experience of the intervention:

I'm more inclined to be myself. Like, I've found my strengths and my weaknesses which, in my, you know, lowest days, I just look at my strengths and pull myself out of it...That's how resilience is for me. Like to actually prevent myself in going down, instead, I mean, just to stay focused...compared to before. Optimism and positive outlook, where I look at things in [a good way] and try to take the good stuff, not the bad stuff [Gillian].
The other major perception of resilience was that of a process of internal change over time; a view that had been enhanced by the experiences of growth coming from the intervention. Some participants believed resilience was about a greater awareness of self that led to changed attitudes and changed behaviours over time. These perceptions were conveyed in the following words of some of the participants, as they shared their personal meanings of resilience post-intervention. The articulate responses they gave about the personal meanings of resilience to them were evidence of the deep, reflective process they had undergone:

*Resilience – it’s like every bone in your body is in that word, something is related to resilience... [It means] if you can get yourself to be released and cope with other stuff, [if] some more difficulties come up you can cope with that* [Tina].

*It’s about keeping going and keeping managing and being there, but I suppose the most important thing is looking after yourself and knowing yourself, because the more you can do that the more you are able to stretch it, do the balancing thing, the more you’ll be having resilience* [Jodie].

*For me resilience is a way that you deal with things but don’t let those things affect you in a way. It’s like you actually bend backwards and forwards but at the end of the day you feel confident about yourself in that your self-esteem is still there. And you know, as a person, where you are and where the edge is, you know your limits.* [Gillian]

### 7.16 Making meanings of resilience through creative expression

Another aspect of the intervention was making meaning of personal resilience through the use of creative arts such as painting, mandalas, poetry and journal writing and creative movement. Creative expression was viewed as a way of knowing and being; the participants were encouraged to find their own metaphorical connections to abstract concepts or emotions through creativity and imagery (see Appendix Q). This method also led them to discover the best strategies for them to use to develop and maintain their personal resilience through the meanings they ascribed to it themselves.

Using creative methods of facilitating learning was successful for most of the participants, although it was seen as unfamiliar, new or something not done since
school days. The majority of participants found it enjoyable and a helpful access point to exploring their beliefs and feelings about resilience. Using creative arts was useful for evoking individual meanings and knowledge about resilience. Lucinda explained how her painting of the ocean recalled for her an attitude of fostering resilience in her life (see Appendix Q):

*I love those blues and greens, the tranquil colours and the water had calm and ripples and waves in it. It was expressing that while there might be the odd waves that dump you and rougher times, that if you just kind of maintain that calm approach where you can in life that is the whole thing and that is a factor of resilience. You know, you can get through it, slowly but surely...It shows the calm amongst the, not chaos, but against the ripples and waves* [Lucinda].

One of the most popular workshop exercises was making a personal shield using arts materials to depict the external and internal factors that the participants were using for resilience. An additional outcome of this exercise was that the participants identified from their own shield some of the ways their concept of resilience was formed (see Appendix R). Several participants used similar motifs of flowers, gardens and animals to depict the roles of significant people and beloved pets in their understanding of the meanings of resilience. Gillian reported that this activity made her think deeply about the connections she had with her family and faith that had formed her resilience and did indeed give her a core of strength in difficult times:

*It made [me] think not just literally about it...I had to read between the lines and find what things that I have to put into the shield, you know, it’s not a literal shield, but it’s a shield inside of you...To find “Oh yes I do have a shield, no one can see it, but it’s my shield”...It made me realise I’m really grateful, because I look at other people’s and yeah it’s very different, it made me proud of my shield* [Gillian].

An aspect of the meaning-making of resilience was seeing and discussing what other meanings participants had created. Important comparisons were made that led to understandings of themselves and their colleagues as they reflected about aspects of resilience. This was fundamental to the realisation that there were many views of resilience and many ways it could be expressed:

*It was really interesting to see what other people had drawn and for me, what I got out of things and what other people saw...Actually, its something I can do myself in my own time...The one that I really liked was the visualisation...what is your favourite smell, your favourite sight, what is your favourite sound...Still to this day I will see a beautiful scene and I will think about the course and contemplate that for a moment* [Lucinda].
Creativity was also useful as a way of pinpointing the ways participants were withstanding the adversities they faced, for themselves and others to see. One exercise called upon the participants to use their imaginations while verbalising their thoughts and feelings about an element of the workplace in a 3 line haiku poem (see Table 6.1). The nature of this activity caused them to focus on essential words of description for a feature of the workplace and the attached emotions. While beginning the group discussion in a more discrete way, the activity led on to more concrete listening and discussing by the cross-section of the group about the real-life workplace environment. Although this was potentially risky because of the multi-generational and hierarchical differences within the collective case, it also enabled participants to communicate their feelings and emotions about work with more clarity than was usually aired. This was an important learning outcome given that hearing others’ perspectives about the effects of working in their environment and different ways of coping was one of the most commonly stated benefits of the workshops given by participants. They were positive in their feedback about participating in the workshop discussions, such as the following:

*It was interesting talking and listening, we rolled around ideas, and I was able to give input into it as well, you know, you say something and then someone else builds on it, and so it’s beneficial to everyone. You sort of then find out things that are going on in other places too [in the unit] and you realise, well, I guess people react differently to the way things are and if everything’s not hunky dory…Realising I’ve got a good position compared to some people from hearing their stories … [Lynette]*

*It was a group of people that were very different and I didn’t know anything about anyone. It was interesting to become part of their world…I have more understanding about how people are different and how some people are quirky and you don’t see that until you spend a bit more time with them and it makes them more likeable…that is what it is, their humanity, and I think I probably see that more in people than I did before [Lisa].*
7.17 Summary

This chapter sought to present the experiences of the participants during the post-intervention phases and reveal the effects of the intervention upon their work and lives. The intervention was able to elucidate many aspects of personal resilience that brought the participants a range of positive effects. As a result of building, strengthening and maintaining personal resilience in the intervention, they received both personal and professional gains. The participants were able to utilise new knowledge and skills to improve and maintain their health and wellbeing, fulfilment and commitment to stay in nursing and midwifery. They were also able to further their understandings of personal resilience through creative means that brought them deeper insights into aspects of themselves. Greater self-awareness and insight assisted them to move forward into the future with increased hope and self-confidence.
CHAPTER 8: Abstract

This chapter contains a critical discussion of the study’s central findings. The discussion is integrated into significant themes relevant to both personal and organisational perspectives of personal resilience. The personal aspects of resilience discussed relate to building resilient nurses and midwives, perceptions of resilience and those nurses and midwives who flourish despite the contemporary nursing environment. Organisational aspects discussed are those relevant to building a better workplace with personal resilience and the implications for using a work-based intervention to build and strengthen personal resilience. The chapter synthesises past and present research findings into the critique of the current study’s findings. The chapter concludes with the main conclusions of the case study under investigation.
CHAPTER 8: Discussion

8.1 Introduction

This chapter reveals the interplay between the findings of the research study and what may be understood from them; as well as potential implications for nurses and midwives working in clinical practice in the contemporary workplace. The discussion centres on some of the key issues for the current study; building resilient nurses and midwives and building a better nursing workplace through developing and enhancing personal resilience. The foundations for this discussion chapter are findings presented in chapters 4, 5, 6 and 7 that revealed the serious effects of workplace adversity and the benefits to be found in enhancing personal resilience. These findings resonate with an extensive body of Australian and international literature suggesting that the current nursing workplace is in many ways an unhealthy one for nurses and midwives (Duddle & Boughton 2007; Jackson, Clare & Mannix 2002; Lambert et al. 2004; Sabo 2006).

The resilience of nurses and midwives was understood as the capacity they have to counteract the negative effects of workplace adversity. Fortunately, the intervention in the current study demonstrated that personal resilience was developed, strengthened and maintained by means of an educative initiative. Earlier research found that personal resilience was a response to the serious problems of dissatisfaction, stress and emotional labour that currently apply to the nursing workforce (Jackson et al 2007; McAllister & McKinnon 2008). The motives of this research study extended those findings to focus on how nurses and midwives can learn about their personal resilience and the application of beneficial strategies.

The current study revealed the nature of workplace adversity in the setting, its serious impacts on the physical and psychological health of the nurses and midwives and the means by which they limited its harmful effects. The study intervention was able to elucidate the positive effects of personal resilience in the collective case and assisted the participants in their knowledge and skills in this area. The major findings will be discussed under the following headings:
Building resilient nurses and midwives

The findings of the current study indicated that improving personal resilience had advantages for personal health and wellbeing, self-confidence, social skills, inner strength and personal growth. The study suggested that an intervention built around developing, strengthening and maintaining personal resilience may effectively diminish the harmful effects of workplace adversity.

Knowing about the personal attributes of resilience

The need for educative programs that develop capacities and personal resources in nurses and midwives so that they can handle difficult situations was identified in recent nursing research (Vessey et al 2009). The intervention in the current study built the resilience of the participants by offering them personal experiences that related to the positive characteristics of resilience. The benefits of hardiness, nurturing relationships, optimism, emotional intelligence, work/life balance, spiritual connectedness and reflective skills were all highlighted during the intervention phase. The part each component played in the experience of personal resilience was defined and clarified for the nurses and midwives from what had been learned in previous research. However, positive changes also occurred in the participants because of the self-exploratory process they embarked upon and the experiential nature of the intervention. The participants had developed their own lexicon of significant knowledge and “ways of knowing” about resilience from their life experiences and these were defined and extended because of the intervention. They became more knowledgeable about the significant and meaningful understandings of personal resilience for them. This result
corresponded with current notions of the need for nurses and midwives to become proficient at utilising tacit and experiential knowledge and who can integrate nursing theory, practice and research (Freshwater & Stickley 2004).

8.2.2 Regaining hope and a positive outlook

The intervention assisted participants to regain positive emotions, such as hopefulness and optimism, for both their current situations and their futures in nursing and midwifery. Feelings of hope and positive outlook were referred to in other nursing studies investigating nurses’ perceptions of their work (Tusaie & Dyer 2004; Tugade & Frederickson 2004). Hope has been described as an “internal energy resource” for nurses (Duggleby & Wright 2007: 46). Duggleby and Wright’s (2007) findings also suggested that hope for nurses was activated through perceptions of making a difference and having supportive relationships with other team members and patients. These findings corresponded with the current study as personal satisfaction in the collective case was enhanced and maintained by similar motives. The current study’s intervention facilitated the participants feeling more hopeful than in the past. Through a process of critically analysing the legitimacy of their work and their motivations to continue doing it a more positive set of intrinsic motivations was developed.

Previous studies suggested approaches to building personal resilience through positive emotions (Jackson et al 2007; Zander et al. 2010). During the intervention the participants were upheld as intrinsically significant and valuable by their mentors. They also experienced positive support and recognition from each other. They developed more effective professional networks that could be reinforced in the workplace, especially in times of stress. The intervention in the current study presented various pathways to continue the enhancement of positive emotion in the participants, in both their work and outside-work spheres.

The participants in the current study were able to build a more hopeful and positive outlook in several ways: by contributing to their workplace, their colleagues and their clients. During the intervention they spent time relating to each other in a positive
atmosphere outside the workplace and gained deeper perspectives of their shared and divergent opinions. This led to increased credibility in the perspectives of others who shared their workplace; and in the influence of their own contribution to teamwork. Their attitudes and behaviours were conducive to a more positive outlook about the work environment than before.

Having a more positive view of themselves and their individual strengths and weaknesses enabled the participants to perceive themselves as conscientious nurses and midwives who were useful to others. Some found their self-esteem improved after participation. McCratty et al (2003) also found that emotional health could be raised in workers exhibiting stress by the intervention of a program training them to use strategies to refocus and restructure emotions more positively in the workplace. Their study found there were significant increases in workplace satisfaction and sense of contribution. The current study also confirmed the positive benefits of gaining a more genuinely positive view of work and the workplace by recognising the value and influence of one’s contribution.

The participants recognised the importance of possessing a positive explanatory style, which meant they came to view themselves as active influencers in their own lives and able to resolve difficulties when they encountered adversity. Previously, popular psychologists have seen this aspect of self-esteem as important for coping (Seligman 1991; Moneta Schneider & Csikszentmihaly 2001). In addition, Karanikola, Paphanassoglou, Giaanakopoulou & Koutroubas (2007) considered self-esteem as contributory to professional satisfaction in nurses, as nurses who were satisfied with their work interactions and status exhibited higher self-acceptance. The positive results of the current study indicated that improving the outlook of nurses and midwives so they felt more positive and hopeful about the future assisted their hardiness to the most negative aspects of their work.
8.2.3 Developing self-care and improving health and wellbeing

The intervention brought about positive changes to the health and wellbeing of the participants by raising their awareness of the relationships between health, wellbeing and personal factors. Research suggested that nurses had good decision-making skills regarding lifestyle choices and health and were generally more physically active than the broader female population (Friis et al 2005). However, they were also prone to back and neck problems, and a range of somatic symptoms that were work-related (Arafa et al 2003; Waters et al 2006). The intervention was successful in assisting the participants to focus on their own health choices and current strategies for self-care. Their increased awareness of the need for maintaining health and wellbeing as a part of personal resilience caused them to adopt strategies such as conserving energy levels outside work, having better sleep and work regimes, and seeking professional help for chronic health issues. It also caused them to regard the effects of workplace adversity on their physical, mental and emotional health more seriously than before. Smith (2006) proposed the relationship between personality and health was mostly about how people encountered and responded to situations that affected their health. He found optimism to be the clearest link to health; however he also found that the recurring features of the social environment such as reciprocity between individuals were also important. The current study has extended research knowledge about the role and significance of self-care by showing the positive results of taking up various self-care strategies. The current study confirmed the ability of self-care measures to counter workplace adversity, and that personal resilience is vital for the health and wellbeing of nurses and midwives.

8.2.4 Improving individual practice with personal resilience

Recently, Vessey et al. (2009) noted the need for personal strategy development to address interpersonal problems between work colleagues, especially for vulnerable nurses and midwives. The current study revealed the effectiveness of providing opportunities for nurses and midwives to learn skills for coping with workplace incivility in a safe and supportive environment. During the intervention, the
participants explored and reflected on their own problems and issues with workplace bullying and aggression, and assessed their current attitudes or behaviour where change was indicated. They became more aware of irritability or stress triggers and strategised and practised creative innovations for their own individual practice amidst the safety of supportive relationships with peers and mentors. The participants became more accomplished in their repertoire of relational skills, for example by learning to relinquish harmful emotions such as guilt, over-responsibility and worry more readily. They improved some of their collegial relationships and communication in the workplace by encouraging respect and providing support for each other.

The participants also learned to affirm and reward themselves in the absence of support and recognition from others. Therefore, they were able to approach utilising their new insights about resilient practices in the workplace themselves from a more prepared and flexible position. Glass (2009) noted that nurses and midwives in her study were aware that their organisations did not feel responsible for the activities of renewal and healing that they required due to workplace issues. The current study’s finding associated with self-affirmation and personal resilience extended the recent research discourse (Hodges et al 2008; Glass 2009; McAllister & McKinnon 2008; Stupans & Owen 2010) regarding the potential and need of evidence-based interventions to protect nurses and midwives from unhealthy work environments by improving resilient behaviours.

In addition, the influence of a positive mentor enabled some participants to develop a broader world-view of the scope and potential of their work, rather than focusing on their present -- sometimes pessimistic -- view of their workplace. Through the mentoring program, the participants were exposed to people outside their organisation who had demonstrated their personal resilience through having their own successful careers, and who had a realistic yet optimistic demeanour about nursing and midwifery. The nurses and midwives were able to detach from unhelpful emotions and give less attention or respond more appropriately to unsupportive communication in the workplace. The research literature has acknowledged the influence of a supportive mentor on mentees’ positive feelings about work, comfort and effectiveness in the nursing workplace (Wilkes 2006; Wagner & Seymour 2007). The positive impact of mentoring was also important because of the degree of confidence that nurses and midwives develop through being supported. This factor was known to
be a definite influence, not only on short and long-term performance, but on decisions to stay in nursing (Parker & Hegney 2003; McKinley 2004). This determination was congruent with our study findings; the mentoring program was a significant component of the intervention’s success in raising the mentees’ aspirations and hopefulness about their careers.

A further influential factor of improving resilient practices in nurses and midwives was maintaining a healthy balance of time spent between work-time and leisure-time. This required careful and prudent use of the time available to achieve sufficient work, rest and leisure; and enjoy satisfactory personal relationships (Andrews, Cowan & Atkinson 2004). The argument for nurses’ evaluation of whether their activities in both work-time and leisure-time were well spent was previously alluded to by Brown and Adebayo (2004). In the chaotic pressure and constant change of this case setting, finding a workable solution to fulfilling work demands, while meeting study and care responsibilities in other spheres and maintaining proper self-care, was a difficult challenge. The intervention focused the participants’ attention on the reality that work/life imbalance was compromising their most valued objectives in life, the quality of their personal relationships and their physical and psycho-social health and wellbeing. The intervention also challenged them to adapt some previously held beliefs and assumptions about the nature of productivity and “spillover,” when work encroaches more and more on non-work activities (Pryce et al 2006: 183). Once this aspect was identified, the participants changed their normal work routines to give priority to other areas that were being neglected or under-valued. They found this was beneficial for both their efficacy and enjoyment of work, and it reportedly improved their resilience to the negative aspects of the workplace. The participants believed the moves they initiated were rewarded by an improved quality of life and wellbeing.

In response to the intervention, the participants also began to exhibit greater assertiveness as a strategy to counteract the imbalance in their lives caused by the heavy workload and pressure to work longer hours. The participants experienced growing empowerment to make cognitive and behavioural changes related to addressing organisational demands, shift work, resolving conflicts, expressing difficult or unpopular emotions at work and seeking support. In addition, they took on more responsibility for inserting the required boundaries in some of their relationships and
maintaining their own self-care plans. They practised feeling comfortable doing less and adding new things to life as strategies for balancing work and life (Fuimano 2005). Creating more 'space' in life and thereby enhancing work/life balance gave the participants a greater sense of their own personal autonomy, a characteristic described in nursing research as consistent with job satisfaction and positive health outcomes (Andrews et al.2004; Fuimano 2005).

8.2.5 Creating authenticity

The participants in the current study also confirmed that development of personal resilience was concerned with finding personal opportunities for creative and meaningful self-expression. The necessity of responding to emotional labour in a healthy way has previously been identified in nursing research (Freshwater & Stickley 2004; Gerits et al 2005). Emotional intelligence was defined earlier as a “core aptitude related to one’s ability and capacity to reason with emotions, especially in relation to others” (Freshwater & Stickley 2004: 92), and viewed as a strategy to combat emotional labour. The current study revealed that supporting the notion of being a person with the freedom to hold and express authentic perspectives was significant for building personal resilience.

The idea expressed by Virginia Woolf (1929) as “having a room of one’s own:” -- that any writer, or woman for that matter, must have personal liberty to be creative -- was emphasised through this intervention. This process entailed recognising the need to uncover the inner strength and beauty of one’s personal attributes, values, goals and desires; and building a way of life and work in accordance with life purposes. Over time and through their participation in this intervention, the nurses and midwives in the current study learned to trust and respect their genuine emotional responses in workplace relations with colleagues, clients and the organisation. They also learned to value the personal meanings they created to understand themselves and their personal practices as individuals and as nurses and midwives.
The provision of opportunities in the intervention to be creative assisted the participants to connect cognitive and affective domains, or the head with the heart. For some the intervention was their first opportunity to do so. Through their creative work, the participants engaged in reflection about their life and work experiences and the ways they had shaped their personal resilience in the past. The resulting determination was to continually self-monitor the authenticity of their life experiences. They recognised by the post-intervention phases that their personal resilience as women, and as nurses and midwives, was inter-related with their capacity to create authenticity in their lives.

While engaged with their own creative projects in the intervention, projects that represented the internal creative process of defining their authenticity, the participants were encouraged to engage in continual self-reflection of ways and means of renewing themselves in the face of workplace adversity. This aspect of resilient nursing practice has been discussed previously in a wealth of nursing research (Authier 2005; Becker Hentz & Lauterbach 2005; Thorpe & Barsky 2001; Turkel & Ray, 2004). The essential practice of therapeutic caring work has been identified as the ability to be fully present in the caring moment (Authier 2005). Turkel and Ray pronounced that “discovering or re-discovering the caring self is an important source of nourishment for the emergence of creative, caring energy” (2004: 251). Moving on from individual perspectives of caring, the participants were able to define a collective vision and purpose for the work that they were doing and the nature of caring work they wanted to do. By doing so, they formed a more cohesive group of workers within the workplace. Therefore, the current study demonstrated that learning to maintain self-care and renewal activities enhanced the proficiency of therapeutic caring in this collective case.

8.3 Nurses and midwives who thrive and their personal resilience

The collective case contained some nurses and midwives who utilised personal attributes and processes of maintaining personal resilience so that, in their estimation, they thrived in their workplace. The discussion of enhancing resilience should
therefore include the relationship between personal resilience and the adaptations made by those who thrive within an environment understood to be difficult, challenging and even harmful (Moola, Ehlers & Hattingh 2008). As the intervention focused on building on personal strengths already present in order to enhance personal resilience, those who believed they were already thriving provided important implications about the facilitation of personal resilience.

The participants who considered themselves as thriving, rather than surviving, in their workplace were, for the most part, senior and experienced nurses and midwives who felt they belonged after working in the environment for more than ten years, and sometimes for twice that time. As previously noted, they already had well-established informal support networks with colleagues and within the managerial structure of the organisation. They held privileged positions in the nursing hierarchy largely because of their knowledge and experience of nursing and midwifery, the informal networks and organisational processes and policies of the hospital. This allowed them the ability to do better within the organisational culture and protect themselves from some of the most virulent sources of dissatisfaction, such as isolation and lack of support. They needed less professional support than some of their peers due to their varied and rich knowledge and experience within the clinical context. This finding was congruent with other research findings that nurses and midwives who thrived in their careers were given recognition by patients and colleagues for doing an excellent job and possessed effective relationships with colleagues (Perry 2008). Perry (2008) noted that such nurses also received intrinsic motivation and satisfaction from unseen nursing activities, such as protecting the vulnerable, meeting patient needs in creative or unexpected ways, and helping patients meet the essential everyday needs of nourishment, comfort and personal hygiene. The self-identified thrivers in the current study also reported deep satisfaction from meeting personal standards of excellence, resolving questions or difficulties for clients about health care and caring for vulnerable client groups.

Although there was some evidence of the presence of emotional labour in the sub-group of participants who self-identified as ‘thrivers’ -- that could have resulted in a potential reduction of self-awareness and subsequent disclosure of non-coping -- in most cases, they had found effective strategies for maintaining their own personal resilience. They relied on personal attributes of inner strength, self-confidence and
detachment from work concerns outside their control. Similar findings about the ability of some nurses to cope at work in the context of workplace adversity due to competence and knowledge were found in a study of operating room nurses (Gillespie et al. 2007). The inference for the thriving participants in the current study was they had developed these attributes and practices over long careers in nursing and midwifery, and perhaps in the environment of an earlier time when they encountered less volatile and challenging workplace demands.

They had also sought out and established positive relationships with colleagues. Indeed some ‘thrivers’ felt they were placed securely within an effective collegial support network with others who were themselves in similar circumstances and with whom they had worked for some years. This finding supports the conclusions drawn by Ulrich, Lavandero, Hart & Woods (2006), who found that a strong indicator for retaining nurses was their positive relationships with colleagues. The thriving participants in the current study with higher self-rated personal resilience already identified that they possessed stable, supportive family and social networks as well as well-established work-based relationships.

In addition, these participants believed they had a high level of personal autonomy over their environment and work tasks, in part due to their longevity in the same workplace. Because of this perceived autonomy they experienced enjoyment and a sense of purpose in their jobs. They believed they exercised control over the variety of work they did, and were able to have flexibility of tasks within their teams which afforded them fulfilment. These participants were also able to achieve a high level of satisfaction because their proficiency with work tasks gave them access to experiencing the personal benefits of engaging in therapeutic care of patients. Engaging in the ‘caring’ work of nursing and midwifery was the major source of motivation and fulfilment for the participants in the current study. These experiences held true despite the deficiencies of other aspects of their work circumstances. The perceptions of these participants were congruent with the recent research findings by Perry (2008).

Furthermore, the sub-group of ‘thrivers’ did not find it as difficult to manage two of the most common concerns of the other participants: achieving adequate self-care and
work/life balance. They were proficient at creating enough space in their lives for leisure and pleasurable activities. They had more time to spend on reciprocal relationships with partners, family and friends that they experienced as satisfying. Interestingly, none of the sub-group of thrivers had full-time caring responsibilities for children. All were at life stages where they experienced less stressful conditions outside the workplace, being older and more financially secure than their younger peers.

This is not to say that this sub-group of participants were not facing stressful personal challenges; they were dealing with health problems or those of family members, marriage breakdown and separation, and financial changes associated with preparing for retirement. The most disabling aspect of the personal resilience of these participants was their health. The impact of their work caused problems with fatigue, physical degeneration and adequate sleep. The most common health and wellbeing issues for older women coping with nursing work have been explored in contemporary nursing research (Gabrielle, Jackson & Mannix 2008; Wray, Watson, Stimpson, Gibson & Apsland 2007). Wray, Aspland, Gibson, Stimpson and Watson (2009) found, in their study of the experiences of nurses and midwives aged over 50 years, that their respondents with work-related illness or disability had poorer quality of life and psychological health than younger nurses. The current study extended research knowledge about the life choices and chances of this group of older and experienced nurses and midwives. The experiences of the sub-group of ‘thrivers’ in this study indicated that this group may be advantaged in the area of personal resilience and may be of great value in transferring their knowledge and skills in surviving and thriving to younger or less experienced colleagues.

Some of the self-identified thriving participants in the current study were also encountering workplace-specific issues that caused them stress. These issues included experiencing stress from the responsibilities of mentoring midwifery students, taking on relief positions or higher duties and overload from always being the most experienced team-members. Wray et al (2009) suggested that an aspect of the declining reward and fulfilment for older nurses and midwives was because of the unavailability of genuine experiences and opportunities for training and advancement. Conversely, all the participants in the current study, regardless of age, believed the
opportunities for professional development and training were excellent. The majority of self-rated ‘thrivers’ were satisfied with the positions they currently held. Overall, the ‘thriving’ participants were not facing as many combined factors associated with workplace adversity as some other participants, and they had had more time in which to develop the coping mechanisms already discussed.

The thriving participants in the current study had succeeded in achieving congruence between their personal wellbeing and their enjoyment and wellbeing at work. Glass (2007) previously proposed a close relationship between self-integration and personal resilience. The thriving participants had been successful in integrating themselves authentically into their work and home spheres and, for the most part, had defined themselves as both individuals and nurses and midwives to the stage of personal satisfaction. They had evolved over time into individuals that could survive and thrive within their environment. The discussion of these participants purporting to have higher personal resilience demonstrates progress to the theoretical understanding of the development and maintenance of personal resilience in nurses and midwives.

8.4 Nurses’ and midwives’ perceptions of resilience

The concept of resilience has become an influential one in workplace and organisational literature, as well as in a variety of disciplines seeking to improve personal outcomes for human health and wellbeing (Engel 2007; Jackson et al 2007; Lee 2003). Understanding personal resilience required the exploration of relevant concepts to do with the process and attributes of resilience (Lundman et al 2009; McGee 2006; Rew et al 2001). Some researchers have noted a tendency to examine personal resilience in response to trauma and catastrophic events (Badger 2004; Glass 2007; Laditka et al 2005) rather than in relation to everyday events. There continues to be a need for research which focuses on resilience in everyday workplace contexts (Glass 2007). This collective case study represented a research initiative that dealt with nurses and midwives who worked in a busy and challenging workplace, yet in the current health climate, one that was not unusual. The findings in the current study suggested that, post-intervention, possessing personal resilience assisted the nurses
and midwives in various practical ways during their everyday work life, even while encountering many different stressors. Reportedly, strengthened personal resilience was a catalyst for dealing more confidently with difficult interactions at work and improving their perspectives on the workplace environment because of a sense of flexibility and autonomy. Because they had enriched other areas of their lives outside the work sphere, the participants perceived the dissatisfying elements of the workplace from a more accepting perspective and were also more able to withstand workplace adversity.

The severe shortages in nursing and midwifery have been attributed to the prevalent negative factors: heavy workloads, oppressive environments leading to stress and anxiety, an aging workforce and high numbers of retiring nurses, chronic fatigue and other effects of rotational shift work, role stress from constant organisational restructuring and cost-cutting, workplace bullying and hostility, and lack of support and communication between colleagues (Geiger-Brown et al 2004; Fischer et al 2006; Hutchinson et al 2006; Timmins & McCabe 2005; Tinsley & France 2004; Wray et al 2007). Therefore, as they were affected every day by the challenges in their work environment, the perceptions of the participants in this case study about the enhancement of their personal resilience were significant and narrow the research gaps in this area.

Jackson et al (2007) suggested that nurses and midwives could actively participate in building and maintaining their own personal resilience and thereby help to insulate themselves against the effects of workplace adversity. The participants in the current study conceptualised resilience in a similar way, as a mechanism for positive change. They thought personal resilience was an effective means of protecting themselves from the effects of stress, emotional overload and difficult interactions they were subjected to. They saw their personal resilience as a protective mechanism that they could perceive in themselves and maintain in order to preserve their quality of life. This protective aspect of personal resilience has been well-established in the research literature (Edward & Warelow 2005; Hodges et al 2008; Jackson et al 2007; Tusaie & Dyer, 2004).
Resilience was conceived in the past as a process of changing the effects of stressors into coping with them (Ablett & Jones 2007; Glass 2007, 2009; Polk 1997; Zander et al. 2010). This process has been seen as a critical one for nurses and midwives (Hodges et al 2008). The development of professional resilience was also understood as the integration of formal nursing education and the realities of the workplace that occurred as a result of moving through significant turning points of experience (Glass 2007). Over the duration of the intervention, the participants were observed to redefine and crystallise their perceptions about the meanings of personal resilience. It was evident that during the intervention their reflective insights and experiences, and observations of others’, had assisted them to devise richer connotations of the concept than they had held previously.

Glass (2007) viewed resilience as the outcome of being self-reliant during the process of holding on to one’s personal goals in changing circumstances within the workplace organisation. This process was also observed by Papandatou, Bellali, Papazoglou & Petraki (2002). After the intervention, the participants believed that becoming more resilient had helped them to understand the extent to which their own strengths and coping skills had assisted them to withstand workplace adversity in the past, and to reflect on their own significant socialisation experiences. They felt they had learned additional strategies that were effective in improving their work life. They regarded personal resilience as a useful concept for them in their work and lives, one that was beneficial now and for the future.

Another conceptualisation of personal resilience revealed by the study’s findings was its transformational power and influence on internal potential and experiences, such as heightened self-esteem, self-image and self-awareness. Personal resilience activated a more holistic approach to the self-concept of the participants. The imperative for nurses and midwives to uncover personal meanings of the self through reflection and identify meanings they had in common with others has been explored in nursing research previously (Becker Hentz & Lauterbach 2005; Lundman et al 2009). Becker Hentz and Lauterbach (2005) believed the self-reflective process was essential for appropriate caring for self and others. The participants in the current study thought their reflections on their personal resilience had brought richer dimensions to the ethical and spiritual elements of their lives, through acknowledging their most
important values in life such as family, relationships, faith-based beliefs, pets and
nature. They believed that increased positive emotions of gratitude, self-esteem and
happiness made them more aware of themselves and their surroundings, and enhanced
their personal resilience. This study’s intervention revealed the aspects of selfhood
that were required for the participants to feel more complete and balanced, enhancing
their personal resilience.

These finding also supported the work of Freshwater and Stickley (2004) who
proposed the importance of an ability to balance rational and emotional aspects of the
self in caring work. The participants’ experiences in this regard suggested that
understanding the self was a key factor of developing various personal qualities such
as integrity, self management and caring for others. In fact, they indicated the
importance of the self – self belief, self awareness, self management -- in
strengthening and maintaining personal resilience.

Zander et al (2010) argued that personal resilience was the result of overcoming
negative circumstances that interfere with one’s personal growth. In the current study
too, the participants became more aware of their human potential in the internal areas
of personal growth through the growing recognition of their inner strengths, sense of
belonging and connectedness to others. An increased sense of coherence and
belonging as a result of self-reflection was found in a previous study of nursing
students (Becker Hentz & Lauterbach 2005). The participants in the current study
also displayed greater confidence in their ability to deal more capably with adversity
in the future.

A further conceptualisation of personal resilience emerging from the findings of this
case study was the development of the shared notion of personal resilience that related
to their professional identities as nurses and midwives. Wengstrom and Ekedahl
(2006) described the contribution of shared perspectives and contact between
colleagues in the growth of competence in professional caring work. During the study
intervention personal definitions of resilience overlapped to form a shared concept,
one that was understood and accepted by the participants as appropriate for their
workplace setting. The shared definition revolved around monitoring the
characteristics they had learned were associated with personal resilience that were
exhibited by themselves and others in the workplace. They used this shared definition to review the experiences of colleagues, assess the severity of workplace adversity and its effects and encourage each other at work. The shared concept of personal resilience was also useful for maintaining collective perspectives of nursing and midwifery in general and cohesiveness between the nurse and midwives in the workplace.

In the current study personal resilience was regarded as an encompassing concept by the participants; one that could be utilised to determine the desired feelings, attitudes and behaviours with which to respond to aspects of work or general life experiences. This was especially so in areas that had the potential to affect their wellbeing and capacity to cope. Therefore the current study’s findings supported the current discourse about resilience as a concept.

8.5 Building a better workplace with personal resilience

The results of this case study also showed that building and enhancing personal resilience improved the professional assets of a workplace. The intervention was instrumental in fostering in the participants positive professional attitudes, collegial networks, collaborative practices and intention to remain in the workplace. The networks of reciprocity and support, communication, trust and shared vision were all positively affected by the study intervention.

8.5.1 Building effective communication in the workplace

Before the intervention many of the participants experienced communication difficulties, distrust and fears related to managerial decisions or attitudes that limited the autonomy over their work environment and conditions. The lack of autonomy in nursing and midwifery work was identified as a serious staff management problem that influenced the efficacy of health care organisations (Fradd 2006). Through their participation in the current study, participants were able to gain a sense of enhanced
personal autonomy. They described feeling greater confidence in asserting their own perspectives and confronting differences of opinion with supervisors, especially when dissatisfied about their treatment or working conditions.

The experiences and insights gained by participants from the intervention’s mentoring program provided them with greater professional assuredness to speak with others within the organisation, and to value their own knowledge and experience when giving their opinions. This development came about because the participants engaged in mentoring partnerships that, although goal oriented, involved interacting closely with a retired or senior nurse leader. The participants perceived their mentors as influential, authoritative professional nurses and midwives; yet they experienced their mentors’ willingness to become their personal mentors and friends. The demonstrated enjoyment that the mentors conveyed from working together on their goals convinced them of their self-worth, as individuals and to their profession.

The communication between mentor and mentee was based on valuing each other’s knowledge, experiences and insights. The intention of mentoring relationships to be supportive, interactive and mutual has been proposed in past nursing research (Jakubik 2008; McCloughen, O’Brien & Jackson 2006; McKinley et al. 2004; Mills, Lennon & Francis 2006). The mentoring experience empowered the participants and built their capacity to interact within a hierarchical workplace. The mentoring partners were effective in addressing the work-related concerns of the mentees because they shared specific understandings of the workplace culture of a large health care organisation which aided effective communication between them. Latham et al (2008) discussed the need for improved understanding and evaluation of complex hospital organisational culture. The findings of the current study supported this recognised outcome of past nurse mentoring programs. The participants had already possessed knowledge of the informal networks operating within their workplace; now they more fluently negotiated the formal organisational, unit and team agendas on their own behalf.

The dissatisfying experiences of pre-intervention communication between the nurses and midwives in this case study also corresponded with previous research findings in similarly challenging nursing workplaces (Timmins & McCabe 2005; Scott-Cawiezell et al. 2004). Prior to the intervention, the participants did not engage in open and assertive communication with each other primarily because of fears about reprisals in
the future or damaged work relations with colleagues. With the building of collegial
techniques during the intervention came more assertive communication by the
participants in the workplace.

The participants’ communication patterns changed from resigned resentment
expressed only to perceived allies, but not to the individuals involved in altercations;
to more effective conflict resolution methods. They also developed greater
understanding of the inherent reasons for difficult and emotion-loaded conversations
with colleagues and managers in their workplace. They found if they approached
them with greater professionalism and perceptiveness they could be given a fair
hearing. The argument for addressing workplace communication problems at the
conversation level has been posited in the nursing literature (De Cicco et al. 2006;
Duddle & Boughton 2007; Moola et al. 2008; Pilette 2006). The improvements to the
range and depth of communication in the participants indicated the intervention
influenced them positively at the conversation level.

They were encouraged to do this firstly through honest discussions between nurses
and midwives away from the toxic workplace atmosphere of discordant
communication and poor conflict resolution procedures. This finding extends the
research knowledge about how similar interventions could impact on negative
workplace communication patterns in other nursing and midwifery contexts and
settings.

The participants felt they were hardier and more assertive in their communication with
others in the workplace after the intervention, and this was reflected in an increased
sense of fulfilment. This finding corresponded with that of previous research that
linked professional autonomy with satisfaction and work/life balance (Gould &
Fontenla 2005; Mrayyan 2005). At first glance, the outcomes of the current study
related to increased hardness and assertiveness in negotiations over working conditions
with supervisors may seem to be dis-incentives for large, bureaucratic health
organisations. However, this case study affirmed that assertive staff communication
patterns reflecting a growth in personal autonomy may actually result in greater
satisfaction and commitment to the organisation by nurses and midwives (similarly,
Stordeur et al 2007).
8.5.2 Building support networks in the workplace

The occurrence of predatory alliances and bullying behaviour as a reinforcement of normative behaviour in nurses has been discussed previously in the literature (Hutchinson et al. 2006). The nurses and midwives in this case were affected by similar phenomenon in their workplace. The general effect was that supportive collegial networks were difficult to establish. However, the study intervention proved to be a catalyst to breaking down the isolation and controlling norms by creating a space where the participants could interact personally with each other away from the inhibiting conditions of the workplace.

The case study revealed that those nurses and midwives that were not in privileged, powerful positions in the nursing hierarchy felt they were often not respected or recognised by their colleagues. This is not to say that collegial support was not a characteristic of the collective case, but that it was more readily experienced by those with higher or more established positions within the informal networks. The fact that nursing staff were affected negatively by working in stratified organisational hierarchies has been discussed previously (Latham et al 2008). This intervention provided the participants with the time and opportunity to get to know, appreciate and care about each other as individuals. These experiences resulted in the development of stronger ties of affinity between the participants, creating a sense of community with shared concerns and interests. They were empowered by the knowledge that they could utilise these bonds of reciprocity in the workplace during difficult circumstances in the future.

Not only had individual support networks been developed or widened between participants, but a cognisance of monitoring the flow of supportive behaviour between other nurses and midwives in the workplace had developed. This kind of transformational change was identified in the research literature as an element of servant leadership. Servant leaders are those who are committed to building a sense of community and the success of the constituents within organisations, rather than the organisational goals themselves (Jackson 2007). They provide a range of professional assets, such as empathic and active listening, encouragement and positive models of
behaviour for all those around them. Their presence within a stressful and damaging workplace is believed to make a real difference to the milieu of the workforce. The insights of some participants in the current study after the intervention suggested they developed in similar ways to those previously assigned to servant leaders. They were more committed to supporting their colleagues through teamwork and encouraging resilient behaviours in others by role-modelling their own. They were conscious of contributing to a positive atmosphere in the workplace and invested time and energy in their colleagues’ development through teaching and mentoring roles. The intervention in the current study demonstrated that work-based groups within health care organisations can effectively monitor and support the personal resilience of group members, and even influence the awareness of its benefits in the wider workplace environment.

The intervention’s objective of exploring personal resilience gave the participants the opportunity to engage with each other on human terms, without bringing into play the negative or punitive measures of the workplace hierarchy or alliances. Indeed, as much as they desired to protect themselves from the censure of their colleagues in the earlier stages of the intervention, they also wanted to express to them their experiences of coping. This was because they particularly valued hearing the stories of how their colleagues responded to stress and difficult workplace experiences and their strategies for coping. This finding corresponded with previous research to do with shared social support between nurses (Maytum, Heiman & Garwick 2004). The intervention created an environment where the nurses and midwives had time to develop deeper interactions with each other and could speak more freely and openly than on the wards. They took up the opportunity of discussing the real emotional complexities of some of their experiences and reflecting on the challenges they faced with others. This case study extends research knowledge by revealing how important it was for the participants to make sense of their experiences collectively, with the people they perceived could most understand and offer meaningful and practical support. From this base of common experiences of workplace adversity and shared confidences, it was possible for ties of trust and reciprocity to be formed -- and once formed they were transferred back into their workplace.
8.5.3 Building collaborative capital with improved personal resilience

During the intervention the participants shared the highs and lows of some of their experiences. Mutual respect grew for the diversity of experience and competing perspectives of nursing and midwifery that were revealed. Pilette (2006) argued that collaborative capital could be best fostered through conversations between colleagues. This finding was supported as the participants in the current study began to understand some issues and concerns of other nurses and midwives they had been unaware of; and in relation to different units within the workplace. Greater understanding of the diversity of experiences and therefore the need to support those colleagues experiencing difficulties, led to an increased commitment to teamwork. Kalisch et al (2009) have recently stated the importance of factors such as collective orientation, mutual performance monitoring and backup behaviour to effective teamwork in nursing. Through understanding the need for changes in their own behaviour and level of commitment, the participants began to see their own efforts as pivotal to the success of any nursing team they were part of.

The participants also began to perceive their colleagues through a more compassionate lens. After the intervention, if others displayed poor communication skills or unsupportive behaviours and attitudes the participants attributed these more to a skills deficit than to a personal critique. The participants displayed greater tolerance for those colleagues; or found they could at least discount their negativity and not become drawn into it. These findings implied the growth of collaborative capital in the participants as they put their new insights into action. They began to give added time and effort to creating positive workplace relations and experienced the benefits of this positive change.

Judkins and Ingram (2002) explored the concept that personality hardiness, or the belief that circumstances can change through one’s direct influence and action, was connected with increased collaborative capital, demonstrated through higher involvement in workplace issues and responsiveness to change in the work environment. Raising collaborative capital has also been described as crucial for
teamwork in healthcare organisations typically characterised by paucity or absence of effective communication (Pilette 2006). These findings were congruent with the outcomes of the current study. After the intervention, some participants became more motivated to initiate supportive relationships with colleagues because they could see the necessity of being part of a support network. They also realised that facets of their work environment actively discouraged positive relationships between nurses and midwives, and so they needed to make proactive moves to establish and maintain good working relationships with colleagues at work. They perceived collegial relationships and support in a more positive way than before and had realised that accepting the different personalities of their colleagues could make their collegial relationships more interesting and positive.

The intervention also built collaborative capital by offering consistent acknowledgement of the potential to “co-create communities of caring” (Turkel & Ray 2005: 251). In effect, the potential for a more tolerant, compassionate and collaborative environment between colleagues was formed. The more restrictive norms of accepting or rejecting colleagues based on the informal interpersonal networks present in the workplace were challenged for the participants. This process assisted them to recognise they did possess a shared vision of the care they wished to provide in their workplace and that, despite the workplace adversities present that obstructed that vision, it was a basis for group cohesion and collaborative work practices. The benefits for the nurses and midwives, and ultimately for patient care outcomes, were observed in the collective case due to their experiences in the intervention.

8.5.4 Building personal fulfilment with work through personal resilience

The findings from the post-intervention phases of the current study showed that enjoyment and satisfaction with the workplace improved. The participants gained personal insights into the intrinsic nature of job satisfaction for them and greater awareness of the facets of work that determine job satisfaction in a nursing and
midwifery context. Discovering coping strategies that reduce stress and increase job satisfaction for nurses and midwives has been a strong research focus in the past (Healy & McKay 2000; Hegney et al 2006; Joiner & Bartram 2004). Through participation in the intervention the participants learned about the role that work environment, working conditions and daily challenges played in their own experiences of intrinsic satisfaction with work. They reflected on what factors of their jobs needed to be present for them as individuals to feel more enjoyment and satisfaction from their work -- and how they could experience those factors more fully. In addition, there was a greater uptake of progressive career moves by the participants.

During the intervention, the participants began to understand that the problems in the workplace environment and conditions that impacted on their feelings of fulfilment were endemic and complex and would not be solved quickly or easily. Nursing researchers have argued that increased empowerment of nurses and midwives provided more opportunities for them to participate in the provision of health care that was satisfying (Brancato 2003; Joiner & Bartram 2004). This finding was supported in the current study. The increased knowledge of the benefits of personal autonomy empowered the participants to take transformative actions both inside and outside the work sphere; actions that changed their working hours, direct environment and scope of practice.

Increased knowledge of and commitment to work/life balance and self-care, to prioritising activities in a new way, assisted the participants to achieve enhanced enjoyment of work. Providing quality care remained a high priority; having time and access to therapeutic interactions with clients was identified as a significant factor in personal satisfaction. Engaging in supportive relationships with clients and their families, and having adequate time to provide care has been found to influence appraisal of future outlook and satisfaction in other nursing contexts (Duggleby & Wright 2007). However, the participants came to recognise that this source of satisfaction was not likely to be a major one for them in the current context of their workplace. This represented a shift in the participants from previously held expectations about the rewards of their work.
Nursing research discourse supported the notion that the sense of fulfilment perceived by nurses and midwives is most commonly affected by the structural and managerial characteristics of the workplace, such as relationships with nursing managers, working time, handover shifts, schedules, role ambiguity and conflicts (Chang et al. 2007; Stordeur et al. 2007). However, although the discourse usually argues for increasing personal satisfaction through a top-down approach of making organisational changes that attract and retain nurses and midwives, the participants in the current study also improved their sense of fulfilment with work by instituting their own personal and changes. The current study evidenced that both personal and organisational approaches are necessary components of improving the satisfaction levels of nurses and midwives.

The sense of fulfilment in the case was also improved by rich experiences during the intervention. The participants' lived experiences of being mentored by a senior or retired nurse or midwife allowed them to focus on their own job fulfilment in a new way for them. Research determined that mentoring partnerships positively influenced mentees’ satisfaction with the work environment by analysing the best sources of support and steps for career progression (McMahon 2005). The mentoring partners in the current study planned and executed actions that improved the worst effects of their workplace and increased their personal enjoyment of work. The mentoring program built the capacities of the participants for job fulfilment by facilitating the development of more flexible and satisfying career aims. It also initiated the requisite learning experiences, training or skills acquisition the participants needed to ensure their achievement.

A stronger sense of autonomy also deepened the belief by participants that they could influence and improve their own fulfilment by finding intrinsic values in their work and utilising a positive outlook for the future, regardless of external factors. The relationship between intrinsic value placed upon nursing work and job satisfaction was described previously by Hegney et al (2006). The participants recognised they had greater options for work in the future than they had realised previously and there was a sense of re-invigoration with the breadth and scope possible in nursing and midwifery.
There was also a perceptual change in the participants that, even if conditions and environment were not optimal for much enjoyment at present, this would likely not always be the case. The conceptual meaning of hope includes fluidity of expectations; it can exist even “in the event that the desired object or outcome does not occur” (Faran Wilkin & Popovic 1995: 6). Duggleby and Wright (2007) previously noted the importance of hopefulness in palliative care nurses for reducing work-related stress. The findings in the current study confirmed that hopefulness is also linked with feelings of fulfilment in nurses and midwives working in a women’s and children’s health service. Further, this dimension of hope for a positive future was an outcome of the intervention and denoted recognisable growth of personal resilience (Jackson et al 2007).

8.6 Building personal resilience through a work-based intervention

In the current study, participants at all points along the resilience continuum, somewhere between surviving and thriving, assisted each other in their attempts to deal with the challenges of the workplace by learning to become more resilient. The intervention became an exploration of a work-based learning and support group, one that was formed before our eyes. A collaborative learning group resulted where personal resilience was the learning imperative influencing the shared domain, community and practice of the case.

Organisational perspectives about knowledge as capital have led to understandings about the place and function of the social aspect in learning experiences. From a situated context, learning occurs, not within a specific time and place, but rather in an ongoing process of participation in life experiences (Cobb & Bowers 1999). As the problems of managing knowledge emerged, the challenges of transferring both explicit and tacit knowledge to the health sector, including nursing and midwifery, were also identified (Stupans & Owen 2010). The participants in the work-based group of this study had opportunities to transfer their tacit understandings of their work, workplace culture and adversities, and methods of coping to each other. They
also received tacit understandings about the nursing culture from their experienced mentors, who had negotiated their way through health care organisations before them. The aptitude for nursing mentors to stimulate positive analysis in their mentees from mutual professional experiences was noted by Bally (2007). This aspect of the intervention demonstrated the potential of mentoring partnerships to act as conduits for tacit information useful to nursing practice and their effectiveness as a strategy for nurses and midwives vulnerable to workplace adversity.

The work-based learning program of the current study provided additional implications about the role of interventions in nurses and midwives becoming more resilient. The modern-day nurse/midwife needs both ‘global’ knowledge and skills for making a living and ‘local’ skills and knowledge for making a life; both are the products of social functions. Nurses and midwives require knowledge for both self interests and organisational interests. One way of achieving this is through situating learning in a social unit, such as the intervention in the current study. Walker (2003) urged for ‘thinking globally, acting locally’ initiatives in nursing practice development. The intervention in the current study emphasised transformative learning at the local level of the group, and yet conceived of creating a better workplace, and world, in which to practice nursing and midwifery.

The intervention enabled the participants to form an identity of their own around personal resilience that was inclusive of each other as holders and sharers of particular knowledge. The participants were linked by an area of knowledge that could be examined, clarified and developed in order to more successfully reach best practice. Gerber (2001) referred to this knowledge as the ‘common sense knowing’ that results in smart and practical ways of completing work successfully. Gerber suggested that the common sense knowledge is that which is understood and used by other workers in the workplace. The professional identity of the participants became both an individual and a collective one that knew about and utilised personal resilience as a way of surviving and thriving in their workplace. Identity formation is a continual process of finding meaning both of the world and of one’s own experiences in it (McCarthy & Moje 2002). The nursing and midwifery identity is driven by context-specific concerns and ways of knowing, such as ‘caring’ or ‘professionalism’ (Deppoliti 2008). Through the intervention, the participants were able to find value in
their own personal knowledge and insights with others who possessed similar contextual knowledge and meanings. This allowed individuals to build their own credibility in the presence of respected others.

The discussion of this case study allows for the posing of a defining question about whether work-based learning groups should and do emerge naturally or through design and facilitation. The findings of this case study suggested that whether groups are made up of people from similar or discrete backgrounds, whether they share one common goal or practice or cross organisational boundaries, supportive learning groups can be both emergent and intentional. What does seem necessary for success, from this case study’s example, is that an evolutionary process occurred out of personal ownership and responsibility for learning by the participants themselves.

An important aim of the study was developing a learning intervention to improve the personal resilience of nurses and midwives. This required building the resilient self within the learning group. Self-examination and self-discovery must be an important aim for programs that seek to build resilience, even when the primary focus is on the workplace. Glass (2007) previously wrote about the importance of integrating both personal and professional resilience. She claimed that achieving career satisfaction both inside and outside the workplace was necessary for resilience and for supporting the health of workers. The participants in the current study learnt to interpret their situations, bring a variety of knowledge and experiences to assist their interpretations and reflect on their own feelings and actions. They made personal meanings of their experiences and built a more integrated personal identity through their own narratives. This process served to stimulate the ability to reflect on their own practice and positively influenced their personal resilience. Therefore, personal resilience needs to be developed in both personal and work spheres concurrently to be most effective and permanent.
The current study has added to and informed the knowledge base of workplace adversity, resilience and the use of interventions to improve resilience. The findings are not only applicable to the case under study, but to other contexts of nursing and midwifery, and could be utilised in any areas where people work in organisations.

The new knowledge in relation to workplace adversity was the detailed explication of the phenomenon for nurses and midwives. The current study reinforced existing knowledge about the factors associated with workplace adversity. This study provided additional understanding about the effects of workplace adversity and the need to manage it by enhancing the self and developing personal resilience.

In relation to personal resilience, the current study has shown that in order to be resilient one must strive for authenticity. This is not well emphasised in the literature. The intervention’s mentoring program was unique in that it used retired mentors, and showed the importance of mentoring for nurses and midwives coping with workplace adversity. The intervention workshops reinforced current knowledge of various andragogical techniques such as experiential and creative learning opportunities. Another area of new understandings provided by the current study was the associations between personal resilience and health, wellbeing and sense of fulfilment from work.

The current study showed that learning the skills and knowledge requisite for personal resilience was possible through a work-based, educational intervention. The intended learning outcomes of the intervention were achieved, to varying degrees with individual participants. Increased resilience afforded the participants a range of benefits that strengthened and sustained them. It was evident that the selected strategies used in the intervention to build and maintain resilience had merit and resulted in positive outcomes. These findings provided new implications for the possible ways of engaging people working in organisations in the task of self-development and the improvement of resilience.
8.8 Summary

This chapter discussed the study findings in relation to building resilient nurses and midwives and building a better workplace through personal resilience. It also discussed the implications for conceiving and implementing work-based interventions to improve personal resilience. This discussion explored the concept of an intervention that emphasised group support and experiential learning. These findings concurred with existing literature, but extended understandings about how such learning is beneficial for nurses and midwives facing workplace adversity. It has been shown that building and strengthening personal resilience has positive effects for nurses and midwives, in both individual and organisational contexts. The nurses and midwives in the current study were able to build on several dimensions of themselves and the workplace environment that afforded them better health, wellbeing, fulfilment and commitment to stay. The potential benefits of regaining hope, monitoring and maintaining self-care, and adding authenticity to successful nursing and midwifery practice were also indicated. The discussion conveyed the ways and means the participants improved their workplace through personal resilience, by building more effective communication, collegial support and collaborative capital. The chapter contextualised the meaning of what it means to ‘thrive’ in the nursing and midwifery setting which extends understandings of extant literature.
CHAPTER 9: Abstract

This chapter concludes the thesis and summarises the principal findings of the current case study. The chapter also discusses the strengths and weaknesses of the current study and their influence on the findings. The chapter presents the implications and recommendations for nurses and midwives, nursing managers and health care organisations revealed by the findings of this case study.
CHAPTER 9: Conclusion

9.1 Recapping the findings

A primary aim of this case study was to investigate the phenomena of personal resilience in a group of nurses and midwives. Another principal aim was to explore ways an effective intervention could be developed and implemented that would improve their experiences in the contemporary clinical context. Fourteen nurses and midwives participated in the study from a women’s and children’s health service. The study intervention comprised a series of workshops about personal resilience in a work-based learning and support group, and the establishment of mentoring partnerships with senior or retired nurses or midwives for a period of six months.

The use of a qualitative, collective case study methodology enabled detailed and rich interpretations to be made of the case. The participants’ experiences and insights before, during and after intervention were used to develop a detailed picture of what constituted workplace adversity, and how personal resilience was developed, strengthened and maintained by these nurses and midwives. In-depth participant interviews, field notes and a reflective journal further illuminated the development of personal resilience over time, and after exposure to a work-based learning and support group.

The findings of the current study concluded that the development and strengthening of personal resilience increased health and wellbeing, sense of fulfilment at work and commitment to stay. The nurses and midwives in the current study became more knowledgeable about the attributes and process of personal resilience and more adept at identifying and implementing strategies of resilience that were useful in their everyday lives. They realised the benefits of possessing greater personal resilience than they had before. These characteristics included the possession of greater personal autonomy, positive outlook and hope, and more manageable and satisfying work/life balance. Significant changes to these characteristics improved their personal resilience, as evidenced by their ability to better withstand the deleterious effects of workplace adversity.
The study findings also indicated the positive benefits associated with personal resilience as a process. Over the study period the study participants reportedly became more resilient through engaging with various internal processes of self-reflection, authenticity and creative self-expression. Greater self-awareness had implications for positive changes in self-care, engaging in teamwork and supporting informal networks within the workplace.

Study findings revealed that increased personal resilience positively influenced the personal and workplace factors associated with workplace adversity. The participants understood more about the problems associated with workplace adversity and were aware of the range of strategies they could use to assist them coping with the issues that most concerned them. They found healthier ways to cope with the characteristics of workplace adversity they experienced -- stress, fatigue and emotional overload. Some participants became proactive in creating more balance between work and life spheres, or more committed to protecting the time they wished to spend with family and friends, or on their own recovery between work shifts. They gained personal benefits by putting resilient behaviours and attitudes into action. In the workplace they became more autonomous and assertive in communicating their own needs and opinions, especially during stressful incidents or when encountering communication problems with colleagues or managers. In addition, the participants reportedly felt more in control and hopeful about their future prospects in life and work.

Another conclusion drawn from the study was that the intervention was a successful method of enhancing and maintaining personal resilience. The implementation of a work-based learning and support group allowed the participants to widen their networks of collegial support, form positive relationships with colleagues based on trust and shared experiences, and share insights about coping and maintaining wellbeing in their profession. In addition, there were opportunities for the participants to practise strategies that they had not conceived of or used before, such as relaxation and self-care techniques, assertive communication and letting go of harmful emotions. The intervention provided the participants with a mentor who worked with them to progress their career and personal goals. The mentors performed the role of a critical
friend, who supported the participants in their efforts to understand, adapt and flourish within a large, bureaucratic organisational culture.

The problems of coping with workplace adversity in various nursing workplaces and settings are observed across the world. The program intervention was an innovative attempt, in its broad range of learning strategies drawn together, to assist in the alleviation of serious and complex difficulties encountered by the nurses and midwives in a complex and problematic setting. The intervention was successful in achieving its aims of understanding the current levels of workplace adversity and resilience in the case and developing, trialling and evaluating a model for building, strengthening and maintaining personal resilience.

9.2 Implications for nurses and midwives

The current study’s findings had implications for the way nurses and midwives approach their everyday lives and work. Personal resilience involves the accomplishment of knowledge and skills that enable progression through and beyond personal setbacks. Therefore it has an integral part to play in the experiences of all nurses and midwives, who will no doubt face professional and personal challenges during their careers.

The current study confirmed the notion that care-giving is dependent upon one’s personal resources and the ability to rebuild and replenish them periodically from internal reserves within the self (Authier 2005). The findings support literature suggestions that it is crucial for nurses and midwives to prioritise the development of resilience for the sake of their personal health and wellbeing (Gillespie et al. 2007; Holman et al. 2009; McAllister & McKinnon 2008). Practitioners who define and monitor their own personal resilience may be better able to survive and thrive in the workplace.

A dimension of the study findings reflected the importance of the notion of self-discovery in the incidence of personal resilience. Integration of both ‘work’ and
‘outside work’ personas was crucial to the high self-appraisal of personal resilience within the collective case. The experiences of the participants revealed that personal resilience needs to be developed in both personal and work spheres concurrently to be most effective and permanent. The participants became more aware of the need for authenticity in their lives in order to enhance and maintain their personal resilience. This ability also had implications for the level of energy and personal resources they had available to practise quality patient care in the way they desired.

The findings also indicated that it may be important for nurses and midwives to develop and maintain a collective response to workplace adversity through personal resilience. The participants in the current study re-defined their concepts of resilience to incorporate an understanding based on shared tacit knowledge and similar experiences of the workplace and the intervention. From this informed concept, they utilised new strategies of resilience to counteract workplace adversity; the participants’ narratives of coping within the group were taken up and applied by others in replicate work situations. This finding had implications for understanding the role of shared experiences in the utilisation of personal resilience. It provided further insights about the personal development needs of nurses and midwives at every stage of their career.

Another part of the collegial response to workplace adversity revealed by the findings was reciprocal support between nursing colleagues. The experiences of the study participants showed the protective value of positive collegial support to coping with adverse events and averting professional burnout. The positive communication and supportive relationships formed between the participants led to them feeling less stressed, more comfortable at work and able to enjoy their work. This finding revealed the importance of nurses and midwives forming reciprocal bonds of trust and support before effective teamwork and professional communication can eventuate in workplace environments. Emphasising personal resilience may be a way for nurses and midwives to develop and maintain the elements and behaviours of a collaborative workplace.

The value of experiential learning, creative self-expression and exposure to new ideas and strategies for personal resilience was also illuminated by this research. The
findings suggested that creative self-expression may be a helpful activity for the renewal of hope and re-invigorating passion and commitment to nursing and midwifery work. Participating in mentoring relationships for personal and career growth was also found to be a significant way of expanding the professional networks of nurses and midwives. Findings suggested that mentoring was vital for nurses and midwives facing workplace adversity. The current study’s program was instrumental in guiding career progression for the participants, and developing their self-confidence and maturity in dealing with the culture of large health organisations.

9.3 Implications for nursing managers and health care organisations

The current study’s findings also suggested several organisational initiatives that would complement the incidence of personal resilience in nurses and midwives. Insights arising from the study indicated that managerial responses that incorporate personal resilience into the workplace environment and practice wherever possible are beneficial. It is claimed that even small, incremental changes that allowed staff to experience less frenetic circumstances during a shift may be beneficial in maintaining a sense of wellbeing. The findings indicated that the development of specialist nursing roles and other opportunities to provide nurses and midwives with greater personal autonomy are effective in reducing the effects of workplace adversity. This knowledge is important for nursing managers who need to maximise staff efficacy and wellbeing but are constrained by workplace conditions of constant staff shortages and rising organisational demands.

The findings of the study regarding self-care and work/life balance have several implications for staff development programs within health care organisations. Previous studies have advocated for the inclusion of educational interventions, for example regarding workplace bullying, that are appropriately timed in the socialisation experiences of new nursing graduates (Hutchinson 2009). The current study has also shown that timing is important; that periodic or “refresher” workplace interventions to do with maintaining self-care practices are recommended, especially
for nurses and midwives working in environments of considerable workplace adversity. Additional operational approaches, such as the enforcement of proper shift breaks and equitable self-rostering systems, allow for greater flexibility and work/life balance and are also necessary to facilitate personal resilience in nursing and midwifery staff.

The personal enjoyment factor of work was an important motivation to stay and continue in their jobs for the participants in the current study. The participants’ motivation came from working with specific client groups, challenging obstetrics and gynaecological diagnoses and treatment, and finding variety within their role. It is crucial that nursing managers are aware of the elements of their team members’ jobs that are fulfilling to them. These findings are an inducement for managers to foster opportunities for their staff to maintain adequate contact with clients or nursing work that will continue to intrigue, fascinate and fulfil them.

The findings of the current study found managerial support to be another important organisational asset for the maintenance of personal resilience. The participants perceived that the support of the nursing unit manager was pivotal to feeling encouraged, recognised and a sense of coping at work. These findings suggest the importance of transformational leadership qualities in nursing managers, and especially in the context of managing nurses and midwives who are exposed to workplace adversity. Managers need to convey confidence in their staff and make a personal investment in the sense of achievement experienced by the nurses and midwives they manage. The findings also indicate the importance for health care organisations to ensure stable, effective management structure, positions and staff policies in areas where there is little control over patient demands or workload.

An additional aspect revealed in the study was the role played by collegial support in developing, building and maintaining personal resilience. Participants believed that support and feedback from their colleagues was as meaningful, and in some cases more meaningful, than that of their partners and closest friends. Organisational efforts that encourage peer support and the development of professional networks between colleagues are therefore crucial. Managers need to ensure that adequate and appropriate opportunities for staff to de-brief with each other are provided, on a regular and continuous manner rather than in response to traumatic events. It is
critical that managers foster a sense of community in the workplace, and value and support leadership qualities that produce a collective orientation amongst the staff.

The study revealed the need for interventions of this nature to be reinforced with regular small groups that continue the aims of consolidating and maintaining learning outcomes. There was evidence to suggest that compulsory minimum attendance should be attempted, because of the staff perceptions that voluntary initiatives may allow non-cooperative or uninformed staff members to avoid confronting issues such as bullying and workplace aggression. Access to meetings for all modes of shift workers would be another important component of effective interventions. These work-based groups could be modelled on a community of practice framework (Andrew Tolson & Ferguson 2008; Wenger 2006), a group-managed structure that could provide collective support and assist nurses and midwives to withstand workplace adversity. These small groups would need appropriate facilitators to help colleagues engage in safe and honest communication with each other about workplace issues. The groups could also reinforce resilience measures such as self-care strategies. An additional benefit could be to reduce and circumvent relational difficulties between colleagues that might otherwise escalate to official conflict resolution procedures.

One element of the participants’ positive emotions about their workplace was the continuing commitment of the organisation to providing staff development and education programs. The provision of work-based learning opportunities, even in workplace contexts of heavy workload and patient volume, had significant implications for staff retention and is a recommendation of the current study. The findings of the current study bolstered the argument for the inclusion of personal resilience in work-based learning programs and as an important part of staff development. The current study indicated that having knowledge, skills and strategies to withstand workplace adversity is in fact crucial for the longevity of nurses and midwives and for the long-term improvement of workplace environments.

Similarly, the value of implementing mentoring opportunities in the workplace emerged from this study, especially for nurses and midwives who are potentially vulnerable to experiencing difficulties in coping with work demands or who already
face onerous family or study responsibilities. The current study demonstrated the successful outcomes of a mentoring program involving retired and senior working nurses and midwives as mentors. The benefits of providing organisational support in this way for staff members is now clear and should be implemented more widely.

9.4 Recommendations for future research

The significance of the findings in the current study suggested that personal resilience in nursing and midwifery is a rich field for future research. The current study was a collective case study of nurses and midwives in a women’s and children’s health service. Further studies that focus on wider clinical contexts are required, so that findings from other areas of nursing are compared and contrasted with those of the current study. Future research could indicate how broadly interventions of this kind can be applied in different operational areas or organisations in the health sector. Further studies could also explore whether there are context-specific adaptations of personal resilience within nursing and midwifery that must be considered for best results.

Future studies should also discover whether other demographically-defined cases, for example older nurses and midwives, overseas-qualified nurses and midwives or those working in remote and regional areas, have particular requirements for the development and maintenance of personal resilience. Comparisons could be drawn about the experiences of these groups in relation to others and the requisites of appropriate work-based interventions for them.

Furthermore, this research highlighted many aspects of personal resilience that were helpful for the participants in coping with everyday stresses and challenges. The characteristics of personal resilience that were used to frame this investigation, based on previous work by Jackson et al (2007) and others, included several positive concepts such as optimism, work/life balance, reflective thinking, emotional intelligence, spirituality, hardiness, supportive networks and relationships. Further
research is needed to discover more about the effect of these attributes and processes of personal resilience that particularly assist nursing and midwifery work.

Additional studies are required to investigate further the development and implementation of resilience interventions, especially in the work-based context of learning. Similarly, the successful implementation in the current study of a mentoring program involving retired nurses and midwives has additional implications for future research. Continuing research could confirm and extend the findings of this study, by potentially increasing the mentoring period, increasing support for the establishment phase of the program or by including opportunities for mentoring partners to spend time together in the clinical context.

9.5 Limitations of this study

In keeping with case study method, the current study revealed the experiences, attitudes and perceptions of the collective case under investigation. Therefore, it was important that broad generalisations were not made about the perceptions of workplace adversity and personal resilience in all other contexts of nursing and midwifery, or other health services.

The chief challenges of using a collective case study were to do with the co-ordination and management of the large amount of research material generated. Effective and systematic organisation of the huge amount of data provided a challenge in itself. The intense engagement required with study participants over a prolonged period of time, developing relationships that facilitated the collection of deeply reflective insights, was an additional challenge. The use of substantive theories such as authenticity of participant narratives was a vital component of this research. Authenticity refers to the faithful portrayal of the “range of different realities...the feel and tone of participants’ lives as they are lived” (Polit & Beck 2009: 493).

A limitation of the current study was the chronic shortage of nursing staff in the case setting, which potentially reduced the number of participants for the study. Although
the hospital organisation was supportive and the Director of Nursing was part of the research team, there was a staffing situation that may have discouraged some nursing unit managers from releasing potential participants for the study. This was because the participants were required to have an entire day away from the wards each month to attend workshops. These workplace pressures may have affected the number of participants, and therefore the potential inclusion of other insights and opinions of nurses and midwives than was possible. Participants were also recruited by voluntarily responding to a pamphlet placed in staff tea-rooms; therefore some potential participants may not have been aware of the research study because they did not see the pamphlets.

Another limitation of the study was that it was not possible to recruit a corresponding number of retired mentors for the number of participants in the study at the time of the intervention. While it may be that many retired nurses and midwives possess a potential wealth of knowledge and skills advantageous to mentees, the retirement stage of life is often characterised by a desire for flexible lifestyle options, travel and pursuit of interests that may have been neglected before. Therefore, recruiting suitable retired mentors who were available during the study intervention period was difficult and created a potential limitation to the richness of mentoring experiences.

9.6 **Strengths of this study**

The current study was conducted using a qualitative methodology, which afforded great strength and complexity to the sum and richness of the data pertaining to the phenomena under investigation. This facilitated better understandings of the presence of workplace adversity faced by nurses and midwives and its impact upon their lives. The use of in-depth interviewing of participants over the three phases of the study added strength because it evidenced the means by which the development and strengthening of personal resilience over time has the potential to alleviate the effects of workplace adversity. The sequential research design allowed for initial theories to be developed, and built upon at each phase. These sequentially developing theories were also valuable in assisting the research process as they revealed unfolding themes.
and categories that required further exploration. In this way, findings were validated in subsequent phases and more conclusively drawn in the final analysis.

The intervention chosen was a strength of the research; it was responsive and comprehensive in its approach to dealing with the real-world problems of the collective case, established from the first phase of the study. The work-based learning intervention was an effective program in addressing the aim of improving personal resilience in the case. The experiential learning opportunities provided were shown to be effective in communicating the need for personal resilience and strategies for its alleviation to the participants. The variety and range of learning activities were also beneficial for nurses and midwives who were experiencing negative effects through aspects of their health and wellbeing. The mentoring program was innovative in its use of retired mentors, who proved to be most effective in translating tacit and explicit knowledge about succeeding in nursing careers within large health care organisations. Therefore the current study established a unique model for approaching learning in the workplace. The intervention included both group learning opportunities for developing communication, cohesion and support networks in the workplace, while also attending to the participants’ needs for personal growth and career development with a mentor outside the work sphere.

9.7 Summary

This thesis has presented the evidence for promoting personal resilience as a crucial part of the contemporary nursing workplace. The findings contribute a series of insights about the serious effects of workplace adversity upon nurses and midwives in both professional and personal areas. The thesis adds to understandings about the ways personal resilience is developed, strengthened and maintained by nurses and midwives, and highlights the reasons why some nurses and midwives continue to survive in the current nursing climate, and enjoy their work amidst harsh environmental conditions. The current study evidences one way that nursing leaders may support the development and strengthening of personal resilience in the nurses and midwives working within their organisations. The findings also demonstrate the
personal benefits to be found from maintaining personal resilience for individual nurses and midwives. This thesis includes a comprehensive framework for a model work-based intervention in this area. As indicated by the outcomes for the participants in this study, it points the way to what personal resilience interventions may achieve in other contexts of nursing and midwifery. It heralds the future of nursing research in this important area that may see beneficial outcomes for more nursing staff in the future.
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APPENDICES
## Appendix A: Summary of research study details

<table>
<thead>
<tr>
<th>Reference</th>
<th>Methodology and method</th>
<th>Sample</th>
<th>Context</th>
<th>Aim/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ala-Mursula et al (2002)</td>
<td>Quantitative Analysis of questionnaire and register data</td>
<td>6442 (4,952 women)</td>
<td>Finnish municipal employers</td>
<td>Investigate employees' work-time control on health, accounting for other aspects of job control</td>
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<tr>
<td>Borges &amp; Fischer (2003)</td>
<td>Quantitative Self-administered questionnaires</td>
<td>20</td>
<td>15 Brazilian practical nurses and 5 registered nurses</td>
<td>Assess the impact of 12hr fixed night shift on sleep-wake cycle, duration/quality of sleep and work-time alertness</td>
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<tr>
<td>Button (2008)</td>
<td>Quantitative Self-report survey</td>
<td>212</td>
<td>Nurses and midwives</td>
<td>Examine the role of social support and individual coping strategies (problem focused, emotion-focused) in health care related occupational stress and health</td>
</tr>
<tr>
<td>Cash et al (2009)</td>
<td>Mixed methods Focus groups, 6 survey instruments</td>
<td>115</td>
<td>Canadian Nurse educators</td>
<td>Meta-analysis of nurse educator recruitment and retention</td>
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<tr>
<td>Cline et al (2003)</td>
<td>Qualitative Focus groups</td>
<td>7</td>
<td>US acute care nurses who resigned</td>
<td>Explore how and why of nurses who voluntarily left employment</td>
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<tr>
<td>Costa Sartori &amp; Akerstedt (2006)</td>
<td>Quantitative Multiple logistic regression analysis of surveys</td>
<td>21,505</td>
<td>Data set of 3rd European Survey on working conditions</td>
<td>Analyse variability and flexibility of working hours and health and wellbeing</td>
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<tr>
<td>Draper &amp; McSherry (2002)</td>
<td>Editorial</td>
<td>NA</td>
<td>Nursing research</td>
<td>Critique spirituality and spiritual assessment in nursing</td>
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<tr>
<td>Duggleby &amp; Wright (2007)</td>
<td>Mixed methods Herth Hope Index, open-ended survey questions</td>
<td>113</td>
<td>Professional care-givers in palliative care, Canada</td>
<td>Explore and describe hope and its impact on work-related stress</td>
</tr>
<tr>
<td>Study Authors</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Research Design/Approach</td>
<td>Research Question</td>
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<tr>
<td>Fischer et al (2006)</td>
<td>Quantitative Statistical analyses Work Ability Index (WAI)</td>
<td>996</td>
<td>Brazilian public hospital nursing personnel</td>
<td>Identifying variables associated with inadequate work ability</td>
</tr>
<tr>
<td>Garrett &amp; McDaniel (2001)</td>
<td>Quantitative Multiple regression analysis</td>
<td>287</td>
<td>US full-time registered nurses</td>
<td>Explore relationships between environmental uncertainty, social climate and burnout</td>
</tr>
<tr>
<td>Geiger-Brown et al. (2004)</td>
<td>Quantitative Postal &amp; telephone survey of 32 postal non-respondents</td>
<td>473</td>
<td>US female nursing assistants</td>
<td>Explore the impact of demanding work on mental health</td>
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<tr>
<td>Gould &amp; Fontenla (2005)</td>
<td>Qualitative Interviews</td>
<td>27</td>
<td>UK nurses in clinical grades in two contrasting trusts.</td>
<td>Explore opportunities to undergo continuing professional education, family friendly policy and holding an innovative or traditional post on nurses’ job satisfaction and commitment.</td>
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<tr>
<td>Greenhaus &amp; Powell (2006)</td>
<td>Research proposition</td>
<td>NA</td>
<td>Positive emphasis on interdependencies between work life and family life</td>
<td>Propose a theoretical model of work-family enrichment and examine an instrumental path and an affective path to enrichment.</td>
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<tr>
<td>Harrisson et al (2002)</td>
<td>Quantitative Self-administered questionnaires, multiple regression analysis</td>
<td>171</td>
<td>Canadian nursing assistants and registered nurses</td>
<td>Examine relationships between hardiness, psychological distress and work support in nursing assistants and registered nurses</td>
</tr>
<tr>
<td>Healy &amp; McKay (2000)</td>
<td>Quantitative Self-administered questionnaires, 5 standardised questionnaires</td>
<td>129</td>
<td>Australian registered nurses</td>
<td>Measure coping strategies dealing with work stress</td>
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<tr>
<td>Hegney et al. (2006)</td>
<td>Quantitative Postal survey</td>
<td>1447</td>
<td>Australian registered nurses, AINs, ENS in Queensland Nurses Union</td>
<td>Identify intrinsic and extrinsic work values and impact on job satisfaction</td>
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<tr>
<td>Hutchinson et al. (2006)</td>
<td>Qualitative In-depth, semi-structured, qualitative interviews</td>
<td>26</td>
<td>Australian registered and enrolled nurses</td>
<td>Exploring nurses’ experiences of being bullied and their beliefs, meanings and perceptions about bullying</td>
</tr>
<tr>
<td>Isen &amp; Reeve (2005)</td>
<td>Quantitative Behavioural experiment</td>
<td>60</td>
<td>US psychology students</td>
<td>Examine relationship between positive affect and self-regulation and self-control with work tasks</td>
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<tr>
<td>Reference</td>
<td>Type of Study</td>
<td>Sample Size</td>
<td>Setting</td>
<td>Focus of Study</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
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<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Keller, Berryman &amp; Lukes (2009)</td>
<td>Literature review</td>
<td>NA</td>
<td>US occupational health nurses</td>
<td>Reviews current literature on shift work, error rates and adverse outcomes</td>
</tr>
<tr>
<td>Laschinger Finegan et al (2001)</td>
<td>Quantitative Postal survey</td>
<td>273</td>
<td>Canadian medical-surgical and critical care nurses</td>
<td>Evaluated the effects of employee empowerment on perceptions of organizational justice, respect, and trust in management</td>
</tr>
<tr>
<td>Mathes (2005)</td>
<td>Literature review</td>
<td>NA</td>
<td>Individual nursing practice</td>
<td>Explication of moral autonomy and moral responsibility in nursing</td>
</tr>
<tr>
<td>McCraty, Atkinson &amp; Tomasino (2003)</td>
<td>Quantitative Treatment and control group experiment</td>
<td>38</td>
<td>Male and female hypertensive employees of global IT company</td>
<td>Determine if stress management course affected blood pressure</td>
</tr>
<tr>
<td>McQueen (2003)</td>
<td>Literature review</td>
<td>NA</td>
<td>Individual nursing practice</td>
<td>Reviews literature on emotional intelligence, emotional labour and value of EI for nursing</td>
</tr>
<tr>
<td>Morante (2005)</td>
<td>Report of a staff support initiative</td>
<td>Unknown</td>
<td>Nursing staff of a UK specialist psychiatric service</td>
<td>Gives an account of how the group used psychoanalytic thinking to create a regular reflective space to manage anxieties arising from their close contact with patients struggling with severe mental illness.</td>
</tr>
<tr>
<td>Mrayyan (2005)</td>
<td>Quantitative Electronic survey</td>
<td>300</td>
<td>US nurses</td>
<td>Study American nurses’ work autonomy and, in particular, autonomy over patient care and unit operations decisions.</td>
</tr>
<tr>
<td>Noblett (2003)</td>
<td>Quantitative Electronic and hardcopy survey</td>
<td>210</td>
<td>Staff from a medium-sized, public sector organization located in a large Australian city</td>
<td>Addresses some of the barriers to adopting the health promoting settings approach when tackling occupational stress</td>
</tr>
<tr>
<td>O’Connell, Young, Brooks &amp; Hutchings (2000)</td>
<td>Quantitative Self-report questionnaires</td>
<td>209</td>
<td>Australian nurses in a metropolitan teaching hospital</td>
<td>Determine nurses’ perceptions of the nature and frequency of aggressive behaviours in general wards and high dependency areas</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Method(s)</td>
<td>Sample Size</td>
<td>Setting</td>
<td>Study Object(s)</td>
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<tr>
<td>-------------------</td>
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<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Piko (2003)</td>
<td>Quantitative Self-administered surveys</td>
<td>420</td>
<td>Student and registered public hospital nurses in Hungary</td>
<td>Detect the effects of demographic and socio-economic factors on variables of psychosocial work environment as an indicator of psychosomatic health</td>
</tr>
<tr>
<td>Sang, Ison &amp; Dainty (2009)</td>
<td>Quantitative Self-report questionnaire</td>
<td>110</td>
<td>UK practising architects</td>
<td>This paper aims to explore the job satisfaction of architects on their occupational well-being and work-life balance</td>
</tr>
<tr>
<td>Scott-Cawiezell et al (2004)</td>
<td>Mixed method analysis Survey and open-ended questions</td>
<td>995</td>
<td>US nursing home administrators, managers and clinical staff</td>
<td>Explore nursing home staff perceptions of communication and leadership</td>
</tr>
<tr>
<td>Strang et al (2002)</td>
<td>Quantitative Postal survey</td>
<td>141</td>
<td>Registered nurses, managerial staff and nursing auxiliaries from neurology, neurosurgery, oncology, psychiatry, palliative care and nursing home nursing</td>
<td>Describe how Swedish characterise the meaning of spiritual needs in a broad context and what kind of significance nurses place on the spiritual dimension</td>
</tr>
<tr>
<td>Swody &amp; Powell (2007)</td>
<td>Theoretical paper NA</td>
<td>NA</td>
<td>Organisational management</td>
<td>Proposes two parallel conceptual models of the complex, multi-level mechanisms behind employees’ decisions to participate in their organisation’s family-friendly programs</td>
</tr>
<tr>
<td>Walker, M.J. (2006)</td>
<td>Quantitative Quasi-experimental design</td>
<td>98</td>
<td>US nurses working in six hospitals within a hospital network</td>
<td>Test the effects of nurses’ practicing of the Heart Touch technique (internal method of changing thoughts and feelings) on their perceived stress, hardiness, and spiritual well-being</td>
</tr>
</tbody>
</table>
Appendix B: Ethics approval letters

mc

May 11th, 2007

Prof. Debra Jackson
University of Western Sydney
Campbelltown Campus
Locked Bag 1797
Penrith NSW 1797

Dear Prof. Jackson,

Re: HREC Project No. 07/011: Surviving and Thriving in the Face of Workplace Adversity: An Intervention to Develop Personal Resilience in Nurses and Midwives – Prof. Debra Jackson, A/Prof. Lesley Wilkes, A/Prof. Margaret Vickers, and Ms. Glenda McDonald

Thank you for your letter and required amendments dated 10/5/07, in response to the HREC’s letter dated 20/3/07. As all matters raised by this HREC have been addressed, we are pleased to inform you that your study now has final approval.

This approval is valid for a period of three years, from the date of this letter.

The following study documents have also been approved:
- Participant Information Sheet version No. 02 dated May 2007
- Participant Consent Form version No. 02 dated May 2007
- The Resilience Scale.
- Job Satisfaction Survey for nurses and midwives.
- General Health Questionnaire.
- ‘The Social Support Network’ form.
- Invitation letter to participants.

Please ensure compliance with the following conditions of approval of your study and keep this HREC informed regarding:

1. Any serious or unexpected adverse events, involving participants, as applicable to your study.

2. Changes to the research protocol, including if the project is not commenced or is delayed by more than six months from the date of this letter; or is discontinued.

3. An Annual Report should be submitted to this HREC as well as a Final Report on completion of the project. The first Annual Report is due in May 2008 and a template is attached for your use.
4. All current policies relevant to your project must be fully complied with. These policies include, Duty of Care, Infection Control and Occupation Health and Safety (as applicable to your study).

5. The HREC is to be provided with immediate reports of any unforeseen even that might affect the ethical acceptability of the project.

The project approval becomes operative when the attached copy of this letter signed, dated and returned to , Research & Ethics Officer, at address mentioned on this letterhead.

The HREC wishes you success with the project.

Yours sincerely.

I accept, acknowledge and will comply with the conditions of approval for this project.

.................................  .................................
Chief Investigator/Designated Researcher    (Date)
31 May 2007

Professor Debra Jackson, Associate Professor Margaret Vickers & Professor Lesley Wilkes
School of Nursing
University of Western Sydney NSW 1797

Dear Debra, Margaret and Lesley

UWS Registration number HREC 07/106 Surviving workplace adversity: An intervention
to develop personal resilience in nurses and midwives

The UWS Human Research Ethic Committee has accepted the external approval for the
above mentioned research project issued by Sydney West Area Health Service Human

You are advised that the Committee should be notified of any change/s to the research
methodology should there be any in the future. You will be required to provide copies of
the external annual reports on the ethical aspects of your project during its progress and at
the completion.

The UWS Registration Number HREC 07/106 should be quoted in all future correspondence
about this project which should be forwarded to the Executive Officer, Kay Buckley.

Yours sincerely

Associate Professor Louise O'Brien
Acting Chairperson/Deputy Chairperson
UWS Human Research Ethics Committee
Appendix C: Study Poster & Brochure

SURVIVING AND THRIVING IN THE FACE OF WORKPLACE ADVERSITY

Are you thriving? Or just surviving?

Resilience Workshops are coming!!!

All nursing staff in Maternity are invited to take part in a series of six one-day workshops on-site exploring the key areas of resilience. They will be held from 8:45am to approx. 4:30pm. Lunch is provided.

The workshops will include:

**Fri 4th July – Level 3 West Block Auditorium**
- Positive Relationships and Networks & Mentoring Relationships

**Fri 8th August - Level 3 West Block Auditorium**
- Maintaining a Positive Outlook & Building Hardiness

**Fri 5th September - Meeting Room, Tresilian**
- Intellectual Flexibility & Emotional Intelligence

**Fri 3rd Oct – Level 3 West Block Auditorium**
- Achieving a Life Work Balance & Enabling Spirituality

**Fri 7th Nov - Lecture Rm 1, Learning Centre**
- Reflective and Critical Thinking

**Fri 5th Dec – Lecture Rm 1, Learning Centre**
- Moving Forward & Planning for the Future

These workshops are a totally new initiative for Nepean Hospital and the participants will be required to participate in some evaluation of the program. Participants who attend the whole series of workshops will be paid as if they are on study leave and therefore will be given release time to attend. The hospital administration is very supportive of this venture.

Places are limited!! Bookings close 20th June!!

Please call me now on 0403 411 136 or 47 342343 or email me at glenda.mcdonald@swahs.health.nsw.gov.au to get more information.

Thank you

Glenda McDonald
PhD Student, UNIVERSITY OF WESTERN SYDNEY
As a participant you are invited to:

Fill in some general health and resilience surveys and take part in an audio taped interview

Attend 6 monthly workshops from July 2008 (No assessments)

Be paired with a nurse mentor to support you

After the workshops end, fill in surveys and take part in another interview

Six months later, take part in final surveys and an interview.

Glenda McDonald (PhD student) is conducting a research study into resilience at Nepean Hospital with nurses and midwives. She has a background in Social Science, Nursing Research and Adult Education. She has worked as a facilitator in community education and is passionate about the benefits of lifelong learning.

Nurses & Midwives
Nepean Hospital

Building Resilience Workshop Series

This research project has been approved by the Human Research Ethics Committees of SWAHS and UWS
Are you thriving at work?  
Surviving?  
Or somewhere in between?  

**Have you encountered:**  
☑ physical and emotional exhaustion  
☑ difficult interactions at work  
☑ work stress  
☑ an imbalance between work and life

Then our study needs **YOU**

---

Resilience is the *bounce back* response to adversity or stress.

Join us at 6 new workshops designed to allow you time to reflect on your current resilience level.

**Be connected with a senior, experienced nurse mentor.**
We will explore creative and fun ways to build and maintain resilience. Get more from your 'work' life – you're worth it!

Please call me now
Glenda Ext. 42343  
or 0403 411 136  
Email  
g.e.mcdonald@uws.edu.au

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**Workshops include:**
- Interactive discussions & activities  
- Real-life strategies  
- Guest speakers  
- Art therapy  
- Relaxation  
- Movement

<table>
<thead>
<tr>
<th>Workshop Dates</th>
<th>Workshop Details</th>
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</thead>
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<tr>
<td>4th July</td>
<td>Positive nurturing relation Ships and networks and the mentoring relationship</td>
</tr>
<tr>
<td>8th Aug</td>
<td>Maintaining a positive Outlook and building hardiness</td>
</tr>
<tr>
<td>5th Sept</td>
<td>Developing intellectual flexibility and emotional intelligence</td>
</tr>
<tr>
<td>3rd Oct</td>
<td>Achieving life balance and enabling spirituality</td>
</tr>
<tr>
<td>7th Nov</td>
<td>Encouraging reflective and critical thinking</td>
</tr>
<tr>
<td>5th Dec</td>
<td>Moving forward and Planning for the future</td>
</tr>
</tbody>
</table>
Appendix D: Participant Study Information pack

PARTICIPANT INFORMATION
NURSE/MIDWIFE

Study Title: Surviving and thriving in the face of workplace adversity: An intervention to develop personal resilience in nurses and midwives.

Short Title: Surviving workplace adversity: an intervention to develop personal resilience in nurses and midwives

Chief Investigator: Dr Debra Jackson, School of Nursing, University of Western Sydney

What is the purpose of the study?

This study will develop, trial and evaluate a program aimed at increasing personal resilience in nurses and midwives. It is being conducted so that the needs of nurses coping with workplace adversity can be addressed. It is hoped that this study will provide an effective tool to assist nurses and midwives to survive, and even thrive, in workplaces that are potentially harmful to staff.

Who will be invited to enter the study?

You have been invited to enter the study because you are a nurse or midwife currently working in a specialist women and children's health unit at XX Hospital.

What will happen on the study?

Upon recruitment into the study, you will be invited to take part in an in-depth interview that will be audio-taped, and to complete 4 surveys. The surveys will ask questions relating to your individual resilience, your social support network, job satisfaction, and general health. It is estimated the interview and surveys will take approximately 2 hours to complete. In the next stage of the study, you will be invited to attend six (6) one day workshops approximately one month apart over a period of six months. You will be paired with a senior retired nurse in a mentoring relationship whom you will have access to over the six month period. Then, six months after the workshops have been completed, you will again be invited to take part in another audio-taped interview and asked to give your opinions about whether the workshops and mentorship program helped to improve your personal resilience level, and if so, in what ways the intervention was beneficial.

Are there any risks?

The known risks of this study are:
It is possible that you may become distressed by discussing personal life experiences about workplace adversity. If this occurred to you, access to an experienced counsellor would be offered.
PARTICIPANT INFORMATION

| Study Title: Surviving and thriving in the face of workplace adversity: An intervention to develop personal resilience in nurses and midwives. |
| Short Title: Surviving workplace adversity: an intervention to develop personal resilience in nurses and midwives |

Are there any benefits?
The aim of the workshops is to provide you with a range of skills and positive experiences in the areas of maintaining a positive outlook, building hardiness, developing emotional intelligence and intellectual flexibility, achieving a life balance, enabling spirituality, encouraging reflective and critical thinking, and maintaining positive and supportive relationships and networks. You will also have the opportunity to benefit from taking part in a mentoring relationship with a senior experienced nurse. It is the intention of the researchers that those taking part in this project will acquire helpful skills and abilities to assist both in their nursing practice and their personal lives.

Confidentiality / Privacy
All aspects of this study, including results, will be strictly confidential and only the researchers will have access to your personal information. Any publication of the results from this study will use only de-identified information.

Do you have a choice?
Your participation in this study is entirely voluntary. If you choose not to join the study, or you wish to withdraw from it at any time, you may do so.

Contact details
If you have any problems while on the study, please contact

Dr Debra Jackson

Working hours Telephone No - 02 46203532
After hours Telephone – 0403 411136
CONSENT TO PARTICIPATE IN RESEARCH

<table>
<thead>
<tr>
<th>Study Title: Surviving and thriving in the face of workplace adversity: An intervention to develop personal resilience in nurses and midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Title: Surviving workplace adversity: an intervention to develop personal resilience in nurses and midwives</td>
</tr>
</tbody>
</table>

Name of Researcher:

1. I understand that the researcher will conduct this study in a manner conforming with ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.

2. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Glenda McDonald and I, being over the age of 16, acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

3. I acknowledge that I have been given time to consider the information and to seek other advice.

4. I acknowledge that refusal to take part in this study will not affect the conditions of my employment.

5. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

6. I acknowledge that this research has been approved by the XX Area Health Service Human Research Ethics Committee.

7. I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

Before signing, please read ‘IMPORTANT NOTE’ following.

Name of participant ____________________________________________
Date of Birth _______________________

Address of participant
______________________________________________________________

Name of parent or person responsible(where applicable)
______________________________________________

Address of parent or person responsible (where applicable)
______________________________________________

Signature of participant ____________________________ Date: _______________________

327
Signature of parent or person responsible (where applicable) ____________________ Date: ______________  
Signature of researcher __________________________________________ Date: ______________  
Signature of witness __________________________________________ Date: ______________  

IMPORTANT NOTE
This consent should only be signed as follows:
1. Where a participant is over the age of 16 years, then by the participant personally.
2. Where a participant is between the age of 14 and 16 years, it should be signed by the participant and by a parent or person responsible.
3. Where a participant is under the age of 14 years, then the parent or person responsible only should sign the consent form.
4. Where a participant has impaired capacity, intellectual disability or is unconscious, then specific approval for the process for obtaining consent must be sought from the Human Research Ethics Committee.

WITNESS:

I, ________________________________________________ (name of witness)  
of ________________________________________________ hereby certify as follows:

1. I was present when _____________________________ (“the participant”) appeared to read or had read to him/her a document entitled Participant Information Sheet; or I was told by ______________________________ (“the participant”) that he/she had read a document entitled Participant Information Sheet (*Delete as applicable)

2. I was present when _________________________ (“the researcher”) explained the general purposes, methods, demands and the possible risks and inconveniences of participating in the study to the participant. I asked the participant whether he/she had understood the Participant Information Sheet and understood what he/she had been told and he/she told me that he/she did understand.

3. I observed the participant sign the consent to participate in research and he/she appeared to me to be signing the document freely and without duress.

4. The participant showed me a form of identification which satisfied me as to his/her identity.

5. I am not involved in any way as a researcher in this project.
Name of witness
_____________________________________________________

Address
_____________________________________________________

Signature of witness  ___________________________  Date: ________________

Relationship to participant
_____________________________________________________

DEMOGRAPHIC INFORMATION SHEET

STUDY TITLE: Surviving and thriving in the face of workplace adversity: an intervention to develop personal resilience in nurses and midwives

Age: ___________________

Education level: ____________________________________________

Marital Status: ____________________________________________

Position Title: ____________________________________________

Years Experience __________________________________________

Type of Employment _______________________________________
(full-time, part-time, casual)

Cultural Background: _______________________________________

Thankyou for filling in the demographic information sheet.
Appendix E: Pre-intervention Interview Schedule

Research Aim: to explore participants’ understandings of surviving and thriving in the workplace

How would you describe yourself at work at present – surviving, thriving, or somewhere in between?
Can you tell me some more about why you feel you are thriving/surviving/in between?
Do you see this as a short-term or long-term prospect? What changes do you expect?
What are you future work goals? 2 years? 5 years? Longer term?
What factors have helped you remain in nursing?
Do you try to pass on your knowledge about resilience to others at work? How?

Networks
How would you describe your relationships at work?
How were you treated by others when you started?
Has this changed and developed over time? How so?
What sort of personal support do you have outside work?

Work Environment
How would you describe your work environment?
How would you describe your satisfaction level with work?
Do you have any issue with work/life balance? Family commitments? Older family members you are responsible for? Study?
How do you feel about your present workload?
Are there any concerns you have about your workload?
eg. Extra hours? Breaks? Shifts?
How much control do you have over your work schedule?
Have you found shift work affects your health and wellbeing? How so?
Have you had any injuries in the past year? Work related?
How do you usually sleep?
Can you describe how much control you have over your own work practice? Eg.
What jobs you do at work?
How do you feel about the quality of care you can give?
Have you felt physically or emotionally exhausted during or after work? How often does this happen? Why do you think it happens/happened?
What do you like to do outside work hours? Activities/hobbies? Leisure? Recreation?
What sorts of things do you do if you are feeling stressed about work?
How do you practise self care when you’ve had a bad day/week?

Support
How do think you are supported by the organisation you work for? If not, what do you think could be done to improve things?
How committed do you feel to the organisation?
What is your opinion of the opportunities for professional development for you at work?
Research Aim: to explore participants’ understanding of resilience

What does the term resilience mean to you?
Can you name 3 qualities you have that make you resilient?
Can you put them in number order from 1 to 3 of how important you think they are to resilience?
What qualities do you think are important for a person to improve their resilience?
How do you think these factors can be developed from inside the workplace to raise nurses’ and midwives’ resilience and protect them from burnout?
Some people have written about how their resilience developed from their childhood experiences. Would you agree with that statement in your case?
How do you think you need resilience to work in your job?
Can you think of any positive event that has affected your resilience? How?
Any negative event? How?
How has your health been affected by your resilience levels during your time in this job?

Research Aim: to discover if the participants have issues/concerns that could be addressed at workshops/mentoring relationship

Questions

What sort of qualities would you value in your mentor?
How much contact would you like with them during the study?
Do you have any particular concerns/issues that you would like covered at the resilience workshops?
Do you have any areas of interest you would like to explore at the resilience workshops?
Are you interested in or enjoy any of the following:
- Aromatherapy
- Massage
- Movement – dance, yoga, exercise
- Art
- Relaxation
- Journalling
- Others…………………………
Appendix F: Immediate Post-intervention Schedule

To evaluate intervention:
What comment/s would you like to make about your experiences of the workshops in general?
What did you like about the workshops?
What did you think about the way the workshops were run? (Prompt size, setting, casual style of learning, experiential?)
Were there any personal or professional benefits from the program for you? Can you explain?
What did you think of the way the program was organised? Venues? Content? Study materials? Resources? Style of presentation? Guests?
What did you think about the discussions in the group?
What are your criticisms of the workshops?
Did you think about or use any of the material covered in your everyday life?
Did you want more/less of anything or something else covered in the workshops?
What did you think about using arts and humanities to learn about the topics of the workshops? Eg. Art experiences, photographs, paintings, images, poetry
Have there been any changes to relationships with your colleagues? In the group? At work?
Have you spoken to anyone about the program? Friend/family? Colleagues?
What did you speak about?
Would you recommend this workshop to any of your colleagues for the next cycle?
What are your thought on an ongoing support program (periodically)?

To evaluate mentorship program:
What was your general opinion about the mentoring partnership?
What did you find out about your mentor eg: life or work experiences? Why was that memorable for you?
Did you relate well with your mentor? Why or why not?
What did you learn about with your mentor? What areas were your focus?
Where did you meet?
How regular were your meetings?
Were there any conflicts with your mentor? Were they resolved?
Were you happy with the ways things went?
Will your relationship continue?
Did you feel you were supported by the researchers well while you were mentored?
If not, what would have helped?
Do you feel the experience has helped you in professional ways? Egs.
Did your mentor provide you with any insights about living life well that have helped you? Can you explain?
In what ways could this program be improved –
- frequency of meetings
- ease of access
- choice of mentors
To understand changes or development of resilience:
How did you describe yourself at the beginning of the project? Surviving, thriving or somewhere in between?
How would you describe yourself now?
How are you coping with work stresses at the moment?
What about other sources of stress on you?
Have there been any changes in your work or personal life since you started the project?
How are work relationships going at the moment?
Do you think there have been any changes in your ideas about resilience from before the workshops? In what ways?
Have you changed in any areas of your practice due to the study?
Have you made any changes in your personal life as a result?
How would you explain the meaning of the word ‘resilience’? Has that changed since the start of the study?
How do you feel at the moment about the management? Your supervisor/s?
Has being in the program brought any changes to your relationships with family, friends etc.?
Do you feel any difference in your self-esteem or self-confidence? Can you give an eg of how you know?
What are your plans for the next 6 months? (Work, outside work)
How do you feel about your future at the moment?
Have you made any changes to your lifestyle as a result of participating in the study?
Eg: hobbies, activities, relationships, time management, health, diet, sleep etc.
Appendix G: 6 months Post-intervention Interview Schedule

Workplace Adversity:

Do you still face the same amount of workplace adversity as you did 6 months ago?

How is it experienced currently? (prompts)
- Tiredness, coping, inability to bounce back
- Job dissatisfaction, work conditions, work/life balance, autonomy
- Pressure, workloads, conflict, stress and anxiety, greater responsibility
- Un or under-valued by organisation or colleagues
- Lack of clinical supervision
- Work environment, blaming and shaming, lack of recognition, distrustful atmosphere, intimidation, bullying

What would you say are the 3 primary sources you face at the moment?

Has your health and wellbeing changed over the last 6 months? Has this impacted on your resilience? How so?

Support:

Do you still feel the same level of support from colleagues as you did 6 months ago?
Do you currently talk over work issues and incidents with any colleagues?
Do you find it important to speak with someone who has/had similar experience to feel supported? Has this changed from before?
Do you support other colleagues at work currently? How important is that to you? How do you do this usually?
What is the most deeply satisfying aspect of your work currently? Are there others?
Are you still in contact with your mentor?

Developing personal resilience:

What is your understanding of resilience now? What are its characteristics?
How do you think it has changed over the period of your participation?
Do you believe that your own resilience level has changed from the start? How so?
Has there been any negative or positive events/people etc. that have impacted on your personal resilience over the last 6 months?
Do you believe you increased your knowledge about resilience from your participation? How so?

Have you made any changes over the last 6 months eg: work, home, study, health, lifestyle, practice etc. that you attribute to your participation?

Do you think there has been lasting change from your participation? In what way/s? What do you think were the positive things about the study participation for you?
What about for others?
Were there any disadvantages or drawbacks to participation in your opinion? What were they?

Do you believe that personal resilience has to do with:

- Overcoming adversity
- Coming through negative experiences
- Creating or strengthening one’s sense of self?
- Asserting one’s sense of self against negative events or people?
- Coming from childhood or upbringing
- An innate quality
- A process over time

What is your opinion of the statement, “People can change their personal resilience through receiving education/training?”

Do you believe there is a relationship between resilience and:

- Optimism and positive outlook
- Self-esteem
- Flexibility
- Hardiness
- Emotional Intelligence
- Spiritual awareness
- Work-/life balance
- Supportive relationships
- Organisational support and strategies

Do you think your resilience is shown by personal character traits? Or personal skills and capacities?

Managing personal resilience:

Are you now using different or additional strategies of maintaining your personal resilience than you were 6 months ago?

Self-care strategies, activities, philosophy etc.?

How did that come about and when did you begin using them?
Appendix H: Poem ‘Resilience Journey’

We are like stars each time we meet
Our courses clash, collide and shift
Our words like comets sizzle and flash
Our insights sparkle as jewels of light
Bearing witness to our plight
We are a crew that practise hope
We set our course to explore the self
Resilience is our rocket ship

We come as seekers on this trek
To listen and tell our stories lyrical
“To better myself” we hear one say
To help us whistle as we work each day
To balance our families and our hurts
To cope with stress and challenges to come
To adjust to environments foreign and new
To grow in person and professionally too

We’ll push off the monkey, “No” we will say
Plan for the difficult and the dismayed
The parade of the prickly, profane and in pain
We’ll find our sanity ‘midst crazy reality
We’ll guard ourselves for safety and protection
But not inside walls of blindness and rejection
We’ll find our own skills and some wondrous reflections

We’ll survive and thrive in this troubled, wild land
Converse in the language we all understand
Trust - the banner stretching between us
Learn from a mentor who has journeyed before us
Guide one another as we take our turn
To lead with confidence through the terrain
Our knowledge and experience go hand in hand
And together we will continue to stand
Workshop 6 Evaluation Sheet

Name: (optional) ____________________________________________

What did you think went well today/strengths?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
___________

What aspects, if any, could be added or improved in your opinion/weaknesses?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
___________

How would you rate your experience at the workshop?
Please tick or circle one:

😊 😊 😒

Comment:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
___________

please turn over
**Workshop Series Evaluation**

We would value your comments on the resilience workshops series as a whole.

**What did you think of the series in general?**

**What did you think of the course content? Was any of the information presented new to you? If so, please give details**

**What did you think of the course facilitator?**

Thank you for taking the time to provide your feedback 😊.
## Mentoring Partnership Agreement

This **Mentoring Partnership Agreement** is between

____________________________________________ (Mentor)  
___________________________________________ (Mentee)

This partnership will start on ___________ and end on ______________.
The purpose of the partnership is

___________________________________________________  
___________________________________________________  
___________________________________________________  

Our shared expectations of the roles involved are

Mentor:  

___________________________________________________  
___________________________________________________  

Mentee:  

___________________________________________________  

Our shared expectations of partnership confidentiality are

___________________________________________________  
___________________________________________________  

The logistics of our mentoring partnership will be:  
(communication methods, frequency of meetings, location etc.)

___________________________________________________  
___________________________________________________  

Our shared understanding of the mentoree’s goals for development of professional or personal resilience are

1._________________________________________________  
2._________________________________________________  
3._________________________________________________

We will monitor our progress as a partnership by

___________________________________________________  
___________________________________________________  

We have discussed possible challenges to our partnership and how we will handle them

___________________________________________________  
___________________________________________________  

Name _____________ Signature _______________ Date _________  

Name _____________ Signature _______________ Date _________
APPENDIX K: Mentor Selection Form

Demographic Form for Retired or Senior Nurse/Midwife Mentors

Name: ____________________________________________
Address: ____________________________________________

Phone Contact: ____________________________________________
Preferred time to contact: ____________________________________________
Email: ____________________________________________

(NB: The information above will NOT be used for any purposes except for the researchers to contact you)
Age: (decade if preferred) ____________________________________________
Gender: ____________________________________________
How long you have been retired (if applicable): ____________________________________________
Main Career Position: ____________________________________________
Nursing association memberships? ____________________________________________

What is your opinion of the current approaches in nursing education? ____________________________________________

What kind of support do you think nurses and midwives need? ____________________________________________

Why did you consider participating in the project? What do you think are your best qualities as a mentor? ____________________________________________

My availability as a mentor:
☐ Cycle 1 - August, 2007 til February, 2008
I would be available to have contact with my mentoree on the following basis:
☐ In person ☐ As often as negotiated with my mentoree
☐ By telephone ☐ Weekly
☐ Both by phone or in person ☐ Fortnightly
☐ Monthly
I would be interested in attending mentors get-togethers
☐ monthly ☐ 3 monthly

Thankyou for your assistance in filling out the demographic information sheet.
Calling all senior nurses and midwives!!!

Would you like to pass on your knowledge and skills?

Are you interested in mentoring the next generation of nurses and midwives at XX Hospital?

We need you! 
Please turn over for more details…
Surviving and thriving in the face of workplace adversity: an intervention to develop personal resilience in nurses and midwives

**Research team**: Prof. Debra Jackson, A/Prof. Margaret Vickers, Prof. Lesley Wilkes, Glenda McDonald, PhD student (UWS)
Mrs. Marie Clarke and Mrs. Maya Drum, Mrs. Shantala Mohan (SWAHS)

An innovative research project at XX Hospital will explore why some nurses and midwives are able to survive, and even thrive, in a workplace well recognised as difficult and potentially harmful to the health and sense of wellbeing of staff.

Personal resilience is well documented as an essential attribute for successful and adaptive nurses. This study aims to raise awareness of how and why some nurses have developed resilience, and what are the best ways to pass their knowledge and experience on to others.

**Mentoring program**
A significant component of the project will be the development of a specific mentorship program. The mentors we are seeking will be experienced, senior nurses and midwives who have retired. The aim is to establish a positive mentoring relationship through partnership between a nurse/midwife and a mentor. Upon their recruitment the mentors will be asked to participate in the first workshop of the series where they will be able to reflect on their expertise in mentoring. They will have a chance to meet the nurses and midwives taking part in the study and the other mentors. The mentors will be required to maintain regular contact with one of the nurses or midwives taking part in the study for at least the six (6) month period while they are attending the workshops. It is envisaged that they would provide positive feedback, modelling, and support for their partner. The mentors will be appropriately supported during the project by contact with the PhD candidate and regular opportunities to network with the other mentors. The other workshop topics for the study participants (nurses/midwives) will include

- Establishing positive nurturing relationships and networks
- Understanding mentoring relationships
- Maintaining a positive outlook and personal hardiness
- Developing intellectual flexibility and emotional insight and intelligence
- Achieving a life balance and enabling spirituality
- Encouraging reflective and critical thinking
- Moving forward and planning for the future

These themes may be useful to trigger conversations between mentors and participants.

Please consider the contribution you can make by becoming a mentor for a nurse or midwife currently in the workforce. If you would like to participate in the project, or would like more information please contact Glenda McDonald on 0403 411 136 or 47 342343, or email her at glenda.mcdonald@swahs.health.nsw.gov.au
Appendix M: Mentor Study Information pack

2nd July, 2007

Dear,

Re: “Surviving and Thriving in the Face of Workplace Adversity” study

Thank you so much for your interest in the study and your agreement to participate as a mentor. We are excited about the prospect of beginning the mentoring program, and hope that you will enjoy participating.

As you may know, you are invited to attend a Mentoring Information Day on Monday 6th August, 2007 at xxxx from 10:00am – 2:30pm. Refreshments and lunch will be provided. Please RSVP to me by 20th July for catering purposes.

Professor Debra Jackson and Professor Lesley Wilkes from the School of Nursing, UWS will lead the sessions, and it will be a good time to reflect on mentoring experiences and re-hone skills. There will also be an opportunity to meet the nurse/midwife participants in the study as well as the other mentors. If you are definitely unavailable on that day due to work or teaching commitments, please let me know and I can make other arrangements.

I will be arranging regular informal meetings over the coming months for the mentors to meet together and I am looking forward to hearing your thoughts about the mentoring experience.

Please find enclosed a Participant Information Sheet, Consent form, and Demographic Information form. Please read them at your convenience, and if you are happy to proceed, sign the Participant Information Sheet and Consent form and complete the Demographic Information form. Please return them to me at the address below.

I would be happy to speak with you if you have any questions at all.

Yours sincerely,

Glenda

Glenda McDonald
(On behalf of the Research Team)
PhD Candidate
Clinical Nursing Research Unit
PO Box 63
Nepean Hospital
PENRITH NSW 2751
T: 61 2 47342343
F: 61 2 47343182
E: g.e.mcdonald@uws.edu.au; glenda.mcdonald@swahs.health.nsw.gov.au
PARTICIPANT INFORMATION
NURSE MENTOR

Study Title: Surviving and thriving in the face of workplace adversity: An intervention to develop personal resilience in nurses and midwives.

Short Title: Surviving workplace adversity: an intervention to develop personal resilience in nurses and midwives

Chief Investigators: Prof Debra Jackson, A/Prof Margaret Vickers, Prof Lesley Wilkes, University of Western Sydney

What is the purpose of the study?
This study will develop, trial and evaluate a program aimed at increasing personal resilience in nurses and midwives. It is being conducted so that the needs of nurses coping with workplace adversity can be addressed. It is hoped that this study will provide an effective tool to assist nurses and midwives to survive, and even thrive, in workplaces that are potentially harmful to staff.

Who will be invited to enter the study?
You have been invited to enter the study because you are a retired and/or senior experienced nurse or midwife.

What will happen on the study?
Upon recruitment into the study, you will be invited to attend a mentoring information day to reflect and recap on your expertise in the mentoring process. You will have the opportunity to meet the nurse/midwife study participants on the same day. You will be paired with one of the study participants whom you will have contact with in person or by telephone regularly over the 6 months’ (approximately) duration of the intervention phase (workshops). You will also have the opportunity to meet with other mentors involved in the study and the group facilitator for discussion and support.

Then, after the workshops have been completed, you will be invited to take part in an audio-taped interview and asked to give your opinions about the mentoring experience and your evaluation of the program’s benefits.

Are there any risks?
The known risks of this study are:
It is possible that you may become distressed by discussing personal life experiences or experiences of workplace adversity. If this occurred to you, access to an experienced counsellor would be offered.
PARTICIPANT INFORMATION
NURSE MENTOR

Study Title: Surviving and thriving in the face of workplace adversity: An intervention to develop personal resilience in nurses and midwives.
Short Title: Surviving workplace adversity: an intervention to develop personal resilience in nurses and midwives

Are there any benefits?
The aim of the mentoring partnership is to provide a mutually beneficial relationship between a mentor and a study participant. It is expected that the mentors in this study will be able to experience a dynamic interaction that provides opportunities for self-reflection, openness, and sharing.

It is the intention of the researchers that those taking part in this project as nurse/midwife participants will acquire helpful skills and abilities to assist both in their nursing practice and their personal lives.

Confidentiality / Privacy
All aspects of this study, including results, will be strictly confidential and only the researchers will have access to your personal information. Any publication of the results from this study will use only de-identified information.

Do you have a choice?
Your participation in this study is entirely voluntary. If you choose not to join the study, or you wish to withdraw from it at any time, you may do so.

Complaints

If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact

Dr Debra Jackson
Working hours Telephone No - 02 46203532
After hours Telephone – 0403 411136
CONSENT TO PARTICIPATE IN RESEARCH

<table>
<thead>
<tr>
<th>Study Title:   Surviving and thriving in the face of workplace adversity: An intervention to develop personal resilience in nurses and midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Title: Surviving workplace adversity: an intervention to develop personal resilience in nurses and midwives</td>
</tr>
</tbody>
</table>

Name of Researcher:

8. I understand that the researcher will conduct this study in a manner conforming with ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.

9. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Glenda McDonald and I, being over the age of 16, acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

10. I acknowledge that I have been given time to consider the information and to seek other advice.

11. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

12. I acknowledge that this research has been approved by the Sydney West Area Health Service Human Research Ethics Committee.

13. I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

Before signing, please read ‘IMPORTANT NOTE’ following.

Name of participant _______________________________ 

Date of Birth _______________________

Address of participant ________________________________________________________________

Name of parent or person responsible(where applicable) ________________________________

Address of parent or person responsible (where applicable) ______________________________

Signature of participant ___________________________ Date: ______________________

Signature of parent or person responsible (where applicable) ___________________________ Date: ______________________

Signature of researcher ___________________________ Date: ______________________
IMPORTANT NOTE
This consent should only be signed as follows:
5. Where a participant is over the age of 16 years, then by the participant personally.
6. Where a participant is between the age of 14 and 16 years, it should be signed by the participant and by a parent or person responsible.
7. Where a participant is under the age of 14 years, then the parent or person responsible only should sign the consent form.
8. Where a participant has impaired capacity, intellectual disability or is unconscious, then specific approval for the process for obtaining consent must be sought from the Human Research Ethics Committee.

WITNESS:

I, ________________________________________________ (name of witness) hereby certify as follows:

6. I was present when _____________________________ (“the participant”) appeared to read or had read to him / her a document entitled Participant Information Sheet; or
   I was told by _______________________________ (“the participant”) that he/she had read a document entitled Participant Information Sheet

(“Delete as applicable)

7. I was present when _____________________________ (“the researcher”) explained the general purposes, methods, demands and the possible risks and inconveniences of participating in the study to the participant. I asked the participant whether he/she had understood the Participant Information Sheet and understood what he/she had been told and he/she told me that he/she did understand.

8. I observed the participant sign the consent to participate in research and he/she appeared to me to be signing the document freely and without duress.

9. The participant showed me a form of identification which satisfied me as to his/her identity.

10. I am not involved in any way as a researcher in this project.

Name of witness
___________________________________________________
Address
___________________________________________________
Signature of witness __________________________ Date: __________________________

Relationship to participant
Demographic Form for retired or Senior Nurse/Midwife Mentors

Name: ___________________________________________ 
Address:  ____________________________________________  
_______________________________________________  
_______________________________________________ 
Phone Contact: ____________________________________________________ 
Preferred time to contact: ____________________________________________ 
Email: ____________________________________________________________ 
(NB: The information above will NOT be used for any purposes except for the researchers to contact you)
Age: (decade if preferred) ____________________________
Gender: ________________________________________________
How long have you been retired (if applicable): ________________________
Main Career Position: ____________________________________________
Nursing association memberships____________________________________
What is your opinion of the current approaches in nursing education? _______________________
What kind of support do you think nurses and midwives need? ________________________________

Why did you consider participating in the project? What do you think are your best qualities as a mentor?

______________________________________________________________

______________________________________________________________

My availability as a mentor:
☐ Cycle 1 - August, 2007 til February, 2008
I would be available to have contact with my mentee on the following basis:
☐ In person ☐ As often as negotiated with my mentee
☐ By telephone ☐ Weekly
☐ Both by phone or in Person ☐ Monthly
I would be interested in attending mentors get-togethers
☐ monthly ☐ 3 monthly

Thankyou for your assistance in filling out the demographic information sheet.
## APPENDIX N: Mentors Information Day Program

### Workshop 1: Mentoring Workshop Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Activity</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 mins</td>
<td>Welcome and Introduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9:00)</td>
<td>Objectives of workshop, schedule</td>
<td></td>
<td>Overhead p4</td>
</tr>
<tr>
<td></td>
<td>Overview of w/shop series and project: time release, how mentorship</td>
<td></td>
<td>Overhead</td>
</tr>
<tr>
<td></td>
<td>program will work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OH&amp;S – facilities, breaks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 mins</td>
<td>Introductory Activity – explain how it will allow greatest potential</td>
<td>Q&amp;A: a list of ice-breaker q's</td>
<td>Question sheet</td>
</tr>
<tr>
<td>(10:20)</td>
<td>for self-selection if desired</td>
<td>given so that ppts/mentors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>have 3mins? with each other</td>
<td></td>
</tr>
<tr>
<td>10 mins</td>
<td>Morning Tea</td>
<td></td>
<td>Hot water, tea/coffee, milk,</td>
</tr>
<tr>
<td>(10:30)</td>
<td></td>
<td></td>
<td>sugar, cups, spoons, serviettes,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>biscuits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Toilet facilities</td>
</tr>
<tr>
<td>1.5 hrs</td>
<td>Session 1: Mentoring in Nursing</td>
<td>Reflect and write 1: Collect</td>
<td>Handout, overhead pres</td>
</tr>
<tr>
<td>(10:30)</td>
<td></td>
<td>and copy each to be used in</td>
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<td></td>
<td></td>
<td>Reflective/Critical Thinking</td>
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<td>workshop</td>
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<td></td>
<td></td>
<td>Reflect and write 2</td>
<td>Handout p5, Photocopier</td>
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<td></td>
<td></td>
<td>Reflect and write 3</td>
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<td>Reflect and write 4</td>
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<td>Pairs discussion:</td>
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<td>What experiences have you had</td>
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<td>with mentoring types?</td>
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<td>(12:00)</td>
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<tr>
<td>Time</td>
<td>Content</td>
<td>Activity</td>
<td>Resources</td>
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<tr>
<td>1 hr</td>
<td>Session 2: Creating a Mentoring Partnership</td>
<td>Reflect and write 5</td>
<td>Handout, overhead pres</td>
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<td>(12:00)</td>
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<td>Reflect and write 6</td>
<td>Handout p 32</td>
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<td>45 mins</td>
<td>Lunch</td>
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<td>Catering, toilet facilities</td>
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<tr>
<td>1.5 hrs</td>
<td>Session 3: Knowledge and skills to support a successful mentoring partnership</td>
<td>Reflect and write 7</td>
<td>Handout p37</td>
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<td>(1:45)</td>
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<td>Reflect and write 8</td>
<td>Handout p 40</td>
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<td>Reflect and write 9</td>
<td>Handout p 43</td>
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<td>Reflect and write 10: Link mentoring to leadership ?</td>
<td>Handout p 44</td>
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<td>= (3:15)</td>
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<td>Reflect and write 11</td>
<td>Handout p 45</td>
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<tr>
<td>45 mins</td>
<td>Group Activity – explore personal resilience, ppts and mentors together</td>
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<td>(4:00)</td>
<td>Afternoon Tea</td>
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<td>15 mins</td>
<td>Potential for natural selection of partnerships</td>
<td>Nominate 3 preferred mentor/ees if desired</td>
<td>Handout p 45</td>
</tr>
<tr>
<td>(4:15)</td>
<td>Evaluation and conclusion</td>
<td>Reflect and write 12:</td>
<td>Handout p 45</td>
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<td>What was the best thing about today?</td>
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<td>What could be improved?</td>
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<td>What element/s do I need to develop?</td>
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APPENDIX O: Participant Awards

Australian Women with Resilience

Cycle 1

- Lorrie Graham Award for an adventurous spirit in discovering one’s destiny
- Irene Moss Award for hard-won knowledge and skills in protecting the interests of herself and others
- May Gibbs Award for creative vision and ability to imagine the world differently
- Nancy Bird Walton Award for skill and daring in dangerous conditions
- Marjorie Lawrence Award for extraordinary talent, drive and belief in oneself
- Pat O'Shane Award for outspoken commitment to making the world a better place
- Alice Betteridge Award for intelligence and determination to persevere
- Dawn Fraser Award for natural talent and a fierce will to succeed and survive
- Louise Savage Award for remarkable personal strength and resolve to pursue one’s dreams

Cycle 2

- Margo Lewers Award for innovation in exploring new pathways to creativity and colour
- Maie Casey Award for whole-heartedly embracing life, learning and a poetic spirit
- Bobbi Sykes Award for revolutionary acts of caring and valuing the rights of others
- Judith Wright Award for meeting life’s challenges with resilient courage and stylish grace
- Margaret Olley Award for commitment to understanding the interior landscape of the self
APPENDIX P: Participant Creative Artworks
APPENDIX Q: Participant Representations of resilience
APPENDIX R: Participant Personal Shields