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Resilience and well-being in palliative care staff

Ablett, Janice

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Resilience and Well-Being
in Palliative Care Staff

Janice R. Ablett

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Although working with cancer patients is considered inherently stressful, palliative care staff experience similar levels of psychological distress and lower levels of burnout than staff working in other specialties. There are few empirical studies in palliative care to explain this. Since working in a stressful job does not inevitably lead to psychological distress, the antecedent factors that promote resilience and maintain a sense of well-being are worthy of study. This thesis reviews two theoretical perspectives from the broader psychological literature, the personality constructs of hardiness and sense of coherence, which may promote resilience. It then outlines a qualitative study that used interpretative phenomenological analysis (IPA) to describe hospice nurses' experiences of work. During the analysis, themes emerged relating to the underlying interpersonal factors that influenced the nurses' decisions to begin and continue working in palliative care, and their attitudes towards life and work. These themes were compared with the theoretical personality constructs of hardiness and sense of coherence, and this comparison highlighted many similarities. The nurses showed high levels of commitment, and imputed a sense of meaning and purpose to their work. An area of divergence was their response to change, and this is discussed in relation to hardiness and sense of coherence. It is suggested that increasing our understanding of resilience in palliative care has implications for individual staff well-being, and for staff training and support, which, in turn, may also impact on the quality of patient care provided.

Ethics Proposal

Resilience and well-being in palliative care staff.

Janice R. Ablett

Division of Clinical Psychology

University of Liverpool

Proposed additional author: R.S.P Jones

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Resilience and well-being in palliative care staff

Abstract

Working with cancer patients is considered stressful. Yet, palliative care staff experience similar levels of psychological distress and lower levels of burnout than staff working in other specialties. There are few empirical studies in palliative care to explain this. Since theoretical perspectives from the broader psychological literature, the personality constructs working in a stressful job does not inevitably lead to psychological distress, the antecedent factors that promote resilience and maintain a sense of well-being are worthy of study. Two of hardiness and sense of coherence, are reviewed. Increasing our understanding of resilience in palliative care has implications for individual staff well-being, which, in turn, may also impact on the quality of patient care provided.

Key words

resilience, well-being, palliative care, hardiness, sense of coherence

Introduction

There is little doubt that healthcare workers experience high levels of psychological distress compared to the general working population (Haynes, Wall, Bolden, Stride, & Rick, 1999). Such distress can include physiological, cognitive and behavioural symptoms experienced as, for example, anxiety and depressive reactions, sleep disturbance, decreased concentration, irritability, and low self-esteem. More specifically, in the literature cited for this study, the term assumes a narrower definition, referring to scores above the cut-off on a screening tool, the 12-item General Health Questionnaire (Goldberg and Williams, 1988) used in community samples and occupational settings, indicative of "caseness" for the presence of mental health problems. In the most recent large scale study of NHS staff in the UK, Warr and his colleagues found that 26.8% of NHS staff reported significant levels of minor psychiatric disorder, compared to 17.8% of people in the general working population (Warr et al., 1997). Rates were highest among managers, doctors, nurses, and professions allied to medicine. Similar rates have been reported in the US, where staff reported less job satisfaction, support, autonomy and role clarity than non-health related employees (Moos & Shaeffer, 1997). Furthermore, the concept of burnout is often applied to workers in health care settings. Directly related to high levels of work demand, this syndrome is conceptualised as resulting from a misfit between the intentions of the member of staff and reality of what can be achieved at work. It is characterised by high levels of both emotional exhaustion and depersonalisation, and a reduced sense of personal accomplishment. (Maslach, 1996).

Increased levels of psychological morbidity and burnout have implications for both the mental and physical well being of staff and for their employing organisations. For example, research has shown that burnout is linked with a decrease in the quality of patient care, with distancing and poorer communication (Heaven, Maguire & Clegg, 1998; Ramirez, Graham, Richards, Cull & Gregory, 1996; Whippen & Canellos, 1991) and with absenteeism, intention to leave, and high staff turnover (Cordes & Dougherty, 1993).

Traditional approaches to understanding the psychological causes of these experiences have examined both individual and environmental variables. More recently, attention has focused on the complex interactions between organisational and personality variables as explanatory factors of work related psychological distress (Karasek & Theorell, 1990; Marchand, Demers & Durand 2005; Siegrist, 1996). Here, work related stress refers to the set of job related factors and workplace demands that can affect people's attitudes and mental health at work. In situations where the demands exceed the personal resources and coping strategies available, then work related psychological distress may occur.

An alternative psychological approach to investigating psychological distress in healthcare settings is to focus on areas where the problem seems less pervasive despite the presence of similar environmental stressors.

Working in a stressful job or environment does not inevitably lead to physical or psychological illness (Wiebe & McCallum, 1986). The absence of pathology, i.e. the lack of psychological morbidity or burnout, does not sufficiently explain this. Nor does it explain why some workers experience distress and others remain well when working in the same environment.

This has led researchers to consider the antecedent factors that maintain a sense of well-being, rather than the absence of psychopathology. In particular, investigating the interpersonal or personality factors that promote resilience and mitigate the effects of stressful life events might provide valuable information not just in the area of prevention, but in understanding the wider relationship between stress and health.

Resilience is influenced by experiences and life events during childhood and adolescence through to adulthood. According to Rutter "the promotion of resilience does not lie in and avoidance of stress, but rather in encountering stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility" (Rutter, 1985, p. 608).

This review will focus on resilience in palliative care staff, a population that appears to show reduced levels of work related psychological distress when compared to other healthcare workers.

Occupational Stress in Palliative Care

It is clear that working in cancer care is considered to be inherently stressful (Abeloff, 1991; Brennan, 2004; Graham & Ramirez, 2002). There is a widely held belief that staff working in cancer and palliative care services are exposed on a regular basis to the pain and suffering of patients, some of whom may be dying, and that this is a major source of job stress. In addition, there may be conflict between the curative focus of professional training and the daily reality of interacting with patients who have advanced disease and cannot be cured that could lead to a sense of helplessness and personal failure when treatment inevitably becomes palliative (Whippen & Canellos, 1991).

Working with patients who are young, or with whom the member of staff identifies can be distressing (Graham, Ramirez, Cull, Finlay, Hoy & Richards, 1996). In addition, staff working in end-of-life care are confronted with issues of their own mortality (Nash, 1989).

Although palliative care services have traditionally provided end-of-life care for cancer patients, more recently services have broadened to include palliative treatment for people with other life threatening conditions. This presents further challenges to palliative care staff (Addington-Hall & Higginson, 2001).

Yet, perhaps surprisingly, palliative care staff do not report higher levels of stress than staff in other specialties. Indeed, staff report lower levels of burnout even compared to other staff working in other areas including oncology (Vachon, 1995; 2002). Findings from focus group research with palliative care staff did not support the view that frequent contact with dying patients was stressful. In contrast, results indicated that such contact with patients and their families was a major source of job satisfaction (Grunfeld, Zitzelberger, Coristine, Whelan, Aspelund & Evans, 2005).

These findings appear robust and have been replicated across different studies. For example, in the UK, hospice nurses and midwives reported lower levels of psychological morbidity than in other specialities (Dunne & Jenkins, 1991). Similarly, palliative care physicians reported similar levels of psychological morbidity and lower levels of burnout than consultants working in oncology, radiology surgery and gastro-enterology (Ramirez et al., 1996). The prevalence of psychological morbidity and burnout in the US appears similar, with hospice nurses reporting less burnout than intensive care nurses (Mallett, Price, Jurs & Slenker, 1991).

To date, there are few empirical studies within the palliative care literature that directly explain these findings. There are, however, two theoretical perspectives from the broader literature on resilience to life stress that may be applicable to palliative care staff. These are the personality constructs or dispositions of hardiness and sense of coherence. The study of these two concepts marked a shift in the focus of study from a pathogenic paradigm, which focuses on psychological morbidity and burnout, to a salutogenic paradigm, which focuses on health and well-being, when faced with stressful situations. Additionally, as both are factors concerned with personality style, they can be said to derive from an evolutionary model incorporating survival, adaptation and replication (Millon, 2000).

Hardiness

The concept of hardiness, developed by Kobasa (1979), emerged from existential theory of personality. Theoretically defined as "a resistance resource in the encounter with stressful life events" (Kobasa, Maddi & Kahn, 1982, p.169), it has been described as "the characteristic manner in which a person approaches and interprets experience" (Bartone, Ursano, Wright & Ingraham, 1989) and as part of an individual's search for meaning (Turnipseed, 1999).

Hardiness has been studied in many work settings since Kobasa and Maddi's early work with corporate employees in the US. Although it's relevance in such organisations continues to be studied, hardiness has also been researched in other populations, including disaster helpers, prisoners of war, and war veterans (Bartone et al., 1989; Zakin, Solomon & Neria, 2003). Thus research has ranged from occupational settings where there may be chronic, less severe stress to situations of conflict or disaster where there is acute stress and exposure to severe trauma.

Some studies have been carried out in healthcare settings. Although hardiness was found to be associated with decreased burnout and improved coping in junior doctors, and in nurses (Keane, Ducette & Adler, 1985; Topf, 1989), it has not been studied empirically in palliative care staff (Vachon, 2000).

Hardiness is composed of three closely related dispositional tendencies; commitment, control and challenge. Commitment refers to a sense of meaning and purpose that an individual gives to his or her life, encompassing self, others, and work. It is expressed as a tendency to become involved in whatever one is doing, and involves activity and approach rather than passivity and avoidance (Bartone et al., 1989). Control refers to a sense of autonomy and ability to influence one's own future. It enables a person to develop a broad repertoire of responses to stressful events which is thought necessary for stress resistance (Averill, 1973). Challenge is akin to a zest for life and living that leads an individual to perceive changes as exciting and as opportunities for growth, rather than as threats to security or survival (Kobasa, Maddi & Kahn, al., 1982; Maddi & Kobasa, 1984). Change rather than stability is seen as normal in life (Turnipseed, 1999).

There is evidence that hardiness influences how people cope with stressful life circumstances (Kobasa, Maddi & Pucetti, 1982), and that it has its greatest health preserving effect as stressful life events increase. In terms of psychological well-being, hardy individuals are "more likely to perceive challenges and opportunities for growth where others see only threat and disruption" (Bartone et al., 1989). Thus, it can be considered an operationalisation of existential courage (Orr & Westman, 1990).

It is hypothesised that, as with resilience, hardiness develops as a result of early childhood experience. Individuals with hardy attitudes in adulthood reported a combination of adversity together with secure and supportive family relationships in their childhood and adolescence, which was distinct from those individuals who were low in hardiness (Khoshaba & Maddi, 1999). Hardiness continues to develop into adulthood, and is associated with being older (Schmied & Lawler, 1986). This is consistent with the growth and maturity hypothesis that older individuals tend to have a more effective and mature repertoire of coping skills which younger people may not yet have developed (Diehl, Coyle & Labouvie-Vief, 1996; McCrae,1982; Soderstrom, Dolbier, Leiferman & Steinhardt, 2000).

The hardiness model assumes that hardy individuals have adaptive cognitions that result in lower levels of psychological distress in response to stressful events or situations (Gentry & Kobasa, 1984; Lazarus & Folkman, 1989). Thus, hardiness affects the perception and appraisal of stressful events, in a manner which means they are then more likely to be met with acceptance, understanding and successful coping (Funk,1992; Turnipseed, 1999).

The empirical evidence regarding the specific mechanism whereby hardiness mediates the effects of stressful events is equivocal in the literature. Three differing roles have been theorised: firstly, a buffering or moderating effect (Kobasa, 1979; Kobasa,Maddi & Kahn, 1982; Aldwin & Revenson, 1987; Rhodewalt & Zone, 1989); secondly, a direct effect on stress and health, via the coping process which leads to active or transformational coping (Banks & Gannon, 1988; Kobasa et al., 1982; Kobasa & Puccetti, 1983; Nowack & Hanson, 1983; Funk, 1992); and thirdly, an indirect role through improved health practices and social support (Wiebe & McCallum, 1986). These roles are not mutually exclusive, since, for example, Orr and Westman (1990) demonstrated that the direct effect of hardiness on well-being was stronger than its stress buffering role.

It is of interest that two studies have specifically attempted to discriminate between the effects of hardiness on physical and psychological well-being. Support was found for the effect of hardiness on psychological well being in that it buffered against depression (Brookings & Bolton, 1997) and predicted psychological distress (Clark & Hartmen, 1996), but neither study found it to affect physical health.

Hardiness has also been found to have an effect on death awareness (Florian, Mikuliner & Hirschberger, 2001). In their preliminary study, the authors suggest that hardiness enabled individuals to rely on inner resources to react to reminders of mortality in an active and transformational way. This is in line with the conclusions of Westman and Orr (1990) that hardy individuals have the capacity to confront their mortality and recognise the implications of death, whilst maintaining an optimistic outlook that focuses on life. This may be pertinent to health care professionals faced with issues of mortality in their daily interactions with patients.

The research on hardiness has been criticised from a methodological point of view. As a construct, hardiness has been poorly operationalised (Funk, 1992) even though it contains within it behavioural and cognitive components (Kobasa & Puccetti, 1983). Various hardiness measures have been developed over the years, making comparison of the outcome of studies and meta-analyses difficult to undertake. There has been debate, too, about what hardiness scales actually measure, with Funk and Houston (1987) proposing that they measure neuroticism.

There has also been lack of agreement about the uni-dimensionality of the hardiness construct. Several researchers considered that the three components of hardiness should be considered separately (Bohle, 1997; Carver, 1989). “If a researcher finds high-hardy subjects are less ill than low hardy subjects, this difference could be attributed to differences in commitment, control, or challenge, or to some combination of these characteristics” (Carver, 1989). Commitment and control have been found to predict outcomes consistently, whereas challenge was a less reliable predictor of well-being (Hull et al., 1987; Klag & Bradley, 2004; Sheppard & Kashani, 1991; Williams, Wiebe & Smith, 1993). Maddi, Kobasa and colleagues continue to argue that hardiness should be conceptualised as a global measure (Maddi, 2002).

The majority of empirical studies were cross-sectional in nature, therefore limiting inferences about causality. They also relied on retrospective self report across varying time intervals. Kobasa, Maddi and Kahn (1982), however, demonstrated that the buffering effects of hardiness occurred prospectively as well as retrospectively. Many studies used university students and predominantly male corporate employees as participants. Whilst these might be viewed as convenience samples, taking into account that the original research on hardiness grew from studies of corporate employees, this has lead to a lack of generalisability of the findings.

Notwithstanding these methodological considerations, the research into hardiness and its application to understanding both individual and occupational stress and well-being continue. Maddi and colleagues have given consideration to organisational variables. Khoshaba, Pammenter and Maddi (1999) call for organisations to facilitate hardiness by the characteristics of their climate, culture and structure. Control, commitment and challenge at an individual level are considered to correspond to "co-operation, credibility and creativity to an organisational level" (Maddi, 2002). In applying these concepts to organisations, more recently studies of "hardiness training" have shown this to improve job performance, job satisfaction and well-being of employees (Maddi et al., 1998; Maddi, 2002).

Sense of coherence

Sense of coherence is a theoretical construct that reflects an individual's capacity to respond to stressful situations. It has been considered in the literature in relation to resilience and both physical and psychological well-being. It has been investigated empirically in small scale studies, and also in large-scale population studies as the concept fits well with the public health agenda of health promotion. A literature search for the purposes of this review did not yield, however, any studies of sense of coherence specifically in palliative care staff.

Sense of coherence was developed by Antonovsky (1979) following his observations of women Holocaust survivors who remained well despite the trauma they experienced in concentration camps. It developed from his idea of "salutogenesis" in that he posed the question "Why do people stay healthy?" rather than "Why do people get sick?" His approach focuses on individual strengths that confer resiliency, and encompasses the physical, psychological and social factors that predict a person's position along a health-disease continuum (Antonovsky, 1979; 1987). It serves, therefore, as an active coping resource that maintains health and well-being.

According to Antonovsky, sense of coherence consists of "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that: (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable (comprehensibility); (2) the resources are available to one to meet the demands posed by these stimuli (manageability); (3) these demands are challenges worthy of investment and engagement (meaningfulness)" (Antonovsky, 1987, p.19).

In addition, Antonovsky considered that "the sense of coherence is, hopefully, a construct (and the items which constitute its operationalisation) which is universally meaningful, one which cuts across the lines of gender, sense of social class, religion and culture. It does not refer to a specific type of coping strategy, but to factors which, in all cultures, always are the basis for successful coping with stressors. This, of course, does not mean that different groups will have an equally strong average sense of coherence," (Antonovsky, 1993, p.726).

A further concept introduced by Antonovsky was that of general resistance resources, which were hypothesised to comprise of the resources necessary to cope with everyday demands (Antonovsky, 1979). Individuals with a strong sense of coherence were considered to utilise a greater number of resistance resources, such as wealth, ego identity, knowledge, coping strategy, cultural and social support, and a religious or philosophical view of life.

This concept, which incorporates Antonovsky's salutogenic paradigm has been widely researched. To operationalise this construct, Antonovsky developed the Sense of Coherence questionnaire which can be administered as a self-report measure or at interview. The scale has been found to have good reliability and validity, and be applicable across cultures (Eriksson & Lindstrom, 2005; Feldt, Leskinen, Kinnunen, & Mauno, 2000). Consistent with sense of coherence being a global construct, Antonovsky (1993) repeatedly argued that the scale should be used uni-dimensionally rather than attempting to measure each component separately. Although numerous empirical studies are reported, the diversity of methodologies and differences in the versions of self-report questionnaires used make meta-analysis difficult.

Sense of coherence is thought to develop during childhood and adolescence with active involvement in the family and emotional closeness to family members being deemed as pre-requisites for a strong sense of coherence (Antonovsky & Sagy, 2000). Whilst not fully developed in young adults (aged between 18 and 25 years of age) it appears to become stable around the age of thirty (Antonovsky, 1987). Thus, once fully developed, it is hypothesised to be a stable personality disposition (Sagy & Antonovsky, 1993) that remains unchanged unless an individual undergoes major life events requiring considerable adjustment to life goals. In a recent study, however, sense of coherence was found to increase with age although the reason for this was not adequately explained (Eriksson & Lindstrom, 2005). With regard to gender, sense of coherence is equally stable in both sexes (Kivimaki, Vaherta, Feldt, & Nurmi, 2000). Also, education did not show a direct association with sense of coherence (Dudek & Makowska,1993; Feldt, Kinnunen & Mauno, 2000).

As already mentioned, sense of coherence has been found to be related to both physical and psychological health. For example, individuals with a strong sense of coherence reported higher levels of self-esteem, greater control over their lives, greater optimism, and less negative affectivity (Pallant & Lae, 2002). Sense of coherence was found to buffer life stress in healthy older adults (Lugendorf et al., 1999) and, in a large scale epidemiological study, it was associated with decreased hostility and neuroticism. Geyer (1997) noted a strong inverse correlation with anxiety and depression, and questioned whether sense of coherence was, in fact, a measure of negative affect. Kivimaki et al. (2000) found that a strong sense of coherence decreased the likelihood of individuals' appraising events as stressful. In interpreting their results, they noted that sense of coherence may influence health, and vice versa, thus highlighting the reciprocal relationship between the two.

In terms of physical health, sense of coherence was found to be related to health and well-being (Feldt et al, 1997; Johnson, 2004; Lutgendorf, Vitaliano, Tripp-Reimer, Harvey, & Lubaroff, (1999). It was also found to be related to well-being in cancer patients (Forsberg, Bjorvell, & Cedarmark (1996), to mediate the effects of stress in cancer patients and their spouses (Mullen, Smith & Hill, 1993) and to be negatively related to post traumatic stress symptomatology and fear of recurrence in haematological cancer patients (Black & White, 2005). Additionally, a strong sense of coherence appears to confer resilience to the risk of developing long term conditions (Suinomen et al., 2001), and has been found to be a mediating factor in dealing with existing disability (Shnyder, Buchi, Morgelli, Sensky & Klaghofer, 1999). Furthermore, a strong sense of coherence was associated with a reduction in mortality in men.

Whilst many of the studies are cross-sectional and report correlational data from which causation cannot be inferred, there are some large-scale longitudinal studies reported in the literature. For example, a strong sense of coherence predicted subjective good health in both men and women at four year follow up when initial state of health, occupational training, and initial sense of social integration were controlled for (Suimonen et al., 2001). To date, however, there do not appear to be any reported prospective studies that examine the relationship between sense of coherence and psychological distress.

Most empirical studies employ quantitative methodology. In the only qualitative study revealed by the literature search for this review, young female doctors who had a strong sense of coherence were not as work-oriented as had been predicted. Using a narrative approach, Loyttyniemi, Virtanen and Rantalaiho (2004) found that their sense of meaningfulness was gleaned from their family life rather than their career.

The importance of the interaction between personality and organisational variables was noted earlier in this review, and this appears to hold too for sense of coherence. A good organisational climate and job security was associated with a strong sense of coherence in employees (Albertson, Nielsen & Borg, 2001; Feldt et al., 2000), and this, in turn, was associated with lower psychological distress and burnout. A strong sense of coherence was also negatively associated with perceived work stress (Ryland & Greenfeld, 1991) and with burnout (Palsson, Hallberg, Norberg, & Bjorvell (1996).

Integration and Synthesis

Hardiness and sense of coherence have considerable conceptual overlap (Geyer, 1997). They both describe generalised resistance resources that predispose individuals to appraise stressful events in a manner that leads to active transformational coping, which in turn promotes resilience and maintains a sense of health and well-being. They are both derived from an understanding of personality variables, and they emphasise an interactional view of personality, looking at the sense of meaning for individuals within their social context. A difference would seem to be that hardiness has developed from existential theory of personality whereas sense of coherence is based within a cognitive framework, and is also influenced by Antonovsky's background in anthropology.

Both hardiness and sense of coherence are salutogenic in origin, in that they are derived from questioning why people remain healthy rather than asking why they become sick. Furthermore, adopting a salutogenic paradigm presupposes that health is qualitatively different from the absence of disease (Strümpfer, 1990).

In terms of their development, both constructs are thought to develop during childhood and adolescence, with secure and supportive family relationships being prerequisites. In addition, hardiness studies report that high hardy individuals experienced adverse experiences in childhood. According to hardiness theory, hardiness can increase over the course of the life-span, whereas Antonovsky postulated that sense of coherence would be relatively stable by the age of thirty. This is not wholly borne out in the literature as studies suggest that sense of coherence can become stronger during adulthood (Geyer, 1997).

The concept of hardiness was developed from Kobasa's work with executives in the US, leading to the criticism that it is culturally specific. Sense of coherence, on the other hand, appears to be applicable across cultures and backgrounds (Antonovsky, 1987; Eriksson & Lindstrom, 2005). It has been utilised as a measure in large scale population studies as it fits well with the public health agenda focussed on prevention of illness and health promotion (Lugendorf et al., 1999; Surtees, Wainwright, Luben, Khaw & Day, 2003).

For both hardiness and sense of coherence, there has been debate about whether each concept should be reported as one construct or three separate components. Kobasa and Maddi (1982), and Antonovsky (1987) respectively argued that the constructs should be viewed as uni-dimensional and a global concept.

When the constituent parts of each construct are compared, however, there are many similarities. Commitment, which describes a sense of purpose, seems to overlap closely with meaningfulness. Control and manageability are likewise similar, though some difference in the perception of control is noted. In hardiness, a distinction is made between those with a high internal or external locus of control (Kobasa & Maddi, 1982). When considering manageability, Antonovsky takes a broader view that the resources to meet demands may be under one's own control or controlled by significant others. This aspect could reflect the different cultural backgrounds to the two concepts. The main variance between the components is challenge in hardiness, which perceives change as an opportunity for growth, and comprehensibility in sense of coherence, which stresses the need for stability, and a structured and ordered world.

Although the conceptual overlap between hardiness and sense of coherence is recognised in the literature, there are few empirical studies that provide a comparison of the two constructs. In one of the few studies found during the search for this literature review, Kravetz et al. (1993) confirmed a two-factor model of health proneness and negative affect. According to this model, sense of coherence, hardiness and locus of control were related to the same factor of health proneness, whereas anxiety, depression and anger were related to a second factor, that of negative affect.

It is suggested that empirical research is required to investigate the similarities and differences between the two constructs, and their constituent parts. The current literature is equivocal concerning the exact mechanisms by which these two constructs confer resilience to stressful life events, and the methodological concerns are alluded to above. Notwithstanding these concerns, the empirical studies do show that these approaches have merit in understanding why some individuals remain healthy in the face of adverse circumstances.

The role that hardiness and sense of coherence may play in contributing to the resilience of healthcare professionals does not appear to have been determined, and certainly does not appear to have been studied empirically in palliative care settings. Their association with other theoretical models such as Bowlby's attachment theory and post-traumatic growth (Tedeschi & Calhoun, 1995) has yet to be ascertained.

Thus, although the theoretical models of hardiness and sense of coherence provide frameworks for understanding resilience and well-being in general, further work is needed to explore their relevance to healthcare staff in palliative care settings. Gaining an understanding of factors which promote resilience and well-being in palliative care is important for individual staff, for organisations, and, in turn, may impact on the quality of patient care provided.

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Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work.

Janice R. Ablett

Division of Clinical Psychology

University of Liverpool

Proposed additional author: R.S.P. Jones

Running head: Resilience in Hospice Nurses

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Summary

Although working with cancer patients is considered stressful, palliative care staff experience similar levels of psychological distress and lower levels of burnout than staff working in other specialties. There are few empirical studies in palliative care to explain this. Since working in a stressful job does not inevitably lead to psychological distress, the antecedent factors that promote resilience and maintain a sense of well-being are worthy of study.

This qualitative study used interpretative phenomenological analysis (IPA) to describe hospice nurses' experiences of work. During the analysis, themes emerged relating to the underlying interpersonal factors that influenced the nurses' decisions to begin and continue working in palliative care, and their attitudes towards life and work.

The emergent themes were compared with the theoretical personality constructs of hardiness and sense of coherence, and this comparison highlighted many similarities. The nurses showed high levels of commitment, and imputed a sense of meaning and purpose to their work. An area of divergence was their response to change, and this is discussed in relation to hardiness and sense of coherence. The implications for staff well-being, and for staff training and support, which, in turn, may impact on the quality of patient care, are discussed.

Key words: qualitative, resilience, well-being, palliative care, staff, hardiness, sense of coherence

Introduction

Within the current healthcare context there is continued research interest in the effects of stress on the well-being of staff (Haynes, Wall, Bolden, Stride & Rick, 1999). Workplace stress has serious implications for both the physical and psychological health of staff, for patient care, and for organisations (Firth-Cozens, 1999).

In the most recent large scale study of NHS staff in the UK, Wall et al. (1997) found that healthcare workers reported experiencing higher levels of psychiatric morbidity than the general working population (Haynes et al., 1999). Staff working directly with patients were found to encounter stresses to a more intense level, in terms of increased workload and exposure to the emotional and physical needs of their patients, than other professionals (Haynes et al., 1999). Similar rates were found in the US, with healthcare staff reporting less job satisfaction, support, autonomy, and role clarity than non-health related workers (Moos & Shaeffer, 1997). With regard to patient care, burnout has been associated with a decrease in the quality of patient care, with greater distancing and with poorer communication (Heaven et al., 1998; Ramirez, Graham, Richards, Cull & Gregory, 1996; Whippen & Canellos, 1991). From an organisational perspective, psychological morbidity and burnout is linked to absenteeism, intention to leave, and high staff turnover (Cordes & Dougherty, 1993).

Working in cancer care is considered to be inherently stressful (Abeloff, 1991; Brennan. 2004; Graham & Ramirez, 2002). There is a widely held view that staff working in cancer and palliative care services are frequently exposed to the pain and suffering of patients whose disease cannot be cured, and who may be dying. The conflict between training that is focussed on curative treatment and the reality that some patients have advanced disease that cannot be cured can lead to a sense of helplessness and personal failure when treatment is palliative (Whippen & Canellos, 1991). Staff can find it more distressing to work with younger patients, or with patients with whom they identify strongly (Graham et al., 1996). Additionally, working in palliative care confronts staff with issues of their own mortality (Nash, 1989). Recent trends to broaden the remit of palliative care services to include end-of-life care for people with other life threatening conditions as well as those diagnosed with cancer has posed a further challenge to specialist palliative care staff (Addington-Hall & Higginson, 2001).

Given the above concerns, it is somewhat surprising that palliative care staff do not report higher levels of psychological distress. Indeed, they report lower levels of burnout than staff working in other specialties, including oncology (Vachon, 1995; Vachon, 2000). These findings appear robust, having been replicated across different studies. Palliative care doctors reported similar levels of psychiatric morbidity and lower levels of burnout than consultant working in other specialties, including oncology (Ramirez et al., 1996), and hospice nurses and midwives reported lower levels of psychological distress than nurses working in other specialties (Dunne & Jenkins, 1991). Similar rates of psychological morbidity and burnout were found in the US, with hospice nurses reporting that they experienced less burnout than intensive care nurses (Mallett, Price, Jurs & Slenker, 1991). Furthermore, focus groups of palliative care staff reported that contact with dying patients and their families was a major source of job satisfaction (Grunfeld, Zitzelberger, Coristine, Whelan, Aspelund & Evans, 2005), and, according to Levinson (1990) confronting one's own mortality is a task that can lead to greater fulfilment.

There are few empirical studies within the palliative care literature that explain these findings. Traditional approaches to understanding workplace stress have focussed on outcome variables, with little attention being paid to antecedent or causal factors (Haynes et al., 1999). They have explained both individual and environmental factors, and more recently, have focussed on the complex interaction between personality and organisational variables as explanatory factors of workplace stress (Karasek & Theorell, 1990; Marchand, Demers & Durand, 2005). Empirical studies have employed quantitative methodology in the main, yet the way in which questions are posed is crucial. For example, doctors interviewed about workplace stress gave qualitatively different answers on self-report measures than in semi-structured interviews (Firth-Cozens, 1999).

Whilst it is clear that working in a stressful job or environment does not inevitably lead to physical or psychological illness (Wiebe & McCallum, 1986), these findings are not explained adequately by the lack of psychological morbidity or burnout in staff. Neither do they explain why some staff with very similar roles remain well when others experience psychological distress. Attempts to understand this have led to a shift in the focus of research from a pathogenic paradigm focussing on psychological morbidity and burnout to a salutogenic paradigm focusing on health and well-being when faced with stressful situations. Thus, researchers have considered the antecedent factors that maintain a sense of well-being rather than the absence of psychopathology. In particular, studies have investigated the interpersonal factors that promote resilience. According to Rutter, "the promotion of resilience does not lie in an avoidance of stress, but rather in encountering stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility" (Rutter, 1985, p. 608). Within palliative care, gaining an understanding of the antecedent factors that promote resilience and well-being, and mitigate the effects of stress is of relevance for individual staff, for the quality of patient care, and for the employing organisation.

This study aimed to describe hospice nurses' experiences of their work in order to understand the factors that help to promote resilience and mitigate the effects of workplace stress. It also aimed to explore the processes by which nurses continued to work in palliative care and maintain a sense of well-being. A qualitative methodology was adopted, which allowed the researcher to consider the "insider's perspective" (Conrad, 1990). In depth semi-structured interviews were carried out, and the data was analysed using grounded theory methodology (Strauss & Corbin, 1990), specifically interpretative phenomenological analysis (IPA) (Smith 1996; Smith & Osborn, 2003). This approach is suitable for analysing complex data involving staff attitudes and beliefs in a way that is not possible when responses are reduced to predefined categories (Smith, 1995). It is particularly useful when considering the processes operating within models, as opposed to traditional focuses on outcome research (Brocki & Wearden, 2006). It also has strong ecological validity, in that staff are asked about their own experiences of work, rather than hypothetical situations or vignettes. Similar methodology has been used to examine the nature of staff feelings and beliefs about challenging behaviour (Whittington & Burns, 2005), staff perspectives on working with people with severe learning disabilities (Clegg, Standen & Jones, 1996), and the theoretical model underlying mental health nurses' assessments of carers' needs (Carradice, Shankland & Beail, 2002). In line with the recommendations of Strauss and Corbin (1990) that shorter papers report the richness of particular themes from qualitative research rather than attempting to summarise all the data, this paper focuses on themes that describe aspects of the nurses' work that are relevant to their resilience and ability to continue to work in palliative care.

Method

Participants

A purposive sample of ten palliative care nurses was recruited from a hospice in the north west of England. As the sample was derived from a very small population, in order to maintain confidentiality only summary demographics will be presented. The group consisted of nine women and one man representing a spread of ages. All participants were trained nurses, and all spent the majority of their working time providing direct nursing care to palliative care patients in the hospice. Although many of the hospice staff knew the first author as a clinical psychologist, the author did not provide any clinical input to the hospice throughout the duration of the study or afterwards. Both the medical and nursing directors of the hospice were supportive of the study and readily allowed the nurses to participate.

Interview procedure

Semi-structured interviews were conducted, according to guidelines suggested by Smith (1995). Participants were interviewed at the hospice by the first author for approximately one hour (range 35 minutes to 80 minutes), and the interviews were managed in a conversational style. The interview schedule, comprising a list of open-ended questions, guided the interview yet allowed flexibility to adapt to the narratives presented and areas of interest raised by the participants.

The interview began by asking the nurses about their general experiences of working in palliative care, and then moved on to explore more specific interpersonal factors as the interview progressed. At the end of each interview participants were invited to add any additional comments relating to the areas discussed that seemed pertinent to them. The interviews were audiotaped and transcribed verbatim.

Analysis

The transcript data was analysed using thematic analysis techniques derived from IPA (Smith 2003). Each first transcript was read several times to become familiar with the content of the interview. The author also listened to the audio-tape of the interview to recall the context, and the emotional content, of the data. The author noted preliminary codes in the left hand margin. The transcript was read again, and the preliminary themes were recorded in the right hand margin. These themes represented the beginning of the conceptualisation process. This process was iterative in that it involved an interaction between the reader and the text. The preliminary themes were word processed then were clustered into groups of themes, according to common features in terms of meaning. These were validated by checking back to the transcript. Themes were then written down under the super-ordinate headings, and the words were written alongside to ensure they were derived from the original data, and to begin to illustrate the themes. Any themes that were not adequately grounded in the transcript were dropped. The above process was repeated for each transcript in turn. The preliminary analyses were then combined into a consolidated summary of the master themes or super-ordinate themes for the group. A table of these themes was drawn up whereby the super-ordinate themes were derived from themes, the themes from sub-themes. Identification of super-ordinate themes required a greater degree of interpretation of data.

Statement /bracketing

The data collection and analysis was carried out by the first author, a clinical psychologist working in oncology and palliative care. The following statement of perspective at the time of data collection is provided to enable readers to interpret her understanding of the data, as suggested by Elliott, Fischer and Rennie (1999).

I had worked as a clinical psychologist in oncology and palliative care for four years at the start of the data collection, and in other specialties in the NHS prior to that. I had worked with people who were addressing end-of-life issues, and also had been involved in providing staff support to healthcare professionals.

At the start of the study, I expected to find that the nurses would acknowledge that work was stressful, yet that they would feel that they had the inner resources to deal effectively with those stresses. I also expected that it would be important for them to feel confident in their role, and in control of their workload.

Results

This research aimed to describe hospice nurses' experience of their work, and in particular sought to determine aspects of their interpersonal style that enabled them to be resilient and maintain a sense of well-being whilst continuing to work with terminally ill patients and their families. Themes that emerged from the analysis related to interpersonal aspects and to each individual's perspective of their 'job-person fit'. Central to these themes was the extent to which the nurses chose to work in this area, and were committed to it, believing they could "make a difference" to the people for whom they were providing palliative care. Awareness of both their mortality and their spirituality were additional prominent themes that emerged from the data analysis.

Coding and analysis of the interview data generated 10 themes related to hospice nurses' experience of working in palliative care. The themes are presented in Table 1, and the findings are discussed more fully below:

Table 1.

Emergent themes from interview data.

1	An active choice to work in palliative care
2	Past personal experience influences care-giving
3	Personal attitudes to care-giving
4	Personal attitudes towards life (and death)
5	Awareness of own spirituality
6	Personal attitudes towards work
7	Aspects of job satisfaction
8	Aspects of job stress
9	Ways of coping
10	Personal/professional issues and boundaries

As the full transcripts are beyond the scope of this paper, excerpts are presented to illustrate each theme. The development of each theme from the text is shown in the Appendix 5, and a copy of each transcript is shown in Appendix 7.

(1) An active choice to work in palliative care.

All the nurses indicated that it was a positive career choice to become a nurse, and more specifically to work in palliative care. Indeed, several of the nurses who had worked at the hospice for a number of years indicated their wish to stay working in this setting.

> It's something I've always wanted to do, I always wanted to be a nurse, I always wanted to care for people and I have wondered over the years whether it's because I wanted to be cared for, but this was long before I had the knowledge....it's just something I want to do, I want to care. *[Participant 5]*

There was a high level of commitment, with several nurses mentioning that they viewed it as a privilege to nurse people at the end of their lives.

> For myself, I put it that there are two important events in anyone's life, and the first one is being born, and the second one is dying. And to be part of those processes is a privileged post to have so I find working in palliative care to be a privileged post to have really. *[Participant 10]*

(2) Past personal experience influences care-giving

Many nurses spoke of their own experience of close relative dying of cancer, and how this affected their care-giving, either because the care their relative received had been very good, or because they were dissatisfied with the care their relative had received and wanted to offer better quality of care to others.

> My dad died of cancer… and for me, having looked after my dad and seeing what it was like .. as upsetting as it was…it sort of turned my dad's dying into a positive thing, you know, that I could understand then what it was like for other people. *[Participant 10]*

This also resonated with the nurses who spoke of their previous experience working in hospitals, and who wanted to have time available to provide different care to that which they were able to provide as a ward nurse.

(3) Personal attitudes towards care-giving

Nurses were keen to convey their commitment "to make a difference" in their role. This was something they strived for, believing that only their best was good enough for patients and relatives, and that they had to give 100% at work.

> How I look after people, with the way I am, means that only the best I can do for them is good enough really. So that's why here gives me that opportunity and I feel I have done my best for people. I am not a perfectionist, I just like to be right, to the best of my ability… I want it to be right for them, not necessarily right for me… it's about them not me. *[Participant 1]*

> The best part [of working in palliative care] is making a difference to the way people spend the closing times of their illness...actually making a difference and giving somebody a good death. *[Participant 3]*

(4) Personal attitudes towards life (and death)

Several nurses remarked on their own sense of mortality. It appeared that this awareness afforded them a heightened zest for life, exemplified by comments such as "life is for living" and " I just think, today is today and I'm going to enjoy it!"

> I think I had to be ready to come into this before I actually started it. I think with palliative care you've got to have been through a bereavement yourself and sorted out your questions yourself, you know, 'Why are we here? Why does this happen?' ...well, it made me question life really and what's it all about.... I think I had to be ready, and I suppose it does affect your life because you realise life's short really and it changes your values. *[Participant 7]*

Those that appeared to have considered issues of mortality for themselves also reflected on the concept of "a good death", and the importance of this for patients and their loved ones.

> I tend to think of how I would like things for myself, if I was in that situation, because I don't know how I'm going to die...where, or when... and I hope that I

> look after patients now the way people will look after me when my time comes.
> *[Participant 3]*

(5) Awareness of own spirituality

Akin to a sense of their own mortality, many participants spoke of their own spirituality, and how an awareness of their own spirituality helped them to address the needs of their patients and their families.

> And I think that until a person is comfortable with their own spirituality, whatever they regard that to be, I don't see how they can be comfortable with the patients'- dealing with patients' needs to the full extent...thinking about the patients' end of life issues, when it might be affecting them personally. And they might be having to deal with their own fears and anxieties as they're dealing with patients' [fears and anxieties]. *[Participant 3]*

It is of note that those who did not mention existential issues or spirituality spoke of the need to possess a good sense of humour when working with people who are dying. Humour is clearly important in this setting, and has many functions. In this context, it may indicate the protective function of humour, acting as a defence against uncomfortable aspects of mortality and spirituality.

(6) Personal attitudes towards work

This theme again demonstrated the nurses' commitment to their work, and their need to perceive themselves as being in control, and their work situation and the task to be done as manageable.

> I like to be in control of what I'm doing and things and I like to know, you know, to have some structure to it and then you know what's happening. *[Participant 2]*

> Even when change is taking place, I still like to be in control of those changes taking place. I like to know the process and work with it. *[Participant 3]*

In a setting where there is considerable uncertainty about the life expectancy and death of patients (as even within a palliative care setting, prognostication regarding the terminal phase is very difficult) there is perhaps a greater need for staff to feel in control. This need is also engendered within medical and nurse training.

> I like the challenge... and I like different patients coming in with different things....the variety of the job. *[Participant 9]*

(7) Aspects of job satisfaction

Nurses indicated several factors that afforded them a sense of job satisfaction. As might be expected these included factors such as supportive work colleagues, a manageable workload with time to listen and talk to patients, and a pleasant working environment.

> I suppose basically I like the job. I get great satisfaction out of the job, great personal reward, my colleagues, the colleagues that I'm really close to... they're very kind, very nice people, they're some of the best people I've ever worked with, the surroundings are nice. *[Participant 5]*

(8) Aspects of job stress

Job stress related to busy periods when the workload felt less manageable, the impact of working shifts, and the effects of staff shortages and working with bank staff who were unfamiliar with the hospice routines.

Other aspects that were perceived as stressful related to communicating to relatives that their loved one had died, and the effect on other patients when someone died.

> ..when somebody dies, and you've got to get that patient from the bed in the ward to the bedroom and get the bed ready for the next person coming in... last week...there was no time for the staff even to feel sad because I was going from the relatives of the person who had died, and then trying to be bright and sparkly to the next relative and the next patient coming in. *[Participant 5]*

Several staff spoke of experiencing "frustration" at work, rather than feeling stressed. This appeared to imply that although they adopted more active strategies, they were unable to achieve their goals for their patients, due to organisational factors outside of their control.

(9) Ways of coping

Many nurses indicated the behavioural and cognitive coping strategies they utilised both during work and at the end of their shifts. Strategies included offloading to colleagues, the use of humour, maintaining a healthy work-life balance, and having good social networks.

> You have to have a good support system at home...a social life... other interests outside here, and I think that is very important. *[Participant 2]*

> I talk to colleagues and we do actually discuss how we feel or how something could have been managed and we give support that way. *[Participant 5]*

(10) Personal/professional issues and boundaries

The nurses showed awareness of maintaining professional boundaries. These also appeared to have a defensive/protective function in that they distanced the nurses from the emotional distress resulting from working with patients who were themselves addressing existential end of life issues. This was particularly apparent where nurses described formation of attachments with patients, and where there was identification because a particular situation was too "close to home".

> You get involved in your job and what you need to do....but I think you have to protect yourself as well. *[Participant 2]*

> I had my uniform on, I was a nurse behind this barrier. *[Participant 5]*

> You do get very fond of some people and you get upset, but if anybody dies, I would never go to their funeral... I wouldn't like to intrude on somebody's grief...but apart from that I wouldn't go because I think you've got to switch off somewhere. *[Participant 9]*

Discussion

The results of this study yielded ten themes that hospice nurses used to describe and conceptualise their work. The themes related strongly to a high degree of commitment and sense of purpose about their work. These themes were evaluated against the literature to understand further the possible interpersonal factors at play in promoting resilience and buffering or moderating the effects of workplace stress.

Within the literature, two theoretical models that explain resilience are the personality constructs of hardiness and sense of coherence. Hardiness comprises three closely related dispositional tendencies; commitment, control and challenge. Commitment refers to a sense of meaning and purpose in life; control refers to a sense of autonomy over one's life; and challenge is akin to a zest for life that leads an individual to perceive change as an exciting opportunity for growth (Kobasa, Maddi & Kahn, 1982; Maddi & Kobasa, 1984). Change rather than stability is seen as normal in life (Turnipseed, 1999).

According to Orr and Westman (1990), hardiness can be considered an operationalisation of existential courage.

Sense of coherence, introduced by Antonovsky (1987) is an integrated perception of one's life as being comprehensible, manageable and meaningful. Comprehensibility refers to a cognitive component whereby one's life is interpreted as rational, understandable, structured, ordered, and predictable. Manageability concerns the extent to which individuals believe themselves to have the resources, internal and external, available to meet the demands placed upon them. Meaningfulness represents a motivational component whereby demands are appraised as challenges worthy of investment and engagement (Antonovsky, 1987). Sense of coherence is considered to be a personality disposition that is a "stress resistance resource" (Antonovsky, 1987).

Hardiness and sense of coherence have considerable conceptual overlap (Geyer, 1997). They both adopt a "salutogenic paradigm" in that they propose that health is qualitatively different from the absence of disease (Strümpfer, 1990). Both seek to explain why some individuals remain healthy when under stress, rather than focussing on why they become ill. They both derive from an understanding of personality variables, and emphasise an interactional view of personality, looking at the sense of meaning for individuals within their social context. Both models emphasise that they should be considered as unitary concepts, rather than three separate components (Antonovsky, 1987; Kobasa, Maddi & Kahn, 1982). The main difference is that hardiness views change as the norm in life, whereas sense of coherence stresses the importance of stability and structure. Neither appears to have been studied empirically in palliative care staff.

When the nurses' experiences, as described by the emergent themes, were compared to these personality constructs, there appeared to be striking similarities. These are shown in Table 2.

Table 2.

Comparison of themes to personality constructs.

Theme		Hardiness				Sense of Coherence		
		A	B	C		D	E	F
An active choice		✓				✓		✓
Past personal experience		✓				✓		
Personal attitude to caregiving		✓	✓			✓	✓	
Personal attitude to life and death		✓		✓		✓	✓	✓
Awareness of spirituality		✓		✓		✓		✓
Personal attitudes to work		✓	✓	✓		✓	✓	✓
Aspects of job satisfaction		✓	✓			✓	✓	
Aspects of job stress			-ve	-ve			-ve	-ve
Ways of coping			✓	✓			✓	
Personal/professional issues and boundaries		✓	✓				✓	

Note: A = commitment
B= control
C = challenge
D = meaningfulness
E = manageability
F = comprehensibility

In comparing the themes to hardiness, all the nurses in this study indicated a high degree of commitment to their role and perceived themselves to have a high degree of control and autonomy over their workload. Some viewed the challenge associated with their work as an important factor in gaining a sense of satisfaction and achievement. This was not so for everyone, however, as some nurses stated that that they disliked change and preferred a degree of stability in their work.

When the themes were compared with sense of coherence the nurses ascribed meaning to their work, and a sense of purpose. They perceived their work as manageable, and were driven by a wish to meet the needs of their patients and enhance their quality of life. An awareness of their own mortality and spirituality led them to perceive aspects of their work as comprehensible. Those nurses that disliked change indicated their need for stability in an uncertain world.

It is important to note that, as determined by the methodology, the emergent themes were both phenomenological and interpretative. Similarly, the comparison of the themes with the two theoretical constructs, as shown in Table 2, was also subjective in nature, being determined by the interpretations made by the researcher. Whilst there appeared to be a "good fit" between the emergent themes and the theoretical models, given the subjective nature of these conclusions, further research is required to assess the applicability and validity of these findings.

For the purpose of this study, the sample was a homogenous group of hospice nurses. In keeping with qualitative methodology, the findings described the experiences of this group of staff (Smith & Osborn, 2003). The researcher suggests that these findings are applicable to other trained palliative care nurses. Comparative studies with palliative care nurses in hospital and community settings, and well as in other hospices would provide valuable additional data concerning the transferability of these findings. Furthermore, undertaking quantitative studies of hardiness and sense of coherence would yield additional empirical evidence regarding the applicability of these constructs to palliative care staff.

Conclusion

In conclusion, the findings illustrate the interpersonal factors that may enable hospice workers to remain resilient and effectively buffer or moderate the stressful effects of working in palliative care. On comparing these findings with the literature, specifically the theoretical personality constructs of hardiness and sense of coherence, there are many similarities. A source of divergence in the data concerns the nurses response to change. This is consistent with the main variance between the two constructs; the need for stability in sense of coherence and perceiving change as an exciting opportunity for growth in hardiness. This would suggest that hardiness might explain some nurses' resilience at work, whereas sense of coherence explains others. The determining factor appears to be an individual's attitude towards change. This occurs within a work context characterised by change, whether that be individual patient care, where there may be uncertainty around life and death, or national policy, where new agendas for supportive and palliative care are being introduced and implemented.

The findings suggest implications for staff training and support in that the factors that promote resilience, particularly hardiness and a strong sense of coherence, could be developed through staff training packages. It is suggested that change should be implemented sensitively, recognising that staff who are resilient may hold opposing attitudes towards change. The opportunity for reflective practice may enable staff to acknowledge the emotional impact of working in end of life care, and to address their own existential issues. It is suggested that staff who are resilient and maintain a sense of well-being may be more likely to continue working in palliative care, and furthermore, may remain committed to providing the best care for their patients and their families.

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Contributions to Theory, Research and Clinical Practice

Janice R Ablett

Division of Clinical Psychology

University of Liverpool

This paper presents a critical review of the research investigation carried out in the previous section of this thesis. In order to set the context for the review, a brief overview of the findings of the study will be provided. The rationale for the methodology, and the limitations of the study will be mentioned, together with a further ethical consideration that arose during transcription of the interview data. The paper will then discuss the implications of the study for future research and for clinical practice.

Overview of findings of study

The present study used qualitative methodology, specifically interpretative phenomenological analysis (IPA) to investigate hospice nurses' experiences of their work. In particular, the interpersonal factors promoting resilience and a sense of well-being were explored in order to gain a greater understanding of how nurses are able to maintain their psychological well-being and buffer or moderate the effects of workplace stress. Ten themes that emerged from the data analysis were compared to two existing theoretical constructs, those of hardiness and sense of coherence. There were striking similarities, and just one source of divergence, the nurses' response to change. This was consistent with the main variance between the two constructs; the perception of change as opportunity for growth in hardiness, and the need for stability in sense of coherence. This would suggest that hardiness might explain some nurses' resilience at work, whereas sense of coherence explains others. The determining factor appeared to be the individual's attitude towards change.

Rationale for IPA methodology

IPA was utilised in this study in order to allow the researcher to consider the "insider's perspective" (Conrad, 1990; Smith & Osborn, 2003). This approach is suitable for analysing complex data involving staff attitudes and beliefs, and is particularly useful when considering the processes operating within models, as opposed to traditional focuses on outcome research (Brocki & Wearden, 2006; Smith, 1995).

In line with the recommendations of Strauss and Corbin (1990) that shorter papers report the richness of particular themes from qualitative research rather than attempting to summarise all the data, this paper focused on themes that described aspects of the nurses' work that were pertinent to their resilience and well-being. Thus the study had validity in that it provided an in-depth understanding of the antecedent factors contributing to resilience in palliative care nurses.

In line with the principles for quality in qualitative research it is argued that the study design should be contributory, defensible in design, rigorous and credible (Spencer, Ritchie, Lewis, & Dillon, 2003). Furthermore, according to criteria suggested by Yardley (2000) it is suggested that the research findings should be sensitive to the context, show commitment and rigour, be transparent and coherent, and their impact and importance be discussed. In terms of credibility checks (Elliott, Fischer & Rennie, 1999), the transcripts and tables showing derivation of themes are included in the appendices to aid transparency.

Limitations of the study

There are several limitations to this research investigation, and these are addressed prior to considering the research and clinical implications. Firstly, in line with Carradice's (2002) study with mental health nurses, it is suggested that the researcher's role as a clinical psychologist rather than a nurse may have introduced a bias, yet potentially this may have avoided other sources of bias. When speaking to someone from a different professional background nurses may have felt that there was a lack of understanding of some aspects of their role. Conversely, being from another profession may have avoided power issues in speaking to a nurse of a more senior grade. As the researcher was known to the hospice staff as a psychologist this may have been a further bias in that the nurses might have found it easier to talk to someone they did not know. Alternatively, this may have aided the development of the interviews and the quality and detail of the responses as the nurses were aware of the boundaries, particularly concerning confidentiality, that the psychologist operated within. A further consideration is the possibility of response bias, in that staff may have responded in the semi- structured interviews with what they considered to be the proper answers. This is of particular concern given the strong team ethos within the hospice.

The research findings are inevitably limited by those who take part. Although it was apparent that, of the total number of hospice nurses approached to participate, there was a high response rate (66.7%), still there was a proportion who declined to participate. It can only be conjecture whether the nurses that did not consent to take part in this study are as resilient and healthy, or perhaps less resilient and less healthy, as those who did participate, or indeed whether they are hardy and possess a strong sense of coherence.

Conversely, it could be argued that those who were more stressed and less satisfied with their work might have grasped an opportunity to state their views in a confidential setting. Anecdotal evidence would suggest that the nurses who declined to participate were not less healthy than those who participated, as several nurses informally sought out the researcher to explain their reasons for not taking part.

The data was collected at a single time, which poses a risk that central concerns were not revealed. Glaser (1998) suggested a further round of interviewing, rather than being satisfied with the initial reports of participants. Neither a second round of interviews nor a response validation survey was undertaken for three reasons. Firstly, the manner in which respondents replied to follow-up and probing questions during the interview suggested to the researcher that further interviews might not have yielded additional or different data. Topics were pursued with the participants until there was indication that they were unlikely to have anything further to say about a particular area of questioning. This was interpreted by the researcher in terms of maintenance of professional boundaries which served a defensive and protective function, and it was the view of the researcher that it would be unhelpful, and unethical, to challenge this further. Similarly, a response validation survey could have afforded participants opportunity to comment, add to their answers or clarify responses if it was felt the researcher had incorrectly interpreted any of the data. Secondly, further data collection was not undertaken due to time constraints. Both undertaking a further round of interviews, and sending out a survey would be beyond the scope and time limitations for this study. Thirdly, the researcher was aware of the goodwill and support from the hospice in allowing interviews to take place. It was felt that requesting further interviews with staff would be perceived as "above and beyond the call of duty".

A further limitation is that the themes were not corroborated by another checker. According to Yardley (2000) reliability and replicability may be inappropriate criteria. She holds that two people coding a text in the same way simply becomes an interpretation by two people, and cites Seidel and Kelle (1995), "the use of inter-rater reliability as a check on the objectivity of a coding scheme is meaningless". The sample was a homogenous group of hospice nurses. It is suggested that the findings are dependable, and are transferable to other hospice nurses, and indeed to other palliative care nurses working in the community or hospitals settings.

Ethical considerations

An ethical consideration that arose at the data analysis stage which had hitherto been overlooked was the effect on the transcriber of listening to distressing information contained within the interviews, especially when the information was presented aurally through headphones. During several of the interviews the nurses spoke about their work with people who were dying, and about existential issues concerning their own mortality and spirituality. At times, some of the nurses cried audibly during the interviews, and although this distress was contained by the researcher throughout the interview process, the transcriber was exposed to listening to the nurses' accounts and heard the emotional content too.

From the author's experience of analysing the data it seemed that the material presented aurally through headphones was more intense, in that it was more emotionally laden than reading the spoken conversation on the page of a transcript. Although each transcriber was briefed about the nature of the interviews before commencing to transcribe the interviews, it was apparent that after typing one tape some transcribers felt that they could not continue with subsequent tapes. The transcriber used for the latter transcripts had typed interviews, in previous work, with people who had been given a diagnosis of cancer. She was able to reflect that some of the material in the tapes for this study made her feel sad, and that, at times when the nurse cried and became upset, the content was distressing to listen to. She commented that she felt also that the tapes were hopeful, in that the nurses talked about positive aspects of what they did at work.

To the author's knowledge, the psychological effect on typists of transcribing in-depth interviews has not been investigated. Neither is it usual, in the author's experience, for this to be addressed as an ethical consideration in the research protocol. This is in contrast to the great care taken to ensure that participants, be they service users, carers, or health professionals, are offered psychological support as necessary following any research study.

Further consideration was given, too, to the quotes presented in the research paper in order to preserve confidentiality among responses from a small group of nurses, several of whom have indicated they would be keen to read a copy of the research paper once finalised.

Implications for future research

There are a number of research implications arising from this study. Further qualitative work with palliative care nurses working in hospital and community settings to explore their experiences of work could lead to a greater understanding of the factors contributing to resilience in this group of nurses. As in this study, the findings from the emergent themes could be compared to existing knowledge about hardiness and sense of coherence. Thus the validity of the findings of this study could be explored further, firstly with other palliative care nurses, and secondly with other health care professionals working in palliative care. As previous studies, such as Ramirez et al. (1996), have considered psychological morbidity and burnout in palliative care physicians, it would be of interest to replicate this study with palliative care doctors. This raises the question of sample size, as only a small number of doctors work in any one hospice. To date, there is much variance in sample size in qualitative studies, with reports varying from one to thirty (Brocki & Wearden, 2006). In order to have a larger sample, this would necessitate interviewing doctors from different hospices. It is suggested that this would provide a richness of responses derived from doctors working in different locations and for different organisations. Further research in this area would make an original contribution to the knowledge base as the current literature tends to focus on burnout rather than resilience, and hardiness and sense of coherence do not appear to have been studied in doctors (Rabin, Matalon, Maoz & Shiber, 2005).

In addition to further qualitative work, there is merit in quantitative studies being carried out. The themes emerging from this study could be used as a basis for the development of a self-report questionnaire measuring resilience in palliative care nurses. Additionally, further studies, utilising the existing self-report measures for hardiness and sense of coherence, could be administered to a larger sample of palliative care nurses. This may shed light on whether the nurses are indeed deemed to possess hardiness and/or a strong sense of coherence. If both measures were administered, this might provide valuable additional information concerning the similarities and differences between the two constructs. To date, the reported studies with health care professionals are cross-sectional in design. Conducting studies using a longitudinal design to measure resilience, perhaps including hardiness and sense of coherence, at different times during the nurses' careers in palliative care might provide data regarding the stability or otherwise of these constructs. In addition such a research design could also perhaps provide information about the maintenance of resilience and well-being, and also retention of staff in palliative care.

A further avenue for research might be to explore the extent to which resilience and well-being is maintained in nurses working in other specialties where there is considerable exposure to death and dying, for example in accident and emergency, critical care, and burn units. As yet, there seems to be insufficient literature to ascertain whether there are differences in resilience between nurses working in what are traditionally viewed as acute settings, and those working in more long term service settings. There are considerable palliative care needs, for example, within services for older adults, and within services for people with other long term physical health conditions. It would also be of interest to determine if individuals can develop or learn to increase their resilience, and this is alluded to further in the following section on clinical applications.

A second area of research, arising from the theme concerned with maintaining professional boundaries, might be to explore further the extent to which the nurses engage at an emotional level with their patients. There is evidence that psychological distress is significant in palliative care patients, yet is under-diagnosed, and hence untreated (Pessin, Potash & Breibart, 2003). It is of relevance to ascertain whether the nurses attend to and address significant emotional distress in their patients, or whether they distance themselves so as not to experience the distressing feelings that can be evoked within themselves. The extent to which resilient individuals engage with patients is as yet undetermined. Indeed, whether distancing is a necessary component of resilience is open to empirical investigation. Furthermore, it could be hypothesised that staff who are resilient are adept at maintaining an emotional distance with their patients that serves a protective function, maintaining their well-being and enabling them to continue working in a setting where they are exposed to potential distress on a daily basis.

With regard to implications for theory development, further research is needed. Although the emergent themes from this study map on to the theoretical constructs of hardiness and sense of coherence, and hence they are discussed in the literature review, there may be other, more applicable, ways of understanding resilience in this context. To date, however, there is scant literature available. In addition, given the aetiological development of the constructs of hardiness and sense of coherence, it is suggested that there is merit in comparing further the similarities and differences between them. For example, the relationship of these constructs with attachment theory does not yet appear to have been studied.

Implications for clinical practice

It is suggested that the main clinical implications arising from this study concern staff training and support. Clinical psychologists, whose role encompasses working with staff groups and teams, involvement in staff education and training, and working in a consultancy role at an organisational level, are well placed within a health care system to initiate the development and implementation of staff training and support, and to communicate the rationale for their implementation at various levels within the organisation.

Firstly it is suggested that staff training packages might be developed that aim to foster resilience in palliative care staff. Applying a salutogenic paradigm, such packages would be viewed as best practice and ongoing staff development, rather than being offered as assistance to staff who cope less well with the effects of stress and are at risk of developing symptoms to the level of "caseness" for psychological morbidity. Approaches formulated from an understanding of the antecedent factors would aim to build resilience, rather than being reactive to work related stress outcomes as is the case with more traditional stress management approaches.

If adopting a hardiness model this might entail ensuring that staff are given appropriate autonomy within their role, further developing problem solving and solution focused strategies, and encouraging shared governance arrangements, sufficient challenge in terms of new learning experiences, and positive changes in work behaviour and practices that enhanced patient care and maintained their sense of commitment to their role. The development of "hardiness training" which "improves, performance, morale and health" in employees is reported by Maddi (1999, p.71), and it may be that there are aspects of this training that could be applied to the UK healthcare context. Such training would include tasks designed "to learn active transformational coping, give and get assistance and encouragement in social interaction, engage in self-care, and use feedback from these activities to deepen the hardy attitudes of commitment, control and challenge" (Maddi,1999). A further task might be to explore individuals' attitudes towards change, in order to gain insight and understanding both of how they are affected by change, and of how they might implement change. Given the similarity between the constructs of hardiness and sense of coherence, it may be possible to monitor and evaluate, within an action research framework, any changes in both hardiness and sense of coherence that result from implementing staff training and support. This might give an indication of the extent to which hardiness can be learned and sense of coherence strengthened. The difference in individual response to change could be made explicit, so that there is greater awareness of the need to implement change in a sensitive way that gives recognition to individuals' differing responses to change.

Even with such a salutogenic approach, as opposed to a pathogenic one, it is considered unlikely that such changes would be sustainable without recognition from the organisation of the complex interactions between employee and employer/organisational variables, and without commitment from the organisation to the concepts of improving well-being of employees and developing a healthy organisation. Clinical psychologists, it is argued, can work effectively with other senior staff consulting at an organisational level to develop policies and frameworks, and to communicate strategies for such a comprehensive approach to developing resilience and enhancing coping. By so doing, it is argued that a culture of continuous improvement can be developed.

Such interventions require ongoing evaluation and monitoring, both to demonstrate their effectiveness and to adjust to any changing needs of the employees and the organisation. Furthermore, in addition to auditing outcomes and cost-effectiveness of ongoing work, research is needed to determine the most effective components both within the organisational framework, and of specific training packages. Additionally, ongoing audit and research is required to determine the similarities and differences, and the relative effectiveness, of salutogenic approaches that focus on increasing resilience, and more traditional stress management approaches with their focus on alleviating the effects of stress and burnout in individuals, and on providing employee assistance programmes within organisations.

The study also suggests there might be merit in providing regular staff supervision and support, so that staff have a forum where it becomes good practice to reflect on the emotional content of their work with patients, and the personal thoughts and feelings this evokes in staff. As this would be different to "offloading" that the nurses mentioned in the study, there would be a need for this to be facilitated and contained. In addition, given the likelihood of existential issues being evoked in both staff and patients, it is suggested that such a support group should be facilitated by an experienced therapist who could address both the group dynamics and process, whilst maintaining boundaries. Clinical psychologists who are trained in providing supervision and group work, it is argued, are well placed to facilitate such groups, or alternatively, to offer supervision to the facilitators themselves. If the emotional concerns and existential issues of the staff are attended to, then individual members of staff may become more confident in attending to the emotional needs of their patients rather than distancing themselves from others' distress. Furthermore, facilitating resilience at work may result in a staff group that has an improved sense of well being. In turn, this may be reflected in lower sickness and absence, and increased retention of staff.

Finally, this study suggests that staff who themselves are resilient and possess a sense of well-being may be more likely to continue to give high quality care which does indeed make a difference for the patients, families and carers they work with.

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Appendix 1

Appendix 2

Appendix 3

Interview schedule.

1. What is it about working in palliative care that gives you a buzz?
2. What is the essence of it that you really like?
3. What is it that gives you a sense of personal satisfaction?

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4. What do you think working in palliative care tell us about you as a person?
5. What does it tell us about your personality?
6. What are the most stressful aspects of your job?
7. What do you find yourself doing when it gets stressful?
8. What helps you cope?
9. Are there things that are less stressful?
10. What is it that makes you stay working in palliative care?
11. How does working in palliative care affect your own view of life?
12. Can you leave work here, or do you find you take it home with you?
13. How do you find a balance between home and work life?
14. How important is it to feel you have got things right/ done your best at work?
15. Are you the sort of person that usually finds you can make things happen in the way you want them too?
16. How much control do you have over your workload/ how autonomous can you be in your work?
17. Do you usually feel that things that happen to you at work are hard to understand?
18. Do you usually manage to find a solution to problems and things that others might find difficult or hopeless?

lead

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19. Do you usually feel that your work is a source of personal satisfaction?
20. Anything else that you wanted to add?

Appendix 4

INFORMATION SHEET FOR PARTICIPANTS ABOUT THE STUDY

Date: April 2004
(Version 2)

Resilience, hardiness, and coping in palliative care: a qualitative study of nurses' experiences of work.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Who is conducting this research study?

This study is being conducted by Janice Ablett, Consultant Clinical Psychologist, and Dr Richard Corney, Clinical Director of Clinical Psychology Services, Royal Alexandra Hospital, Rhyl. The study is being undertaken by Jan Ablett as part of her course work towards the Continuing Professional Development Doctorate in Clinical Psychology at Bangor University.

What is the purpose of the study, and why have I been chosen?

This research project aims to investigate how nurses perceive the stresses of working in palliative care settings, and the processes they employ to manage them and deal with them effectively. In order to do this, we are asking all the trained nurses working in the Palliative Care Service if they would be willing to take part in this study. It is expected that this will take place between April and June 2004.

Do I have to take part?

It is up to you to decide whether or not to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form that should be returned to Janice Ablett. You will be given a copy of the consent form to keep.

If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your work situation at any time. Similarly, if you decide not to take part, your work situation will not be affected in any way.

If I take part, what will be expected of me?

If you agree to participate, you will be interviewed by Janice Ablett about your experiences of coping with your work, particularly about what you find helpful in managing and dealing effectively with the stressful aspects of your role.

The interview can be carried out at your place of work, other health service premises, or at Hospice. It is envisaged that the interview will last approximately one hour. Prior to the interview, you will be asked to sign an Audio-tape Recording Consent Form to give permission for the interview to be audio-taped. You may also be asked for a second interview to help clarify any points that you raised in the first interview. You are, of course, free to refuse a second interview.

What are the possible benefits of taking part?

It is not envisaged that taking part in this study will be of particular benefit to you. It is hoped, however, that information from this study may contribute to the knowledge of how nurses' working in palliative care settings buffer stress and stay healthy when faced with work related stresses.

If, as a result of talking about your experiences at work, you become more aware of any personal difficulties you can contact the In- House Counselling Service at the Department of Psychological Services at . This confidential service can be accessed by contacting Counselling Co-Ordinator on .

RESEARCH CONSENT FORM

Title of Project: Resilience, hardiness, and coping in palliative care: a qualitative study of nurses' experiences of work.

Name of Researcher: Janice R. Ablett

Please initial box

1. I confirm that I have read and understand the Information Sheet dated April 2004 (Version 2) for the above study. ☐
2. I confirm that I have had the opportunity to ask questions and discuss the study. ☐
3. I confirm I have received satisfactory answers to my questions. ☐
4. I confirm that I have received enough information about the study. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
6. I agree to take part in the above study. ☐

Name of Participant ______________________ Date ______________ Signature ________

Researcher ______________________ Date ______________ Signature

1 copy for participant, 1 copy for researcher

AUDIOTAPE RECORDING CONSENT FORM

Title of Project: Resilience, hardiness, and coping in palliative care: a qualitative study of nurses' experiences of work.

Name of Researcher: Janice R. Ablett

As a participant in this research study, you are being asked to agree to your interview with Jan Ablett being audio-taped.

If you agree to this:

- Audio-tape recordings of your interview will be confidential, will be kept securely and will be erased as soon as the content has been typed up.
- In the transcript of the audio- tape, any details that might identify you will be changed to make it anonymous. The content of your interview will not be discussed with, or shown to, anyone else working in the Palliative Care Service or the Trust.
- If, at any time during the interview, you wish the recording to stop, then you can request this.
- If, at the end of the interview, you wish the tape to be erased immediately, you can request this.
- Refusal to consent to recording will not affect your work situation in any way.

I have read and understood the above, and agree to this interview being audio-taped. I understand that this is solely for the purposes of the above research project.

______________________	______________	________
Name of Participant	Date	Signature

I, Janice R. Ablett, undertake to maintain proper care of this recording which will be used solely for the purposes of the above research project. The contents of the tape will be erased as soon as possible after the interview has been typed up.

______________________	______________	________
Researcher	Date	Signature

Appendix 5

Text	Category	Sub -theme	Theme 1.
I always wanted to be a nurse… I just wanted to get into nursing.	Becoming a nurse was an ambition from childhood	Nurses demonstrate a positive career choice.	An active choice to work in palliative care
I think I was always meant to do this work.			
It's just something I've always wanted to do, be a nurse.			
I just wanted to get into nursing – I saw the way they looked after my relative	Deciding on career after observing nurses.		
I find working in palliative care to be a privileged post			
I came onto nursing late. What I always wanted to do was look after people, make things a little better for them, and I find this job does everything.	Changing career to come into nursing	Nurses choose to specialise in palliative care.	
That's something I would like to do – make a difference to people who are dying.			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis.

Text	Category	Sub -theme	Theme 2.
Having seen a close relative have a terminal illness and seeing the care they got was very good	Caregiving: giving the care you would want for yourself	Many nurses had experienced the death of a close relative, and this lead to an increased empathetic response to patients and their relatives.	Nurses' past personal experiences influence care-giving.
If I'd not been through a close bereavement I'd have found it a bit more difficult			
I've had bereavements myself so I can empathise			
My relative died and there was no support	Caregiving: giving the care that your close relative didn't receive		
I hopefully was able to give more support than I had			
The treatment we didn't get, I'd like to make sure that somebody else did			
If it's someone your own age you relate to them	Younger people are harder to nurse because it's "close to home"	Nursing younger people leads to identification with own personal situation.	
Young deaths affect us all really			
If it's a young person and they're the same age as your children you think there but for the grace of God go I and then you have to take stock			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 3.
I know I've done my best for the patients, and I've done what I can and I can't do any more.	Striving to give 100% at work.	Nurses are highly committed to their role	Personal attitudes towards care-giving.
I like to give 100%			
If we're going to do this job we need to do it to the best of our ability; second best isn't good enough			
I like to be in control of things.	Being self confident and competent in one's role	Being in control at work is important	
I always manage to get through a sticky situation looking like I'm in control			
You see the patient as a person with a life and a history rather than just a condition	Contrasts with hospital care – there is time to get to know the patient and their family	There is time in palliative care to "be there" for patients and families.	
I'd like to be looked after by me.			
It's being able to look after the whole individual and address all their needs			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 4.
Life is for living!	Increased zest for life		
I just think today is today and I'm going to enjoy it!		Awareness of own mortality	
It makes you realise how precious life is. I think it makes you appreciate each day.			
Family life and life outside work are important	Value relationships with others	Altered perspective on life	Personal attitudes towards life – and death.
I feel kinder towards other people; you don't know what they've been through			
I think of how I would like things for myself if I was in that situation	Emphasis on quality of life	Reflective about own end of life care	

.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 5.
I'm quite a spiritual person & I think spirituality is a big aspect in palliative care	Staff have personal beliefs	Awareness of issues concerning spirituality	Awareness of own spirituality.
I have my own belief system			
I meditate and I find that helps			
	This is addressed openly at the hospice		
We recently had a session on spirituality			
It's not all doom and gloom – you have to laugh	Function of humour can be defensive	Not demonstrating awareness of issues of spirituality	
There's no answer to it.			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 6.
I like to be in control	Need to be in control	Need for order in an uncertain world	Personal attitudes towards work.
I like the challenge			
I like things to be tidy, to be completed.			
I like the different patients with different problems and it's always the unexpected .	Enjoying challenges	Thriving on variety and difference	
I don't like change	Conflicting views about change		
I'm comfortable with change			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 7.
They're some of the best people I've worked with	Team support and good teamwork	Supportive working colleagues	Aspects of job satisfaction. (of job/person fit)
There's a good team, camaraderie.			
There' time to talk to the patients	Time to give high quality care	Fulfils aims	
It's a nice place, a nice environment	Finding one's niche	Good working environment	
I like it here, and I'll stay til I retire			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 8.
It's frustration not stress	Factors concerning patient care – which are outside of nurses' individual control	Manageability of workload	Aspects of job stress.
When you've more than one admission on a shift			
When someone dies and you need the bed for the next person coming in			
The computer	Organisational aspects of role	Impact of change; new systems implemented	
Not having time to talk to the patients	Increased workload as consequence of type of treatment undertaken in hospice now	Changing role of hospice care – symptom control etc	
We're more acute now.			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 9.
Family and home life are important	Recognition of life outside work	Active coping outside of work setting	Ways of coping.
Talking to my friend and sitting in her garden			
You need a good social life outside work			
I go home and I go quiet	Maintaining work/life balance		
We look out for each other	Staff endeavour to support each other at work	Coping at work	
We sit down at the end of the day and offload and then chat generally			
Coffee and chocolate			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Text	Category	Sub -theme	Theme 10.
You get involved… but have to protect yourself too	Active employment of (avoidant?) coping strategies that serve a protective function	Makes explicit an awareness of operating boundaries	Personal/ professional issues and boundaries.
I think you've got to switch off			
When someone dies I would never go to a funeral	Self care		
At the end of the shift I take of my uniform and I'm […] again	Significance of adopting role as nurse	Appears to be keeping boundaries (well defended during interview)	
At home things pop up in your head and you think about things that have happened but nothing causes me any problems or concerns			

N.B. This table is not a comprehensive summary of the data contributing to the theme, but shows examples of data at each level of analysis

Appendix 6 : Statement of word count

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