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Portraits of nursing resilience: Listening for a story

Vicki Cope
Edith Cowan University

Edith Cowan University

Faculty of Computing, Health and Science

School of Nursing and Midwifery

Portraits of Nursing Resilience: listening for a story

Student: Vicki Cope RN, RM, BA, Dip Ed,

Grad Dip (Nsg), MHealthSc (Nursing),

Student Number: ▮▮▮▮▮

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Principal Supervisor: A/Prof Bronwyn Jones

Associate Supervisor: Dr Joyce Hendricks

Associate Supervisor: Dr Christopher Churchouse

ABSTRACT

The nursing workforce in Australia is a workforce under pressure. Within in-patient settings, rapidly increasing turnover of more acutely ill or co-morbid patients, and staff retention issues, place those staff that remain under extra pressure to maintain a quality service. In nurse education settings the increasing imperative to recruit more students into the profession combined with financial cutbacks leading to staff retention issues creates a similar tension. Yet many Registered Nurses (RNs) do remain in their chosen work setting displaying tenacity and resilience despite well documented trials and tribulations.

A qualitative approach, Portraiture, was used to construct a collection of portraits which enabled an exploration of the 'why' that relates to the individual nurse's remaining in a workplace often described as awful.

A narrative analysis of the portrait data allowed a meaningful interpretation based in current literature and contemporary experience in uncovering the individual's resilience and motivation to continue. The portraits give an overarching insight of the nurse participant's world view and why each continues in her work. The traits and attitudes uncovered have implications for educators and employers of nurses as well as for consumers of nursing care.

Several recommendations arose from the findings in relation to further research, education and policy making. These recommendations could contribute to enhance a satisfying professional milieu for the practising nurse; and to the education and ongoing professional development of nurses which acknowledges the changing socio-political and fiscal environment in which nursing service takes place.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

- incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;

- contain any material previously published or written by another person except where due reference is made in the text of this thesis; or

- contain any defamatory material.

Signature ……

Date ………… 23rd April 2013………………………

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CONTENTS

Chapter Four - THE METHOD

Chapter Five - THE PORTRAIT GALLERY   65

Chapter Six - INTERPRETATION

Chapter Seven- CONCLUSION AND RECCOMMENDATIONS

List of Figures

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

PREAMBLE

The nature of nursing work is multifaceted. It takes place in a myriad of contexts; but through changes in education and healthcare it is now accepted as a profession. The profession and its members have been the subject of much research around problems in the provision of nursing services. It is my own experience as a nurse however, which has led me to believe that there are still stories to tell which celebrate persistence, commitment and resilience, by professional nurses and their contexts of care.

Contemporary research has provided evidence of the worth of nursing in the amelioration of illness, the survival rates of critically ill patients and the quality of collaborative health care within many health systems (Aiken, Clarke, Sloan, Sochalski & Siber, 2002). It is of concern therefore to government and health care managers in most developed countries that a combination of fewer nurses entering the profession and an exodus of qualified nurses from the profession is resulting in a predicted shortfall of nurses required to maintain a viable and effective nursing service.

It is generally accepted that advances in medical sciences, consumer expectations and diminishing and/or stretched financial resources have led to the current crisis in the provision of international, national and local health care. As I was contemplating further study an increasing number of media reports described the Western Australian healthcare system as being in disarray (Fong, 5/4/07). After nearly 30 years of working in nursing and midwifery in different settings both public and private, my curiosity was piqued. Reflecting on these reports caused me to pose questions: Why were nurses remaining within such a system? What keeps them working? Setting aside the simplistic and valid matter of "making a living", what is it about these nurses that enables them not only to cope with and manage perceived stressors, but to enjoy a fulfilling working life? Thus the focus of what I want to explore within my study was clarified: the nurses' personal stories of resilience must be explored; I wanted to tell their story.

After reviewing other qualitative approaches including phenomenology, folkloristic biography, ethnography, and discourse analysis, I came across a methodology called Portraiture. Portraiture offered a blend of several qualitative approaches and I found that it offered me several advantages: importantly portraiture as my counter narrative has its conceptual foundation focused on success; thus it offered an approach that could be both emancipatory and empowering as I attempted to represent the experiences of nurses, not floundering or overcome by the pressures of the current health care system, but by bringing forth their stories of overcoming the adverse conditions of work and life in which they find themselves. It is creative in intent and allows me to utilise my prior educational and life experiences as a starting point for narrating the stories. Further, the approach allows my voice to be present within the crafting of the portraits or the 'painting with words'. The method also allows the highlighting of the subjective experiences and perspectives of the participants as I wanted to use their own words as they shared their experiences with me, capturing the subtle finer points of each particular story. This enabled me to create inspiring portraits to demonstrate that these nurses are survivors and victors, actively engaged in their own empowerment, resistance and resilience. Portraiture is a method that "seeks to document and illuminate the complexity and detail of a unique experience … hoping that the audience will see themselves reflected in it, trusting that the readers will feel identified" (Lawrence-Lightfoot & Davis, 1997, p.14).

So, to be true to my method of choice:

I wanted to develop a document, a text that came as close as possible to painting with words. I wanted to create a narrative that bridged the realms of science and art, merging the systematic and careful description of good ethnography with the evocative resonance of fine literature. I wanted the written pieces to convey the authority, wisdom, and perspective of the "subjects"; but I wanted them to feel as I had felt, that the portrait did not look like them but somehow managed to reveal their essence. (Lawrence-Lightfoot, 2005, p.6).

I believe I have done so.

CHAPTER ONE- INTRODUCTION

Taking up the brush

"You hear the best stories from ordinary people"
(Chuck Palahniuk, O'Hagan Interview, 2005)

Introduction

The health service in Australia, as in many developed countries, has been under pressure for a myriad of reasons, including financial and socio-political influences. Studies have shown that a healthy workforce translates into an efficient service with subsequent benefits to the users of that service (Duffield, Roche, Blay & Stasa, 2010; English, Jones, Maloney, & Barratt-Pugh, 2005; Kirschling, Colgan & Andrews, 2011; Shacklock & Brunetto, 2011). Nurses are the largest occupational group in the Australian health workforce, a workforce that remains predominantly female who work in diverse practice contexts (National Health Workforce Taskforce, 2009). The profession is losing qualified Registered Nurses (RNs) whilst also finding it difficult to recruit into the profession. The nursing workforce is aging, its practitioners reaching retirement age. Shortages of nurses are predicted to increase, with the exacerbation of undersupply being felt for years to come (Australian Institute of Health & Welfare, 2008). Coupled with these influences is the impending demographic time bomb of the retiring baby boomer generation. This crisis is not only of national, but of international concern (Australian Institute of Health & Welfare, 2008; Coomber & Barriball, 2007; Duffield, Roche, O'Brien-Pallas, Diers, Aisbett, Aisbett & Homer, 2009; National Health Workforce Taskforce, 2009) with the nursing profession being significantly affected. Furthermore, alarming research shows that many Australian nursing graduates intend to stay in the profession for less than 15 years (Eley, Eley & Rogers-Clark, 2010).

The need for research

There is little doubt that nursing is a stressful profession (Scudder, Rheaume, Clement & LeBel, 2011). Workplace stress is correlated with high or excessive workloads, rationalisation and restructuring, bullying and horizontal violence, lack of autonomy and chronic staff shortages with high acuity of patient care, an aging nursing workforce with an inadequate skill mix, and the dynamic organisational, technological and system change currently being experienced in health care (Duffield et al, 2009; Jackson, Firtko & Edenborough, 2007). The continued high impact of the negative effects of nursing turnover and increased workload and workplace stress on the morale of nurses means that many have left or are leaving the workforce (AHWAC, 2002; Buchan & Aiken, 2008; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). Furthermore, Eley et al (2010) contend that new nurses are disillusioned with nursing, intending to leave, and a growing number of nurses are dissatisfied with their career. Burnout and stress are cited as reasons for leaving the profession (Scudder et al, 2011).

There is a dearth of research which seeks to debrief nurses, hearing personal narratives as to why they remain and thrive in the workplace; how they perceive difficulties and challenges yet maintain resilience. Prolific quantitative research to demonstrate and measure job stress and resilience has been implemented (Hjemdal, 2007; Ruiselova & Prokopcakova, 2005; Ungar, 2008); however, there is a dearth of qualitative studies that would provide a greater depth of understanding of nursing resilience. Trochim and Donnelly (2007) explain that qualitative research excels at telling the story from the participant's viewpoint, providing the rich descriptive detail of their human context.

Thus by undertaking a qualitative research study of the Portraiture kind I expected that a clearer understanding of nurse resilience would be established; thus their resilience would be reflected so as to help make it visible to others. The personal, professional and contextual components of resilience uncovered in the study may assist to identify a focus for the attention of workforce managers, human resources and health care providers (Letvak & Buck, 2008). For example the

provision of additional support for students and nurses (via mentoring programs) who may be at risk of succumbing to stress may be helpful (Hendricks, Cope & Harris, 2010).

Given the landscape of the nursing care environment just described, resilience would seem to be a necessary quality for surviving the negative effects of workforce challenges and stress (Tusaie & Dyer, 2004). Contemporary research has shown that those who possess the human qualities or characteristics of resilience are more readily able to weather and survive workplace stress and even to thrive in spite of that stress (Strauss, 2009; Tusaie & Dyer, 2004). It seems reasonable that a study related to understanding of how resilience is developed, and how it can be enhanced efficiently in nurses would not only have organisational benefit, but assist in developing a personal repertoire with resilience as the centrepiece for all nurses and the profession.

Resilience

In order to develop a personal repertoire of skills with resilience as the centrepiece, a shared understanding of the concept is required. Most commonly, the term resilience has come to mean an individual's ability to overcome adversity and continue his or her normal development (Siebert, 2008), or as defined in the seminal work of Masten (1994) as "a pattern over time, characterised by good eventual adaptation despite developmental risk, acute stressors, or chronic adversities" (p. 141). Thus, if resilience is the ability of an individual to adjust positively to adversity, then insights into the resilience of nurses are important areas for exploration. Michael Ungar, Principal Investigator with the Resilience Research Centre in Halifax, Nova Scotia Canada, has suggested that resilience is better understood as follows:

*In the context of exposure to significant adversity, resilience is both the capacity of individuals to **navigate** their way to the psychological, social, cultural, and physical resources that sustain their well-being and their capacity individually and collectively to **negotiate** for these resources to be provided in culturally meaningful ways* (Ungar, 2008 p.225 Emphasis in the original).

Ungar's definition is significant because it moves the understanding of resilience from the individual to a more culturally embedded understanding of well-being. Understood in this way resilience is made explicit in that it is more likely to occur when people are provided with the services, supports and health resources that enhance the likelihood for them of doing well and thriving. In this sense, resilience is the result of both successful navigation by the individual *to* the sources of resources and the negotiation *for* those resources. These resources are able to be provided by the organisation, the workplace or by others in meaningful ways. Ungar's definition provides the working definition of resilience for this study because I believe that nurses who have chosen to remain in the workforce are adept at negotiating, challenging and overcoming 'bad times' while being successful at maintaining personal and professional well-being.

Recently, Larrabee et al (2010) have shown that enhancing stress resiliency is cyclical. That is, stress resiliency has the potential to affect the hardiness of nurses, encourages their intent to stay within the profession, and increases their job satisfaction. Building stress resilient individuals who can contribute to a more healthy workplace overall, or nurses who have the enhanced ability to survive and thrive is the aim. The pool of contenders will more likely come from those who are more satisfied with their jobs and therefore more likely to stay; this is the aim of strengths-based resiliency training programs (Seligman, 2002). Further, studies suggest that such resilience training programs should be considered as a part of professional practice environments (Lake, 2007; McClure & Hinshaw, 2002). This adds to a growing body of literature which suggests a proactive health promotion approach to building resiliency capacity which enhances an individual's ability to cope should be undertaken within organisations (LaMontagne, Keegel & Vallance, 2007; Manojlovich & Laschinger, 2007).

Portraiture

Portraiture is a qualitative methodology described by Lawrence-Lightfoot (1983) as an amalgamation of life history, narrative inquiry, and ethnographic methods. The endeavour of the researcher is to represent those under research with a subjective, empathetic eye through valid, compelling, written portraits of their experiences and setting**s** (Dixson, Chapman & Hill, 2005; Lawrence-Lightfoot, 1983).

Portraiture being a descriptive method enables a search for the essence and meaning of resilience to the nurses participating, and allows for the understanding of their everyday practice, within a time where the healthcare system in which these nurses work has been described as being in disarray (Adams, 2007). Portraitists examine the ways in which people get together, negotiate and conquer challenges (Lawrence-Lightfoot, 1983; Dixson et al. 2005): it is a descriptive method which explores and describes the personal and professional identities of nurses who have chosen to remain in the workforce with a deliberate focus on the positive**,** and one which enables a clear depiction of the attributes and capacity to be resilient in the nurses participating**;** it would seem to make an appropriate methodological fit.

The researcher's aim is to depict examples of success, rather than focusing on the negativity that often makes those involved in the health **c**are system feel powerless**,** thereby achieving little. This spotlight draws attention to the goodness of an environment that serves to provide care, which aims for better health outcomes, and yet is an environment often overshadowed by the dysfunction of a precariously overwrought system. This view of 'goodness' does not deny that there are things wrong with healthcare, in fact, Portraiture assumes that difficulties are fundamental within any system of study, but provides a more hopeful starting point for renewal (Lawrence-Lightfoot & Davis, 1997).

Portraiture concentrates on 'unearthing goodness' and highlighting successes rather than being another study depicting what is wrong in health care. The Portraitist listens for the authentic central story as perceived by each

participant in the work setting, choosing to explore and describe their stories from a framework of strength rather than deficiency (Lawrence-Lightfoot, 1983). Occupational and everyday life/work events may be fashioned onto the canvas of the portrait, thus revealing a composite image of individuals' beliefs regarding the organisation in which they work, in the current place in time (Lawrence-Lightfoot & Davis, 1997). This approach is particularly appropriate within the field of nursing , since, Lawrence-Lightfoot postulates that more may be gained from examining successes rather than failures as the Portraitist adopts a "generous stance … looking for strength, resilience and creativity" (Lawrence-Lightfoot & Davis, 1997, p.158). My simple pursuit was to ascertain why and what qualities exist in those nurses who remain in the workforce? Why are they staying in nursing? It is possible that this could produce only idealised portrayals, but this is not my aim, rather it is based on "empathetic regard" (p.159) as I see and reflect the world through the participants' eyes and as I also remain in nursing as a participant observer.

Purpose of the research

The purpose of the study is to:

1. Develop an understanding of why nurses make the choice to remain in the Western Australian nursing workforce.
2. Illuminate the qualities of resilience shown by nurses who have chosen to remain in the Western Australian nursing workforce.

Significance

This study focuses on the positive experiences nurses have developed and expanded their reasons for remaining in the workforce. Through an understanding of resilience qualities revealed in stories of nurses who choose to remain in the workforce information will be provided pertaining to retention strategies, educational decisions and policy formulation which will facilitate resilience training.

Aims of the research

1. To explore why nurses have chosen to remain working in the Western Australian health care system;

2. To increase knowledge related to the role of resilience qualities of nurses in the Western Australian healthcare environment;

3. To expand knowledge related to the resilience experience for nursing;

4. To discover new insights into the impact of resilience on the ability of nurses to manage within the context of nursing work; and

5. To illuminate the key characteristics of resilience displayed by nurses who have remained in the work setting.

The researcher's position

My gaze as a researcher was deeply influenced by my background in nursing, midwifery and teaching. I have personally experienced emotional and work stress on many occasions and yet still remain in the nursing profession in Western Australia. I know my story, but the story of my colleagues remains untold.

In this study, I acknowledge prior knowledge of the clinical environment, issues of resilience, and being of the same time period within the same health system as the participants. I believe in the value to society of nursing as a profession and hold it in high regard. This will influence the research process and my interpretation of data; however, the qualitative methods used within this study allow for this experience and understanding.

I began this study by listening to each participant nurse's story, and through the unfolding of each story I sought and learnt about the common threads of what being resilient means to them. During the course of the interviews, I developed a rapport with each nurse/participant and was amazed that each stated they felt grateful for the opportunity to talk with me about their nursing - an experience and work choice so personal and critical in their life. April, Ginger, Jade, Lucky, Maggie, Jean, Mary-Anne and Vivien took the opportunity to use a pseudonym, but they wanted their stories told and they wanted to be listened to. I am privileged to share their stories with you, the reader.

Theoretical Framework

This study is underpinned by a conceptual framework of resilience which captures the interplay of personal characteristics, life experiences and culture, and environmental variables and their effect on individual resilience. The combined effects of broadening and building upon protective 'buffers' which assist each individual to adapt and thrive after being exposed to threat or adversity of a personal or environmental nature is the basis of the framework (Alvarez-Dardet & Ashton, 2005; Frederickson, 2004; Seligman & Csikszentmihalyi, 2000; Ungar, 2008). These buffers may assist nurses to continue to function as competent, effective and satisfied professionals, 'balancing' between adversities and flourishing within their differing nursing contexts (Koen, Van Eeden & Wissing, 2011; Nath & Pradhan, 2012). The review of the literature and my experience in industry has informed the construction of a theoretical framework based upon this 'balance'.

My depiction of the balance is divided into two main constructs namely stress and coping. These are presented as the weights on a scale with vertical columns of descriptors aligned to personal, context, system and professional issues able to 'tip' or 'balance the scale', showing albeit two-dimensionally, the tensions that can arise. In addition, I was aware that elements of each theme overlap considerably with each making an independent contribution to the situation under consideration.

This conceptual framework provided reference points to the literature and assisted me to make meaning of the stories heard, providing a structured approach to communicating my findings to the reader. It was also the starting point for reflection about the role of resilience in the context of nursing and why certain nurses remain in the workforce; it enabled me to draw a mind map of issues under scrutiny, communicating this as a simple visual depiction (Figure 1:1).
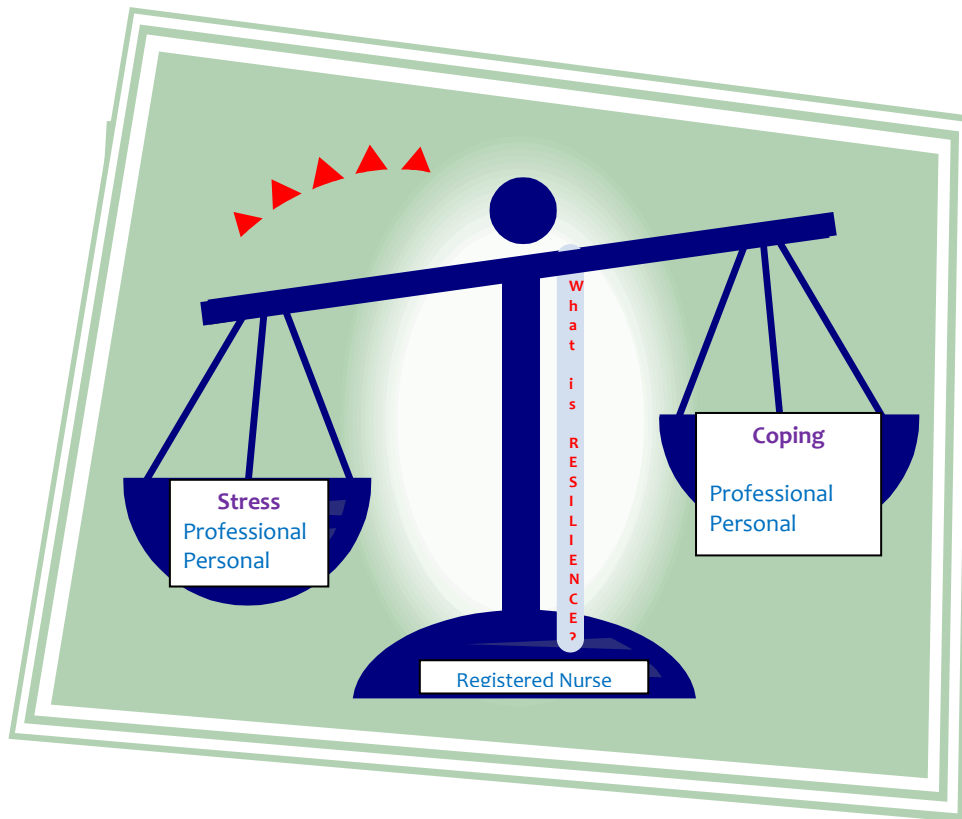
Figure 1:1 Theoretical framework: resilience, stress and coping

The researcher was interested in exploring whether resilience is the lynchpin between stress and coping for nurses. In order to investigate this concept, a metacognitive perspective was necessary. That is, assumptions expounded by the interpretive approach concerning the nature of knowledge, provided an apparently secure philosophical tether for my investigation of complex interactions between nurses, the system and the nursing context in which they work.

Two extensive bodies of knowledge were used as cornerstones for organising my thinking. From philosophy, Habermas (1987) theorises that human beings socially construct their knowledge and that the perspective that they generally use, governs their actions with respect to each other and their environment. Also, prominent in the literature of stress and coping is Frederickson's (2004) **'**Broaden and Build**'** theory which describes the value of positive emotions in developing a resilience repertoire which can be utilised for coping. Significantly, my reading of Seligman's (1991) seminal work on Learned Optimism also provided the

meta-cognitive cornerstone needed because of its coherence as a macro-theory and its inherent applicability to the analysis of resilient individuals coping with dynamic and stressful change within the social world of nursing work. It emphasises positive attitudes and the proactive cultivating of the optimistic self-fit with the idea that nurses must be resilient to stay in nursing.

With these constructs in mind the researcher was able to set forth on the investigation with a sound foundation. Extensive theorising is drawn upon to render a common language and find reference points from which to structure a personal palette, colourful and vivid, for my construction of the nurse's portraits.

Summary and conclusion

In summary, this chapter has discussed the stresses of the clinical environment and the consequent repercussions for the workforce. It has highlighted that many nurses have chosen to remain in the workforce despite the increasingly challenging environment. It has been asserted that these nurses may have qualities of resilience that is enabling of their personal and professional well-being. It has been noted that most of the research pertaining to nursing workforce has focused on the negative attributes of the environment rather than asking the nurses who remain in the workforce for positive reasons for their remaining in the nursing workforce.

The study uses a Portraiture approach to glean a rich understanding of how and why nurses remain in the Western Australian workforce despite personal and professional hardship. This approach to research is innovative and *spirit lifting* as it focuses on the positive and the strength, vitality and sheer determination to succeed in those who choose to remain in the nursing profession. The insights uncovered, lead to recommendations which may assist in the development of strategies to build a sustainable and resilient nursing workforce.

An overview of the chapters

The chapters to follow include a review of literature pertinent to understanding the contemporary Australian nursing workforce, workplace settings, positive psychology and the concept of resilience. The second chapter provides an essential background for the more specific focus on the participants' stories in prospect. Chapter Three describes the research approach and Chapter Four outlines the way in which the research was undertaken and the processes used. The nurse's stories which *are* the essence of the Portraiture methodology will be shared in Chapter Five. The focus of Chapter Six is to interpret and explicate the themes arising from the portraits. The final chapter discusses the thesis findings in relation to its portraiture underpinnings and returns to the interplay of nursing and resilience; it will conclude with recommendations and a summary of the study.

CHAPTER TWO - LITERATURE REVIEW

Priming the canvas

"Research is formalised curiosity. It is poking and prying with a purpose".

(Zora Neale Hurston, 1997)

Introduction

A review of the literature reveals that studies relating to resilience, stress and stressors are extensive; they are not new phenomena. Historically, the focus of such studies has been on stress as one of the causes of human unhappiness, yet a change within a psychological focus has led to the burgeoning of research concerning positive constructs of stress related to resilience, well-being, and coping. These constructs are especially significant for workers within the healthcare industry and thus the community they serve, as the health care industry is currently experiencing radical change ("From rosy future," 2008). Change has led to increased pressure placed on nurses, with their workplace often an expected setting for emotional, physical and psychological distress (Holland, Allen & Cooper, 2012; O'Connor, 2002; Rodham & Bell, 2002; Taylor & Barling, 2002). Nursing work, practice environments and nurse satisfaction with their work are now being questioned as nurses are expected to cope with rapid change in complex healthcare environments (Baumann Report, 2007; Rose & Glass, 2006; Walter, 2003). Consequently, managers and policy makers are becoming increasingly aware of the need for greater knowledge in the area of resilience as well as the need for active support in identifying, developing and supporting resilient traits within their workforce.

As already outlined, my interest in resilience stems from a curiosity as to why some people thrive in conditions of adversity; it is fuelled by a nursing career which has experienced good times and bad times. The review of pertinent literature provides an overview of the construct of resilience by identifying salient themes relating to it: coping, nursing satisfaction and positive psychology. These constructs are reviewed within the framework or backdrop of contemporary views of the

meaning of work, the workplace milieu and in particular the work conditions which may be experienced in contemporary healthcare.

Work and its meaning

Motivation theorists and humanistic psychologists have emphatically proven the inherent need for man/woman to have a professional or working life that is meaningful (Csikszentmihalyi, 1990; Maslow, 1943). There is ample research evidence of historical antecedents that questions the relationship between job satisfaction, productivity, morale and rewards, as well as working conditions, performance and purpose in life and work (Maslow, 1943; Herzberg, Mausner & Synderman, 1959). Maslow explored further the idea that work equates with play for a self actualised person, becoming an integral part of the human psyche rather than work being a repetitive series of tasks. Notably Rogers (1984) reported that people find meaning and purpose in work when they achieve or progress towards goals and attainment.

More recently, Schaefer and Darling (1996) found that work is a means and opportunity for an adult to look after others through the service of work. Their contention is supported by Wishner's Meaning of Work study in 1991 wherein the researcher concluded that the meaning of work is the most intrinsically important part of the lives of individuals (cited in Chalofsky, 2010 p. 4). This work purports Chalofsky, "is that which gives essence to what we do and what brings a sense of fulfillment to our lives" (p. 2).

Current work-motivation theories also stress the interplay of the notion of self with work being part of self-expression, self-worth and self-consistency. Especially important is the notion and meaning of work to women with regard to this study; as the nursing workforce remains a predominantly female one. Svendson (1997) revealed that women often 'merge' their professional and personal selves, meaning that they have involved their mind, body and spirit within their work life, with the work, relationships at work and the career growth achieved at work, all

being interrelated to the meaning derived from their work. Svendson coined the term 'integrated wholeness' to reflect this idea.

Nursing work

Generally, the definition of nursing work is wide and far reaching. The International Council of Nurses (ICN, 2010) states:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

In addition, the Royal College of Nursing in the United Kingdom purports that the work of a nurse is to *"use clinical judgment in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death"* (RCN, 2003, p. 3). The American Nurses Association (2011) stated that nursing is: *"the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in health care for individuals, families, communities, and populations"* and The Australian definition of nursing used within the "Defining Nursing" report (RCN, 2003, p.9) states that:

Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick or disabled so that people with identified nursing needs may maintain or attain optimal wellbeing or achieve a peaceful death.

Nurses practise their role and work in a wide range of settings caring for a wide range of patients, clients or residents in major metropolitan, regional and local

hospitals, residential aged care facilities, schools and industry; all of these may be supported by the public or private sector. In addition nurses serve in the armed forces, prisons and in community settings both urban and rural.

Workplace stress and nursing

There seems to be a pervasive view in the literature that nursing as a profession or nursing work is inherently stressful. Studies have shown emphatically that in those occupations where workers are expected to exhibit emotional interaction with others (as in the case of nursing, social work, police work and teaching), stress and emotional exhaustion are evident (Kahn, 1993; Cooper, Clarke & Rowbottom, 1999; English et al., 2005). Moreover, stress is correlated to nursing environments in which a mismatch occurs between the resources available for optimal patient care, the capabilities and competencies of the nurse to express their desire to provide optimum care, and the management of this scenario by the employer (Kawano, 2008). However, there appears to be no concurrence between managing the stress inherent in the nursing role to the benefit of the individual, the profession and to the health of the community for which the nurse cares. The exception pertains to workload numbers which not only affects patient safety but also nursing staff retention (Duffield et al., 2010; Twigg, Duffield, Thompson & Rapley, 2010).

The healthcare system: A contextual backdrop of disarray

When I began my research journey, Western Australians were subject to daily exposure of stories within the media portraying the Western Australian healthcare system as being in complete disarray and not coping with the pressures of dynamic change and economic rationalism within the healthcare environment (Fong, 2007). Those working within the system were also surrounded by in-house publications discussing similar issues. Little had changed by the completion of data collection for this study. The various news outlets continued health reporting, with headlines proclaiming public hospitals to be in crisis, baby boomers facing an aged care bed crisis, dwindling number of nurses, and that nursing numbers will not meet the demand for the predicted future shortage of nurses, a shortfall of 109,000 by

2025 (Deceglie, 2010; Holland, Allen & Cooper, 2012; Health Workforce, 2012). The average weekly working hours for a nurse in Australia have increased; this statistic is likely to have an effect on sick leave in the short term, and burnout, premature retirement and decisions to leave nursing in the long-term (AIHW, 2010). The press reports, while frequently lurid in order to sell their wares, are in fact, supported in the contemporary academic literature.

It is acknowledged that nurses currently work in radically changing times – where the integrity of nursing is undermined by micro-economic reform (Aiken et al., 2001: Archibald, 2006; Needleman, 2008; Squires et al., 2010; Twigg et al., 2010). They are times of challenge, where stress and burnout are an established phenomenon (Maslach, Leiter & Jackson, 2012). Nursing work is hectic, and involves caring for others usually at times of crisis and duress (Archibald, 2006). Nurses are also older, working longer hours and have a higher presence in rural and regional areas than do doctors, according to the Australian Institute of Health and Welfare (AIHW, 2010). Nurses also appear to experience a disproportionate share of stress-related issues, including coronary disease, substance abuse and high suicide rates (Wieclaw, Agerbo, Mortensen & Bonde, 2006). Stressors on the contemporary nursing setting include: the casualisation of the workforce, about 55% work part-time (AIHW, 2010; Holmes, 2006); staff inexperience and uneven skill mix of untrained and experienced staff with pronounced skill shortages in all areas of nursing (Gillespie, Chaboyer & Wallis, 2007; Volp, 2006); a rapid turnover of patients (Hegney et al., 2006); not being able to spend enough time with needy patients (Boykin et al., 2003; Scholes, 2008); conflict with busy colleagues who often have different agendas (Skovholt, 2001); and the often contradictory demands of management which causes a dichotomy between what nurses believe need to be prioritised as care and the reality of practice (Scholes, 2008).

Because of these interrelated trends nurses are experiencing chronic pressure to provide care, personal development and student education within a quality and safety matrix governed by an increasingly hostile system, and with less

nursing resources (Volp, 2006). Nurses are affected by this strain (Aiken et al., 2001) and workforce research suggests this is closely related to a high attrition rate (Clinton & Hazelton, 2000; Holland, Allen & Cooper, 2012; Leighton, 2005). The negative effects of bureaucratic hierarchy; top-down decision making; inter and intra professional hostility; limited autonomy and invalidation; and the view that hospitals are harsh and unresponsive environments with unexciting employment opportunities, widespread unpaid overtime and difficult working conditions, do not encourage nurses to remain in nursing work (Holmes, 2006; Jackson et al., 2007; McAllister & McKinnon, 2009). The snowballing cost of work unhappiness, stress and burnout has and will affect the retention of qualified staff. Ultimately recruitment will be hindered as the problems in the system and of the system are either neglected or escalate (Hegney et al., 2006; Holland, Allen & Cooper, 2012).

Severe nurse shortage is currently being experienced globally due to decreases in the labour supply as many younger people are choosing not to work in a service industry such as nursing, while there is an increase in demand for nurses as populations increase along with aged care, the demand for health services grow proportionately as these rises negate the growth in total nurse numbers (AIHW, 2010). Of the clinical nurses employed across Australia in 2008 (276,751), the majority worked within hospital settings (67.3%). Nurse clinicians were most likely to have reported working in medical and surgical areas (33.1%), followed by critical care (19.0%) and aged care (11.4%). Of the non-clinical workforce, about 35.7% reported working in lecturing, education and/or supervision of new nurses, and 9.0% reported working as researchers. Clinicians worked an average of 33.3 hours per week and non-clinicians, 33.9 hours (AIHW, 2010). In 2009, the 50–54 years age group included the most nurses which points to the expected withdrawing from the workforce of large numbers of Baby Boomers, (those people born between 1946–1964) who are or will be retiring and leaving nursing in the not too distant future (National Health Workforce Taskforce, 2009; Shacklock & Brunetto, 2011). Health organisations have become more unyielding with all forms of resources and whilst tasks and technologies take the upper hand, it may be important to locate

the reality of each nurse's complex way of describing their view of their work as they grapple with the notion of their own resilience and why they stay in nursing.

Three major nursing work settings were chosen as background for this study. Setting one is a residential aged care facility. The population of Australia is ageing rapidly with a concomitant increase in demand for facilities and staff to care for the frail elderly. Nationally the number of persons aged 65 years and over now constitutes 13.0% of the population with a massive increase in the number of people over 80 years of age (Australian Bureau of Statistics, 2005). These factors are placing increased demands on the predominately female residential/aged care nursing workforce which is also aging.

When studying nurses working within aged care or residential settings, Richardson and Martin (2004) found that over 50% of the aged care nurses in their study felt under pressure to work harder and were dissatisfied with staff numbers, skill mix and workplace policies. The nurses in their study also expressed very serious concern about pay, workload, stress, and the physical and emotional demands of nursing work, workplace violence and staff morale. Both public and private residential aged care nurses consider their jobs to be poorly rewarded reporting they cannot complete their job to satisfaction due to excessive paperwork impeding care. Hegney, Buikstra, Parker and Eley (2005) concur, stating that nurses in the aged care sector reported more unfavourable working conditions than did those nurses working in hospital settings. Work hours, pay and staff shortages are among the major work related reasons for leaving the profession (Australian Centre for Evidence Based Residential Aged Care, 2002). It is important therefore to ask nurses, "Why do you stay"?

Within academia, increasing enrolments amplify faculty-to-student ratios, with an increasing mix of English and non-English speaking students adding to the complexity of the already competing responsibilities. Teaching, scholarship, research, marking, supervision, committee membership, faculty service, community engagement and faculty practice are all within a nurse academic's everyday work

(Brady, 2010; Glass, 2001; Rose & Glass, 2006). Nursing courses may be offered year-round, with face-to-face lectures and online delivery of education the norm. Increasing technology needed to deliver those lectures must be incorporated with an increasingly techno-savvy student cohort (Gaberson & Oermann, 2010: Shirey, 2006). This work environment impacts on faculty satisfaction with Kaufman (2007) noting that 45% of nurse educators studied indicating they were dissatisfied with their job with 25% of those respondents citing workload as the mitigating factor of their intent to leave the profession. So what keeps these nurse educators in the University workplace?

A wide range of factors associated with work stress occur**s** in acute settings including: time pressures, deadlines and sustained urgency in work, dealing with death and dying, conflict with physicians, inadequate preparation to deal with the emotional needs of patients and their families, lack of staff support and help, conflict with other nurses and supervisors, too much responsibility, too little continuing education and multiple and conflicting demands imposed by medical and administrative staff including excessive paperwork and inadequate communication (Aiken et al**.**, 2002; Martens, 2009; Sochalski, 2001; Ulrich, Lavandero, Hart, Woods, Legget & Taylor, 2006). The constant rationalisation of budgets and service also adds to the dissatisfaction of nurses within the tertiary hospital environment (Buerhaus, Staiger & Auerbach, 2009; Christmas, 2008).

Studies on shift work have also reported adverse effects on performance, workers' health, and mental and physical fitness, while tasks **n**urses in tertiary environments confront everyday include dealing with disease and ill health, suffering, grief and death make the tertiary hospital setting the optimum environment for the manufacture of stress rather than resilience (Manion, 2005; Martens, 2009). How do these nurses survive such a confronting work environment?

Manion developed 'The Business Case for Happiness' and wrote of joy at work calling for positive practice environments (Manion, 2003, 2005). Underpinning

Manion's work is the belief that when humans feel positive emotion they are at once **m**ore approachable to others. This enables relationships to form that broaden social support, which is especially important in the workplace. Teamwork flows from social connectivity, with supportive behaviour and job satisfaction being manifested (Albaugh, 2005; Dean & Major, 2008; Manion, 2005; Paquette, 2006).

Positive practice environments are an important topic for nursing research as it is contended that these environments have the capacity to retain staff in times of large staff turnover and engender lasting nursing organisational commitment (Aiken et al**.**, 2001; Laschinger, Finegan, Shamian & Casier, 2000; Manion, 2005; Seligman, 2002). Goleman (1995) and Kruse and Prazak (2006) document emotions being highly 'contagious', so the quality of interactions between staff contributes to the patient care environment. Furthermore, negative emotions in the workplace can also have a negative effect on co-workers prompting suggestions that their emotions too could be contagious (Maslach et al**.**, 2012; Schaufeli, 2003).

Within seminal organisational literature the behaviour of leaders and their role modeling has shown there to be a positive influence on staff satisfaction, productivity, and organisational commitment (Hendel, Fish & Aboudi, 2000; McNeese-Smith, 1996, 1997). The cumulative effect of behaviours cascaded beyond modeling, to include "challenging, inspiring a shared vision, enabling others and encouraging the heart" (Kouzes & Posner, 2002, p. 97). Shirey's (2006) study of the stress and coping literature and nurse managers' evaluation of the significance of social support in the workplace, found that satisfied and retained nurses are choosing to work in positive practice environments which enhance the 'buffering' effects of social support on stress.

It has been well established in the literature of psychology that people should be taught ways to manage stress effectively and proactively, specifically addressing hardiness skills as a means to reduce stress and enhance long-term coping (Judkins & Ingram, 2002; Kaminsky, McCabe, Langlieb & Everly, 2007; Kobasa, Maddi & Kahn, 1982). Workplace stress is an essential issue for

organisations and employees to consider as each can be affected badly by its negative effects. Workers affected by workplace stress may experience anxiety, tension, lack of concentration and memory loss, and may choose alcohol or drugs to relieve stress (Jones & Bright, 2001). These issues have ramifications for employers as the lethargy and depression caused by workplace stress can affect job satisfaction and lead to presenteeism, absenteeism, lack of organisational commitment, job turnover and burnout (Jones & Bright, 2001).

Addressing occupational stress and the role of employers and their responsibility for support and assistance cannot be underestimated (Judkins & Ingram, 2002; Maslach et al., (2012). The value of having a healthy balanced relationship between one's life and work has been understood for some time (Maslach et al., 2012; Rose & Glass, 2006). Problems arise when this relationship is out of balance. Nurses have long been expected to nurture at work, at home, and within their community, and this may lead to dire consequences as they 'struggle to juggle' (Younis, Zulfiqar, Arshad & Imran, 2011).

Previous studies focusing on the stress and distress of nurses are prevalent (Edwards & Burnard 2003; Tully, 2004). The very recent survey by Holland, Allen, and Cooper (2012) of 640 nurses across Australia indicates serious distress within nursing workplaces with up to 15% of nurses likely to leave the profession within the year. Some 38% of nurses within the survey were unhappy with their rewards and benefits finding many factors correlated to nursing stress including: unmanageable and demanding workloads; low staff numbers; lack of social support; dealing with death and dying; uncooperative family members and clients; issues with medical staff and concern for the quality of nursing and medical staff; supervisory relationships and concern for the safety and quality of patient care; the inability to deliver quality nurse care due to time demands; role stress; legislation precluding an advanced scope of practice; and low organisational commitment.

Inherent in the nursing role is clinical expertise, accountability, proficiency in computerisation of patient/client/resident records, role modelling/mentoring to

students, research evaluation so as to base clinical decisions, and practice based on research evidence. Nurses are expected to teach, and provide advice and support, as well as problem solve, think critically and plan ahead while prioritising current workload (Maltby, 2008; Sherman, 2005). Many nurses must be active members of various committees including quality and safety, and audit committees. They must also deal effectively with problem patients and family members, ethical dilemmas and resolution of conflict while fostering team building (Sherman, 2005). The nursing role occurs with and through the frequent interruptions, changes and high expectations within healthcare, all of which add to the combination of stress factors for nursing today (Schwarzkopf, Sherman & Kiger, 2012). The Admi and Moshe-Elion study (2010) focused on measurement of nursing role stressors, particularly for charge nurses. Through the use of focus groups and in-depth interviews within a large tertiary hospital they developed a reliable stress measurement tool which measures six factors of stress specific to the role of charge nurse. These included: authority-responsibility conflict, patient-nurse interaction, deficient resources, managerial decision making, role conflict and work overload. Moreover, nurses in the sample often responded that 'care' is a major part of their nursing role; and if that care is not observable, not valued or indeed threatened by the constraints of the above stressors, then a dissonance between their wants and their abilities is reflected (Nowak & Bickley, 2005).

The casting of stress as only causing distress is a contention that is severely limited however. New ideologies refute this and I will argue that research also reveals that work stress may have some benefits to individuals as feelings of accomplishment and pride and job satisfaction can be engendered with many workers expressing enjoyment with "moderate work pressure" (McGowan, Gardner & Fletcher, 2006, p. 92); 'eustress' rather than distress is thereby demonstrated (Selye, 1974). McGowan et al., studied 141 participants across three organisations questioning them on stressful events and their coping strategies to manage their stress. Additionally their emotional reaction to their work was queried. The responses given were both negative and positive concerning their perceived stress. The outcomes of their responses further indicated that it is not the

stress itself which can affect, but the way in which the stress is managed that impact most upon outcomes.   The Positive Organizational Behaviour (POB) instrument designed by Luthans and Youssef (2007) acknowledges that people's capabilities can be developed and effectively managed for highly effective performance improvement and increased productivity through enhancing coping strategies, wellbeing and resilience.

Eminent nursing theorist and researcher Rosemary Rizzo Parse (1994) notes that resilience is an essential element for professional practice in a chaotic healthcare system; and resilience is a vital trait that can be learned.   Parse postulates that students can learn to be survivors, then transferring this learning by further experience thence becoming resilient professionals. Parse and others believe that nursing educators should prepare nurses to be able to confront change and sustain their professional practice, instead of giving up when the complexities of providing health care seem overwhelming (Parse, 1994; Parse 1997; Polk, 1997). Parse came to this conclusion through the development of the Human Becoming School of Thought (HBST) theory in the field of human science which promotes the engagement of students to explore their own philosophy and meaning of caring whilst simultaneously engaging with social and educational connections throughout their education. They thereby learn to conserve personal resources and connectedness by preserving and promoting the student nurse's quality of life, which may assist recovery and resilience should they need to call on these reserves either professionally or personally (Parse, 1998).

The seminal work of Wolin and Wolin (1994) emphasised that resilience requires both suffering and perseverance by struggling to work through obstacles, and by integrating those difficult experiences into one's sense of self. They speak of students developing 'survivor's pride', a feeling of self-accomplishment after achieving a difficult task or getting through a difficult day. Moen's (1997) work in 'turning points' develops the idea of cumulative resilience which extends a professional's stamina and the longevity of their career, much in evidence as nurses reach critical turning points at work but learn to build resilience from their

experiences. Later, Moen, Fields, Quick & Hofmeister (2001) focused on the fundamental changes that life and work offer, giving opportunity for transitions or new trajectories to be taken. The choices made at this time can be constraining or empowering with them either able to open doors or leave them closed. Hodges, Keeley and Grier (2005) also aver that resilience is an ongoing process of struggling with difficulties within nursing and not giving up. It is the accumulation of remembered small successes, as well as the failures, which develops into resilience through the skill of critical reflection.

Positive challenges faced in the workplace can be 'taken on' by nurses armed with optimism (Bright, 1997). This optimism enables the building of resilience when one is able to see, find joy, and experience happiness, within a nurse's current workplace circumstance. Walter (2003) calls for playfulness as a specific strategy for emotional health and professional satisfaction; whilst Shacklock and Brunetto (2011) assert that positive emotions, optimism and laughter are resilience-promoting.

Keeping workplaces healthy and happy is achieved by "laughing to organisational health" (Granier, 2007, p. 1). Granier considers that when members of an organisation are placed in a no-win situation in the presence of unpredictable or uncontrollable stressors such as lack of resources, in terms of money, human resources or time for example, the only response a human can make is to react. Granier asserts that we can choose to laugh or despair but in this instance:

Laughter is the only rational response to all of this since, in order to survive, we need to find a life-affirming way to cope. Being able to laugh about ourselves and our situation helps us to decrease tension, regain our perspective, and accept that which we cannot change. Not only that, it gives us the physical energy and resilience needed to survive. (p.1)

There are many studies concerning nursing burnout (Glass, 2003a; Shirey, 2004; Taylor & Barling, 2002), bullying and horizontal violence, and emotional duress (Farrell & Bobrowski, 2003; Glass, 2003 b & c). New nursing graduates and their adaptation to everyday practice away from the student setting are prone to

the perceived stress this may induce (Hinds & Harley, 2001; Tully, 2004; Walter, 2003). Few studies, however, have been undertaken to explore Australian nurses and resilience.

What might resilience mean and why is it important?

What does being resilient mean? Resilience from its Latin root 'resiliere' means to 'bounce or jump back,' implying a return to a previous state. However, this usage of the term does not encapsulate the change that is required to be resilient, that is, a moving on from the experience, so that there is not a return to the previous state, but rather a growth from it. It is this adaptive capacity to maintain functionality in the wake of significant disturbance, adversity or challenge that is implicit in the conceptualisation of resilience used within this thesis.

The concept of resilience developed from research in which children who were deemed to be at risk grew to become successful adults, while others did not. 'Resilient' was the term given by Werner and Smith (1982) to those children who were able to survive and thrive irrespective of their harsh background or setting. The researchers also discovered protective factors that differentiated the children. Protective factors included: a good natured disposition, responsiveness to people, good self-esteem, self-control, good social skills and communication skills, and the desire to achieve. Werner and Smith further suggest "optimal development is characterised by a balance between the power of the person and the power of the social and physical environment" (p.136). In addition, the challenge of the social or physical environment may encourage some individuals to 'flourish" rather than fail despite harsh conditions (Luthans, Youssef, & Avolio, 2007).

Resilience is often difficult to research because there remains ambiguity concerning whether the concept is an inherent characteristic or a process which can be developed over the lifespan (Gillespie et al., 2007). Several studies have shown resilience to be seen as an asset and a characteristic that can be enhanced within people by various means such as: building positive and nurturing professional relationships; maintaining positivity; developing emotional insight; achieving life

balance and spirituality; and becoming more reflective (Jackson et al., 2007; Lees, 2009). A number of recent studies have examined resiliency as personal strategy in responding to workplace adversity with topical investigations on burnout and workplace stress showing that some nurses can remain within the system even though they face their ongoing challenges (Cline, Reilly & Moore, 2003; McVicar, 2003; Strachota, Normandin, O'Brien, Clary, & Krukow, 2003; Tedeschi & Calhoun, 2004).

World War II popularised the construct of 'stress'. As the number of affected military personnel and family members demanded assistance to deal with issues around nervous functioning and other bodily responses to psychological threat, and the development of 'battle fatigue' and Post Traumatic Stress (Lazarus & Folkman, 1984; Seligman & Csikszentmihalyi, 2000). Research subsequent to World War II led to new insight which correlated to the 'stress' of others, not just soldiers, and the stress caused by their work, their home life and their relationships (Kemeny, 2003). 'Stress' and 'anxiety' became popular idioms as the general populace described their life worlds to researchers (McGowan, Gardner, & Fletcher, 2006). These idioms have since become inextricably linked to physiological illness including heart attacks, stroke, cancers and the development of chronic and degenerative diseases, as well as depression (Nelson & Simmons, 2003).

Positive psychology and the study of happiness are fundamental to the resilient self (Frederickson, Tugade, Waugh & Larkin, 2003; Seligman, Steen, Park & Peterson, 2005; Wallis, 2005). 'We become what we do' is the foundational notion of Anderson's (1997) study. That is, we can become healthier and more successful by consciously modeling and/or 'acting' the happy, healthy positive traits and attitudes we desire. Building self-efficacy is the primary formulation of Bandura's (1997) seminal work which postulates that self-belief and effort can achieve the necessary required goals of perseverance in the face of obstacles, resilience to adversity, and coping in times of stress.

The focus of positive psychology therefore is to develop human wellbeing which includes the study of stress and how it affects people, particularly emphasising how stress affects people's wellbeing in the workplace (McGowan, Gardner, & Fletcher, 2006). Recognition is given to stress as being part of everyday life, but focus is also upon the positive and beneficial outcomes of effective stress management and wellbeing, and on the development of resilience (McGowan et al., 2006). Thus, the importance and significance of this study lies in considering nurses' constructions of resilience and its applicability to their work.

Although a common definition of resilience is elusive, Waller, (2001) is parsimonious: "Resilience, simply stated, is positive adaptation in response to adversity" (p. 292). It is the capacity to remain functioning in the company of noteworthy strife. Individuals, communities and systems with resilience can positively adapt to and cope with, and even develop from, the disturbances to the challenges they come across (Gilligan, 1997), and this ability is evident through to old age (Fuller-Iglesias, Sellars & Antonucci, 2008).

Frederickson's (2004) 'Broaden and Build' theory of positive emotions describes the value of positive emotions which assist people to develop resilience and broaden their array of skills. Positive emotions seem to fuel resiliency as they build and deepen the physical, social and intellectual repertoire. These reserves are drawn upon when required for coping and survival, and for optimising health and well-being.

Tugade, Frederickson and Feldman Barrett (2004, p. 1162) write of psychological resilience and examine the benefits of positive emotions on coping and health, stating "positive emotions play a crucial role in enhancing coping resources in the face of negative events". Their study explores psychological resilience or the ability to bounce back from negative events by using positive emotions to cope, and employing positive emotional granularity, which is the tendency to represent the experiences of positive emotion with precision and specificity, to demonstrate how these traits can assist people to cope with change.

Resilience then, as the ability to survive and thrive in the face of adversity (Ungar, 2008), has been viewed historically from two major viewpoints. The first being physiological resilience where human beings have innate homeostatic mechanisms to foster 'resilience' after haemorrhage or stress, and the other that resilience is a psychological characteristic which includes personality factors or traits giving individuals the ability to move on in a positive way from negative, traumatic or stressful encounters (Tugade et al., 2004). Qualities associated with resilience are resourcefulness, self-confidence, courage, curiousness, self-discipline, level-headedness, wisdom, flexibility, emotional stamina, hope, justice and problem solving (Cloninger, 2005; Connor & Davidson, 2003; Coutu, 2002; McCullough & Snyder, 2000; Peterson & Seligman, 2004; Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

Positive psychology resilience research has spotlighted the skill and strengths of resilience and their application in various forms, particularly in the workplace (Luthans & Youssef, 2007). Resilient workers have the psychological capital to take on challenging tasks; to be optimistic about success; to persevere; and "when beset by problems and adversity, sustaining and bouncing back and even beyond (resiliency) to attain success" (Luthans et al., 2007, p.3). Research also attests that the protective factors characteristic of resilient people are thus able to be developed (Masten, 2001; Seligman et al., 2005; Waller, 2001), and although the past cannot be changed, nor the influences of one's childhood, coping strategies, problem solving and emotional intelligence and positivism can be developed, enhanced and sustained through education and training; it can ultimately be combined to foster resilient skills and capabilities within people (Caverley, 2005; Coutu, 2002; Everall, Altrows & Paulson, 2006; Luthans et al., 2007; Reivich & Shatt, 2002).

The development of resilience within employees has been researched in organisational literature, highlighting its importance in relation to reducing risk, stress and vulnerability whilst encouraging the development of personal resources

and self-efficacy (Luthans, Avolio, Walumbwa & Li, 2005). Luthans, Youssef, and Avolio (2007) suggest that job satisfaction and organisational commitment are increased with the development of employee resilience. Furthermore, research has indicated the development of employees' resilience allows not only the individual but also the organisation over time to be more adaptive and successful (Luthans, Vogelgesang & Lester, 2006). Research therefore confirms that resilience education may become a vital part of professional development within organisations as rapidly changing work environments cause stress and employees are challenged, not only to survive, but to thrive and flourish in the face of adversity (Caverley, 2005).

The ability to develop critical resilience skills or to enhance personal inherent resilient characteristics plays an important role in coping in current nursing environments where many professional nurses feel emotionally and physically overloaded causing stress and dissatisfaction in their role. The effect of increasing these resilient capabilities increases coping mechanisms and is instrumental in ultimately increasing nurses' satisfaction levels which in turn aid retention levels, nurse staffing and patient safety outcomes (Duffield et al., 2010;. Koen et al., 2011; Twigg et al., 2010).

Conclusion

This review of the literature has revealed important aspects of the resilience construct and its relationship to nurses, their work and their workplace. Resilience as a natural phenomenon as well as a skill that can be developed was explicated, and coupled with the effects of resilience education, shown to be a vital strategy for organisations to consider thereby enhancing organisational commitment and adaptability in times of dynamic workforce change.

This chapter also discussed literature concerning resilience, positive psychology and nursing. These examples lend weight to the claim that the study is relevant and timely from a Western Australian perspective as the literature relates multiple factors in the development of resilience as a strategy to overcome

difficulty in practice in contemporary health care environments. To follow in Chapter Three is a description of the methodology used to frame the participant's stories.

CHAPTER THREE - METHODOLOGY

Sketching the Outline

A story can be seen as a circle, a design which implies

future possibilities and future decisions ...

Each story circle then, effectively done, expands our awareness

Cory and Underwood (1995, p. 133).

Introduction

The preceding chapter reviewed literature related to the current social context of nursing and the propositions of positive psychology, in particular resilience as an individual attribute that may allow some people to continue to work despite personal and professional hardship. The literature demonstrated that research abounds with studies related to the work environment and employee satisfaction. However, it mainly discusses the negative attributes of the workplace, issues that relate to job dissatisfaction and what organisations are required to undertake to ensure employee retention. Little has been reported on the use of resilience factors which buffer the nursing workforce in a time of duress; or why nurses remain in the workforce despite these tensions.

Historically, social research has tended to concentrate on the negative attributes of environments with Maslow (1943) asserting early that "it is as if psychology has voluntarily restricted itself to only half of its rightful jurisdiction; the darker, meaner half" (p. 354). Contemporary commentary continues this critique with East, Jackson, O'Brien and Peters (2010, p. 19) pointing out that research often concentrates on the "sad rather than happy experiences"**,** frequently relaying the traumatic, the horrible and the vulnerable sides of humanity. Although philosophers have often considered happiness to be the ultimate goal for humans with 'nirvana' the highest aspiration, the pathological focus of social research remained entrenched until after the second world war which influenced the direction of psychology (Seligman & Csikszentmihalyi, 2000) with psychological research being

primarily focused around diagnosing and curing mental illness (Luthans & Youssef, 2007; Reivich & Shatt, 2002; Seligman & Csikszentmihalyi, 2000).

Recently, the literature outside nursing (Manion, 2005, Seligman & Csikszentmihalyi, 2000) has changed focus suggesting that research should be undertaken to focus on the positive, to look for those occurrences that 'give joy to work' (Walter, 2003). A new method of research which shifts the focus of research from the negative to discover the positive impacts of the health care setting is Portraiture. Portraiture is an innovative approach to research as it resists the vigilance which focuses on the negative and searches earnestly to find what is good within research settings.

This chapter describes Portraiture, a qualitative design and a method of inquiry which is appropriate for illuminating the resilience of nurses in the health care environment, and to discover the influence of resilience in keeping nurses working. This approach to research shares some of the features of ethnography, phenomenonology, case study and narrative enquiry to describe the human experience of professional lives (Lawrence-Lightfoot & Davis, 1997). It differs from them however, because portraiture embodies artistic and literary elements providing detailed accounts of individuals or groups whilst embracing the 'good' of success. It also delivers the 'aesthetic whole' based on cachets of data collected through observation, interview and data review, grounded and rendered through written accounts or portraits that are easily accessible to a wide reading audience (Davis, 2003).

The Interpretive Process

The seminal work of Geertz (1973) relays the fundamental underpinnings of research, which is the search and presentation of evidence of real events in time and circumstance through description of demographic data, cultural ideas and mores, and accounts of specific experiences. These, upon closer inspection, provide the cornerstone for interpretive speculation. Thus, the interpretive process seeks to uncover each individual's experience of their life and to develop an

understanding, or make sense of, lives lived considering the context of the individual's social world as a result. 'Understanding' has to do with the experience of other individuals and their thoughts, and relies on the meaningfulness of all forms of expression in which their experience is couched. 'Meaningfulness' is bestowed on expression by interpretation and seeks to "identify patterns, extract themes, and begin to distinguish beliefs and behaviours" (Wolcott, 1994, p. 107). The researcher attempts to provide a detailed examination and description of experiences and events and is concerned with the meaning**s** attributed to these experiences by the participant**s**. That is, the explanation of their 'lifeworld', with the interpretive process being a dynamic interaction between the researcher and the researched. The researcher takes a primary role in searching for meaning within the participant's personal world, to 'see their minds eye' (Gadamer, 1979). But this is difficult, an almost impossible task, as one cannot 'be another' as no one has direct access to the mind of another. Hence, understanding another's experience is dependent upon the researcher's own views and perceptions in order to make sense of that other personal world through the process of interpretive activity. This researcher is aided positively in this investigation through being an active participant in the public health industry.

Heidegger (1977) refers to this interpretive activity as a two-stage interpretive process, or a double hermeneutic. That is, the participants are trying to make sense of their world whilst the researcher also is trying to make sense of the participant**s** trying to make sense of their world in order to gain understanding and attribute meaning (Denzin, 1995). Here meanings are constructed by individuals within both a social and a personal world**,** and the person is a cognitive, linguistic, affective and physical being with connection inherent between their words, thoughts and emotions (Heidegger, 1977).

It is typically assumed that humans share similar features with other humans and can 'understand' or gain understanding through the reciprocal nature of social interaction, the functional use of language, empathy, and the understanding of others' emotions and actions (Denzin, 1995). This allows the researcher to attribute

thoughts, desires, and intentions to others, to anticipate or explain their actions, and to generate their intentions (McHugh & Stewart, 2012). However, the relationship of all of these interactive processes provide the researcher with a quandary as participants may struggle to express their thoughts and emotions, and may not wish to self-disclose to the researcher. Thus the researcher may not only have to interpret from what is said, but often what is not said through analysis and interpretation of the story heard (Denzin, 1995). Moreover, according to McHugh and Stewart, understanding is not an autonomous, ahistorical, human activity but a medium through which the world is interpreted, providing a basis from which one is able to postulate in relation to self and others. Thus, to understand why some nurses have chosen to remain in the workforce requires an examination of the workforce issues from a stand point of reasons to remain, rather than leave, at a contextual time and place.

The experience of going to work is an everyday one linking the subjective sense of self to the perceived 'objective' reality of the world and other people, thereby allowing the discussion of feelings and emotions with regard to work. Here, the work world is a shared world, created and sustained by a shared understanding in the form of language. Thus, understanding becomes linguistic and contextual, and interpretation is now not an activity so much as a disclosure. In interpreting reasons for remaining in the workforce with resilience as the centerpiece, the researcher and the resilient nurse do not, so to speak, throw a 'signification' over some naked thing which is present-at-hand, rather when resilience is encountered as something 'within the world', the experience already has an involvement which is disclosed in our understanding of the world (Heidegger, 1977).

The shared understanding of the concept resilience and the contribution of this personal attribute to a person (nurse) remaining in the workforce is best described by the concept of the hermeneutical circle (Heidegger, 1977). This circle implies that in order for the experience of resilience to be understood, those concerned with experiencing the phenomenon must have a pre-understanding of the concept in order to understand the concept. These reciprocal pre-

understandings function as a structure through which understanding is re-experienced and re-examined. At the moment of understanding, pre-understanding and understanding are a dialectical entity, in which both parts are dependent upon each other (Heidegger, 1977).

Interpretation, therefore, is never a presupposition, or an apprehen**sion** of something presented to one, but is founded on what is already known and the nurses' experiences of it. Furthermore, Heidegger (1977) contends that interpretation places in the open what is already understood. Thus, remaining in the workforce works in a dialectical relation with attrition of staff as one informs the other and vice versa. McHugh and Stewart (2012) declare that there is no escaping the historical situatedness of understanding because understanding is the ontological ground of our 'being-in-the-world'. Thus, meaning through understanding is not determined by the subjective intentions or utterances of the resilient nurse, rather the linguistic system as a whole imparts meaning of the experience. Thus the participant's narrative text is blended with the interpretive perspective of the researcher combining to create an authentic and convincing gestalt, in this study presented through Portraiture research method.

Portraiture

Portraiture is an interpretive process. It is a less known methodology developed in 1983 by Sara Lawrence-Lightfoot, a Sociologist and Professor of Education at Harvard University. Portraiture borrows its name from the visual arts and the researcher undertaking Portraiture is accredited with artistic flair to construct 'portraits', or verbal canvases that are detailed narratives. These narratives function individually as artful accounts or stories; or, as separate 'works of art' of the research subject under scrutiny (Davis, 2003). The creativity of the researcher blends the intent of the research, the research questions, the settings, and the participant's narratives into amalgam forms that unfold into a story, the written portrait, with themes and meaning emerging as the research progresses (Pickeral, Hill & Duckenfield, 2003).

Portraiture is an insightful and appropriate approach for examining why nurses have chosen to remain in the workforce because it gives voice to the experience of each nurse's choice to remain in the workplace by focusing on the context, relationship, emergent themes and the 'aesthetic whole' (Davis, 2003). By the merging of art and science, the aesthetic and the empirical, the meaning and the essence of why some nurses have chosen to remain in the workforce and the role played by personal resilience, is revealed in this choice.

Portraiture merges the careful describing and interpreting of good ethnography and interactive research with the participants one is studying. Erlandson, Harris, Skipper and Allen (1993) assert that Portraiture is fused with the creation of fine literature, vivid with 'thick description'. It is an authentic representation of what one is seeing, with the creation of a written rather than visual 'portrait'. It embraces a holistic perspective, and studies the participants in their full contextual and historical milieu by embracing sensitivity to place and time (Lawrence-Lightfoot, 1983). The portraits also capture attitudes, feelings, colour and ambience, giving the text what Taylor cited in Lawrence-Lightfoot & Davis (1997, p. 28) terms 'expressive content.' This in turn gives the vivid description that leads to the emergence of artistic refrains or emergent or universal themes against the background of time (Lawrence-Lightfoot & Davis, 1997).

In direct contrast to traditional research approaches, where researchers strive to maintain objectivity and seek to eliminate bias, the researcher or portraitist aims, Wolcott (1999, p. 19) to: "regard ourselves as humans who conduct our research *among* rather than *on* them" (emphasis in original). The Portraitist rejects the notion of the dispassionate, detached observer often identified as being the 'ideal' researcher. Instead, the Portraitist embraces and shares in the passion of the portraits, and is more palpable than in any other methodological form for their visibility which is central to, highly valued and acknowledged in the narratives. Consequently, the research is greatly influenced, by the researcher's individual attributes and perspectives (Lawrence-Lightfoot & Davis, 1997). Close proximity and

involvement with the phenomenon and with those under study can be viewed as a definite benefit according to Clandinin and Connelly (2000) when they aver:

In narrative inquiry, it is impossible (or if not impossible, then deliberately self-deceptive) as a researcher to stay silent or to present a kind of perfect, idealised, inquiring, moralising self (p. 62).

The encounters between the Portraitist and the participants, or the subjects of the life drawing, combine to form the portraits (Lawrence-Lightfoot & Davis, 1997):

The portraits are shaped through dialogue between the portraitist and the subject, each one participating in the drawing of the image. The encounter between the two is rich with meaning and resonance and is crucial to the success and authenticity of the rendered piece (p.3).

The researcher and the subjects of the life drawings become co-constructors of the narrative (Lawrence-Lightfoot & Davis, 1997). Notably portraits are not auto-ethnography in which the writer tells the story of their own lived experiences relative to the broader socio-political context. Although Patton (2002, p.86) claims Portraiture may be an extension of "auto ethnography" which "is self-awareness about, and reporting of, one's own experiences and introspections as a primary data source". Portraiture, while interested in the context of culture, goes beyond ethnography which is largely concerned with the depiction of social life and culture. Ethnographers listen *to* a story; in contrast, the Portraitist's approach is to listen *for* a story, hence the title of the study (Welty, 1983). In a similar fashion to an ethnographer, the Portraitist becomes absorbed in the research environment, entering people's lives, engaging them in interactions, and actively questioning their roles and sense of place within the setting (Hill, 2005). Le Compte and Schensul (1999) believe that Portraitists are more effective researchers as they are able to pursue their intuition and engage with the people they study.

In creating the gestault that is the portraits, Portraiture draws upon features of case study, phenomenology and ethnography, amalgamating life history and

narrative into a blend of all. This blend captures in real time the backdrop, the essential features, and the participants' interpersonal experiences which provide a powerful form of description, affording the picture or snapshot of the 'life-world' that is required (Lawrence-Lightfoot, 2005).

The portraits are not phenomenological whereby Husserl (1998) argues that it is important to reflect upon worldly experiences to present 'the life-world 'by bracketing out preconceptions so as to separate the 'real' from the' essence'. This is not an integral part of Portraiture. In fact, Portraiture encourages the researcher's presence to be affronting and confronting. Heidegger (1962) argues that the research participant lives in the world and is always affected by it, thus dissolving the 'separation' of Husserl, and furthers that the 'world' is common to both the researcher and the participant giving the researcher the ability to understand parts of another person's life-world.

According to Heidegger and Gadamer (Gadamer, 1960), this understanding becomes a dependent part of the hermeneutic circle. Thus, in wanting to understand the nurses' stories, I am unable to view them independently of my own pre-understanding and the stories and interpretation I make will lead me to understand a situation and a phenomenon with empathy because our life-worlds of understanding are similar yet unique. Phenomenology looks to the essence and the meaning of nurses' stories but does not focus on the writing of these stories, with the aim of making them "people's scholarship - a scholarship in which scientific facts are gathered in the field to give voice to a people's experience" (Featherstone, 1989, p.377). However, this is what I wanted to do and I decided on the methodological stance I needed to use in order to do so. The consequence was to exclude these afore mentioned methods and to choose Portraiture as the most suitable research methodology to provide the narrative of the nurses' stories.

Narrative

The development of the use of narrative inquiry as a research approach has been evident since as early as the eighteenth century (Alvermann, 2000). More recently, narrative inquiry has been as far ranging as: focusing on people's lives and lived experiences (Baldwin, 2005); telling stories of how individuals understand their actions through oral and written accounts of historical episodes (Riessman, 2002); and using the methodological aspects of storytelling (Richardson, 2000). This shift in research emphasis to allow the narration of peoples' understanding of themselves and their experiences began in the mid-1970s, when, according to Bruner (1986), "the social sciences had moved away from their traditional positivist stance towards a more interpretive posture" (p. 8). Narrative makes the association between events and meaning so that one gains wisdom and is able to make sense of the amalgam. Stories embrace the 'I' and the 'we'. In the act of telling a story or in the art of writing a story, others are invited in to connect with the tale and it is within the narrative framework that the story has a beginning, middle and end with a view to entertain, to teach, or to just be.

Barthes (1966) asserts that "the history of narrative begins with the history of (hu) mankind; there does not exist, and has never existed, a people without narratives" (p.14). Narrative is fundamental to human understanding, communication and social interaction and provides a way of communicating "stories lived and told" (Clandinin & Connelly, 2000, p. 20).

This study through Portraiture builds on the narrative whereby the 'presence' of the Portraitist is indelibly part of the product, which enables the reader to experience what is being portrayed more deeply and with greater understanding than by reading a disconnected report (Hackmann, 2002). The reader can 'see' the narrative. This creative flair provides an end product which embraces intimate storytelling; and the tone and style, the creative nuance, the researcher's voice, will be evident, together with the participants. This is what I sought as a Portraitist; I wanted the nurses' stories to be told because narratives give expression to discourse or stories; and, in employing this research approach,

discourse is presented as written portraits. Foucault (1977, 1991) espouses the idea that physical things and actions exist but can only take on meaning and become objects of knowledge within discourse, as it is discourse, not the things themselves, which produces knowledge. Therefore, a study of nursing has to include statements about nursing in the form of narratives to engender knowledge, as they reflect experiences of a particular place and a particular time, in short, a social construction or story.

Denzin (1997, p. 266) subscribes to the need for new ways of thinking, confirming that narrative provides a different textual form by asking for text and dialogue to bring people's stories alive. Further, Denzin states that stories using an interpretive framework provide a base to detail and criticise the world, rallying researchers with the cry that stories are waiting to be constructed, whereas the text mirrors the real world whilst simultaneously providing the reader with a "cozy story". Every participant carries within them a story and by uncovering that story and creating a narrative, the Portraitist is able to offer the reader access to personal experiences and aspects of human life that enable the comprehension to make social sense of the encounter. In this way, the individual story becomes a reflection of the social world, the cultural system and the organisation wherein the individual as participant resides. When personal stories are shared, a meaningful articulation of experience occurs according to Denzin (1997). Personal narratives tell personal stories he opines:

in a way that assists in the construction of identity, reinforces or challenges private and public belief systems and values, and either resists or reinforces the dominant cultural practices of the community in which the narrative event occurs (p. 250).

Trochim and Donnelly (2007) explain that telling a story from the participant's viewpoint provides the rich descriptive detail of their human context, describing 'what is going on or what exists' (p. 5), while Rappaport (1995) believes that it is by understanding the story of an individual that one can become familiar with stories that are reflective within a group or collective in line with Corey (1998,

p. 250). Further, Rappaport (1995) used the term narrative synonymously with storytelling where the main character is the main player, or to relate this to Portraiture, the main subject for the portrait.

Narrative – story - portrait

Mello (2002) suggests there exists universally in the human mind a story and the essence of how individuals make sense of their world; their experiences are through telling their story, a construction requiring plot and structure with censored and embellished memories over time. Further, Lawrence-Lightfoot and Davis (1997) propose that narratives have an educative function, telling of interpretations of the past, and telling stories that have been reflected upon and relived, all while experiencing the present and anticipating the future. Ong (2002) believes that the act of writing is, in itself, a reflective event and that it delivers the "consciousness out of the unconscious" (p.150).

Portrait writing is what Atkinson (1992, p. 9) describes as 'writing down' and 'writing up', from the drafting of field notes (the writing down) to the accomplished portrait (the writing up). Portraiture is located within an interpretive framework of writing but based solidly on text and contextual materials. This will be explained further in the chapter to follow.

Good narratives, stories or portraits should allow the reader to come as close to the experience being related as they are able, being transported through space and time into the realms of the imagination and of the story itself. A good story should be interesting, enticing the reader to read and know more. It should not be jargonistic but written in language that the reader can understand yet crafted with the language of words. Richardson (2000) asserts that readers should be emotionally moved and engaged by the writing, evoking feelings of happiness or sadness, reminding the reader of similar experiences in their own lives and as such, must be seen to be 'real' in terms of credibility by providing a truthful account of the experience it depicts.

To reiterate, narratives cannot be independent of their contexts as they are social constructions replete with cues located within their specific time and place and easily recognisable by other members of the same community who are able to understand the meanings of the tale. The story tells of how the narrator has made sense of the particular events, problems and experiences of lives lived and how they have dealt with them.

No matter what term is used, a narrative, story or portrait can only ever be a representation, an interpretation, a sketch, of a particular aspect of an event or of a life. Clandinin and Connelly (1994) succinctly write:

Stories are the closest we can come to experience as we and others tell our experience. A story has a sense of being full, a sense of coming out of a personal and social history…. Experience … is the stories people live. People live stories and in the telling of them reaffirm them, modify them, and create new ones (p. 415).

The manner in which nurses in this study told their story was according to their own volition. They were linking different personal and work life events, experiences and perceptions to recount why they had remained in the workforce, and the role played by resilience in their choice. Each had different words and responses peculiar to their specific life circumstances, experiences, background and work context, and each responded to me differently. Their narratives become the new perspectives or new knowledge gained, as the reinterpretation (a telling of what was and a retelling of the told) is inherent and acknowledged in storytelling and in the portraits too.

Portraiture, my research methodology of choice, allowed me to have the voices of nurses heard in a way that differed from other 'state of nursing' reports (Meissner 1986; Sauer, 2012). I wanted to represent, as best I could, the experiences of their professional lives, with special emphasis on *the good*. Rather than focusing on the ills of the system I wanted to "characterise and document health" (Lawrence-Lightfoot & Davis, 1997, p.11) in that system which is often overlooked in the face of the documented ills. A focus on the good acknowledges personal

strength and provides a window into why particular nurses were still there, still working.

The Portraiture approach concentrates on 'unearthing goodness' and highlighting the successes of a given group within a given context. For the purposes of this study, that is, nurses who have chosen to remain in a system fraught with problems (Buchan & Aiken, 2008; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Scudder et al., 2011). The Portraitist listens to the story as experienced and perceived by participants in particular settings, choosing to explore and describe their stories from a framework of strength rather than weakness (Lawrence-Lightfoot, 1983). The Portraitist may embellish the story, that is, interpret what is being said by the teller in the story. This is consistent with artistic license of the Portraitist who by painting the story is responsible for the mixing of colours of language and the shades of hue.

Portraiture necessitates the researcher's voice to be an elemental and tangible feature of the Portraiture methodology (Lawrence-Lightfoot & Davis, 1997). This voice moves from a less obvious presence within the text as a witness, to a more overt presence fully involved in dialogue with the nurse/participants. Rather than being traditionally veiled behind the linguistic conventions of third person writing, the researcher's voice is obviously evident, and should be so as Richardson (1997) so forthrightly comments:

We are restrained and limited by the kinds of cultural stories available to us. Academics are given the "story line" that the "I" should be suppressed in their writing, that they should accept homogenization and adopt the all-knowing, all-powerful voice of the academy. But contemporary philosophical thought raises problems that exceed and undermine the academic story line. We are always present in our texts, no matter how we try to suppress ourselves (p. 2).

The portraits produced involved intimate storytelling or painting with words where the subjects 'felt seen'. The tone and style, the creative nuance, the researcher's voice, is evident, together with the participants and both together,

making meaning. The visibility of the Portraitist enhances the reader's trust. The reader is clearly aware of the authenticity of the work, knowing where the Portraitists are *coming from* and can then, as informed readers, becoming immersed in the portraits whilst forming their own interpretations of them (Lawrence-Lightfoot & Davis, 1997, p.96).   This is in keeping with the seminal work of Geertz (1973) who celebrates the researcher's imagination and visibility as a fundamental aspect of the depiction of a culture and adds the humanistic dimension. Simply, I wanted to understand why and what personal qualities are in and shared by those nurses who remain in the workforce and why they have remained in nursing.

The Portraiture approach enabled the capture of the full complexity of nursing resilience by focusing primarily on the dialogue between the portraitist and each participant. Through the use of the nurses' own words their voice is elucidated by the provision of intimate evidence of their thoughts and feelings; by their moods and use of language; and by giving their individual unique opinions of resilience. These multiple dialogues must resonate with readers, some of whom may work within healthcare and thus share a contextual background. Harre (2009) asserts that "... when a person uses the pronoun ' I ', they are not ascribing a property to a substance, a hidden mental state to an ego substance, but expressing, that is making public, 'how it is with me'" (p.197).

The knowledge revealed by the nurse's narratives, their private storytelling, gives a rich, contextual knowledge of nursing now, where they occupy a legitimate position to relay their own story with their retrospective thoughts and feelings about their life-story to the researcher and the reader. The portraits are not designed to be idealisations of nurses, but to reflect and document the individual nurse's resilient strengths while unconsciously revealing their vulnerabilities. Whilst the portraits show snapshots of nurse's interpretation of their profession, they do not distract readers from the issues of the nursing work environment in general. The nursing work environments, in which this study occurs, are reflected by a depiction of sights, sounds and impressions as told by me, and in this case given further voice by the nurses in their workplace settings. Occupational and everyday

life and work events may be fashioned onto the canvas of the portrait, revealing a composite image of individuals' beliefs relating to the organisation in which they work, in the current place in time (Lawrence-Lightfoot & Davis, 1997).   Although each portrait focuses on the distinctions of every particular story, they are relayed with subtlety and care in the nurses own words, thereby reducing the potential for misinterpretation, and the particular, having the potential to offer insight**s** into the arena of the many.

The method of portraiture

The Lawrence-Lightfoot (1994) method for the creation of portraits is not clearly articulated into procedural steps. However, a familiarity with her works (Lawrence-Lightfoot, 1983; Lawrence-Lightfoot, 1994; Lawrence-Lightfoot & Davis, 1997; Lawrence-Lightfoot, 2005; Lawrence-Lightfoot, 2009) reveals some important commonalities which have been articulated to guide the steps undertaken in this study.

The steps are described as:

1. *Placing the easel;(Procedures and Method)*
2. *Painting the words;(The Portrait Gallery or Results)*
3. *Revealing the brush strokes; (Interpreting)*
4. *The Frame and Signature. (Conclusions and Recommendations).*

Placing the easel (Procedures and Method)

Placing the easel means researching and describing the social and historical context; choosing the appropriate nurses for the phenomena under study; and gaining ethics approval and access to the study settings. It includes immersion and observation in the setting and the conduct of interviews. It is the procedural work that needs to occur before any 'painting' or writing can begin.

Painting the words (The Portrait Gallery or Results)

Painting the words means sketching the central characters that comprise the portraits. This is done through dialogue between the researcher and the sitter within the setting. Here, voice is given to a respondent's (*nurse's*) experience so

that the experience is seen. The researcher/Portraitist is consciously using audio/visual/perceptual/experiential data in creating the portrait, exceeding the representation of literal description by providing expressive content to form the aesthetic whole (Lawrence-Lightfoot & Davis, 1997).

Revealing the brush strokes (Interpreting)

Revealing the brush strokes refers to the interpretations of the portraits as the portraits are hung in a particular context, with a social and historical collage, and coloured and shaded by the sitter's personal palette. This reveals the searching for the central themes and the depicting, discussing and interpreting of the little pictures within the larger portraits by the researcher.

The Frame and Signature (Conclusions and Recommendations)

The Frame and Signature is the final touch to the exhibition. It offers further discussion to guide recommendations for research, education and practice for the future.

Summary

Portraiture is a method structured upon the conventions of phenomenology and sharing the immersion techniques of ethnography yet providing much more than case studies to combine and amalgamate the best of those methodologies to consciously and carefully form authentic portraits of those under scrutiny. It offers a multidimensional and alternative approach which combines the blending of the genres and the use of a creative language which guides the expression of the narrative and offers the reader a new methodology of choice where the writing is the methodology. Richardson (2003) asserts that writing is not to tell but to show; to re-present significant moments in people's lives (p. 190).

The art of the Portraitist is to link the stories, edit them, deconstruct them and then refashion them to make a coherent narrative and complete portrait. We can then look for correlations, similarities and differences through our own interpretation. Portraiture makes the nurses' stories accessible and interesting and

the readers are bought into their world far more fully immersed than constrained by the conventions of other pure methodological forms.

The Portraiture approach is particularly appropriate within the field of nursing, since, it is postulated, by Lawrence-Lightfoot and Davis (1997) that more may be gained from examining successes rather than failures as the portraitist adopts a "generous stance…looking for strength, resilience and creativity" (p.158). Also acknowledged is the drive in the human response to rally for the underdog, to hear of stories of people triumphing over the odds, a glimpse of inspiration from other's determination to keep going (Mealer, Jones & Moss, 2012).

Looking for strength through resilience was professionally important to me as a nurse and as a survivor of some of life's adverse events. This approach to research allowed my own voice to be heard and my experiences to be acknowledged. This enhanced my creative role as a researcher. Hence I was able to engender a deeper relationship with the study data. In keeping with Lawrence-Lightfoot and Davis (1997, p.14) I was the "primary research instrument". Importantly, I as the portraitist was responsible for documenting and interpreting the perspectives and experiences of the people studied.

Conclusion

This chapter has described the Portraiture research methodology approach and its usefulness to illuminating the strength and resilience of nurses who have chosen to remain in the workforce. The processes and procedures for data collection are presented in the following chapter.

CHAPTER FOUR – THE METHOD

Placing the Easel

"So we create by our actions a series of events that move in one direction toward some meaning … The world we know is the world we make in words"
(Rouse, 1978, p.187)

Introduction

This chapter discusses the series of actions which describe the design of the study. As indicated in Chapter Three, Portraiture is a research methodology framed by the traditions of phenomenology and ethnography; however, it broadens the palette of those methodologies to combine narrative and analysis through the use of the portraitist as the primary research instrument. The documentation and interpretation of the experiences of people is made visible through the creative development of their portraits.

Setting selection

The study was conducted in Western Australia. The participants resided and worked in the metropolitan area of the capital city, Perth. A variety of workplace settings was approached in order to select participants who, based on the contemporary literature, could best be expected to illuminate answers to the study questions.

The settings chosen were three typical nursing workforce situations of high workplace stress. These are: a residential aged care facility, a tertiary hospital and a nurse education facility. A convenience sample comprising three senior nurses from each of these settings was chosen to be the research cohort. The settings reflect the wide scope of contemporary nursing practice; each setting has several characteristics found to have significant bearing on nursing stress and wellbeing, combined with factors which may have effect on a nurse's resilience (Duffield et al.,

2010). Work environments play an important role in a nurse's satisfaction and retention for various reasons. Patient acuity, diagnosis and nursing workload among other indicators have the potential to alter resilience in a tertiary healthcare setting (Christmas, 2008), whilst chronic care and end of life care can alter resilience in a residential aged care setting (Fagin, 2001). Academic workload and student demands can also have effect on an academic nurse's resilience (Brady, 2010).

Observing the nurses in their workplace setting ensures authenticity of behaviour. Portrait locations were chosen to enhance diversity of workplace settings and to enhance the capture of possible contextual influences on experiences of resilience by nurses. For the purpose of ease of data collection, settings were confined to metropolitan localities.

Gaining Access

This study was approved by the Edith Cowan University Ethics Committee and participating research venues prior to commencement of the study. In addition the appropriate Director/Manager of each nursing workplace setting was approached for permission to access their facility and workforce.

Having secured ethics approval, a timetable for visits and staff communication was made with the appropriate ward and departmental areas. All potential nurses available at the time of my visit were spoken to on an individual basis to explain the study in detail. The aims and objectives of the study were described and the part they could play. This explanation was accompanied by a written plain language statement titled "Participant Information Letter" (Appendix One).

Each participant was given two letters of consent to sign, one for consent for observation (Appendix 2), a further explanatory letter pertaining to the interview (Appendix 3), and another for consent to interview (Appendix 4). Each participant also completed another form which requested some demographic

details for participant entry criteria (Appendix 5) and gave the pseudonym in order that each participant maintained anonymity.

The right to privacy and confidentiality is fundamental to any research involvement and this is particularly important should the research reveal intimate knowledge of self or of stories that may be of a controversial nature. In order to preserve this privacy, the safeguard of a pseudonym was employed. These steps were taken to ensure the confidentiality and anonymity of nurses complies with ethical guidelines as outlined by the National Health and Medical Research Council.

In order to allow the nurses the right to reconsider their involvement in the study at any time, they were informed that they could withdraw their consent and participation at any time during the study. Prior to the commencement of the study each participant was given a 'cooling off' period in order to reflect on their potential involvement in the study. Following this period, appointments were made to discuss the study and clarify any issues.

This study safeguarded the human rights of all nurses by adopting a number of strategies:

- Nurses were clearly made aware that they had the right to withdraw consent for involvement, voice concerns, or make comments at any time of their involvement with the project.
- Nurses were made aware that they could view the transcripts of interviews, draft portraits and completed portraits to suggest changes as co-constructors of the narratives.
- During interview sessions nurses had the right to either cease the interview or have the recorder turned off.

I provided privacy and comfortable surroundings during each interview as able, as some interview settings were chosen by the nurses. Confidentiality of each participant was protected by adopting the following measures:

- The use of pseudonyms by the study nurses.

- Audiotapes and transcriptions of data was de-identified and information pertaining to the study was kept in a locked cupboard to be destroyed by incineration five years from the time of examination of the thesis as per the University's Research Record Keeping policy.

- Signed consent forms and all recorded data are stored in a locked place to which only the researcher has access.

- No information about the nurses will be revealed to people unless written authorisation is gained from the nurses. The information was for the sole purpose of the study only.

- The nurses had the right not to be harmed in any way during the course of the study. The observations and interviews may cause the participant some distress over what may be revealed of practice and experience. However, in discussion with the nurses, it was acknowledged to them that involvement in the study may be an uplifting experience as someone was 'listening to their story'. The researcher however, was prepared for individual responses to the study experience. Strategies for maintaining the safety of the nurses included:

   1. The free access to their own study transcripts and portraits and the right to clarify and address issues transcribed.

   2. An acknowledgment by the researcher to be open and responsive to the needs of the nurses, with the well-being of nurses being of utmost concern and the treating of them with respect.

Participant selection

The number of nurses selected for this study was not predetermined. The researcher explained the purpose of the study to interested nurses and then invited them individually to participate in an interview/conversation designed to elicit data to address the study questions. John Beverley as cited in Denzin and Lincoln (2008) believes it is imperative to a qualitative approach that it focus in-depth on participants who demonstrate the criteria required to answer the study questions

(p. 258). This purposeful selection of participants engenders information-rich cases for in-depth study with their testimony providing what Shirey (2004, p. 5) describes as a "tapestry of detail", wherein the researcher can gain fresh insight about the nurses common shared meanings and shared contemplations of their feelings about resilience within their differing work settings.

To gain theoretical saturation which is required to enhance rigour in interpretive research it is important that participant inclusion continues until the researcher is reasonably satisfied that all possible issues and/or aspects for analysis have been revealed. Sandelowski (1995) states:

> An adequate sample size in qualitative research is one that permits by virtue of not being too large …the deep, case-orientated analysis that is the hall mark of all qualitative enquiry, and that results in … by virtue of not being too small …a new and richly textured understanding of experience (p. 183).

Participants

Nine nurses (n=9) agreed to be included in the study. Three from interim and residential aged care, three from the academic setting and three from management within tertiary acute care enabled data saturation.

Criteria for inclusion

1) All participants were English speaking;
2) Registered with the Nurses and Midwives Board of Western Australia; and
3) Having more than five years' experience in the Western Australian healthcare environment. This condition was to enable reflection on significant and ongoing changes within the workplace as a possible source of resilient behaviours.

The process for the inclusion of nurses in each setting varied. In the interim residential care setting my memo (see data collection methods) notes: *'the nurses interrupted their handover to welcome me and hear what I had to say (they had*

previously been alerted by management that a PhD student would be coming to speak to them). Each nurse to whom I explained my study supported my work and all were happy to commit. I left information sheets and consent forms with the Manager to enable each of them to think about their involvement. One (the CNM) was going on leave the next week so decided to sign up there and then.' (Memo, 05/09/2008). Three participants from the first handover visit became study participants.

Nurses from the acute care setting willing to participate in the study were more difficult to recruit. The time constraints and the commitment to interview(s) seemed to hold them back and make them a much more hesitant group. A number of approaches by the researcher were required to fit around their busy schedules. However, once these nurses committed, they were open to assist the researcher in whatever way they could. Another of my memos are reflective of this: *'I was having difficulty coordinating interviews with nurses with such busy work lives, family lives and just lives in general. Sometimes three of four interview times were cancelled by them for a different range of reasons, all feasible, ranging from illness, too busy with work, being away from the facility due to their role, and even because of death and illness in the family. These are all valid reasons why an interview would need to be rescheduled, but it was very frustrating because as a student you always have the nagging timeline in the back of your head.'*(Memo, 01/06/2009).

The nurse participants in academic settings were also ready, willing and able; all three volunteered after the initial, tentative approach by the researcher. They somewhat self-selected telling the researcher, *'You need me in your research: sign me up!'* My memo dated the 16th of September, 2009 notes: *'They work in a completely different clinical setting and have to handle completely different clinical issues to nurses within a hospital setting. Therefore what I could observe, and what they could tell me, may be of value to my study.'* (Memo, 16/09/2009).

Data collection

Data collection involved the compilation of field notes, memos, gesture drawings and interviews. A background analysis of documents pertaining to each research site was also undertaken to orientate the researcher.

Background data

Documents related to each research site included a review of contemporary and historical texts from each setting. For example, *Lady Onslow's Legacy - A History of the Home of Peace and the Brightwater Care Group* by Deborah Gare (2001) gave background information on the mission and values of a private residential aged care facility. I reviewed website updates of the major clinical settings and sought information on various groups mentioned by the nurses or visually reflected in the settings, for example, newsletters from the Aged Care Standards and Accreditation Agency Australia. The referral to, and compiling of documents relating to each facility should be melded into the integrated prose of the final narrative portraits as they are a rich resource which illuminate the portraits thereby giving contextual insight (Lawrence-Lightfoot & Davis, 1997).

Field notes

In each of the three settings, extensive field notes were maintained. This allowed me to document situations that occurred in the environments while interacting with the nurses. Field notes are written descriptions about what the researcher or Portraitist is noting. As Lawrence-Lightfoot and Davis (1997) certify they have the advantage of documenting "initial movements and first impressions, and noting what is familiar and what is surprising. The Portraitist gathers, scrutinises, and organises the data and tries to make sense of what she has witnessed" (p. 187). Field notes may contain descriptions of the physical landscape, descriptions of everyday occurrences, and participant interactions (Denzin & Lincoln, 2008).

Although I attempted to visit each setting as often as possible, the nature of constant activity within healthcare settings, and the extreme busyness of the nurses

involved, often hindered my ability to observe them during care episodes, and record incidents contemporaneously. In some instances, I visited facilities and observed the setting. These visits facilitated creating a picture of the workplace and recorded details of place and its ambience. The field notes enabled a plethora of background detail to be collected, allowing focused observation of the study participant when those opportunities were available.

Gesture drawings or Impressionistic records

From first encounters with the nurses and their settings, observing both prior to interview, enabled me to create 'gesture drawings' which are defined as 'brief narratives' (Lawrence-Lightfoot & Davis, 1997, p. 23). These aim to capture the essence of a clinical setting or a nurse of interest, just as a sketch for a portrait would do. These gesture drawings were developed into memos and are important early reflections as they document what is superficially apparent and what may be surprising upon later reflection; they may be used as source material for the developed portrait of the same person.

Memos

I wrote memos at the end of visits to each setting, and also wrote memos to reflect on the study process. These memos could occur at any time of the day or night. The thoughts that I had about the interactions and what was seen and heard and what they meant became embedded in the experiences they represented. Each day the memos and reflections, and ultimately the portraits they painted, continued to grow, build, change, and increase in complexity as reflection and meaning were attributed to them. 'Memoing' was first depicted by Miles and Huberman (1994) where the researcher writes ongoing memos to themselves in an effort to trace and logify the process of description and interpretation, "building towards a more integrated understanding of events, processes, and interactions" (p. 159).

Expanded notes and reflections on daily study occurrences led to the development of reflective memos. By writing down my thoughts and feelings I felt that some insight may be gained and that I may, as a novice researcher, have

epiphanies of inspiration or moments of revelation. Richardson and St Pierre (2005) believe that the act of writing is a recognised form of research and suggest that memos should be included as research evidence of a conduit to research possibilities. It also adds to a project's auditability, a key feature of interpretive analysis.

The use of reflection from first encounters, first observations and first interviews allows a return to the source and an ability to weave the tapestry of themes into the discussion between Portraitist and participant. "Writing these reflections down in a form that encourages rumination, analysis and critique … will make the lens more lucid, less encumbered by the shadow of bias" (Lawrence-Lightfoot & Davis, 1997, p.186).

Portraits were developed individually by being completed one at a time with no overlap. This activity reveals the importance of being immersed in the story of each participant and to write and conclude that experience before moving on to the next participant (Lawrence-Lightfoot, 1983). Writing a portrait and analysing the data occurred simultaneously and continuously and was aided by writing down and thinking about all of the new questions that reflection on each interview generated. I constantly reflected on what was found interesting, appealing, similar or dissimilar every day, building upon the reflections as themes emerged through different dialogues, settings and events.

Interviews

Two interviews were undertaken in this study. The purpose of interviews according to Patton (2002) "is to allow us to enter into the other person's perspective. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit" (p. 341). Patton continues stating that, "The quality of the information obtained during an interview is largely dependent on the interviewer" (p. 341). The interviewer develops the guiding questions which are able to probe deeply by asking the participants, "Tell me more about … " or "Earlier you stated…, please explain?" The

interviewer is able to seek clarification, steering and contrasting, thereby making the implicit explicit (Atkinson, 1988; Padgett, 2004).

The use of in-depth interviewing as a method of qualitative inquiry is ideal for the purpose of listening for a story. Liamputtong and Ezzy (2005) identify the advantages of in-depth interviewing in allowing for an exploration and novel understanding of nurses' subjective meanings and interpretations, while ensuring any potentially socially-sensitive responses are less influenced by the presence of peers. They contend the interview provides an opportunity for the nurses to tell their story in their own way, free of constraints, which, in itself, presents a rewarding experience both for researcher and participant.

Interviews were conducted at a mutually acceptable place and time and took place during a time period from late 2008 to late 2009. Each participant chose their own locations: one choosing a café setting; some choosing their own offices or meeting rooms; while others chose the garden setting surrounding their facility. Each choice of locations was discussed with the nurses to elicit why the location was preferred, in case a deliberate choice of location had issues pertaining to it that could be elicited further in interview. For example, did they choose a setting away from their workplace because they could not bear to be there a moment longer? Or did they choose a coffee shop setting, just because they like the coffee brand there? The semi-structured interviews, ranged from around one hour to two hours, depending upon what issues were raised.

The face-to-face interview process provided the nurses with the opportunity to discuss and articulate their beliefs and feelings about the focus of the study. A limitation of the interview is that, for various reasons, the nurses may not be forthright about their view of resilience and its relationship to the current healthcare setting in which they find themselves employed. The responses to the interview questions are assumed however, to be an accurate reflection of the viewpoints of the nurse at the time of the study as their stories and comments were recorded and field notes taken with their permission. Patton (1990) noted that:

We interview people to find out from them those things we cannot directly observe … We cannot observe feelings, thoughts and intentions (p. 278).

Semi-structured interviews are used in qualitative research which requires the participant to recall past events, experiences and emotions. There is the need to establish rapport with those being interviewed, to attempt to make them feel comfortable and at ease, and to achieve the "dynamic mutuality" described by Lawrence-Lightfoot and Davis (1997, p. 152) where a level of intimacy is established yet with boundaries maintained to protect the encounter. The Portraitist is paying attention to the research questions, focusing on how each individual experience may inform others like it, probing and pursuing interesting areas of response. Simultaneously, there is a wish to try to enter, as far as possible, the psychological and social world of the nurses as they can be perceived as the 'expert' with experience on and of the subject under study; therefore they should be allowed to tell their own story their own way. Thus, the advantages of the semi-structured interview are that it facilitates rapport and/or empathy; it allows for the ability to pursue interesting areas and insights; and it thereby has the potential to produce richer data due to the flexibility of the approach.

The interview guide, or in my case, a semi-structured guide or 'Aide Memoire' was developed as a tool to assist in meeting the researcher's objectives and to prompt responses (Appendix 6); however, semi-structured interviews do not have to follow the sequence of questions rigidly, nor does every question have to be asked, or asked in exactly the same way, of each respondent. Thus, the Portraitist may decide that it would be appropriate to ask a question earlier than it appears on the guide because it emerges naturally from the respondent's current response. Similarly, the manner in which a question is phrased, and how explicit it is, will be reactive to how the Portraitist feels the participant is responding and where the questions should or could lead.

The interview conversations were allowed to flow as naturally as possible as each interviewee led the discussion with the freedom to respond and describe

experiences as they wished. A number of prompting questions which underscore the central themes of the inquiry (Lawrence-Lightfoot & Davis, 1997, p. 153: see Appendix 6) was used which allowed some consistency between interviews but the free flowing nature of the conversations allowed for each individual's life drawings or story to emerge. While some specific questions were posed to each participant, as the interviews progressed and the Portraitist began to see a finer sketch, the line of questioning moved intuitively in its own direction (see Aide Memoire Appendix 6). Interviews lasted approximately 1-2 hours.

Interview one

An initial question was asked to elicit responses and followed up with prompts. The researcher encouraged the nurses to focus on their beliefs about resilience and whether they were able to ascribe these attributes to their own character or to other colleagues with whom they practice. The nurses were asked to give examples of disarray within their practice environment and how they responded to that perceived disarray. They were also asked if their current experiences are equivalent to other areas where they may have practiced in Australia or overseas.

I found that each nurse had a story to tell and they were skilled and willing to do so. Their narratives created experiences not only for me but ultimately for the readers, allowing all of us to enter into their world. I was quite nervous in my initial interviews with each nurse and wanted to put them at ease. However, it was often they who put me at ease, as within minutes of meeting each of them they willingly shared a moving story with me. My relationship with each nurse seemed to develop quickly, possibly because we are of the same nursing 'culture' but also I believe because the Portraiture methodology allows for the intimate sharing of real stories.

Interview Two

Following transcription of the audiotapes of the first interviews it was often found that further clarification of issues raised by nurses was required. The subsequent interviews gave the nurses the opportunity to comment upon or alter

their stories or to reflect on their position. The second interview allowed confirmation of the findings with the interview lasting no longer than an hour.

Transcripts and audiotapes

With permission, audiotapes were used to record details of setting, including descriptions of ambience and physical setting. With the nurses permission interviews were also recorded on audiotape. The audiotape recorder was used as discreetly as possible to encourage a conversational approach to be maintained with each participant; all of the nurses were happy to be recorded and spoke clearly into the device.

As soon as possible after each setting visit, observation or interview, audiotapes were listened to and transcribed verbatim. Most often I would record abridged notes at the time of events, simultaneously trying to record subtle nuances of body language, tone and feeling. After each visit to a setting I would return home to expand upon notes and write memos. Individual interviews took place in diverse settings: in gardens; at coffee shops; and within offices so background noise and interruptions can sometimes be heard **on** the recordings. Transcribing included any emotional responses such as laughter, sighing and signs of being upset as well as any protracted silences.

Verisimilitude and authenticity

Data collection and data analysis often occur simultaneously in qualitative research, and also after the direct research is completed (Goodwin & Goodwin, 1996; Hamersley & Atkinson, 1995). Data collection and analysis were concurrent with the merged transcripts, memos and field notes, generating a large amount of data which was gradually aggregated into portraits from which emerged discrete themes. Data are most credible (the qualitative equivalent to objective) when it reflects the voices of the nurses (Ungar, 2003, p. 94). Credibility was achieved in this research therefore as, according to Lawrence-Lightfoot and Davis (1997), "Paragraph by paragraph the reader is introduced to ... the emergent themes ... of the portrait" (p. 71), "giving a sense of the universal in the particular" (p. 80).

Lincoln and Guba (1981) offer trustworthiness criteria as most appropriate for qualitative research rather than the more usual internal and external validity, reliability and objectivity used in quantitative studies. They define trustworthiness as, "the quality of an investigation and its findings that make it noteworthy to audiences" (p.164). They also offer recommendations for achieving high internal validity and therefore producing more credible results by the undertaking of: prolonged engagement; persistent observations; triangulation; debriefing with peers; and rechecking with nurses concerning their story. An attempt was made to incorporate all of these suggestions into the present research.

Many researchers assert that in determining narrative portrayals' trustworthiness, the research must be well grounded and supportable (Denzin, 1997; Riessman, 1993) or as Polkinghorne (1988) describes, must have verisimilitude, or the appearance of truth. After the creation of the draft final portrait, each was given to the individual nurses to review thoroughly and to check for factual errors within the text. The Portraitist's hope was that on reading them, the nurses would find their portrait interpretive, yet authentic, giving voice to their experience, not by esoteric or opaque language, but rather by dialogue which is revealing the narrative of their real world. By returning the transcripts and portraits to the nurses to ask them to validate the data, trustworthiness is addressed. It also provided an opportunity for the Portraitist to demonstrate to the nurses that their anonymity will be maintained, and that they can actually influence the research process.

This clarification of authentic impressions with the nurses, the prolonged exposure to setting, and the credible interpretations of the interactions with the nurses assure methodological rigour and validity in qualitative research (Whittemore, Chase & Mandle, 2001). Conducting interviews and constructing the portraits to meet the requirement of theoretical saturation adds to the validation of the research. By using these processes it ensured that the themes identified were consistently appearing in the transcripts and were in fact reflected in the portraits, thus ensuring their meaningfulness and validity.

Conclusion

The documenting of this method was challenging, as I was learning about Portraiture and the research process as I was undertaking it. However, by documenting what I did and memoing my reflections, and by my immersion in the data, the journey through the method is complete.

This chapter has outlined the processes and procedures employed as the background to the ultimate construction of the portraits of the nurses. The following chapter presents the portraits of the nine participants, nurses working in contemporary healthcare settings in Western Australia.

CHAPTER FIVE - *The Portrait Gallery*

"Stories are told as spells for binding the world together"

(Rouse, 1978, p.1)

Introduction

This chapter presents the engaging stories of the nurses, individual portraits drawn from each nurse's understanding and multiple perspectives of their personal resilience as relayed in their own voice. The portraits are shaded by my interpretive insights guided by the principles of Portraiture methodology (see chapter 4) and related to pertinent contemporary literature. Therefore the portraits are in-depth personal narratives which emerge from the interview data collected and the researcher's informed presentation.

Detailed descriptions of the researcher's perceptions and the shared experience between researcher and participant are provided as a dialogue to portray the nature of the engagement that occurred; they are rendered with "literary flair in order to bring the subject ... alive for the reader" (Borg & Gall, 1989, p.872). Rapport was established between the researcher and each respondent prior to the interviews taking place. It was important that the nurses felt comfortable with me so that they could reflect easily upon their experiences (O'Donoghue & Punch, 2003). Just as a relationship of trust develops between the portrait artist and her subject sitting on the chaise lounge, I am confident that these stories paint the essence of my subjects as their words give me approval to mirror themselves in words and the events relayed in their stories.

The Sitters

The portrait subjects are:

Mary-Anne is someone who is always looking on the bright side. She points to a resident walking by with a bottle of antiseptic hand gel clutched to her bosom. *"She's a magpie she is. If she likes something- tomorrow she's got it! Watch out, she likes your jeans- don't leave them in the toilet! One day you know, she collected all the*

washing from the laundry which was mainly knickers and then she flung them all out of her window. They landed on a bush- it looked like a knicker tree! Unfortunately her room was diagonal to the Manager's office and it was truly not a good look just outside her window!'

Maggie is probably short for magical because as I sat down with her for my first interview**,** it was such a thrill to begin! It was the beginning of my research journey and a great dialogue ensued. Maggie was giving me insights into her life story, tales of her resilience and demonstrating her humour throughout; I instinctively knew that the write up of her portrait would be magical.

April, who when I asked if she had considered involvement in the research, nodded her head enthusiastically and reached immediately for the forms to fill in. Whilst contemplating the pseudonym of her choice she said**,** *"This is the hardest part - I need a fancy Hollywood name … mm what name should I have?"* I commented that this was her chance to choose the name that she had always wanted and fantasised about, or, perhaps what other names did her mother consider calling her? "Ah" she said, *"That's it! My mother always wanted to call me April."* So April she is!

Grace sees her work as giving her the opportunity to unearth the heart of herself and in the process extend her soul and her spiritual existence through her nursing and midwifery teaching philosophy.

Lucky is biding her time. Although she is committed to the here and now of nursing and midwifery**,** she has big plans for her future.

Ginger arrives and was happy to sign the consent forms prior to interview. She too could not decide on a name. I suggested the first thing that came into my mind: "You can call yourself anything- like Jezebel or whatever," I said. *"What!"* she said *"Do I look like a Jezebel?"* We both laughed. *"Well I won't call myself by my*

internet name, that's a boy's name, so that wouldn't be appropriate - I'll be Ginger" she said.

Vivien is a skilled professional taking stock of her nursing career and her life which are both experiencing huge change and upheaval.

Jean asks me*, "Do you remember all these songs?"* The radio is playing sixties jukebox music in the background. *"I was a rock n roller. We saved our money and went to the Rolling Stones concert - wowee!' Let's have a cup of coffee but keep dancing. It's Friday morning and its springtime"*.

Jade had just had another had 'god-awful' day with all the stress that goes with management and transfer of patients to and from acute care facilities. She apologised and said she just didn't think the interview was going to happen as scheduled - although she did offer two fifteen minute gaps to speak with me between medication administration and another meeting. We decided by mutual agreement that a full-on immersive interview session would be better and set up an appointment for the next day. I returned the next day and she announced *"You know I will be giving up my lunchbreak for you?"* I countered with a twinkle in my eye "Yes but I have chocolate!" A big smile covered her face as I said, "But I am not sure whether to give it to you before or after the interview?" She said I had better make it after!

And I am **The Portraitist** who presents my word paintings. These portraits are unlike a straight interview transcript, but rather they are different in length, tone and emphasis, being illustrated with personal insights. Pseudonyms are used for the participants and some other details are camouflaged to maintain the anonymity of my sitters, but each portrait includes direct excerpts from the participant's interview texts. These direct participant voices are used within the narrative analysis and interpretation to develop emergent themes (see Chapter 6).

The gallery layout

There are three 'exhibition halls' to view as they relate to three nursing work settings and each setting is given an introductory 'pencil sketch' to add to the mosaic of the participant stories. The first three stories are of nurses working in a residential aged care setting; the second group of three stories pertain to nurses working within academic settings; and the final three nurses interviewed worked in management roles within a tertiary hospital setting. Each participant's story is presented in a special script or font to add an individualistic nuance. Participants' demographics are: ages ranged from thirty-two years of age to fifty-seven years with an average age of 49; all were Registered Nurses (RNs); all had, on average, twenty-eight years of nursing experience; and each worked full time.

The Canvas: the residential aged care setting

The first three portraits involve the three participants who work in a residential aged care facility.

The facility where Mary-Anne, Maggie and April work specialises in providing residential, rehabilitation, community care and services for people with disabilities, and older people with high support requirements in a variety of modern environments and in their own homes. This particular venue provides residential care and interim care to older people with high support needs within a metropolitan suburban setting close to Perth. Interim Care is specifically for clients who are awaiting transfer to permanent high care or low care accommodation. The facility consists of five cluster houses which have bedrooms with ensuites, plus formal lounge/dining rooms, and informal activity areas. My first impression of the facility as I drove toward it was of its delightful aspect. Each house was surrounded by eucalypt trees and gardens festooned with various native and introduced flowers.

Upon entering the facility, through a security door (due to the number of dementia residents within), I was welcomed by the manager and greeted by the carers walking through the corridors. That each resident is known by name by every staff member became obvious. There was constant background chatter and sounds

of life. The decorating in the first cluster house is based upon a palette of pale green with darker green tones on the skirting boards. The dining room has display cabinets with the photos of residents on them, and decorated with miniature flowers and figurines. There are calendars on the wall and the bulletin board contained notes describing the 'mouth-watering menus' to be expected from the kitchen during the current week.

Laughter echoes down the corridor in the distance as a carer approaches spontaneously telling me that, *'Once I locked this woman outside; she liked to sweep the paths you know. It got dark in fact pitch black and it was time for dinner and bed. I looked under her bed and then I realised she was still outside - luckily it was a summer's night!'*

Another carer walks the residents to the tea room for a cup of tea. As she guides them by the elbow to their seats, the resident says, *'What do you think you're doing?' "Loving you!"* was the reply from the carer. What a first impression! I ventured forth to meet Mary-Anne, Maggie and April.

MARY-ANNE
"The good that comes out of struggles"

I first met Mary-Anne at the first introductory explanation of my study intentions at the residential aged care facility in which she works. There was a general announcement with an introduction by management that a research student was about to be spending time in the facility, and not to be frightened of me, or question my need to be there. Mary-Anne stood out from the crowd within the staffroom because she is a young, blonde statuesque woman with model-like good looks and a bubbly personality. She laughed spontaneously at the idea of being involved in research and she reached out and took the consent forms that I had in my hand to take home to review. I thought, wow! She is really interested in helping me, and this was such a buzz as this was my first visit to the staff at the facility and the very beginning of my research journey. To have what seemed to be a positive response so quickly was wonderful. I received Mary-Anne's consent forms by mail a little while later.

Mary-Anne and I arranged to meet shortly after my first visit but on a number of occasions the meetings had to be cancelled. One appointment was scheduled for 1-2pm but she recognised there to be no way that she could carve out an hour of uninterrupted time within her workplace setting, wherein the phone will not ring, the pager will not interfere, residents will not stop by to chat or thrust their head through the door, and colleagues would not request advice. She rightly believed an interview would not shield her from all the intrusions of her everyday duties. We quickly agreed that we would need to set up an appointment away from work, perhaps a coffee together with tape recorder and notepad in situ.

Mary-Anne and I established a great rapport from the start. There was just something about her and intuitively I knew we would get on and the rapport achieved meant she would talk freely about the issues of my interest and truthfully answer my research questions.

We set up a date to begin and she appeared eager for this encounter. At our arranged meeting I arrived with notebook and pen in hand as does Mary-Anne - which surprised me. Who was the researcher? Was she in fact going to interview me? She said hello, expressed thanks and sank into the seat I offered. I looked closely at her and thought perhaps she seemed like she needed a break? But I could tell she was looking forward to the novelty of being a research participant as she appeared full of anticipation and as interested in my study as I was!

Mary-Anne had her notebook with her because she had done her 'homework' for our session and she was ready to talk about my topic and how it relates to her. We met at one of the University coffee shops at her request. I asked her why she chose that particular spot and she replied saying she liked the ambiance it creates, having been there many times before. It is indeed a beautiful place- a coffee shop situated amongst gum trees, abundant with cawing magpies and crows, and squawking native Australian parrots and other birds. It is also in very close proximity to a child care centre where she and I watch children play in a safe outdoor area and hear their laughter tinkle in the background as we talk.

As soon as we are both settled into our seats we begin. We smile at each other and chat about the weather - the banter of strangers that helps to lower the potential for any stress. I ask about nursing and her work as a nurse. The clarity and simplicity of her responses are easy to listen to and engage with as she says:

I loved human biology when I was in high school and I also wanted to do something in a caring profession. I was looking at teaching as well, but I suppose the... er... that scientific side really was something you can get in nursing as well as the caring role - the two together. My mum and my grandmum were also nurses, it runs in the family, yes, and in fact my great grandmother as well, she was one of the first ... She trained at the Johannesburg hospital as well, where I trained at. It was the late 1800's I think that's right wearing those terrible uniforms.

Her voice is rhapsodic but soft and reflective and I ask if gerontic nursing is a love or a passion?

Both. I have, I have always felt for aged people. They have come to the end of their life or coming to the end of their life and they've got ... It's almost like a castle; you just get glimpses of what its former glory used to be. You've got to try and understand their life and where they are at and then to make those last few days pleasurable. It's a real privilege. Because with acute care you are trying to plug holes in the dyke, you know you are often only doing stop-gap measures, like give antibiotics to cure the infection but in aged care you are actually trying to make those last bits of life happy and enjoyable and get the most out of life. I started working ... (here) ... 4 years ago and I left a very stressful aged care setting where I was responsible for 40 high care residents plus 35 low care and it was becoming ... the low care was becoming more and more demanding , so that it felt like that I was basically in charge of 75 people. This current nursing home is quite a lot closer to where I live as well, and so it suits my family situation better.

Why so I wondered? Was there anything specific about her family situation that she needed to mention this so early in our conversation? This was where Mary-Anne's own unique history and experiences came to light as she revealed her story: she has a husband who is wheelchair bound with Multiple Sclerosis (MS) at home. With understatement she says:

I am his carer and yes, at times I find it I would just like to book him into respite for a week or two but he is very resistant to because he feels very much part of our little family and I suppose his need for family and friendship, because as I am really one of his only friends, is quite high and it is really quite difficult to deal with at times. He has been diagnosed for ten years and we have a ten year old daughter. His diagnosis came with her at the same time.

I make a comment that she must find it all very hard work, in short, nursing/caring somewhat day and night? Her voice is restrained and her eyes look off into the distance as she says:

I suppose I don't stop to think about it much. You kind of um ... there's a lot of good that comes out of struggles as well. Actually you don't always

appreciate it at the time but when I look at what other people, they didn't get an overseas holiday this year, well that's nothing to worry about really...you actually find that you can cope, I just don't know, you just develop the strength, you have to I suppose ... its survival isn't it? I've got my mum and dad nearby and I've just got my stepsister come over, a year now she's been here. I find my, actually my step mum a very good friend to discuss things and bounce things off because there's the confidentiality there, so I can whinge about my husband and not feel guilty because she loves him too.   She's really good like that and my dad as well, in fact they really feel frustrated with my husband with him not wanting to go into respite care. It's something we have to work at.

I ask if respite care is where the journey is leading and her response is:

Actually we as a family went in as a family for three days just to see what it was like about six years ago. It was a difficult experience for him because there were people there that were a lot worse than he is, and I think that's part of the problem for him, firstly to be separated from my daughter and myself, and to be with people that just give him a fear of what the future holds."

It appears to me that her calm manner and response masks a great deal of anxiety and stress.

I ask her how she manages her home life being with a husband with MS in a wheelchair and dealing with work and caring all day, every day. She reflects on the connotations of my question and responds:

It's funny when you are in a situation you kind of lose sight of your own personal needs. You lose sight of your own needs because you feel so compelled as a nurse to meet other people's needs. Perhaps it's because of my upbringing, I've been the eldest in a big family, well 5 children and then there were 2 more step-brothers and sisters that came. My dad has had three marriages so it's all got quite complicated.

She laughs in all probability at my inadvertent facial expression.

Yes (she chuckles)   *I've got ex-steps and steps and a half brother and I suppose it's kind of in my nature to keep going ... to take responsibility.*

Back at the facility in which she works I am struck by her calm persona and as I watch her in the staff room chatting to colleagues. I sense not only her alert intellect when she answers questions from carers even within her 15 minutes stolen for a lunch break between care tasks. I notice too her acceptance and her warmth when she speaks to her colleagues, and I imagine the residents must feel calm and safe in her presence as well, because she treats them with the same courtesy. Even though she tells of the intense emotional process that her caring work entails she agrees that her focus is on the bright side, commenting on her colleagues thus:

It's great when you work with team members who have great wacky sense of humour and who can really who set the ball rolling and suddenly you're all feeling a so much better.

Mary-Anne needs no prompting and shares some of the fun she facilitates everyday within her work environment:

The gentleman who I said deteriorated recently with the PSP (Progressive Supranuclear Palsy); he has had skin cancer lesions on his head, which he had a skin graft done from his leg to his head about 4-5 months ago. They didn't heal very well and he has had ongoing problems with infection and we had to bandage his head up ... without using tape on his skin because the tape was pulling his skin off. I said "Yes you look like Lawrence of Arabia with that bandage on your head" and he said "Bring me my camel" very slowly, but eventually he got the words out. And he has very long eyelashes and I always tease him that cows would be jealous ... I remember on Friday we were talking about the lady who has had the stroke ... she was very cheeky and there's a lot of banter that goes on with her as well. She has little skin tears often because she's impulsive and I say "Right I've come to do your dressing, show me your leg!" And she loves that, she sticks her leg out and says "It's like doing the can−can!" We have some jokes but she is very difficult. Especially to the agency staff, young or new staff and young carers, because she often tells me she

doesn't trust the young ones and I say "Oh what does that make me?" She calls me bossy-boots I think just to rub me up but she gives us a good laugh.

She continues:

I think humour in or when you're working with dementia residents is very useful as it often transcends words. We have got a lady who sits at the dining room table with a very loud voice, who is deaf herself and she says "Oh look, here comes that big man" meaning me, especially when I am wearing trousers, so I do gestures to show big breasts etc. I am six foot, so I sort I wriggle my hips around. That gets her laughing! She still calls me dad or mum because she loves calling the carers, the people who give her the care, dad or mum. I don't how that works? The problem, the downside of humour with her is that she has a very loud voice and when you get her laughing she continues this false laugh on and on and drives everyone else mad. It goes for at least ten minutes! It's funny to begin with but she keeps going "A ha, ha, ha" "A ha ha ha" but we have a man who is noise sensitive so you have got to be careful not to overexcite her I think.

I think in dementia there's a lot of subtle things that people are picking up on, often words don't mean much, but your eye contact, your gestures, the smile on your face, speaks volumes for them.

I arranged to meet again with Mary-Anne for another interview in case we needed to review my interview notes. By this next visit her demeanour had changed radically. Previously she glowed with happiness when she spoke of work but now her face is downcast with a frown on her forehead as she begins to speak:

I've been thinking of (moving on) perhaps for a few reasons - that they've decided to move all the registered nurses out of residential care except for myself, so I would become like the monarch who signs, the figurehead, who signs off on everything. I was feeling quite exposed I suppose that ... though we often don't see each other very much (the other registered nurses), we often collaborate on problems, ... in putting things to the Drs, just different ideas that might help a resident and I just felt a very huge sense of responsibility,

like a burden of responsibility to be able to think of every option and trying to be everything to everyone.

Mary-Anne explained a little more about the past and present organisation and how it affected her enjoyment of work:

There was a registered nurse on every alternate weekend day shift and the beauty of that was that she got time to, in a day shift, to catch up on paperwork, to do all the weights and referrals to the dietician and speak the speech pathologist. So that's now fallen on my shoulders too ... We also had a clinical nurse who spent three days a week in achieving ... mostly in residential, but she also did go into interim care ..., so my clinical nurse has left to do a different position and then we have been told, I think because for financial constraints, we have been told that there is to be only one registered nurse on site. In other words for sixty-six clients and some of them, twenty-two are under my section and forty-four of them are there on a temporary basis. Except for myself now, we have got 2 enrolled nurses, one does night shift so that she is very limited in what input that she can put into problems and the other enrolled nurse has been there a long, long time and is very good but I have found some sort of personality issues with her because she feels she is equivalent to a registered nurse but being paid an enrolled nurse salary, so that makes the whole situation uncomfortable at times as well.

Stress has really gone up for me ... and this enrolled nurse who has carried a lot of the burden has been on leave for five weeks as well so it's basically fallen on my shoulders and she is going away again soon for another two weeks leave and I have been asking them and asking them if we could get a clinical nurse replacement. The manager thought initially that it might be ok, but then she said no it is not in the budget! Then just this week she said she hopefully can get someone to come in for two shifts per week hopefully to look at the paper work with me. The major problem is that all the care plans need to be signed off by a registered nurse and I need to be looking at all the assessments that are being done and relating the care plan. It's making the enrolled nurse feeling undervalued because she can't sign off on it, because it

has to come to me and she feels what's the point of me being here as I can't do anything without you and it makes the whole situation difficult at times.

About a month ago ... a situation came about where I felt a conflict of interest arose, meaning that in aged care you are dealing a lot with AGfee which is a funding process that the government provides for aged care which means there is a pressure for nursing staff to assess the need for high dependency levels to get or maximise their funding. And I certainly do not feel that my duty as a nurse is to be a fundraiser ... so that's made me very disillusioned at the moment with aged care.

With that issue I wrote a letter to the care manager stating my discontent with the way the situation had been handled and she called me in and tried to justify changing, and increases in scorings and I still protested. I can maybe accept a couple of areas but to double my scoring I just found excessive and uncomfortable ... ethically uncomfortable ... and somebody under me basically was asked to re-do an assessment! It puts me in an awkward position because do I now not get involved with doing assessments directly and then sign off on things that I might not fully agree with, because I wasn't the one doing the assessment? Except that I will also be participating or expected to participate when the AGfee audits occur, in other words when the Commonwealth visits, then how do I sit there and answer for assessments that I can't be convinced are accurate?

I question Mary-Anne as to whether she is considering moving out of aged care nursing or moving sideways and staying within the organisation?

Well the organisation I work for has services for young people, and they are completely exempt of AGfee. They run a completely different funding situation to us ... and it is about the same distance that I travel. But I know the families very well here and I have concerns ... I am not sure that the families are aware that the registered nurses have been moved out ...is that my duty to tell them? I don't believe so? No! And I must admit ... of late, and I'm talking about in the last year, there is almost feeling that registered nurses have to defend or what's the word? Answer for what we can offer that is different to

enrolled nurses ... to justify being there. All we are there for is to carry the DD key and to sign off, that's how you begin to feel, sign off on everything because the government says so.

You feel threatened as to what you role is really, because surely this can be delegated and that can be delegated. We certainly do have a couple of families that are very aware of who the registered nurse is and I find that a lot of complaints and issues are directed to myself because of that ... they are storing up the complaints for me to come on duty, so I do less paperwork some days because I am dealing with difficult families who have got complaints that they feel only I would understand. I have been involved a lot within the last three months with the social worker; we are accessing her services a lot more.

We have a situation where a resident's husband has decided to divorce her, for financial reasons, and she has dementia. It has thrown up quite an interesting legal situation. A lot of young people especially today think that marriage is just this piece of paper but when it comes to healthcare, there is decision-making for end of life, and we have this situation where he has divorced her, where does he stand? We are having a meeting next week with next of kin, all three children, to work out if they are happy with the husband making the decisions?

We've also got a family who have found to be involved in financial abuse of their loved one, and so that's brought up a situation of guardianship as well and the involvement of the public trustee. They are always making complaints about things, whether it's a guilt situation, I don't know, but we've had a lot going on in the last six months. We have had three deaths in the last six months. Remember the lady who dropped her dinner on the floor, and placed it in her lap? We just had her funeral. It was one of the saddest funerals I have ever been to because she had no next of kin whatsoever; it was only those of us who cared for her at the funeral ... I went on my day off.

We also had the situation where a client with dementia is proving very resistant to personal hygiene and has bathed all her life and we only have

showers. So undressing is probably the worst part. She does not look forward to it or does not want water sprayed onto her. She gains a lot of comfort from her clothing. She wears six pairs of underpants and keeps putting more and more clothing on all the time, and you could imagine taking all that off for a shower or a wash is distressing. We tried aromatherapy and music therapy and it worked for a short time but we are now back to square one. She and I have quite a good rapport but for some reason she only is comfortable with trained nurses doing her personal hygiene. I have a feeling this is because the carers are constantly taking away from her the things she collects throughout the day, taking away from her, whereas we are applying the aromatherapy. I have tried to get the carers to do that but it doesn't always work out. We have a lot more contact with her, and with the music. She associates me with music because with the medication time, she always starts wiggling her hips from side to side with a big smile on her face". Mary-Anne laughs here. *"She loves music from the fifty's you see, so I do have the advantage to try to get her to have the shower I put the music on loudly."* I question if this is the lady they all call the Magpie? *" Yes, yes, that's right, she is now incontinent, developing incontinence, and she also applies alcohol gel or shampoo to her face, really making it red and sore, so we are constantly trying to check what she got in her bag, and lock everything else away, so it makes everything difficult for the carers and they are getting stressed.*

We sit in companionable silence for a moment and ponder the Magpie instance. I mention that I feel that the laughter I noted upon opening the facility front door has diminished, asking whether she agrees, and does she still find laughter at work?

 Not so much I must admit (she says), *You have picked up on my tension, especially with the AGfee issues and the paper work has mounted up and I still don't feel convinced that it is all going to work out yet. I've just got to wait and see. So yes it's been, laughs have been few and stress has been ... Perhaps it's the winter?* (She laughs). *I am not the best of people in winter ... and I've had the flu for ten days.*

As I listen I am struck by or suspect that there are still some other underlying issues that have also affected her demeanour. She continued:

Yes … we have a family holiday/reunion actually that we have been trying to organise for April next year, and with people coming from all over the world. I've got a big family, and it is my parents, my stepmoms and my dad's 25th wedding anniversary. We were hoping to meet in Mauritius but we've run into a few hitches there and so there has been talking of it being cancelled altogether. Then my mum got my husband involved in organising it and then he got all interested and excited about it but then it looks as though it's definitely not going to happen in April. It might happen in September, but there is this unknowing. He is getting a bit stressed about it because trying to get nine people together. I am stressed about it because my family are changing their minds and changing the plans on a weekly basis. (Here Mary-Anne giggles like a child and continues) *And my friend who is in the travel business and who has kindly been trying to organise it for us has put a lot of time in … it has been a bit of a tough time!* (And she giggles again).*

And then there is also, I don't know if I mentioned that we are trying to get an assistance dog, for him, (her husband) *a service dog. The whole reason we started this was because my daughter is desperate to have a pet dog and so we looked at the whole feasibility. My husband has always believed that all animals should be outdoors and the only reason that he would accept one is that it is a service dog, I mean he got very excited … But in the meantime we found out that people who provide assistance dogs are not happy for us to have a pet dog for her as well, because she is not allowed to pet this dog, and we are not allowed two together, so it has actually made the situation worse. And yesterday she was crying because "I really want my own pet mum, I'm an only child". She's got a cat but the cat loves her dad and me more!*

Mary-Anne laughs at the injustice and sense of outrage that her daughter shows at this occurrence - but it is a strained sort of laughter.

We looked at a bird, and she was all keen on a bird until yesterday until she said, no I really want a dog. Trying to get her to understand that her dad has special needs, by picking up the mobile phone or if he falls on the floor it

(the dog) *can open doors and it can bark to alert people that he's in need and also it would be really good for him to get out of the home and meeting people because he is very isolated. It's the only child syndrome, she has always loved soft toy. Her bed is still covered at eleven years of age with soft toys.* (She laughs again at the thought).

It seems that the burdens involved with each role magnify due to her personal circumstances and that her caring never stops. She copes with the demands of the multiple roles of wife, mother and nurse, and each is a large and complex care-giving role. How does she cope I ask?

Oh I don't know really … I had a lovely tea/coffee with my mum last week and we had a good chat last week about the family holiday … My husband's first question was - did you speak about me? We wouldn't speak about you! I said, but yes I did speak about him. You need a bit of you know…well my daughter, she's thinking she should talk to my husband but I don't think that's going to work. He is not the most sensitive of people, very blunt about things, and he was just saying last night that he can't wait for the dog to come, so I can't see him giving up the service dog for her and she doesn't want to give up her idea of a dog for him. So …

Mary-Anne explains further about her coping mechanisms and still laughs with me about it all. She elaborates:

Yes … Having haircuts, getting together to have a coffee with people helps… What I would really like to do is go out walking more because I do love space and nature, plants and gardening. I have a lot to do in the garden this weekend. It gives me time … When you work all day with people you often don't want to be with people at the end of the day and you know, pulling out weeds and killing snails is very cathartic!

She laughs heartily at this and the image of squashed snails and battered snails flying over the neighbour's fence is vivid in my mind.

No matter how long our conversations are, I always feel that I want to know more about Mary-Anne. I can imagine and hear the stories of laughter and

can practically palpate and identify her resilience; but her eyes do fill with tears and I can see the pain she bears. I hope that she is still finding some joy at work and she comments:

I would say there are moments during the day and afterwards I suppose at the end of the day that you do feel that you've accomplished something, but often I don't feel that I've accomplished much. You do feel that you've made a difference I suppose, especially when you've been away on leave or off for a few days and then staff and residents say "Oh it's good to see you back." It's a feeling of appreciation of being part of a team and making a difference in someone's day I suppose ... I just love and have a good laugh.

MAGGIE

"It is my passion"

Maggie is young. She is only thirty three years old. She wears a uniform top of dark blue polyester and cotton which has a small abstract pattern throughout, teamed with black trousers and a long black cardigan that reaches to her knees. Her natural brown hair is tied in a small, tight, ponytail.

Maggie does not fit the 'usual' stereotype of a nurse who works in gerontology. She will tell you that herself. She will also tell you that she dislikes the simplistic caricatures that are drawn, usually by other nurses, and that are also often reflected in the media and within the public eye of nurses that work in aged care settings. She seems to anticipate my surprise at seeing such a young nurse who is obviously enjoying and relishing working within a residential aged care environment.

During my introductory visit to the residential care facility that was to become my first setting, every single nurse that I explained the outline of my study to, supported the intent of my research work and all were happy to commit. I left information

sheets and consent forms with the Manager for each of them to think about, and to ponder the extent of their involvement. From my own memo of that visit, I noted that: 'One nurse - One, (the CNM), was going on leave the next week, so she decided to sign up there and then. So it looks good!'

That CNM was Maggie who signed up immediately to be a part of the study. She was enthusiastic from the very beginning. She now looks out at the gardens surrounding the wooden rotunda where we sit. It is a relatively mild September afternoon yet quite breezy with a chilly wind so I offer to go inside to her office, her space, but she shrugs her shoulders and requests to stay outside. I guess that the fresh air is bracing and allows her to clear her thoughts as she tackles another entry in her diary for the day. That is: 'Meet with Vicki'.

I am audio-taping our meeting in the middle of a twenty-two degree Celsius spring afternoon in suburbia. There is no noise, just the quiet peacefulness of the residential aged care setting. We are seated under a gazebo situated between residential aged care cluster houses. Paved stone paths wind between the cluster homes and weave in between the small garden plots and manicured lawn. Tall jacaranda

trees surround the gazebo as well as a large lemon tree with more than a dozen fruit on the bough. Varieties of roses edge the pavement that leads to a number of Hills Hoists, that iconic Australian symbol of wash day. I can see various clothes; knickers, bibs, towels, and blue striped pyjama bottoms. Red bottlebrush and grevillea in flower point toward the large Australian flag blowing in the breeze high on the flagpole that takes pride of place in the centre of the yard.

Green painted wooden benches and plastic outdoor settings abound. I can see over twenty chairs as I turn and look around in a 360 degree circle. The yard contains pink hawthorn hedge in bloom, purple stocks, and under the windows of many residents' rooms grows herbaceous rosemary giving off a gentle scent on the breeze. Bearded yellow and blue iris, flowerpots with strawberry plants overflowing, and hanging baskets with zygote cacti hang from pergola which attract honeyeaters that swoop for pollen among the native plants. Gum trees, acacias, wattles and firs line the walls of the cream brick and red-tiled cluster homes. Air conditioning units and security screens are apparent as they probably give peace of mind to relatives concerning the comfort and security of their loved ones who live within the protection of the homes. Mops, buckets and pegs on the washing lines tell of the work that goes on inside the

homes. Television aerials on the roofs allow persons to remain in contact with current affairs whilst abiding in the secluded privacy of this very quiet place. Path lights guide the way for nurses and carers to move with ease at night and provide soft light to silhouette the foliage against the walls of the facility.

This is my time with my storyteller and I want to get to know Maggie so I look purposefully into her eyes. What I discover is that they are red with weariness and I cannot help but comment on her tired eyes. She replies that it is because of a lack of sleep due to her babies not sleeping last night. She muses that they could be getting a cold? Maggie has two children, a daughter who is three and a little boy who is one. The children are in day care twice a week and Maggie's mother and mother-in-law help out with their day care whilst she is at work.

I ask if she is okay. The multiple demands of wife, mother, nursing and as I also discover running a small business with her husband must be exhausting? She gesticulates with a flick of her hand and says that I am not to worry as she looks after herself. She is doing a dancing class (hip hop) once a week, plus yoga once a week and her sister is the teacher. She has also started a book club and

meets with that group once a month. She works at this facility due to its close proximity to home as she lives in the same suburb and work is quite literally around the corner. Maggie explains further:

I wanted to work in aged care and this facility was close to home. We had just got back from England so I thought it would be good. My husband and I bought a house and also his parent's business within the suburb. He is giving that a try, although he is a trained nurse as well. I met him whilst we were training. The staff is nice here and the set-up is lovely with the cluster homes - a very home-like feel which is nice.

Although so evidently young, on first impression Maggie seems like a profoundly professional and committed nurse. It is difficult to describe why I think this way but her demeanour is just so. She presents herself so well: professionally groomed, crisp ironed uniform, hair tied back and with an affect apparent that she is ready for work. Maggie shares her office space with another member of staff and the delineation of the two areas is easy to note, as again everything on Maggies side of the room is just so! It is extremely tidy, neat, and everything in its place. I take in the layout of the facility just outside Maggie's office. The minutiae reveal the care and attention to detail that management have engineered to make the

facility a home. High ceilings with cornice work and ceiling roses, the sofas and chairs, the hall desks, the shelves of books and bookcases, the photographs and paintings on the wall, all of these add to the finer point of turning a 'care facility' into a 'home'. As do the radio playing in the background and the smell of coffee coming from the kitchen. The weekly newsletters for the facility pinned to the communal noticeboard note in bold the Editor's message for the month which announces: "We are all thoroughly 'sick of the rain although we need it'!" The bulletin board also has notes concerning research into 'Men and Caring', the Aged Care Standards, and the Accreditation Agency notice pinned there in a position of prominence.

The curtains in this area are peach with large floral paintings with heavy gilt frames adorning the corridors. Pastel prints of flowers and ladies in soft floppy hats, plus a mirror here and there, decorate the walls. Maggie's office is in the central corridor close by the Facility Manager's office. It is simple, not ostentatious, and looks like the office of someone who is organised and focused. There is a window looking out onto the garden and the desk holds a computer personalised only by a single family photograph.

It is evident that Maggie is tired but quite willing to talk and once we begin, she speaks quite quickly. It is as if she needs to get this job completed before she moves onto her next commitment. We begin to converse and she tells the story of her distinctive nursing encounters dotted with her own small vignettes so as to let me know of the variety of her experiences and the incidents in her career as a nurse thus far which have affected her profoundly, not only professionally but personally.

Maggie begins:

 My grandma always wanted me to be a nurse; but I don't know why I really chose to do nursing to be honest. When I started care work as a student I really enjoyed it, and I knew it was what I wanted to be. I've always been sincerely interested in the welfare of people and I've always felt a particular connection to older people. I ended up loving gerontology.

But there is something pressing that Maggie wants to talk to me about. She practically blurts out the story she wants to tell *at* me, rather than *to* me. She quickly becomes focused and animated. Her talk is rapid-fire and she begins by telling of a memorable experience, the story of an event that transformed and fashioned her working life. As she remembers, she leaps back and forwards across

the years, across her memories. She admits that there was one incident that occurred early in her nursing career that was nearly her undoing. She leans forward and looks intensely into my eyes and says:

You see, I've had a major crisis when I worked for another residential care facility. There was a major restructure and I got promoted to the manager of the facility and I was very young.

She must have been as she seems so young now for a management role. Already it is obvious to me that this meant that Maggie was thrust into a leadership role, a role that she was obviously not fully aware of its ramifications and not fully prepared for at an extremely young age for leadership responsibilities. Maggie continues:

I was probably just a couple of years out of uni and I messed up and lost my employer a lot of funding. I didn't really have the skills to do the job. And it was an awful, an absolutely awful time! That was just two years before I went to England but in some ways it was the best thing that could have happened because I was managing and I was working all these hours and my focus was all on work and I was so young. I resigned because they were going to demote me and I decided to resign and left. It was a horrible

experience and I felt so humiliated that I'd really screwed up and then I left to do a short term job and then I went off to England travelling and that was the best thing I've ever done.

Confusion mixed with sadness sweeps across her face as she relives the experience. It fascinates me that Maggie needs to tell me of this experience so early in our relationship. It is as if the experience has weighed heavily on her mind and she needed to tell someone or more specifically me of it immediately. Is it the Australian way, to 'lay your cards on the table' or is it Maggie's way to get things 'out in the open' and to be so 'up-front'?

Maggie seizes the opportunity to relive and talk through the experience in her own way. I realise that she needs to do this and that she wants to be able to trust me. She needs to be reassured that I am trustworthy so I nod with tacit encouragement to her to go on, giving her permission to tell me her story in her words. She leans back in her chair, her voice softer and sadder yet her words are intense. Within the quiet retelling she remains enraged and teeming with what appears to be unresolved anger at her perceptions of the injustice of the event. She relates the experience rapidly and her

voice becomes serious when she recalls that difficult time. She shakes her head and says:

I didn't know what to do.

I listen to the surprising ire in her voice, a voice that is usually regulated and in control.

You want to know how I felt. I mean it was a pretty horrible time. At first I don't think I handled it particularly well, but I was young. I was only, I can't even remember how old I was then, early twenties, and I was supposed to stay on and hand over to the next manager that was taking it on, but I think I was just too humiliated and ashamed that I just basically resigned and left, so that wasn't very professional really, the way I handled it. But I just couldn't face going in really, and then for quite some time I was really upset about it, very anxious, and people used to contact me from there and I just didn't want to know.

I had a couple of weeks off from work, more than a couple of weeks, and I just focused on myself and doing stuff with my family and my friends and socialising and living life a bit and then I looked at applying for a another job again. But I didn't go for a management position. I went for a clinical nurse position, and that

was quite frightening to go for another interview, but I was really up-front at the interview. I told them exactly what had happened and they were quite happy to take me on. I worked there for two years before I went off travelling so they were really very supportive of me.

The relief in the initial revealing of her story is written all over Maggie's face. She has told me, and as she relives these moments, she releases a pent-up force of emotions. It is obvious she needed to vent these innermost feelings. The image of Maggie losing her employer "a lot of funding" disturbs me. Involuntarily I have probably shown my dismay at these words on my face and I am aware that my eyes have probably widened in shock. More than likely I am leaning forward in my seat trying to get psychologically closer to her manifested by actually getting physically closer to try to fathom the immensity of her words. I understand immediately that her statements would have had ramifications for her on so many levels. Questions and ruminations ring out in my mind because of her words which surely became interwoven throughout her memories of what was clearly a very early traumatic career experience. Her difficult past has obviously had a deep and prolonged effect on her nursing work ever since. She continues:

I know I could of, I really could have, walked away and not really gone back to it (nursing) because it was quite horrible. I realised I was so young but now I look back and I realise that it was just the best thing because I went off travelling and had the best three years of my life. And you realise as well that you've got to look after yourself because people are so quick to discard you. But the knowledge that I 'd got them through accreditation, that first cycle of accreditation, and that I hadn't had the training, and I was understaffed, and when I left they put on more staff, carried me through.

I did withdraw initially but just having time out and then going out with friends, spending time with family and just doing stuff, doing stuff that I wanted to do. But that was probably one of the lowest points I've ever been in my life, and after it happened, I just felt so humiliated, and I didn't know what to do with myself.

But she had the support of friends. She acknowledges:

I mean just spending time with them, and because I suppose all I was thinking about was work, and what had happened, and I couldn't get my mind off it and I was feeling anxious all the time and thinking about it all the time, so I needed the distraction. I

mean one of the first incidents I remember after it happened was I was in my room. It must have been literally only the day or so afterwards, and it was again all very traumatic because we were going to have a good-bye party on the site, and they, the Management got back and said they weren't allowed to have a party for me on site at the facility, and so that really upset me.

I remember being upstairs in my house and crying and stuff and two of our nursing friends came over and we just had a laugh and we mucked around and stuff. I had a laugh and that was the best thing because I realised that life can go on and there's much more to life than just work. So ...Yeah, friends are definitely very important. I felt so anxious, and I've never felt like that before, apart from when that happened to me. I felt so anxious about everything and I was in a very bad place.

Being with friends helped? I ask. She replies:

Yeah it did, it made a world of difference because it took my mind off it completely and like I said last time, the good thing as well is that I realised that there is more to life than work.

When I told my parents, I remember I went up and told them I had resigned. It's not a very nice thing to have to tell people that something like that's happened and they were really supportive of me and everything.

And even my old boss, because that's how it all came about. There was a major restructure and he was made redundant and I was promoted up two positions, and he was very supportive after I left. He rang me quite a few times and said to me 'that you know, you weren't given enough training and support, just given the role, and set up to fail really'.

All this money as well, and you have a big pay increase and stuff, you know … and I just didn't have the skills to do it, I really didn't know exactly what I was supposed to be doing really. That was the thing really. I felt that that was the biggest thing for me really, because with work, I am a bit of a perfectionist, and I like to do everything really well, but I just didn't know what I needed to do. That was the problem.

It was with great anticipation and some relief that Maggie left for England soon after the incident. She believes it saved her, as it

felt good for her to be away and in a place where the humiliation was not on her mind constantly. The succour of travel and to be 'incognito' was soothing to her soul perhaps.

Questions hang in the silence: was there loss of self-esteem, self-doubt and loss of confidence? Maggie continues reflectively:

I often think about this myself. I didn't experience doubt or loss of confidence with my nursing skills as such, but certainly as a person I did. I suppose it was because I was in a managerial position not really a nursing one. After taking some time off I decided to return to nursing rather than the managerial work as that was all I knew. When I first went to England I didn't work. I worked as a nanny for quite some time before I went back to nursing.

But then she went back to her profession. Her dialogue continues:

I went back and I was very lucky the job that I had in England was just wonderful - my passion.

Maggie worked at the Queen Alexander Hospital Home in Worthing in the south of England near Brighton. She reminisces:

There are a lot of old people down there so we picked well when we moved down there. I think there was something like five or six nursing homes just on our street. It was just a great experience really. The men there were amazing, absolutely amazing. They were all ex-servicemen but they all had so much spirit. Some of them were World War One veterans World War Two veterans, no legs and no arms you know but they were amazing guys. I loved working there - absolutely loved it and they had such life in them considering what some of them had gone through.

I am eager to know more about her current work and Maggie explains that a large part of her current role is dealing with complaints and that there always seems to be more complaints than compliments. She describes the daily grind of this part of her role and the tone of her voice changes as she narrates:

Complaints are daily events ... But I suppose it is not a personal thing, whereas I suppose, the incident that happened (described previously) was all about me and my performance. I suppose the complaints are about the site here and the care given normally. I do still find it difficult because obviously you are defensive about what you do here and you think everyone here does a great job but it's a little bit different so it's a little bit easier to handle.

We've got a really good team here, very, very good, and everyone does back each other up very well so that's all good. I think it just gets you down a little bit when families are complaining all the time and you just feel like you are doing a good job, and you're working really hard, and people still complain, but I suppose they have the right to do that, you know sometimes its valid, and sometimes it's not.

With this site, particularly with the interim care, we have a lot of family conflicts and problems because families are dealing with grief and all that. It gets you down, after you've had a family conflict or you've been abused on the phone, I can tell you. Sometimes they are quite valid complaints but other times it is just families not dealing with the situation, and you know, what can I say, they are blowing it all out of proportion sometimes, but then it's their parents or whatever, and it's hard.

Maggie speaks of the other issues she encounters which often concern the need for adequate staffing to care for the frail elderly. She elaborates:

Especially as we are very short of trained staff, very short. For example my old position is still not replaced, so I'm doing, not as much now, but I am still doing a bit of both roles, and we've still not replaced. We don't have enough enrolled nurses either. I mean I think since I got back in February we have had something like between eight and ten trained staff, as in EN's and RN's, resign here. Some were a good thing to be honest that they left, others wanted to move to different sites, some people went back to working in the acute sector. I mean a lot of it has to do with pay. Aged care doesn't get very good pay, especially for the ENs here.

This ongoing argument of nursing pay within the aged care sector raises it head once again (Nursing Review, February 2009). Nurses working in aged care in Australia face a flattened career structure and pay that fails to recognise years of service. She speaks further of the subtle influence of this in her workplace:

Well …There has been a lot of unhappiness on the site because we just put two team leaders in, … we have got transitional care here now … and they're actually getting paid more than the ENs, (the team leaders), but they are actually carers in those roles, which does seem, yeah it seems wrong. The manager has reported to her managerial team, but there is really not a lot that is going on. I

mean they only get a dollar or more than a carer and all our ENs are advanced skill here, so they do meds, they do dressings … they didn't realise that (they) were actually to get paid more than an EN … it's a structural thing. It's shocking really.

Maggie gives further explanation of her changed role within the facility but she points to the positives rather than the negatives. The management has created a new role specifically for her, a testament to her passion and professionalism in aged care nursing and she is extremely heartened by the fact that they did so. She declares:

I was made Admissions Coordinator yesterday. I had worked three days a week since I had children and I can't do the work as a Clinical Nurse that's needed. They really need someone full-time. I mean the new role is good for me and the children, but it is hard work.

Maggie's new title is Admissions Coordinator Interim Care Services. She exclaims:

It's a mouthful! When they come here (the residents) it's nice actually, because I've met them and I've met the family, then I'll go over and introduce myself so it's nice. With the other role, the clinical nurse role that I did here, it was all managerial mainly, you

know, audits, acc fees and funding tools, appraisals, and family conferences, and all that kind of stuff. I mean I consulted on wounds, or if someone was really ill, or if someone asked my advice, but as such I didn't actually do work on the floor. Whereas now it's nice, because now, I can go out and meet people. I meet clients in the hospital which is nice to have that contact back again with them.

Included in her role is dealing with many workplace issues. Maggie particularises:

My role includes dealing with complaints, staffing issues, and performance of difficult staff members as well, which I find quite stressful. It's hard work ... very much. Never enough hours in the day I tell you, but I'm still laughing. You have to; I think if you didn't you'd really go nuts you really would. I don't know about all nursing but certainly here you would. Some days are really bad. Some days aren't, but the days that are really bad you do have to laugh, otherwise you wouldn't work in the industry I don't think.

The amount of time spent on documentation is often a major source of dissatisfaction for many nurses. Numerous hours spent making certain records are up to date means that sometimes documentation can take more time per shift than any other nursing

endeavour. This paperwork compliance is also a large component of Maggie's role. She laments:

I mean just the amount of paperwork that you have to do to meet all these criteria sometimes is ridiculous. I mean you could actually do all this paperwork and not actually be doing any of it (the care). Do you know what I mean? It's sometimes it's just like window dressing really and then I mean you've got all your acc fees which are funding tools for the government which we have to submit … slightly changed but we used to have to submit them every year for everybody. You know or they'll come out and audit you and take money off you if you haven't got everything up to scratch, so it's quite stressful in that respect because that's funding and that's quite a big deal.

Accreditation is a big deal as well. I mean we've got full accreditation next year, so making sure everything is up to scratch … to submit the application I think in February or something like that, so it's an ongoing thing you have to keep everything ongoing because … I mean we had a spot visit just two weeks ago from them (the Aged care Standards and Accreditation Agency). They are stressful, because they don't give you any notice anymore. They just knock on your door and we recently had the complaints scheme in as well, the

Commonwealth Complaints Scheme. That was from a family member who made the complaint so that's not very nice either ... complaining about showering was one of the complaints ...They wanted to pull all of the shower charts out and they wanted to speak to residents and look through all the documentation. They're a good thing. You understand why they're there but sometimes it takes you away from care and other things that you should be doing on the floor unfortunately.

And the other thing with documentation, we just changed to ICare so everything's computerised which long-term I know it's probably going to be a good thing, but short term it's a bit of a pain in the bum for everybody .... Getting everything put on the computer ... and non-compliance from Doctors.

Here Maggie laughs loudly and then continues:

One GP just refuses to write in there now. The nurses have to make a summary of what he's done, which is really illegal and basically we have just said to them to write 'see medication chart for changes' because you really shouldn't be transcribing what he has written. He has his own Medical Director program which is not compatible with ours so he is refusing to use ours .... We have asked

him to print it off so we shall see if that happens then at least we've got a copy.

Following the path of Maggie's stream of consciousness, the stories flow freely and she elaborates on each point. I ask Maggie, because I am intrigued as to whether humour has helped her throughout this litany of stressors she has revealed to me. Almost before the question is out of my mouth she responds with a gentle laugh and a fairly well organised reply as though she has reflected on this issue well before I ventured into her thought world. She speaks:

Certainly with like the RN's and EN's at handover and things and we have a bit of a laugh. Like you say when something particular happens you have a bit of a laugh or you muck around with your colleagues. I wouldn't say it was fantastic or anything but I mean I have I certainly have fun when I'm down in the office, down that office in residential, and I'm with the RNs and ENs and we have a good laugh. I have a good relationship with them cos we used to share an office. Actually this is a bit rude actually, the other day we were down there and Dr X one of our GP's rocked up. One of the ENs said to an RN actually "I'll do your medications, you go do Dr X "and she went "I'm not going to do Dr X" and went all red because of the sexual connotations and then Dr X laughed. That happens all

the time, the interactions between us. It's more of that type of stuff that we laugh at. Probably not always appropriate! (And she laughs heartily again).

Sometimes the things the residents do, the people with dementia, you do have to laugh … We tell stories, oh we don't tell stories, but you do tell some of the strange behaviours that happen, that kind of thing … mean we were laughing out here … saying how this man was homeless and he was so bad that we had to soak his socks off, and we were laughing a bit about that, even though it's not really what you really should be laughing about. He had alcohol abuse and he's a little bit delusive, so we don't quite really know what he's saying is true or not. He's quite an intelligent man, so they think some of it is quite strange that he's ended up like that. He is in another care awaiting placement facility and he had absconded from somewhere else … some of the strange things they do. Strange things happen every day. A woman who lost her teeth, we couldn't find them anywhere, and she put them somewhere internally and when we were washing her we found them – just awful, absolutely awful … which wasn't really funny really … you'd have to laugh or you'd cry. But you do see some funny things. I think with nursing

you have to laugh you know, because some of the things you have to see are a lot worse.

The recall of the powerful public humiliation and the frustration and disappointment of her early career experience makes me suspect, that in the analysis, the ongoing pain of that time is related to the high goals and standards Maggie set for herself as a very young new graduate registered nurse, when her ideals, far outweighed her experience. I felt for Maggie and my heart was aching for her. My heart still feels for her, because I feel she will always ponder those early experiences as though she is standing on the edge of a precipice as she contemplates any new role or responsibility. There may be many such incidents of struggle and trauma in the future as Maggie continues as a nurse, but if she continues her determined pursuit of a nursing career I am sure she will succeed. I believe that Maggie's story is summed up by her final words which are:

I ended up nursing again and I loved where I worked and I suppose it restored my faith in nursing. I liked what I did, I had really good colleagues who I could have a laugh with, and the rest is history!

APRIL

"I'm being interviewed … with the paparazzi!"

My curiosity is real as I begin to speak to April as she seems so genuinely delighted to be the subject of research, yet she was so difficult to schedule for interview. She acknowledges this with a sharp nod of her head and then exclaims exuberantly to a colleague walking by:

Hello Jane! (She shouts), *Yeah - She finally got me … she finally got me … the bitch!*

I took the obscenity in the spirit in which it was intended, which I hoped was *joie de vivre*, and we continued the interview seated under the gazebo between the cluster houses of the residential aged care facility in a leafy suburb reasonably close to the city. Paved stone paths leading between the cluster houses weave between frangipani, banksias, roses, eucalyptus, grevillea, daffodils and ferns. Roses wind along the pavement edges that lead to green painted wooden benches and plastic outdoor settings where residents, visitors and staff alike can sit and rest and take some respite. I am taping on a late spring afternoon as April leans back in her chair and begins to talk:

I come from East Africa and to get an appropriate education I was sent to Kenya. We lived in Tanzania and Kenya's educational system was a little bit better. If we had stayed in Africa I would have gone to England to finish my education except we migrated over here to Western Australia. In Western Australia I was always told I would make a very good nurse and I believed them! I went to boarding school and when everybody or anybody was sick, they'd all said April

(sic) *will look after you and they all said you would make a wonderful nurse and I said-Yes I will! I will go into nursing!*

I've been a nurse now for over thirty years, and in this role ... five years ... and I enjoy caring for the elderly. I find it very challenging and sometimes a rewarding role ... as ... well, not very often you win. You maintain people generally, or watch them deteriorate. You don't see many of them improve, but every now and again you get that, that... hmm you get that... ooh I don't know what you'd call it? Every now and again somebody improves or they either go home or something happens and they can resume their quality or their life outside of residential care.

There are some people who don't find caring for the aged ... ah ... 'classy enough' I suppose you would call it or 'high tech' enough. I think there is still a stigma associated with caring for older people. I don't think people are aware of the complexities of caring for an older person, in that it's a far more holistic care that you have to provide for an older person than what you would do in an acute setting. There, you'd only be looking after that person for a specific period of time, then sending them home to whatever and not really looking at the person as a whole.

You have to be a very giving person. You do have to be fairly resilient because on occasion it can be a very ploddy job ... Being able to keep going, even though you are not seeing any changes, and just keep going and hoping for that change ... People don't think there are many highlights in it, but there are. Your day is always full.

April pauses and continues wistfully contemplating her thoughts. I wondered what else figured as 'winning' in an aged care setting. She whispers:

When I came here my first thought was how much walking there would be because the houses were so... (April waves her arms around indicating that the houses are far apart)*... But it is a great delight to walk, watching the gardens beds change and smelling the roses when they are out and blooming, but I did not choose this facility for the gardens. No I actually ... like looking after people for short-term ... Yeah I like the interim care.*

April smiles delightedly and continues:

I got a beautiful bouquet of flowers from one of the clients who went home, thanking me personally, which I thought was really lovely ... you may get singled out in a letter or singled out in a group. They might thank Mathew Mark, Luke and John and your name may be mentioned in that as well, but this was specifically. We are not here to be thanked but it is nice to be thanked every now and again.

Superficially a bouquet of flowers is scant reward for nursing work, but it appears to make a huge difference to April as these small recognitions go some way to alleviate the other onerous tasks of her nursing work. She expounds:

We are dealing with things that most people don't have to deal with, and they are, some things are very upsetting, especially some wounds that we have had here. It's become far more stressful. We've become far more accountable, we seem to have rules and regulations for everything under the sun, which is in some respects, is very good, it gives you guidelines, and gives you little parameters.

I think people are more aware now of what their rights are. People are really into; you know ... what is it called when they want to take you to court? Suing and litigation, that sort of thing. ... You've got this at the back of your mind all the time, even in this environment. It's something at the back of your mind very consciously and sometimes, depending what because we are dealing with ...

they're going through a huge grieving process. They've come from a community into an acute area and now they need to have residential care or they're trying to get back to their own home with a TCP (Total Care Package).

They're going through this huge process and its affecting the family and then the family come back at you and they are really quite angry, and guilty, and they take it out on the staff here ... They are hurting so they're looking to hurt back.

In residential people are more accepting of that situation ... they've had more time to reconcile themselves to permanent care whereas in interim they're going through the formality and the transition to interim care and they bring their anger and their guilt with them. I've never, since I've started working, I've never come across so many complaints! Lots of complaints and a lot of anger! It can last from the day they arrive to the whenever they find placement, so they can go in one day and be gone the next because a beds become available. We've had people who have arrived one day and gone the next or some people can stay for up to a year or over, it just depends who they've waitlisted for or what they're wanting.

April's words seemed easy enough - they were easy enough to understand- but they had everything to do with work stress as they were innately about the lack of respect for nursing work and incivility, and at the far end of the scale, abuse of nurses. Seen this way, the constant complaints may undermine anyone's ability to remain working, remain nursing and continue to care. I ask April how she copes and she responds:

How do I cope with that? I try not to take it; I used to take it very personally. (She laughs ruefully). *Now I try and sort of diffuse it, and look at it not as a personal thing. It's a team thing really. It makes you a bit more aware, makes you a bit more ... you double-guess*

before you say anything … you know, all that sort of thing. I think that's why we have such a good team here, and we're able to bounce off each other and to support each other quite well.

I ask April if this 'bounce-off and support' is essential as a foil to the stress of complaints and clients who may not ever return to health. She replies:

It's nice to be able to do that. Also the team here is wonderful to work with. On the majority of occasions I enjoy coming to work and being part of a team. You know it makes a huge difference. It can be very isolating out in the community like this and it's really good to have a team that you can bounce things off, you can laugh with, or you can bitch with!

I think it's very important for nurses to be able to banter with each other because our sense of humour is not necessarily appreciated by other professions. You know when that happens? (She laughs quite playfully now looking at me with wry amusement). *I know it sounds horrible but my husbands, and I was close to her as well, my husband's mother passed away just before Christmas, and we were trying to you know jolly each other along and I said oh I had better ring up work and let them know a beds available at her nursing home. So you know … the look on his face, was just absolutely you know … I could have crawled under…. I thought it was quite funny but he did not appreciate it at all!*

You know you make a comment when you see some really gross wounds and you know you liken it to foodstuffs or bowel motions and people just don't really appreciate that sort of description! We always have somebody who likens a bowel to foodstuffs which puts you off food for a little while which I suppose is quite good … but not for too long at all!

I just try taking each day at a time.

I look at April in profile. She is an older woman with wisdom lines etched on her face. She is sitting on a plastic outdoor chair with a coffee cup in her right hand. I sit a respectful distance away from this nurse whom I consider to be carefully concentrating on describing the nuances of her work. I couldn't help but think that she had a wonderful sustaining sense of humour in spite of everything. Her features relaxed almost imperceptibly and the smallest of smiles played across her mouth as she took it upon herself to try and answer my questions impishly or mischievously at every turn. She was having fun! April sipped her coffee and deliberately became more serious as she continued:

It's very busy, very busy, and it becomes quite stressful when you have, you know anything extra on, you know trying to get everybody to try to attend, yeah it doesn't make it a joy. But I think there is joy at work. Like having a chat with a staff member and sharing a bit of their personal life rather than work life, and having a little joke ... whether it's rude, crude and obnoxious, (she laughs again) *it doesn't matter! I still get enjoyment from it* (nursing*). It's still a challenge which I enjoy. I feel that I don't want to explore any other career options, I'm looking forward to retirement* (she laughs heartily here).... *And then here you are!* (And April laughs once again).

As a very experienced nurse of over 30 years in nursing, April recognises nursing issues of concern and debate. She has seen it all before in one form or another. For example, the resistances to change as care workers adopt new routines based on evidence instead of tradition and/or habits that have worked well for so long. This need for change can make staff 'tetchy' but April has the offbeat charm to persuade others gently to follow her lead. She concedes:

You know, like with most workplaces, it doesn't matter whether you're in nursing or in a cleaning business, ... a new policy comes out

... or something happens and it and rubs some people the wrong way ... it just happens. It's the staff performance management I find that quite stressful, because you are very aware that it is a person's livelihood but they have still got to adhere to, you know, policies and procedures and to provide a service - I find that quite stressful ... and particularly rostering; (April laughs) *you get people ringing in sick just when you thought you'd got it right, then trying to, you know, build it up again, so it doesn't fall down and there is enough staff on. Just trying to think ahead, constantly thinking ahead so that you prevent problems occurring.*

April becomes serious when talking about issues of her work as she speaks about the need for continuing professional development and keeping up to date with current evidence-based research and practice:

I've just done a continence assessors course ... and I found that hugely stressful ... that really brought me out of comfort zone. You think to yourself: how the hell did I do that and still maintain my sanity but I was very well supported here. You know my manager supported me and it was really quite good. I would like to have the opportunity and time to use the skills ... but I don't know, I don't know at the moment. I'm just running from one job to another putting a finger in a pie not really looking at an overall plan and being able to implement it. I'm currently trying to do two roles at the moment now. I was clinical nurse but they couldn't find a registered nurse to replace my position ... I said I couldn't do it I'd go back to being a registered nurse. So I'm currently having a clinical day where I'm doing auditing and that sort of thing on the Friday so this is why I've got this opportunity (for interview) *now, and Monday to Thursday I work on the floor. They haven't replaced my position.*

Right now the most stressful thing is getting your work done, yes, getting your work done so that you're not leaving anything for

the next shift to deal with or you know, doing it all the way through. That is, being able to do something, you start and finish it, instead of having three or four interruptions, and trying to finish and then going back to it, and not having to think 'what was I doing here? Being able to get everything done in your shift …

Some days it just goes bang, bang, bang, and you feel really fulfilled when you leave, and other days you think "what have I done" but I feel absolutely shattered. I think it's not true for all professions …You know you may not be run off your feet, but your brain is overtaxed, but with nursing it's your brain and your feet. In nursing you get the double-whammy. But I think every profession has its stress. But nursing is still the best!

April's comments remind me so much of the speech by ex-British Prime Minister Gordon Brown to the nurses of the UK in 2008 when he said: *"I often ask a nurse why do you do it?' And almost everyone I ask says to me, 'I do it because I want to make a difference. I want to help people' and that is the noblest aspiration of all. But the difference you make is not like any other profession. The difference you make is between distress and security, between pain and comfort, between despair and hope, and often between life and death. And when we talk about professions around this country, there are some professions where people work with their hands, there are some professions where people work, you may say, with their head, and there are some professions, the caring professions, where people have to work with their heart. But there is no profession I know of where you've got to work with your heart, your head and your hands at the same time. That is the great value of nursing."*

Amidst the stress April still wants to leave a legacy. She leans forward in her chair unconsciously letting me know that what she is about to say is important to her. Her voice is strong and she sticks

her chest out and screws up her face in concentration once again and looks straight into my eyes as she says:

I went to my bridesmaid's funeral, and the things that she'd done in her life for the community were just absolutely amazing and I thought to myself well I need to do something! She'd done all this stuff, she lived in Geraldton and she done this huge amount of work for the aboriginal community, and she'd done this, that and the other thing … I still haven't done anything. Hopefully somebody will find something to say for my funeral! (April laughs heartily once again*). I'd like to be remembered as doing my very best for the people that I have been made responsible for. I hope I've improved their life or maintained their life or contributed to their life and their relatives and friends and I'd also like to be remembered as a good team member as well … oh well I hope so!*

No need to worry about that April I thought - you will be.

The Canvas: the academia setting

The following three portraits are of three nurses working within nursing academia.

Grace, Lucky and Ginger work in a tertiary academic setting within a School of Nursing and Midwifery. The faculty aims to educate nursing and midwifery students to be competent and ethical health professionals who are able to assist in improving the healthcare of the people they care for. The School has a multidisciplinary approach and is committed to clinical education innovation including scenario based learning, 'real life' simulations, and intensive clinical up-skilling. It encourages self-directed learning and clinical practicum's to occur within local metropolitan and rural hospitals and regional areas throughout Western Australia.

On entry to the university campus what are most striking are the imposing modern architectural structures which are surrounded by pine trees, a leftover from colonial planting. Concrete building, after concrete building occupies the hectares with students meandering along the brick paths, so small in contrast to their commanding classrooms within the facility walls. The elevator deposits the researcher **o**nto the nursing floor, noticeably dark and quiet – presenting an administrative model of order and decorum. Students of all shapes and sizes, colours and creed, male and female surround the reception desk awaiting retrieval of assessments. I am ushered into an interview room away from the hub of the student's world to meet with Grace, Lucky and Ginger.

GRACE

"Once I found myself again and trusted myself again.

Then within that, I came to trust the essence of who I was.

And who I am is a nurse, a midwife, and a caring person."

Grace has been a nurse for some thirty-seven years now and has been involved in the clinical teaching of nursing and midwifery for a large part of that time. She has also directed and co-ordinated programs within many nursing and midwifery specialties including child health, and is currently teaching clinically within both nursing and midwifery. She says she began on her teaching journey because she was inspired:

by a most wonderful educator when I did my nursing training … and she was just delightful and I would see her lecturing and supporting the students and that was my goal … to be like her and so when I went back and did my nursing degree. I did education as well as administration and always thought if I could just inspire one person like … (she)… inspired me then I would have arrived on my journey.

Grace stands at the front of a large classroom within a university setting. She, by contrast is a very small, diminutive woman who appears to be outwardly fragile yet inwardly she reveals she is made of much sterner stuff. The classroom is rectangular shaped with stark white walls offering no distraction from the subject at hand. Two windows on the left side wall look out over a vast wooded copse of pine trees with pine debris and pine cones littering nature's floor. A large whiteboard

covers the front classroom wall and a pull-down screen is attached to the ceiling, available for use during the inevitable PowerPoint presentation to come. A ubiquitous, stock-standard wall clock passes time on the right of the whiteboard, but makes no sound, so as not to disturb the learning and teaching that is about to occur.

Grace begins to settle the class down after mid-morning coffee break, commencing by reviewing a past teaching session to recall and build on the students' previous knowledge. The students are very new, being only four weeks into their course during which there is much to learn. She gently probes their prior knowledge and questions the class on the twists and turns that the foetal body must make in order to be born. She extolls:

Remember, a foetus is like a corkscrew; otherwise it would end up in a knot!

This consideration of foetal corkscrew turns is a novel learning topic for the new students and as they ponder the beginning of life and its associated bigger issues. However, it is evident by the manner in which Grace speaks that she is very used to contemplating the bigger issues. Besides being a nurse and a midwife Grace is also a pastor which gives a spiritual perspective to her life and work. Her language is full of biblical references and I believe she sees her life and work as a series of opportunities to do good works. She also deliberately searches for a greater meaning in life whilst seeking a balance with work. In fact, I think Grace was seeking a work-life balance long before the term was present in the social literature. She ponders:

Well I suppose my belief in God, my faith is such that I try to live my life according to the principles in the bible and according to what I believe is good and right and proper, and do to other people what you'd expect them to do to you, and to … I have a conscience, a social justice conscience and like to do what's righteous and correct and therefore if that doesn't marry up then that just doesn't fit with me and then I lose my peace and that's when I get stress filled … I have what I believe, is, a fortunate life, in that it has been filled with experiences that I may not have wanted, but they have actually turned out to be some of the biggest blessings because of what has happened afterwards.

Grace tells me of her life experiences, the experiences in the earlier stages of the personal life or workplace lives that affect the whole journey forward. She tells of, and the role of her memory is crucial, her method of approaching the problems of her life, and how she adapted and developed this to become the person that she is today, saying:

There were some things in my childhood that weren't very pleasant and my mum walked out when I was twelve. I brought up my two younger siblings, one was six and one was eight, so my mothering skills started when I was eight years old really, and that mothering was part of I think why I went into nursing and why I went into midwifery as well. So that in itself caused a chain reaction so I think that that has been part of why I've fostered so many kids and looked after lots of children and been involved with kids at times when it was an unexpected thing but it turned out to be a blessing.

And then along my journey there has been other things that have happened that have made me the person that I am and given me the belief system that I have. When I was eight I had a Sunday school teacher that looked beyond the skinny legs and beyond the freckles and beyond the buck teeth and she believed in me, and because of that, I came to believe in myself and so that has set up in place another chain reaction whereby I have the ability to look beyond. I believe what is going on and see that in a person, and believe that everybody has a purpose and a destiny and it's my, my role in life, to assist them along their life's journey to achieve their destiny and their purpose.

The thread that weaves its way through my communications with Grace is a life underscored by her resolve to mother, through the rearing of her own and others children, allowing her to focus her love, time and energy on giving the most to each child as well the attention and structure they need in order to feel safe and loved. Grace has this perpetuating need to foster, whilst at the same time nurturing and bringing love, care and humour and fun not only to her foster children but to the nursing students that she has taught along the way. She recalls:

I come from a big family and our home was always full of everyone's children and so I have always felt comfortable around children and the hustle and bustle of family life, so the decision to foster was never really made as a conscious one. The kids needed help and a home, so it seemed natural to offer them one. Some of the children arrived on the doorstep via word of mouth about my care of kids and others came as formal foster arrangements. I have been a mother to fifteen very different children who have taught me much about myself and about life. Although the

fostering was hard at times and caused my mother's heart to break at times when the children were left my care, it was an amazingly rewarding experience and one that I am able to reflect upon with the fondest memories.

I am amazed at the number 15 and wonder how she coped with such a large number of children to care for and she explains:

It's my belief ... it's the fact that sometimes you're dealing with really stressful situations and therefore in order to de-stress, to lighten that, humour comes into play and it's not that it's inappropriate, it's a coping mechanism and I have seen quite a bit of that as well ... My friend said that I disciplined the kids when they were little with humour - I didn't even realise I was doing that, but other people noticed it and it's really rather than telling a child off, making light and fun about what has been done in such a way that yes they take notice as you would as if you'd yelled at them. But then it de-fuses the situation as well and hopefully because it de-fuses, then they can and will correct the behaviour. So I suppose there's a discipline, you can use it in disciplining armed with the sustaining gift of loving kindness.

I find Grace fascinating. She is always looking for spiritual insights and always aiming for the 'loving kindness' of which she speaks. It is obvious that she wants to make a difference through her dual 'vocations' ('vocation' being the correct use of the word here), of nursing work and God's work. Grace continues:

I trained at (a major teaching hospital) and we were officially the last of the (those who trained there)... so three years I was there, and lived in the nurses' quarters for the first six months coz you had to... (The hospital) was the best training

place, loved it, absolutely loved it and I still keep in touch with the majority of people from the school that I trained with ... I went straight on to midwifery as quickly as I could. I had to do six months of nursing and I'm just smiling coz I'm thinking about that and I went to do my midwifery and I worked there for six months on the Gynae ward with the promise of starting my midwifery and after six months they insisted on keeping me on to do gynae, so, I decided that I'd go and when I went to tell the Director of Nursing, the good old matron I was leaving she said to me "Don't you ever expect to come back and have your babies here, coz you're not welcome!

Grace titters here self-consciously, but it is not a happy sound, it is more of an incredulous titter even after all this time. She mutters:

So that was another one of those little highlights in my life where you think 'oh my goodness this is not what I expected!' so anyway I did my mid and left after the twelve months.

The wanting to speak of the early brush with what could have been the termination of her fledgling career as a new nurse or midwife allows Grace to overcome her initial reticence to speak of her resilience in the face of higher management gaffs. She tells:

Resilience to me is like an elastic band that continues to stretch, even though it's stretched almost to breaking point. It doesn't break, it springs back, so it's that ability to spring back in spite of whatever's gone on ... in my nursing career. But I suppose I was even thinking beyond that in my life, I was being resilient but in my nursing career I have, I've had some situations that have been stressful to me but I've

bounced back, because of probably my personality traits but also because of that part within me that just won't give up.

I had a situation when I was just, I'd only just started working as a midwife so this was, I'd graduated and I'd been working as a midwife for just about four or five months. There's a part of me that really is an advocate for social justice, an advocate for rights of people and I was working at a health facility where the night shift finished at five-thirty in the morning and the day shift came on at six-thirty. I was working night shift and I just could not marry in my head the fact that these women on the anti-natal and post-natal wards would be left for an hour without anyone to care for them. So they could haemorrhage or anything could go wrong and if they rang the bell then the mothercraft nurse from the nursery would actually go and look after them. And so because I couldn't marry this stuff in my head and it just wasn't ethically correct I would stay for an hour and did that continuously when I worked nights. One night when I came on at nine-thirty pm there was the Director of Nursing waiting there for me and said 'Don't expect to get paid' and I said 'Well look I'm not really expecting to get paid but you can be guaranteed that I will not go home early it's not ethically correct.' She sacked me on the spot and that was devastating. I was twenty-two years old, and thought that I was a good nurse and a good midwife and thought that was I was doing was right and it was almost like my whole world shattered underneath me and I did find that that really knocked me for a while. I went to the ANF (the Australian Nursing Federation) the next day and I had my job back within twenty-four hours. But I refused to go back because I just didn't want to be there any longer, but that was something that shook the essence of my being but I

bounced back from it and then went to the country, consolidated my midwifery and really started to get back to where I was at before really. So that was a particular situation where I could of just walked away, could of walked away from midwifery.

So it was three months without a job and three months of some soul searching and three months of no income and I had to go to the country because at that point in time jobs were not that easy to get either and I really didn't know where I wanted to go. In fact, it was: do I really want to go back to midwifery? I'd done nursing to do midwifery, so it was a questioning of values, beliefs, and direction and I think probably for the first month I was pretty shell shocked. I wasn't really actively looking. I was looking, but not really hoping to get a job because I didn't know if I could actually do it, and then I started to actively look and I couldn't really get anything, well, for two months and I went to the country. I think it was called the Country Health Service at that point in time and there was a job going in ... (a large country town). My sister lived there so at least I had family, so I thought well I'll go up there. So I signed a six month contract and in fact I think it was the best thing, because it was out of this setting, it was away from the city, I could find myself again and start to trust my abilities as a nurse and as a midwife. So I came back from there feeling competent and confident so it was good. It really made me a better midwife. It also was a consolidating time for my general nursing skills because there, you were it, so you were working accident and emergency and did suturing and plastering, putting on plaster casts and you could be doing that and looking after miners and then looking after babies and paediatrics and then doing maternity work and so it consolidated my nursing and midwifery skills and gave me the ability to trust my own

instincts and to know that I am a good nurse and midwife. And when I came back it even gave me more fire in my belly to stand up for what's right and what is wrong so really I stood up for the women who couldn't stand up for themselves.

The power of Grace's storytelling is also evident in her teaching. Not only is she able to convey the richness of her life with her words, she is also able to explain to students what they need to know by the use of humour and a tapestry of detail which assists their memory and recall of imperative educational information. Comments throughout her teaching reveal her vital engagement in life and as a clinical teacher. She teaches thus:

You have all heard the latent labour stories? From: I was in labour for three days, to yes but I was in labour for five weeks! They are all just like a fishing story!

And,

Give me a definition of engagement - and not when you and your partner decide to get married!

And

When I went to the gym the other day my muscles were contracting but I wasn't feeling any pain - so what causes the pain of labour? Think about it!

And

Is cleaning the cupboards an early sign of labour - is it evidence based?

These humour filled anecdotes assist in the retention of the real facts of issues concerning latent labour, engagement, labour pain and the evidence base of nursing and midwifery. Grace deliberately chooses to use humour as a teaching method. She explains:

What makes me laugh at work and certainly in the classroom is interacting with the students and seeing them have fun and it makes me laugh and also interacting with my colleagues, the ones that I know really well and if they have a funny situation and obviously I laugh about that. Sometimes my mind goes off on a tangent and I like to play with words, so word games or word associations often will just make me smile and that will start to get my brain working in regards to humour, so it's a whole array of different things. I have fun here and I work with some great people and my team worker, my team teacher, and I banter in the classroom and we play one against the other. So the students will support one of us if the other is picking on the opposite person and so there is this bantering in the classroom ... it's not knocking each other, it's actually just having fun within that and sometimes it's just depending on what's being discussed in the classroom. It can just go off on a different tangent with some fun and some laughter and the students starting to join in as well.

Grace's humour teaches beyond the mere words and laughter. When describing the difference between a face presentation and a breech presentation she has time for fun with the students exclaiming:

Just remember, a baby may suck your finger during a vaginal examination but a bum will not!

The collegial bantering between the team teachers is also very evident from the start of each lesson. *"How long have I got to teach?"* she questions the other teacher. "You should have finished two minutes ago" the other replies. *"Blah, blah it's tangential teaching!"* Grace retorts. "See how she justifies herself" is the other's reply. Yet her story of vulnerability, failure and resilience, challenge and mastery, wisdom and new learning, about self, and about life itself continues through our conversation away from the classroom. She reveals:

When I was pregnant, I worked in child health and I loved child health. I had my own child health centre. It was great, the mums really loved me and they were excited that I was pregnant and that I was going to experience some of the things they were experiencing. So I went to the person in charge, and this almost seems like issues with people in charge of me, and said that I was pregnant and I'd like to have maternity leave. Well there was no such thing as maternity leave and I was told I could come back... if my baby died! So that was very understanding I thought - not at all! And that was just, really awful. I thought, "How dare they say that to me? I've been loyal to this organisation. I want to come back!" And it was once again one of those crisis points of, well I don't want to lose my baby but I do want to go back to work or do I ever want to work for this department again after such awful comments like that? And the horrible thing is, I know it didn't cause it to happen, but it stressed me and then I went into prem labour and I, I was twenty-eight weeks pregnant and I spent the next seven weeks I think in hospital after that. Yeah it was seven weeks coz I had a

baby six weeks early, so, then, after that, I wasn't sure if I was going to return to child health. It was like do I want to work for them again? So that was another crisis thing in my life.

Grace allows herself a nervous snicker expressing a wry, ironic humour:

I did go back to child health and in fact ... I didn't go back immediately but I actually got phoned by child health offering me a job.

She laughs again with wry amusement at the vagaries of life and nursing and nursing management and says:

I had to resign; there was no maternity leave so I was forced to resign.

Grace discloses she has always been steadfast in her commitment and staunch in having the courage of her convictions. She reflects again on the nurse that she is today:

There was a real incident when I was in my nursing training, can I talk about that? (I nod in acquiescence). So I was a student nurse, I was 6 weeks on to my first ward and a man I'd been nursing for that 6 weeks had a cardiac arrest and died and I went into the pan room and I started to cry. The charge nurse came in and said to me you will never make a nurse, you don't have what it takes and I suggest you get out now. That was one of those moments where that person within me rose up and thought how dare you say that! And that has, that was such an event in my life because I showed caring and compassion and I, I felt concern over the fact that this man had died and from then on I have, always felt that ... it's fine to cry with patients

and to allow them to see that you're real. But that has actually had and it did have a huge impact on me and it's had an impact on my teaching because I've spoken with students about that and I've relayed that incident and how I felt at the time and how it made me dig my little heels in and say well how dare you say that to me? You have no idea of who I am or what's going on within me? And from then on I have, like I said, shared with students and said to students if you need to shed a tear it's ok and it's in those moments where you connect with clients and with patients that really there's something that's achieved at that point in time.

Grace unveils more of her professional life telling that she has had a wide and varied nursing career, part of which was a foray into nursing within a prison and/or correctional facility setting. She talks about her time there:

I'm just smiling because I used to wear an apron that had mushrooms on it and I'd put that on over my nursing uniform so it wouldn't get dirty and we used to talk a lot (with the prisoners about my magic mushrooms! (She chuckles to herself). The prisoners would be asking often for my magic mushrooms and where were they and why was I advertising magic mushrooms so it was a bit of, it was a bit of a, not just an, an ice-breaker is probably the word that I'm looking for. The new prisoners, they'd see me walking around in this prison in this little pinafore with colourful mushrooms all over it and even though it may appear to be a little bit childish, it really was an ice-breaker and something we could talk about. It then gave me a bit of opportunity to do what I needed to do with the prisoners and the, the word of mouth went around was 'Oh here's the magic mushroom lady! (She chuckles again at the thought).

My whole life does actually revolve around humour. I've worked with kids for a long time outside of the job and in the job. I worked in paediatrics but also was a state director of a children's organisation for five years and in that I ran kids' camps and did kids' programs, so, working with children has involved a lot of humour, and not only from me to them but from them to me. I have a grandson who often gets in trouble at school coz he's like his nanny, because people don't always appreciate the humour in the classroom when others are trying to be serious. I know that I have role modelled but maybe not always to the best! (She chortles with amusement). Humour has been the way I have coped through my life journey and it has been a significant part of my life to such a point that when I ring up my husband every night when he's on night duty before I go to sleep I'll say, "Can you tell me a joke?" So yeah, it's right from the beginning of my day to the end of my day.

I like to laugh and I find that it does de-stress me and even with that I've written some songs that are silly songs that you can sing when you're feeling down or you just wanna have a laugh and so even songs like 'Doe a Deer' I've changed the words to that and it's got some laughing in it and so that's just an example of how I've used humour just to get through the day.

STRESS LESS by Grace (Sung to the tune of Doe a Deer)

Don't you see my Stress is high?

Roar is all I want to do

Me, I need to deal with this

For a happy song to sing

See my shoulders roll around

Laugh, I need to do all day

Tea, a drink I long to have

Which will blow my stress away?

Grace tells me that it is important that to feel the full effects of the fun nature of this song and that I must do the actions with it. She implores:

When it says Roar, I roar there. When it says about my shoulders, I physically roll them around. When it says laugh, I go Ha! Ha! I also pretend to drink a cup of tea at that line. Then for the final line, I pretend to blow way my stress. It's short and catchy and fun!

Grace is indeed a woman of many talents. She exclaims as gleefully as a child:

And I do clowning! I've done a lot of clowning within the church circles, clowned for (charity), done clowning for when I worked in the... (Governmental Department for the protection of children). I've used clowning, I think it's actually helped me to cope, and in fact I wrote a poem called The Clown, and, with clowning you can actually put on a different persona. You can put on a different face and you can do whatever you like and be as silly as you like without having to be responsible as you are as an adult or as an academic and I think that that has actually given me the balance. I work in a serious environment but when I'm a clown I can just be silly, I can do whatever I like. I never use that as an offence so I don't do it to belittle people that's never part of my clown persona. It's joking and tricks and object lessons and building people up so even when I work with kids and I make a hanky disappear I get

the child to think that they've done it and it's always Wow! Look at how clever you are! How did you do that? So it's never belittling. It's always uplifting and it always makes me feel good. When kids laugh I feel good or when people laugh I feel good. I would have loved it when I worked in paediatrics to be a clown doctor but as a nurse I couldn't do that because that's a whole different role. You're not a nurse, you're a clown doctor and that's where I saw it being used effectively and I loved it. I met Patch Adams and I thought he was the most wonderful man as well, and so he had a bit of an impact on me because he didn't have a wrinkle on his face so I thought obviously humour agrees with him and it's kept him young. I've done tricks and things with kids but not in a clown outfit so in nursing yes I've done some of the object lessons and tricks but never worn the clown outfit. Here in my workplace for a Christmas party, I did some clowning last year. We had our Christmas party and in between all the acts I did some clowning and just had some fun and in fact I think it was a really good way to, as I'd only recently started here, for people to get to know me and see beyond, you know just the role, and that there was a person behind the mask so to speak, who could enjoy life and have some fun. So I have used it in nursing and in work and yes certainly around the chaps as well.

Grace's amazing life is multi-layered. She is simultaneously a mother, a foster mother, a clown, a pastor, a nurse, a midwife, a teacher and academic, a grandmother and a wife, and she takes all of her roles very seriously. She believes that she can make a difference and that much of her life and her work is a calling- a vocation in fact. She reflects on her current positions as a nurse academic and says:

When it's not fun is, when, there's probably a lack of understanding of what goes on behind the scenes. We use a workload model and I don't really believe it fully captures what is actually done and that in itself then frustrates me, because I know that I work hard and I know the people around me, the bulk of them do work hard as well, but it doesn't equate to a, a numbers game. What we do is more than numbers! You can't put it all on a little grid and say this is what I did today. There's lots of liaising with the public, there's lots of supporting of students that, how can you put that into numbers? It doesn't equate to a one hour lecture but it's a lot of the job that you do is that support and trying to role model nursing and midwifery and that's what I believe is my job here, to role model what it is to be a nurse and what it is to be a midwife. So hopefully someone will remember that, because they'll forget the theory but if they remember what, and how they were made to feel within that, and then they will carry that on.

Grace's story is full of major career issues and family incidents which occur randomly and transform her reality, test her resilience, and require her adaptation. She speaks of her resolve and determination to overcome the hurdles thrown in her path. She says earnestly:

It is the story of my fortunate career because like I said before there have been experiences in my life that at the time have looked as though they were traumatic but I have been channeled to do something different or try something that I wouldn't have tried, to go down a different pathway for a while. To me it's a little bit like some people travel along the main road and others go on the scenic route and it's on the scenic route where you often see the unexpected and so, I would probably

call the book of my life 'the fortunate life' or maybe even 'the scenic route journey' maybe that's probably better! The scenic route journey and then the chapters would really be the detours along the way of the scenic route that have caused things to happen or taught me lessons. I have, in spite of a few issues that have happened, I've loved working with the people, and I have loved the journey I've had, investing in people's lives and touching people's lives in a special way not just in nursing but in midwifery and in child health as well, which is still nursing. So in the different areas I've done lots of different areas of nursing, worked in neo-natal for quite a long time as well and in there ,just being able to support parents in critical stages of their neonates' life has been really rewarding, so I think the rewards far out-weigh the horrible stuff that goes on. It is all been so interesting - it's kept me going.

In retrospect, overcoming the false labels and the damage done by others and how Grace navigated, negotiated and resolved successfully those many crises to move on in a different guise, shows her courage and resilience. She notes:

I really think that in order to survive and not take your work stress home to your family so that it doesn't impact on your personal relationships, to be able to laugh with people and to laugh about what you've said or done or how silly you've actually been, and laugh at yourself because you've made a faux pas all that's part of humour as well. Being able to laugh at yourself ... I think if you couldn't do that then it would just be awful and would have to h e some sort of huge impact on your physical being as well as your family. So for me, I can't see, that I could have survived my life, not just in nursing or midwifery or academia, I couldn't have survived my life without humour and I think about some of my life journey outside of work that has been just

awful if it wasn't for humour. I would not have really lasted the distance ... I might have done something silly! (And again she laughs).

The commonplace brown striped floor of the classroom carpet belies the richness of the learning that has taken place within these four walls. The melamine desks and the sturdy blue plastic straight backed chairs, that are not too comfortable but not too hard, empty as the students file out after a long day. As I listened to and for Grace's story, I was reminded of a quote by Frederick Buechner which states, "Your vocation is that place where your deep gladness meets the world's great hunger"; it is my belief that Grace has met and fulfilled her vocation to the people in her life and her work. She knows herself and she is content with her achievements. She concludes:

I think because really it was what I wanted to do. I did nursing to become a midwife and so once I found myself again and trusted myself again. Then within that I came to trust the essence of who I was, and who I am is a nurse, a midwife and a caring person.

LUCKY

"Then when you get to the position of getting it all sorted out.
You think- God I was lucky, gee I was so lucky,
That I was able to do all this.
So I'm going to give my luck to someone else …
Do those good works.
There is nothing nicer than doing it yourself".

Along the carpeted corridor of the university is a door labeled simply: 202. The room is prepared for a lesson that is to come. On the students melamine desks are displayed some instruments associated with human birthing: a delivery pack, swaddling clothes, forceps and the plastic simulation model of the human body.

Lucky stands at the front of this large room, surrounded by white walls on all sides with windows on the left facing toward a pine forest. A tea trolley is set up to the left of the room with coffee, cream biscuits, and an urn which allows the students to make and partake of refreshment whilst at their study. The students file into the room, begin to settle and the review begins.

Lucky has been:

Nursing for over 30 years, mainly in midwifery, because I find that's my passion.

She says she chose nursing and midwifery education as her means of empowerment for patients, women and for her students. Where patients and women feel disenfranchised by the medical treatment they are receiving, and especially where normal birthing is treated as an illness, Lucky works to give all involved the knowledge and confidence to bring about change.

Lucky is a squarely built middle-aged woman of approximately sixty years, with a jaw set with a wide grin and dark eyes which fix upon you but with the hint of a twinkle in each. Today she is wearing a skirt and top made of geometric material with a jaunty, if not bohemian, look to them. At the end of the lesson Lucky and I leave the classroom and walk slowly back to her office, a small room with a large glass window sill decorated with quite a number of coffee cups - many of a humourous bent.

Presents from students, even this!

She throws me a hand knitted woman's breast complete with areola and nipple. There are plants, photos, newspaper articles, posters and many nursing and midwifery books which adorn the shelves. She initiates the interview by saying:

I feel passionate about changing the system, about in terms of making ... you know, you can't change the system from the floor if you're working on the floor. You can only change a system if you get into other positions. So previous positions looking at policies, and getting, you know, getting other people to think about different models and in this system it's ... getting, you know, the students, the younger people who are going to be around for a lot longer than me, to keep that idea in their head that ... midwifery is a normal thing and that we can change it and try to get that groundswell really. So yeah, though sometimes it's frustrating but I think it's certainly one way of getting change happening.

Lucky is an exotically beautiful looking woman with dark curly short hair and big brown eyes. When she speaks of her students, she looks directly at me, focused on getting her message across.

Normal birthing is not alternative practice (she says emphatically).

She is a staunch advocate of natural birthing with women being central and in the care of a midwife surrounded by their support system of family, doulas and whatever else they, the women, think they may need.

This advocacy for natural birthing has been and continues to be a long commitment in Lucky's life and she is proud of that fact:

I think I have quite successful with that because all the students who have had babies here, at the university, have all had home births. So the groundswell is growing, you know, they are getting the message that midwives are capable of looking after normal healthy women, and I think that is going to make a difference in years to come.

Lucky's students are generally women however, the male student midwives are taught exactly the same lesson of empowerment and advocacy. There are male students within the current intake of students. Lucky extends:

I believe in getting the student's involved and helping the students to encourage the women to be in charge of their own bodies. It's about them - the women and the students; I want to be able to give them everything that they should know so each of them can make informed decisions about the care required. The centre or heart of it is the women - it's all about them.

The place and time into which we are born and raised often affects our choice of career and certainly our life journey and when I question Lucky about her background and career choice of nursing she rolls her head back and laughs:

My father didn't believe that girls should be educated because you got married or whatever. So we didn't go to school until we were ten, and we came here and we had to go to school, so I had to teach myself to read and then you are put into a class where everyone can read and everyone can do math off the top of their head and so if you're sitting there thinking they're just a smartarse, then you are not gonna get better, so, you teach yourself faster, so you get to the point where you are equal or you know better than they are, so that sort of

shapes that part of your life. So as a young child coming from a different country, and landing in a land where everyone seemed to be so much better off than you, and had so much more food than you, shapes how you strive to get to where you're next at, so you don't want all these little white children that think they know better than you, being smarter than you, so you work harder at that.

She is fiercely protective of her background and of the people and experiences which forged her. The roles within Lucky's family were traditionally defined; her father was the breadwinner, her mother the homemaker and they had 11 children together. People experience different realities whereby individual life events, individual turning points, take on a unique importance and poignant gravity, and this is how she came to nursing:

You get to the point where there are so many people in the household that you need your own bedroom, so you look around and you find a position that gives you board and lodging. So the choice of where I trained, wasn't sort of because it was the best hospital or wasn't because it was the best education, it was because it gave me the best room! (She laughs heartily with the memory of it).

Lucky is fully absorbed in the interview, dealing with me in an open friendly approach, and not appearing to care about withholding personal information or intricately reviewing or scripting her answers before she speaks. She has a lightness of style and a well-developed sense of humour; smiles often play across her mouth as she contemplates my questions. Each of her answers is etched with personal insight, knowledge and personal wisdom which engender an authoritative confidence, a confidence she not only imbues in her students but also in me. When you are with Lucky, instinctively you know you are in safe hands. She articulates:

There are oftentimes where you have to do jobs that you don't particularly want to do, because it fits in with the rest of your life. For me they would have been crisis's because I'm not really the sort of person or nurse that

likes to be told what to do and certainly if I see things that aren't really how I'd like to do them it's very frustrating for me, especially if it's on a higher level. So those sorts of crises, I don't like to be the underling or feel powerless I guess … You're made to feel as though you can't really change the system because the policy's written as such or 'this is how we've always been done it at this hospital' and you do feel frustrated. I think my way of dealing with those sorts of things was to make light of it but eventually you actually leave that system don't you? Because if you feel you can't change it from that position you need move on to somewhere where you can feel comfortable with your work.

I worked night duty in a private hospital as the night supervisor for probably about 18 months. The actual customer in a private hospital is not actually your client but the obstetrician or doctor so, if they have bad practices or things that you don't like being done to their, to the women you're caring for, you don't get backed by the institution and I found that that was really frustrating. So private hospitals to me have not been," (She laughs), *"you know … I mean, and that's just the way the system is in Western Australia that you know there's a big gap between how women are treated in private or public hospitals. You get more midwifery led care in a public hospital in Western Australia than you do in a private hospital and that's the system. So you do move out of those areas because you feel frustrated because there's no organisational backing for it, for you changing the practice and the midwives that stay there, are happy to follow that practice.*

Making a difference is a real motif in Lucky's life. She admits that her first year of teaching could be rated as the hardest and most challenging nursing work that she has ever done; a complete change of role from a high level policy broker to a neophyte educator. She is up-front about revealing that learning to relate to the students and trying to capture their imagination within her new teaching role at this late stage of her career was extremely daunting and quite terrifying. She reveals:

I can't say I've been totally enamored by it, it's taken a long time to get to this to work to the position I'm in at the moment. I really enjoy the students. I really enjoy teaching them in the classroom now and doing lots of clinical workshop-type things. But that's taken me a good 18 months to get to this position. Mainly that's again sort of being unsure of my own abilities in this sort of aspect because it's a totally new role and also I've never done anything like this before.

But Lucky reveals that she has now developed confidence in her ability as an educator. She acknowledges:

I laugh a lot now which is something I didn't do two years ago. I think it was, it was more my inexperience with the system because the organisation is a totally different organisation to say a hospital or say a health department or a small team. The organisation, the culture, the processes, … nobody really sat down with you and said 'this is how or what we expect, this is the culture, this is how you deal with this, this is how you deal with that'. The team I was working with was the only thing that actually kept you sane because they had lots of experience with different areas and lots of knowledge and forethought.

I think it was the inexperience of not knowing how you deal with this situation and then also, when you are dealing with a big team of people to try and teach them all one thing and you know you can look around and see some people with their eyes wide open and they've got it, you know, they are really into it. Then you look to your right and you see these people that are really just struggling? And trying to sort of mesh that together because you're so used to giving orders you know and having your orders followed that you think- why aren't people getting it? I'm telling everyone the same thing … But I am so used to giving orders or telling people how I think it should be done, that actually teaching people to actually reason and think for themselves is a new concept for me to actually grasp … And that gives you pleasure. That gives you a great deal of pleasure. And now I know which people to go slow with and which people you have to repeat with and which people you can just send off.

It's learning those things as well; you know that as a midwife with your women whether they have got it or not, but with students, you have to learn the cues and how people learn and you have to sometimes say the same thing three times and in three different ways.

I observed Lucky with her students many times and her manner was always the same: an invitation to learn, to participate, and to think and then to decide for oneself, as if the student should control and determine their own learning. This is the same philosophy she espouses for the pregnant women in her care. She guides with a mature teaching style that is evidenced with patience, perspective, expertise and wisdom, yet challenges and engages the students in their own learning journey. What really interests her is that each woman in labour is a unique individual, just as each student is different from all others, and she recognises that she too could learn something new and vital from them, and she is open to that.

In the lessons where I had the privilege to witness her teaching, Lucky explained the fundamentals and demonstrated the connection between key points to her students. She worked carefully and strategically to empower the students with their own learning, deftly traversing the balancing act of good teaching, not giving students too much information, but not giving them too little either, so that they become the pursuers of learning, always seeking more. With each lesson she delivered a subtle message, one that encouraged, supported, and yet challenged them to learn. Evident, just below the surface of the overt teaching, is her expertise and reassurance. It is what lies under the surface and what we often do not overtly see when we see a good teacher teach that may be the most important. We do not see the painstaking hours of research and backbreaking background preparation that takes place before an apparently simple PowerPoint display is given and an essential lesson is learned. But what we know is that this simple exchange of knowledge and ideas is the manifestation of intense preparation and hours of hard work.

This change of role for Lucky as an academic and educator may be the most transformative and generative time in her life as she explores a new avenue to her career; she says:

I see myself at the end of my career now, and in terms of getting set up for retirement and doing things like that I really want to do. I have an orphanage in Vietnam that I support so I would like to be able to go back there and work the street kids there ... I'd like to go back and do that, and do something useful. Here you feel as though, although the jobs useful and you are setting people up to follow and do those good works, there is nothing nicer than doing it yourself.

The orphanage is in the mountains in Vietnam, and we set it up as for homeless, myself and my sister set it up. What we did was, it was just we found some pregnant street girls; they were prostitutes, with nowhere to go. So we started with one room. We hired one room, and the girls stayed there had their babies and of course ran off and left us with the babies, hence the orphanage bit, and then we've just hired workers that look after the kids. So it's now a house with, last count 52 children there. The kids get funding by, you know we put in money, but a lot of it is by donation. We encourage tourists to go and visit and they feel so sorry for the kids they end up giving us food and stuff. It's been taken over now partly by the Vietnamese government because they get the land and stuff for nothing and we just keep funding it. So it's taken, how long has it been? Almost about 7 years. It's become almost self-sufficient so they are regenerating their own money. I used to go once a year, but I haven't been for the last three years and there's been no need to because the staff has been stable. We used to only go if when something happened, like when the staff had all walked out, which happened as the conditions are really poor, but because they get subsidised by us, their wages are a bit more than if they work somewhere else, so it makes the staff stay and the subsidy is not a lot of money in terms of our wages, so ... Yeah it's rewarding but like everything else it falls into your lap and you know you just sort of have to run with it. That's how we see it.

Even though Lucky feels she is near the end of her career she is still yearning for a more productive alternative to retirement. It is not a time for winding down for her, a time of leisure and for resting on her laurels but a retirement wherein she has further opportunity for giving back, a giving of her own wealth and resources altruistically to others. Rather than being disengaged she wants to be engaged. I wonder if the lack of food and money that she experienced as a young refugee/immigrant who has 'made good' and who now lives with relative abundance, enables her to adopt such a nurturing, global-citizen type persona whereby when she sees a problem, she feels she has to fix it? I query this with her and she replies:

Why do you think of me this way?

She gives me a surprised look with a slight wrinkling of her brow which suggests that my question surprises her. She elaborates without a hint of censure:

I don't really have a persona, I just sort of, you know I mean it's just you deal with things as they come to you, you can either pretend they're not happening or you can to deal with it. If you see someone that is hungry you've gotta feed them. If you see someone who is not managing, you help them out the best way you can. Sometimes you can't help people. Sometimes they have to help themselves. Physical things you can help, you know like getting people protected from HIV is really important. Checking kids that might have HIV is really important. And they are physical things you can do for people without too much trouble. Any teenagers or unmarried women can come and get antenatal care or deliver their babies there. We don't encourage them to leave their babies there, we encourage them to take them, but obviously finances you know, it depends on that. So if they have to leave their baby and go back out to work they can, but we try to keep that contact. Most times because they are unmarried and they are young, you don't see them again. So the babies are either adopted out or they're in the orphanage until they get schooling, they go to the local school, and that's part of the commitment is to teach them. The

girls themselves if we can get them work, rather than home or instead of being prostitutes on the street; we try and get them work. They do embroidery or work in the local hotel but there is not a lot of work there for them. Another Australian woman is setting up a factory where they can do embroidery. That's got a lot of girls work that they can do, and work that will keep them out of being homeless and hungry.

Her tone is supportive, not patronising, and I realise that, as she helps mothers give birth to their babies in two countries, she also gives hope and promise of a better future, not only for those in Vietnam but also for the mothers and her students in contemporary Western Australia. In fact, Lucky is so committed to justice that her sphere of nurturance moves even wider than I first realized, as she also has African refugees who she supports within her budget. I think Lucky lives her life by the measure of how she can help someone else. Her nurturing, nursing self has apparently always been evident. She agrees:

According to my family I was always a nurse; from when I was three years old I'd be around making people eat things, taking their clothes off and checking their stomach. I got a nurse outfit when I was about four and apparently wore it until I could no longer manage to wear it, so I suppose it's something that's just progressed.

I question if she still wishes she was four?

I resort to being very childlike in the classroom sometimes, but that's part of my personality anyway. I don't think that we should take things so seriously that it becomes a burden, some things are funny, some things people say amuse me but I don't know whether its childlike or whether it's just a mechanism of letting off steam really?

I ask if she needs to use this mechanism often and she responds:

You know life was fantastic, it was very easy ... and then my husband had an accident and that shaped another part of my life. You are not so focused then on your career. You are focused on getting someone well, and looking

after and still bringing up your child and maintaining your mortgage and all those sort of things, so that makes it a bit different. Then when you get to the position of getting it all sorted out, you think - God I was lucky, gee I was so lucky, that I was able to do all this, then I'm going to give my luck to someone else, hence when you're travelling and you meet people that need help, you respond to that help from your abundance. I am not a rich woman by any means but I am richer than 90% of the people that are out there. So I feel very blessed and very lucky. I don't feel as though I've been hard done by.

It was a terrible, terrible, time, because my daughter was just a teenager so she was forming her own personality and then he has this accident which caused quite severe head injuries, so you end up with someone that resembles the person that you loved, but is not the same person.

Lucky became overcome with emotion at this point and I turned off the tape and let her cry. She doggedly continued to talk:

It is really difficult because you can't live with them, but you cannot not look after them. So you have to find ways to looking after your teenager and protecting them and then looking after that person as well because you can't abandon them. Yeah, that was really awful.

She continues with a deep residue of pain in her voice:

She's a very resilient kid herself, but you don't notice it because you're going through your own traumas and your partner's traumas ... you don't notice that they're missing out. I think she has actually coped by remaining more childlike, now so she hasn't grown up as quickly as other kids have, but I think that's ok. I've got that big extended family so ... she's got about 5 mothers. I guess she always had that support around her ... people hung around and made sure you're alright.

This was a cataclysmic moment in Lucky's life with her nursing work as a backdrop to her home life - A home life where she was dealing with something

more profound, life-changing and far-reaching on her family and herself in every way. She needed to focus her love, time and energy on giving her family the kind of attention they needed but she also needed to work to be able to support them. This overarching personal crisis changed her reality and changed Lucky forever. And the one person she had vowed to care for through her marriage vows was the one person that she could not look after. I believe this realisation is a constant form of stress for her.

We sit together in her office surrounded by some small mementos of her career: pictures with friends and colleagues; books and crafts; a 'Lucky created' space. The poignant silence is broken when her words begin again, and the cadence of her voice is mixed with a tinge of sadness giving evidence of a determination to overcome. She speaks again of her nursing work at the time in her life when she had to work long hours to meet the needs of her family:

Oh you know if you've got a young child, just having to fit in the work to, you know, with the best possible care for them, and you know being a baby boomer, well I speak for myself, you're made to feel guilty if you're separating from your child or putting them into child care, so you want to minimise that, so that impacts on the sort of job you take. So you'd take a school time or school hour's job or in my case it was doing night duty which, you know that impacts on your ability to actually influence the care of the organisational influence how the organisation carries out their care. It changes the whole balance of how even your child sees you, going to pick them up from school in your pajamas is not really, good for them! I remember my daughter running up to the car and saying to me "Mum! Mum! Whatever you do don't get out of the car" and I said "why not?" and she said "you're still in your pajamas!" So you know it impacts everything that you do even like, who would go out in the middle of the day in their pajamas except a nurse that's on night duty running late or not woken up!

Being resilient I suppose for me is having a situation that you're probably not that comfortable with and finding ways to deal with it, and to you know look at different angles of. When you're much younger you barge through it,

don't you? You barge. Barge, that's such a stupid idea that you just barge through and do whatever you like, but as you get older and more experienced you can see two sides of the coin, you sort of tend to be a bit slower at making a decision in terms of how you'll deal with it and you deal with it more logically I think, as you get older rather than barging through or pushing people over as you do it. I guess resilience gets easier as you get older because you are able to make more logical decisions.

The brush with death of her husband is a pivotal life event for Lucky and could be spoken of as a dire calamity; nevertheless Lucky speaks of her abundance since the accident and how the adversity strengthened her and challenged her to do more. I ask her how she manages to sustain herself and she says:

I don't know. I like being busy. I don't like having nothing to do. I guess one of the challenges of being in this job is having to do extra study. That probably stresses me out more than anything else. Because to me that's wasted time. I could be doing actual physical things I like. I enjoy reading for the sake of learning something, but having to actually do assignments and that sort of business is probably the most stressful thing in this job. I enjoy homemaking, I enjoy gardening. I enjoy sewing. I love doing patchwork. Having to study doesn't give me the time to do that, but you cope by putting your life into little compartments, you deal on this in this day, like between 6 and 8 in the morning is the time I spend with my dogs and doing my exercise and you know nobody's allowed to interrupt that! You know 8-10 at night, that's my reading time and nobody's allowed to interrupt that, so don't ring me again either! I suppose you just work it out the best way you can.

I realised later that the quilting or stitching and joining together is an apt metaphor for Lucky's life as she often involved personally and professionally in the mending and healing of families. In her world, this handiwork brings support, warmth and comfort, and with her quilting, craft, reading and daily exercise with her dogs, Lucky mends herself, drawing the line that no-one is

allowed to cross for her own self-protection. This is her time to replenish herself after a day of stressful work by doing the things she needs for work-life balance and for a sense of self fulfillment.

Lucky resonates with the humanistic impulse of wanting to make an impression on the lives of others, whether it is her students, her family, or the wider community. She is an advocate for all of them, nurturing them all on a daily basis as evidenced by: her guiding the next generation through teaching; being involved within her local community through community education and advocacy; and her global activism through her orphanage and family support work. She uses her skills and the 'abundance' she says she has in ways to benefit all; and she actively seeks ways to contribute more meaningfully to the world. I tell her we have come to the end of our discussion and she turns her head to one side and says quizzically:

You know you do become resilient about changing the little things that you can.

Enough said.

GINGER

"You have to have faith in your ability to bounce back"

Ginger works in the nursing academia setting. Idealistically academia appealed to her intellectual interest; however, pragmatically, the academic setting has not met her needs. She hates the sterility and the lack of abstract thought that cannot occur because of current academic workloads; and she hates dealing with the never-ending trivia of enrolments and paperwork.

Ginger started nursing at age 23 after teaching for a while. She tells:

I did hospital based training and then decided to do my mid, then my conversion degree, then did a Bachelor of Nursing. I went on and nursed for a little while in the hospital setting, probably around 2 years, and then I went on to work at ... University, and then worked in the university setting which I did for about 10 years. I got a PhD and a Masters and ... then I returned to the clinical setting.... Three years ago I came back to the University setting and, basically I suppose, my nursing career has been about working in education, and in education roles, or in fairly senior jobs for 20+ years.

Ginger devoted her youth to her schoolwork and was an excellent student. She has a photographic memory and was admired and respected by her teachers and peers. Nowadays, this intellect is marvelled at by others but even as she works diligently at her tasks she denigrates her own intelligence by saying:

If I couldn't be beautiful I could be brainy.

She worked hard so as not to disappoint her father, whose good opinion she sought for the whole of his life. Her face is halfway between a smile and a frown as she ponders his large influence on her life.

Ginger is currently questioning her working life. She is questioning her academic career and wants to reinterpret her academic vision. She slumps into the chair and says:

I'm overwhelmed, completely overwhelmed.

I ask whether it is her workload which is overwhelming her. She replies:

I think workload is significant because I think one of the difficult things to do is that you have to equate your work hours with workload points and justify your workload. You never experience a sense of completion and achievement. I have a book with lots of squares in it and often the squares don't get ticked. Often you go home and you don't know what you've achieved in the day. We might have achieved 60 things but there are 90 more things to achieve. So you never experience 'I've achieved this - it's complete!' There is also the demand of being a good teacher, a researcher, a publisher and answering 65 phone calls. 65 phone calls a day and the 3000 e-mails a day and you are never praised for the good things you do but you're held accountable for the one bad thing you forgot to do, and that's very disheartening ... You have to have faith in your ability to bounce back. As long as I am a good role model for the students and the other academics I am happy with that.

Ginger continues to comment on what she feels is important:

I think you need to be resilient to face the crap every day, but I think on the day where you are resilient, the amount of work is irrelevant as long as you feel supported and valued in what you do. I surround myself with people I like because they bolster me of course. If I share a common sense of humour - they see fun in the things that I see as funny, or they have a particular mindset, or that I can have a conversation with them, or that they are intelligent.

She feels supported by a group of like-minded colleagues who support her, offering her a strong sense of kinship and camaraderie.

She is silent for a time and then launches into describing her discontent with her lot. Her voice is heavy with the changed tone intimating that she is upset as she says:

A lot of the time in this particular unit you have to play dumb in order to ... it's crazy to play dumb in a unit which is supposed to be a place of higher learning! I find that very frustrating, that's not because I'm so clever- it's just because I would expect to have a clever conversation with the people around me. Eventually ... my resilience factor will kick in and my pragmatic mind.

I know that I'm the kind of personality that would get easily bored, and perhaps I'm easily bored here - not stimulated enough here by people around me which makes my bouncability back hampered. But as long as I keep myself entertained with things that challenge my mind, I'll probably function.

I think the biggest thing for people who work in the sector is to remember you're here because you actually enjoy nursing and you enjoy the students. Often people think you come to the university sector because you don't like clinical practice. I certainly came to the university sector because I thought I could make a change. Because I thought the students that were coming out were crap when I worked in the hospital sector. I thought I would be a change agent and I would change what I've learned over my time. Of course the fact is, that we in the university sector work very hard to ensure that the central ingredients of nursing are carried through, but ... some kind of transition occurs where we teach them about patient care and holistic care, but the hospital sector socialisation is so strong that they forget everything they have learned in Uni. - that's my impression.

Ginger lets down her guard, and the protective horny abrasive shell that she dons for survival is pried open just long enough to release her story. She breathes deeply, sighs, and begins again, attempting to incorporate a coming to terms with the extent of her feelings. Rawness comes to her voice as she tells of the chronic and subtle negative experiences that have worn down her spirit, and made her weary and frustrated. Rather than any specific grievances she feels she has been dealt with unfairly and undervalued for the work she does. She reveals:

I've recently shown a lack of judgment re my colleagues about their trustworthiness ... and generally I'm the kind of person who doesn't trust anyone. You have to prove yourself to me and when I have been more trusting, sometimes I've been disappointed with this cut-throat world.

Where I have given someone the benefit of the doubt and trust, and where I've supported them, they have turned around and misused that trust - or not even misused it, but the fact that I've helped them - that I've been in the background - that's not a factor I should have to worry about, but sometimes in that we play in the playing field – it's one upmanship. There are people, some people that I've worked with that probably don't see the world as I do, in that you don't step on others to get where you are, or you don't ignore the people who helped you along the way. There are a lot of people that I've worked with that tend to forget the people who've helped them.

Ginger realises that she needs to shift perspective so that she no longer gets hurt or disappointed in people but she still wishes to challenge the institutional injustices. She feels she has not yet learned to play the scheming games that she believes her male colleagues have played with such subtle finesse for so long. She hates to feel this way, a smouldering bubbling anger below the surface and claims it is not a response to one singular incident, but rather a reaction to an accumulation of chronic and subtle affronts to her spirit that occur on a daily basis. She is courageous is speaking to me of how she truly feels as she acknowledges:

I wipe off my knees and keep going despite adversity … I come from a family that taught me you just need to move on and get on with it. I am disappointed sometimes with myself because I don't appear to be as resilient as I should be and could be from my stoic upbringing. I think we are brought up, certainly in my family, there is an expectation that you cope regardless and I think the pressure has been to cope

regardless. The pressure comes off sometimes when you're not coping and that's resilience … I'm a pragmatist and realise as long as I do my job I am not too much affected by what happens to nursing outside my realm and I guess that's the resilience factor I have in me. You can't care for everyone and everything. You can only care for what you can care for.

With age my tolerance factor has changed and I guess it's not even tolerance … or my 'care less' factor has increased. I don't think you can measure resilience as an increasing factor or a decreasing factor. I think resilience is a character or attitude some people have and others don't. I think that depending on how full or empty your glass is you're more resilient. I think when you get tired your resilience factor drops and you are not as resilient. That's a given, all things being equal. Resilience is a good thing but not all people are resilient. Some people are victims- some people have a victim mentality. They will never be happy because they've spent their life being a victim, whereas there are other people who make the best of whatever they do.

Telling her story is cathartic for Ginger as she can express her displeasure to an outsider, which diffuses the frustration she feels, but gives her the opportunity to voice it just the same. She needs to find a more creative or inspiring or peaceful way to assuage her frustration because she says:

I find happiness and joy when I am writing and publishing and I'm having fun with my colleagues and with some students. I actually get off on seeing other people do well. I think that's a quality I have. I have learnt that there are two sides to every story … I'm very open to people

at all levels, and I am more aware of issues that they experience. I have leadership qualities and I think I have qualities that bring people forward.

Now in her fifties, Ginger is trying to prepare students for leadership positions, which she does outside of her work role and requirements. She does it as an extracurricular engagement opportunity - giving of her time and expertise to the students and the University. She is also a mentor to higher degree students, assisting them in building self-confidence in their research and encouraging their ambition through discipline and hard work. She formed a higher-degree student coffee club as a social network for those students to join together for support through their research undertakings. Yet she still takes time to have fun. She exclaims:

I will disrupt my colleagues to entertain myself and I'll drag them off to be naughty with me and that can be a frustrating point with me but it builds my energy. It probably stresses them a little bit! It does, but being naughty and having fun puts things into perspective. It's childlike and playful. I think people would say when I am at work they all know that I am here because I'm noisy. I'm not noisy because I'm stressed or tired though. They always comment 'the passageway is quiet', so I think being noisy and silly rejuvenates other people. I actually feel when I am being noisy it rejuvenates me and I think when running around being noisy it brings energy around the place and makes the place more fun to be in. I also go home and sleep!

Having lulled me into a sense of frivolity as she talks of fun at work, Ginger suddenly reveals a side of her story that is quite

confronting. As she continues her ruminations, her voice becomes thick with emotion as she says:

I think the thing that's probably made me a better person in terms of my nursing and as a human, is the loss of my children. I don't think people ... having lost custody of them which reflected very poorly on me as a female and as a parent, I don't think anyone would understand what that means, and that's still something you work through even 15 years later. You still have all the guilt of that, and that has probably made me more resilient in the sense I am always actually worried about people who appear resilient all the time, because for me, that's an act, a show that's something's not right. If people appear to be all right all the time, then that's a show that they are putting on, a face that isn't necessarily authentic.

I realise that my eyes have widened in amazement and that I'm sitting ramrod straight in my chair listening to a gushing avalanche of words. She seems to be saying so many underlying things and speaking on so many levels, but we do not explore this aspect of her life further – as I can tell it is too raw.

Ginger remarks that the brunt of her dialogue may be:
Too much and too out there!

And says that it may unfit to use, because she believes that what we talked about was:
Not what I wanted to hear!

Yet this is untrue, however, her comments reveal her frustrations and reflect the many stressors that Ginger tells of whilst relating her story: the loss of her children; the curse of being an intelligent woman with the lack of respect and valuing that she feels is part of that; and the lack of a stimulating work environment. Her personal story has episodes of trauma, juxtaposed with her work life which is also causing her pain. But Ginger is not defeated by her disappointments; she has no time for lament. She reflects, but moves on. She acknowledges the strain that both areas of her life have engendered but laughs them off, shaking her head and saying ruefully:

I'm a sad lonely woman who'd lost her children and her way, but a woman who has bounced back.

With age comes wisdom, but I believe that Ginger is lonely, not only personally through the loss of her children, but she is lonely professionally, and I think most of all, Ginger is lonely for stimulation within the academic nursing setting that she feels is inexplicably but inherently missing within her workplace. And she misses the lack of recognition which she juxtaposes with meaning, success and happiness at work. But what is evident is that she is resilient and she will 'Keep calm and carry on'!

The Canvas: the tertiary hospital setting

The final three portraits are of nurses working **in** a tertiary hospital in Western Australia.

The tertiary hospital where Vivien, Jean and Jade work is one of Western Australia's busiest with a very busy emergency department, medical centre and community health clinics, as well as wards and clinics serving the specialties of

mental health, obstetrics and gynaecology, palliative care, and critical care. The units all service a large geographical area.

Along with this, the hospital is undertaking expansion and refurbishment to cope with the growing demands of the population. I make my way past 'detour' signs and 'work in progress' signs through the car park to enter the hospital to meet with my nurse/participants Vivien, Jean and Jade.

VIVIEN

"I've never worked so hard."

The Intensive Care Unit (ICU) is painted in pastel blue colours with checked curtains framing the windows in the six-bedded unit. Each cubicle has the usual and required ICU equipment: suction, oxygen, intravenous stands and pumps, sphygmomanometers, ECG monitors, and the trolley containing emergency medications, syringes and needles and the various other medical equipment required to save lives. Other general medical paraphernalia is visible - sinks for hand washing, hand washing liquid, sharps bins, chemical waste bags, rubbish receptacles and the chairs and call bell for visitors. A young resident doctor sits at the unit desk reviewing e-mails on a computer. The unit ward clerk nods at me and speaks in a lovely Irish lilt "It was a horrible day here yesterday. Today doesn't look too bad!" She collects patient file notes and then moves off to begin filing paperwork.

A patient opposite the desk is offered a drink of water through a straw. "I can't" he says. "I don't want it: no!" His strong and emphatic *No* reverberates throughout the eerie silence of the unit. He has three intravenous drips in situ, one of which has additives. He also has an indwelling catheter. The nurse caring for him comes back to where I am sitting making notes and spontaneously starts to talk to me about the patient who had been in the unit the day before as all the staff appears to be affected by the events of the day before. "He was very young too" she said. "Only 44, so I am just reading his notes again. He died you know. I looked after him for the first 3 hours after he came up from ED. It was very sad as he had three young children under 10 and a lovely wife and a very supportive family. But he was gone you know really before he got here, but the adrenaline they gave him started a

rhythm, so everything had to be done. The scan revealed and confirmed what the wife said. He had been down too long, so the tubes were taken out and he went within 30 minutes." She smiled regretfully at me and walked off.

Each nurse moving through the unit is dressed in navy trousers and pale blue patterned shirts. Each has a stethoscope draped around their neck and they walk around the unit with a determined pace. To my surprise the staff I see are noticeably very young. Most appear no older than twenty to thirty years of age. A student nurse is easily distinguishable by her crisp white uniform top with her university logo emblazoned on the pocket. She moves to the staff area to make herself a coffee for morning tea. There is the clink of glassware as cups and saucers are joined together in anticipation of refreshment. It is time for a break and Vivien now has time to talk.

Vivien is a tall, tanned woman in mid-life who walks with upright back towards her office whilst carrying an armful of files and folders and motions me to follow. She seats herself at the desk in her office, her hair perfectly coiffured, her make-up looking as if it is freshly applied and her nails, shaped and manicured. She has twenty-nine years of nursing experience behind her. She suddenly slumps in her seat and takes a deep breath and begins to speak. As she relays her exhaustion, Vivien begins to reveal and expose herself. In telling of her experiences, she searches for words and begins tentatively:

My workload is such that achieving one thing in a day gets me through to the next day … It is a hard slog; I've never worked so hard. I've a very high standard, good or bad, because I don't settle for second best for myself. I am constantly putting pressure on myself - I need therapy - that's me! It's exhausting. I like to work full-on all the time!

Vivien is full of anticipation of what she can achieve in her work. She becomes animated and focused, her talk is rapid-fire, listing this

and that work still to achieve, carrying the listener along in a wave of enthusiasm for the tasks ahead. She proclaims:

I'm overwhelmed at the minute. I do feel overwhelmed every day. I would say I had lots of ideas about implementing stuff but I don't have the time to organise them – paperwork and electronic e-mail is constantly overwhelming. I think middle management is probably one of the worst jobs in the entire world. But you can make a difference. With people management - you cannot please everyone and everyone wants a piece of you ... bottom up, top down ... everyone thinks you have to answer to everything and you get pulled all over the place. Time management is totally disrupted by everyone ... it's such a difficult job.

Good managing is a prodigiously difficult job. Vivien recalls how nursing became her way of life, indeed part of her character. She was always interested in the welfare of people and always felt a particular connection to nursing. She is animated when she speaks of her profession:

I qualified in '81, so it will be 30 years in nursing next year. I trained in the UK hospital system. I've been, we call them sisters, a Senior CN, ICU, and 2 ward management positions. I've been a unit manager. I was a nurse consultant and came here for a staff development position, then I went to the University and did unit co-ordination, and I am now Clinical Nurse Manager in WA. Critical care- that's my love ... coming from a completely different system to here, in particular, the governance of the critical care unit is so different. I was used to working very much in partnership with the medical staff and it's not like that here. It something I'm working on and something that I'm changing in this post and I found it very difficult to cope as it is not as autonomous as in the UK. I know a lot of UK nurses would agree with that, so that has been very challenging for me.

Her desk is covered with computer equipment, files and medical records, the bits and pieces of management. She continues:

I managed most things. For instance: new protocols. We did a weaning protocol for ventilated patients in discussion with medical colleagues and senior staff. Everything was very cohesive. I set up meetings…. morbidity and mortality … It would not happen here. I am trying to change the culture here to break down the barriers. There are barriers here I think because of the historical, the history and medical … a lack of cohesion betweens professionals. I am not sure why? You have to prove yourself. I had to do that in the UK as well; show yourself to be experienced and knowledgeable and dependable. You have to prove yourself everyday initially. I think that when you come here you accept the difference and it's a challenge and I want to make a difference. I love nursing. I would nurse in any system at the end of the day.

Vivien seems like a profoundly committed nurse. What is immediately evident is that she is very hard working and very hard on herself. She says she is a perfectionist and it shows. More listing of her work role occurs:

My role is developing practice; policy affecting patient care, weaning protocols, work practices, updating everything. The girl in quality keeps ringing. I feel really bad - it's not evidence based … It's the academic level that I'm trying to bring, to brush it up, to be A1. I'm an academic snob! You see, it is because it is the right way to do it, that's the way I am … I just knuckle down and I do the work. I work my arse off and get it done. That's hard work it is.

I ask her does she try to do too much. Her answer is vehement:

I stay in nursing because I want to make a difference, and it's cheesy but I can see lots of things to improve outcomes for patients. I like to think I can lead by example that I've been doing it a long time and that there is no substitute for expertise.

This statement sheds light on Vivien's thoughts on the realities and responsibilities of her role. During our discussion, her expression

changed markedly, indicating that she was emotionally affected by our conversation. It is not only the inability of trying to maintain the perfection she is always aiming to meet that makes her impatient, (and probably exhausted), but the inefficiencies of the system that often does not meet her expectations. She declares:

There are more ways to skin a cat- experience has a lot to offer. I'm happy in nursing but the pressure in this position is very high. I do a reasonable job. I'm a good nurse - that's what keeps me here ... I try to make the right decisions. I try to lead by example. I feel like I'm doing that anyway. I feel like I am a reasonable manager ... I am not conscious of it, but I do it naturally anyway.

She skips over a recent management incident quickly, her voice hardly pausing:

We compromised - it doesn't sit well with me. I said to the boss I will not compromise the patients.... (The change) ... is a token gesture - but I am very worried about opening the floodgates. I wasn't comfortable. If it was affecting patients, I would go; I would have to make a stand-make a protest - if it is not optimum for the patient.

Vivien is a charismatic woman with a gentle presence and the previous fervent words were striking, giving me a palpable sense of the passion she has for advocacy for her patients, and the moral and ethical stance she is willing to take for her beliefs. I nonchalantly suggest that ICU nurses have a reputation for eccentricity and that ICU nurses often regard nurses from other units with something between fascination and bemusement, as outsiders who cannot possibly understand the complexities of the ICU. I wondered if Vivien agreed. She does and she says:

Ward nurses are not on the same wave length you know. The people, the ICU nurses, have a different sense of humour. We can laugh in the darkest time and I think there might be something we're really pissed off about or at a member of staff and we have a laugh at their

expense (on the quiet). I think it's about being with people at their most vulnerable, building up a relationship with people at that time. It allows me to function and socialise better with my family, I am more tolerant. I'm probably over sensitive; I react, like re the floods in Pakistan - they made me emotional. I am a reasonably good person, I'm an ok person. ICU nurses are controllers - we like patients flat out and we like to have total control. We like the adrenaline thing as well … There's been lots of patients that have unsettled me, children and stuff, but I have never thought about leaving nursing, never.

Along with her serious commitment to the patients is her care of the nurse's in her charge. She laments:

My staff is under stress. There is not enough staff to cope. It's important to be very supportive of staff members because by doing that, helping them, it also makes yourself feel better by debriefing with them. We've got to plan longer term than at the moment. I could sit on my arse and do the bare minimum … the 4 hour rule is a huge quality initiative - the demands are much higher demands…. I like change … no patient stays longer than 4 hours before admission or discharge. This quality initiative impacts the whole hospital which is good. Stuff could be improved upon. I'm in a group looking at the role of the coordinator which is more work. There is a big impetus to get patients out of ED and the pressure is on us!

We are all faced with challenges you know, we are all touched in a different way by events and patients. I don't think there's a difference; we're all affected differently by different things you know. It is difficult here because you're all intimately connected with the patients. I don't see why we are supposed to be more resilient, we're faced with different situations – we do have young people, who don't survive, but to me it is how you pack it away in a little box at the back of your mind. You have to, and you move on.

With experience – it comes with experience - you deal with it and try not to take it home with me. There so many other things going on in the world. You have to rationalise you know: sometimes things happen sometimes for a reason. I'm not a good innings theory - as long as I did the best I could, the nurses did their best, the medical staff did the best they could. Shit happens! As long as we did the best we could - obviously tragedy is all around us.

Vivien finds it difficult to leave work at work. She finds herself thinking about work all of the time, and would like for this to improve. The Weekend - the collective symbol for breathing out and when rest can begin - is not so for her, as she often goes home too exhausted to relax. She articulates:

Sometimes I worry about what's going on on the weekends. I have to make sure it's covered as they all are very inexperienced.

She harkens back to the management issue that she mentioned earlier:

The issue on Friday with another department, due to lack of communication … I spent my days off on the weekend still thinking about it, not so much the patient situation, but how I've handled it, how I would handle it in the future, what I've got to do now.

Vivien often feels overwhelmed by the management load and the added responsibility for patients and staff. She says she often leaves work both mentally and physically exhausted often crying over the stress of her job, but would return the next day because it was just what she had to do. She states:

I got cross on Friday. I try to show that I am fairly static here but at home I'm just evil, very short tempered, very tired. I'm starting not to socialise, not exercise, my diet is out the window, but at work I am absolutely fine. My children don't see a great deal of me, certainly not quality time. My husband gets fed up with my moods and my coming

home late quite badly really. I try, I do recognise it is short-term, and I do try at the minute. I'm studying. I've dropped my hours a day a week because I've got a core of people filling in for me so I'm becoming much better than I was, but back to more work.

Vivien describes her love of learning and her appreciation of the process of learning with the mental calisthenics it entails and her love of developing new skills. She is captivated by the variety and challenge that education offers and says:

All the education I've bloody done over the years. I'm a perpetual student from practice to challenges to Uni. higher education. It is all so interesting.

She changes suddenly and swiftly becomes pensive and melancholy and continues:

I was just about to see a colleague who died quite quickly. She had a young family and I suddenly thought what about me missing a symptom? I have tried certainly to reduce my hours and it has made me contemplate a change; my family life is more important. I think it possibly is? I have had issues with reverse bullying - emotional stuff put on me by staff for holidays and blackmail. I do try to give holiday's etcetera; I am a bit of a soft touch. We've all got lives outside of here but bully me and try to pull the emotional card and…. but with experience comes wisdom and hope.

At work I am generally in good spirits, but other people's lack of organisation and communication gets me down. The company initiative and skill mix; the resistance to EN's in CCU has caused angst, as we don't always sing from the same hymn sheet.

Just outside the windows, workmen can be seen moving amongst scaffolding. There are major changes about to occur here at the

healthcare facility, not only with buildings and structures but in other areas too. Vivien muses:

I think people are receptive to change. I've worked very briefly in the public system, but here if I want to make a change, I'm empowered to do it. I think that's very positive, whereas in the UK, the hierarchy you would have to go through! Here is much more open to change, so it's a pleasure in that respect sometimes. I'm learning, yes, that they will listen if you are accurate and have a good plan.

I think I have been quite fortunate - oh I did have a crisis - I went to do some clinical education in a big teaching course. I left my teaching hospital and got pregnant and applied for my old job back, but I interviewed appallingly and I didn't get the position. Then they offered it to me because the other two people didn't want it and had turned it down. That was a real test of my resilience at that point. It was an ok job, and I did the job 10 years.... but I felt very, very let down. I think it was the whole situation because that was my training hospital, and I had done that job for a long time plus was pregnant – it was emotionally telling. I nearly said 'Forget it' but I took the job, went back after the baby, and I moved on.

I have usually ended up loving each place I have worked within months. Sometimes though, there is the stuff you want to do, like, but I don't have the time. We have a new unit to open … it is very frustrating. The new unit, part of the re-development of the hospital, is to open in less than 2 years - a 25 bed purpose-built critical care unit. When I came into the post I was expected to develop it you know, but I'm a nurse, I'm not a bloody architect. I didn't know what they were on about half the time. Your name is on it, you signed it, and it has increased your workload tons. Stressed!

She is caught in the momentum of telling her tale and regales:

I think resilience is about being able to cope and not be affected by the situation and people that we meet and have to care for. I think it's being able to deal with things in a resilient way without it dragging us down and I guess resilience is coming back each day and doing as good a job as you possibly can despite what has happened to you in nursing because it is the number one thing in my life. Gosh, I suppose it should be wife and mother?

Incredulity is written all over her face as she realises that in allowing herself to be involved in this research and to tell her story, she has allowed herself to reveal her true self and be vulnerable, perhaps to expose her not so perfect self? This experience has shocked her somewhat and made her think, but her vehement statements such as**;** *"I would always be a nurse"* and *"nursing is the number one thing in my life"* are simple and full of feeling. I pack up my gear and leave her to ponder.

The unit cleaner knocks on the door and enters with mop in hand and begins cleaning the linoleum floor. My time with Vivien is over but the unit's work must go on.

JEAN

"That's my idea of resilience - taking it on the chin with the ability to go back for more and feeling that, accepting that, you didn't do something very well, but you will do better next time … but you have got to have rhino skin to be an after-hours manager."

At the outset Jean felt that there were many others who would be better subjects for my study. Her lips crease into a perplexed smile and she raises her eyebrows to question my decision to interview her:

After all, I'm Scottish!

Jean is a tanned healthy middle-aged woman with medium length blond hair that is thick and luxurious. Her face is framed by lavish, blonde curls and her appearance is indicative of a woman who takes care of herself, certainly a woman who takes pride in her appearance. But this superficial beauty is not all that is Jean, as her beauty is imbued with a quiet authority, and her words and actions command instant respect. She does speak with a Scottish lilt in her voice, articulate in defining the character of her work yet she is, at the same time, so softly-spoken that I must move my recording machine closer to her and have the volume on high to record her utterances. She starts:

All I can say is, I don't think just anyone can do what we do. It's not just emptying pans, there is sadness, and abuse and we come back for more. I love it from years ago; I wouldn't do it now! It's a lot harder now and there is not the same respect for nurses now. Police would give you a lift; bus drivers wouldn't charge you a fare. Patients are more demanding and patients are unaware of how busy we are but are savvier re litigation and internet savvy. But it is my passion; I love ICU and I love being able to get patients through a cardiac crisis. I couldn't work anywhere else; there

is not enough challenge. Nursing is a challenge and I am an adrenaline junkie. I love it when the shit hits the fan.

I ask Jean to describe the differences between her experiences in Scotland and in Western Australia and the memories she relays are vivid and animated.

I trained in London at Greenwich District Hospital, then thoracic at Glasgow, then worked and was promoted to Ward sister within 6 months of graduation. I was in ICU for many years; I spent 10 years in ICU in the Middle East and then I came to Australia. At a major teaching hospital for a short time, casual work, then a specialist Spinal Unit, then 10 years at this hospital casual as I had a small son and was more interested in school- cake bakes etc. And then I got a permanent position in nurse specials here.

I wanted ICU but there were no vacancies, so I did relief CNC, After hours as nurse manager, then CN Consultant as a part-time position for three and a half years, then after hours manager for 3 years after a coroner's case because they needed senior nurse experience to oversee the hospital. It's not too difficult to do the dual role. After hour's manager is not clinical- MET calls are usually for logistic reasons to see if you need more help or you need to move patients or bed moves to ICU.

With my insistent prodding she clarifies her expansive role and responsibilities adding descriptive detail and facts, with sometimes a look of pride and at other times a look of dismay upon her face. She enlightens:

The after hour's manager works in partnership with the CNC. If in ED I see a patient not looking too good, I'll phone the CNC and say can you come down. I look over at this one- he looks pretty sick-so I just find out what's happening- it's easy to go from one to the other. I don't particularly like the CNC role because sometimes you can get used as a gopher, like: 'We've got no pumps on this ward. Can you see if you can find one?' Or 'We've run out of whatever antibiotic', and instead of nurses calling a

ward to say have you got this or that, they have started, increasingly … to call me. We should be empowering these nurses, not making them useless. I get phone calls like, 'This patient's got an abnormal BSL!' It's frustrating, and these nurses on the wards are CNs and quite often it's the CNS being used as a 'get out of jail free card'; they think, because they told the CNS, they are not responsible. It's just started to creep in … I think it's easier to pass the buck, but there's not many a time that you're called to see a sick patient and it might be half an hour before you get there, and the last thing they have entered or documented is - CNC called. So it's quite a lot of junior nurses. I sometimes feel my role is to police things.

Some of what Jean describes, the lack of experienced registered nurse resources in the acute hospital, and their lack of accountability and responsibility for the use of their knowledge and skills, worries me. When I inadvertently remark: "That's a worry!" I am at first given only silence in return, and then her voice is full of emotion as she begins to describe her feelings for nursing, nurses and the patients in her care. Now I can start to glimpse the measure of the woman before me as she reveals evidence of the standards and measures that she models herself upon. She is thinking of her work and what she wants to and must achieve to be happy in that work. She is a nurse whose career is mature and yet she still feels frustration at what remains to be done. Jean says:

One Friday late at the 3pm meeting, the manager handed over a patient with a heart rate of 180, so I thought I must get there first, but I got called to another MET call so didn't get there till later on and when I spoke to the nurse in charge I asked re the patient. She said, 'I think he's all right'. I said, 'What's his heart rate now?' She said,

' I'm not aware'. I asked, 'Who is looking after the patient now?' I went to look for the nurse. I said, this happened at 12 o'clock, and I come on duty at 3 o clock. I never got there until 4 o'clock and I said to the nurse, 'What's his heart rate now?' and she said 'I haven't done any obs!' 'I said, "Do you think this man needed obs.? Have you

many patients? Is this man your priority?' I just went in and took his pulse. I think it's that easy, but even when I looked at the chart, it was not recorded at 180, so these are the things you have to do nowadays- it was junior staff.

Jean continued and said that she spoke to all the nurses later about the incident. I have no doubt that this gentle speaking woman can be quite tough on those who do not meet her principled standards as she puts the patients in her care first- as she should, as a professional nurse. In a steady voice but one which reflects expressions of weariness with the system, she extrapolates:

I have been noticing that there is definitely a change in skill mix. There was a big change at one point, when I first started. It was all older people; they were all women with families, very few younger women with a lot more skill. The mix now is pretty grim. You can get maybe three grads on the ward, so lots of pressure on the nurses on the ward.

Her face is a mask of composure but the constant requirements of supervision to keep the care to her standard appear to be taking its toll. She continues:

There are more acute patients on the ward, sicker. We have a big DPU so small surgical things are constant and the patient gets discharged. So what we are really getting are elderly really sick patients and a very high amount of medical patients. The wards have people in their 80's, confused, difficult to look after, so I would say that that has changed definitely. We get the quick turnaround and more acute.

Jean is seated at the table and holds a coffee cup between her hands, but constantly raps and taps her coffee cup with her fingers. Deciding whether to participate in this interview was a tortured process for Jean as she does not feel that she has a vast litany of relevant information to tell me, but I continue to listen to the cadence and style of her words. I know she has presented herself to

me as a research participant and feels in a vulnerable state. She is questioning her role within work and the role of work within her life at this moment in time. She is wondering whether she is being true to her values by continuing working within her current role or whether there is another place more worthy of her input. I ask her, 'Did she think she could change the world as a nurse?' She pauses to consider this and then she responds:

No. I think you now have to prioritise a lot more now, that's got to be a huge part of work. You have to be work savvy, and just learn to work quicker and harder; that's basically it. It is challenges and frustration for all of us. The nurses can't do what they want to-do for each patient but I think there is good team support, and we all think, "Tomorrow I'll do a better job; I didn't do that very well but next time I'll do better; next shift will be better". That's what keeps them there. Nurses are very good at reflecting.

Jean paraphrases and then speaks with the seriousness and humility that often grows out of experience:

I think it's the vast majority of nurses who think like that and I think that. I know I feel like that or you wouldn't stick at it. When girls go home or I go home you'll think what a shit of a shift, but you think we'll sort that out tomorrow. They are resilient; it would be just being able to, or a big part of it is being able to reflect on the challenges of the previous shift. That's my idea of resilience- taking it on the chin and the ability to go back for more and feeling that, accepting that you didn't do something very well, but you will do better next time.

Jean believes that the atmosphere of a place is extremely important. She speaks of the contrasts between some facilities that she worked at whilst deciding on where she would potentially stay to live and work. When Jean first arrived in Australia from the Middle East she tells:

I had a hard time adjusting to nursing here. The first time in Australia was party time- we were in our 30's and I worked part time. I worked at one of the major teaching hospitals and found it very unfriendly. I found them most unfriendly, the most unfriendly place ever to work in my life and I worked in cardio thoracic, and then went to the specialist spinal unit part time and I was there because of my ICU background. They kept on shoving me in a single room with a ventilated patient with no-one to give me any breaks, because they were all too scared to come in because they didn't know what to do. The second time when I came back to Australia again at that major teaching hospital I felt like an outsider- I didn't belong. I stayed six months and gave it my best shot- there was no team work, maybe one or two people were personable.

I had been in management previous to that. I was going back to work on the floor because it was convenient. A manager had said to me, 'What are you going to do?' and I said 'When I go to Australia I won't accept anything but management', because by that time I had been acting up for my previous hospital. It was a big hospital 1000 beds and also stepping in for the deputy director. So she looked at me and said 'Do you need the money?' I said 'No' and then she said 'You have a 5 year old son, don't do it, be there for him and his new school'. So that's what I did.

After a long pause, Jean hesitantly says in a pensive, melancholic tone:

Nursing is my whole life. It's the people you work with; I've a lot of good caring friends. But my job takes so much out of me, definitely middle manager stress. After hour's manager is huge stress and huge responsibility from fire, engineering, clinical, security issues, complaints, staffing and other issues, and the continual interruptions; you cannot hold a 5 minute conversation especially on late shift. It's constant because of phone calls and it's just constant! You can get really frustrated due to sick calls and guilt feelings if you are leaving the ward short.

But I love the challenge. Once there was a snake in the canteen and another time a kangaroo in the car park! I deal with it when handing over to other managers; you just get it off your chest. How am I going to deal with this every single day? I handed over a shit shift and phoned later to ask, "How's your shift because you are on your own." Things like the ED consultant rings and says, "There are 69 patients in ED- what do you want to do about it?" Or surgeons wanting to take patients to theatre at ridiculous times! You have to stand up and say, "You're not doing it!"

There is a sense of frustration in her words and in the tone of her word**s.** Yet her manner remains measured because she has seen and lived these experiences for quite a while. There is a questioning of the hierarchies, restlessness and a querying of authority for legitimate reasons concerning the health care system and its staffing problems as seen by middle management**.**

She still notes:

I'm happy by myself. I can be a team player but I like the autonomy. It can be upsetting; the doctors can be downright rude at times. They will threaten you, like saying, 'If anything happens to this patient …!' I suppose I haven't thought of it as abuse because I'm of the old school: Ward sisters, Sergeant Major Overbearing! I'm used to it; the consultant is the boss!

Jean brings intensity to her work which is quintessentially her. She is dedicated to approaching her work from a variety of perspectives to seek out what works best. She is a woman of action**;** she does not stay still and her face and hands are always in motion **-** the face grimacing, the hands gesturing and both punctuating her words. I question Jean about her love of nursing, "Is it the same now as it once wa**s?"** I wonder whether the issues of middle management are ultimately disenchanting. I think she feels her job is necessary work but that nursing does not sustain her heart as it once did. Is it nursing or is it

management? Jean's language is plain and evocative as she takes time to consider my ruminations and to reflect on her answer:

I never ever think of it that way. The AH managers discussed recently our role- We look after everybody's team- but there is a definite lack of respect for after hour's managers. It comes from the managers. We're under pressure for KPI's, i.e., "Fill the place by midnight- if patient in ED, if seen, and get them up in time for census.

The following day at the 9am meeting, with no after hour's managers represented there, they question why did they put that patient there at this time? This does upset the after hour's managers. Who put this patient in after midnight? Who was the after hour's manager? Why are certain patients in this bed and not that place? They are not there at the time and don't know what happened. At that time maybe that surgical patient went there because it was the only patient ready to go up, and it filled up a bed for KPIs before midnight. This is a big bug bear for after hour's managers because they don't know and they're not there to see why, and we get the snotty e-mails to explain why.

That's the most horrible part of the job I would say - not getting respect, and the question, "Who was after hour's manager?" "Oh! I might have known!" AH's managers have no time to build relationships; it's a 'them' versus 'us' attitude. You have got to have rhino skin to be an after hour's manager. They only see what's not done, not what has been done. But that's the lovely challenge of it!

Jean stops and ponders those moments and then launches into her story once again admitting that she sometimes feels a growing apprehension at the intrusiveness of her work, and that she is very thankful for her husband's staunch support. Her tone becomes mellower releasing a torrent of mixed feelings as she says:

There are a lot of colleagues who say things that are quite hurtful, but you shrug it off and say to yourself that they don't understand the job. I often say, get them to do just one of these shifts and we won't get another complaint. You talk to yourself or someone else about it, and have a couple of glasses of wine, talk to my husband because he always backs me up. I think that's how you deal with it. There is another manager who gets agro and gives them a good telling off; another after hour's lady gives her support. We meet for lunch sometimes; a laugh's the best way; we quite often see the funny side.

I have to ask how she looks after herself. She says:

So often you give to others. I suppose pottering in the garden helps but there are not enough hours in the day. There are times when you think: what about me? I would like to have time to walk along the beach. At home I would say I get stressed because of stuff to do at home and course stuff to do for work. I can split the two up. Sometimes it's a welcome break to cook and clean.

You know there is this management course we now have to do, it's not through choice, right, we are all getting made to do it. The only good thing is that it is a pass or fail. It's causing added stress because of the time factor; getting these things done, you know, you can't do it at work because of the damn phone, so it has to be done at home on days off. A lot of work involved and difficult because they talk about using your team and as after hour's managers we have no team; we look after everyone else's team, so we're encroaching on other people's staff and this makes it doubly difficult. So I had to nip up and interview. I'm doing relief work for someone, so cannot, just cannot, meet the requirements and also there's the crisis management and continual problem solving and staffing.

It has been four months since I tried to organise my interview with Jean and when I arrive I am still worried about the unresolved grief that I know is

part of Jean's personal story. In agreeing to participate in this project she was allowing herself to be vulnerable and to reveal her vulnerability within her story. Part of her anguish and the lingering sadness within her words is that she misses her father deeply as he had recently passed away after a long battle with cancer. I remind her that she is allowed to grieve and give herself time for reckoning with her loss; I recognise the pull of her family back home in Scotland. She nods in recognition of this and in a final parting gesture her hand is on her heart and after a long silence she says slowly:

Yes you're right. I suppose you're right. It is to do with my dad.

She continues to contemplate this and wonders out loud about this and innocently says:

The added stress of always thinking what I've got to do and the pressure I put on myself. I've got lists to do. I do put pressure on myself, but I'm not an overachiever.

Maybe not Jean, but achieve you have.

JADE

"Nothing's too hard to do with a positive spin on it!"

I am walking down the long brown carpet-squared corridors of a medical and surgical ward of an extremely busy tertiary hospital, past the pan room swarmed with patient care assistants doing the tasks pertinent to them and past the 'clean' room where a couple of nurses are collecting supplies for dressings or removal of drains or whatever was required for the care of their patients. The sights, sounds and smells of it are all so familiar.

Sidestepping around patients in wheelchairs, past Intravenous pumps plugged into electrical outlets, past steel trolleys loaded with morning tea, I flatten myself against a wall so that a trolley pushed by ambulance officers can make its way back to the lifts. After a few more harried steps I finally reach my destination and stop to listen before I knock on Jade's office door. I had thought she might be inside, but instead I turn on my heel to face her fast approaching me from the nurse's desk yelling:

Here I am, here I am. I'm coming!

And she races to meet me. We smile at each other and she reaches for a key attached to the lanyard around her neck and opens her office door, indicating courteously for me to precede her through it.

The office has two desks because Jade and a staff development colleague share it. Medical and Surgical texts, paperwork, files, MIMs medication manuals, lever arch files containing numerous protocols and guidelines, committee minutes files and quality data are stacked on the desks and on the bookshelves that cover the walls. More still are strewn on the floor wherever there is spare inch to be found. There are journal articles and memos, and cards and so much more, a cascade of information clearly intended to invite staff to use and enjoy. It is as if I had been transported into Willie Wonka's Magical Kingdom as the room held secrets beautiful and mysterious that I wanted time to explore. I stood in its centre and looked around 360 degrees until Jade motioned for me to sit. She opens with:

It's probably an ideal time for you to come and talk to me, as we've recently had a change in our bed numbers and a change in our configuration and I have noticed that's it's done a lot of things to my nurses. I'm very close to them as I've been with them since 2002. They are on the point of burnout; they are missing meal breaks which I am trying to discourage, and they are going home late. It's not like it used to be, like on an odd occasion; it's constant, and you can't keep that pace up. So I talk things out with my manager and I take that information to my exec because I believe I'm the staff advocate, saying, "These are the conditions we're working under. And we can't!" So we've looked at putting changes into play next week to try and relieve that by a float nurse between 10-4, and we'll see if that's going to make a difference.

Jade has a 'What can I do?' attitude about her. It is obvious from her animated, beaming face that although she is talking about serious work issues concerning nursing workload and the combination of clinical work, management and her advocacy role for her staff, she seems to be very happy. Excitedly she exclaims:

I do for my staff; I look after them so that's why I'm here; I'd like to make a difference. I've got all those cards and things. (Jade points to greeting cards and boxes of chocolates along a ledge to her left) *Because of what my staff says I do about my job, and that's where I get my resilience from. Oh, and from a glass of wine or two!*

Resilience I think is what makes you keep going to do what you do, something; some strength that you draw on to continue to work in a nursing environment which is pretty tough at times ... I've been in this environment for 11 years ... I worked in education originally from 2002, but now I am managing 2 busy wards .... Even in the last 6 months they've become exceptionally busier. So that's why I see it as a challenge to make sure people have a good work-life balance and a positive attitude to what they do to make a difference.

Challenges come from all angles. Currently there is an increased workload. My surgical ward is a 25 bed ward, but by the time you get your admissions, your day cases that will come and go in a day fed from DOSA

(day of surgery admission. We've got our ED dept.; and we've got demands from intra-ward that need to change to different areas. So by the time you see all the patients, on average you see 40 patient changes a day.

The other challenge is a junior work force, grad. nurses, RN's and EN's. It's a very difficult environment to get them up to speed when they come to the wards. They've just changed in February and now we're October and you'll find that they are not up to speed, so they need a lot of support.

But even seniors coping with that workload struggle and are finding it a challenge as well. Patients are sicker and more acute, For example, there are 2 TPN patients on the ward. In years gone by they would never be on a surgical ward, and they would have been specialled in nurse specials or in a special area. So we've got a lot more complex patients managed on the ward, plus the flow-through. An appendix is come and gone within 24 hours, so the turnover is very quick. So it's not unusual that a nurse will see 3 patients in one bed in a day, with the morning person going home and another surgical patient going home.

We also get very diverse patients. We are accommodating orthopaedic patients, we're accommodating medical patients and surgical patients and from an experience level that's a difficult scenario for staff to adjust to. So I do have supernumerary co-coordinator but they are kept

very busy with that role; overseeing that role, to see that things are happening appropriately.

Skill mix? The grads, I don't know if I am allowed to say this? Sometimes you find that they are not really ready for the workforce when they start, so they are almost going back to the classroom to bring them up to speed, but they still don't have any experience. I use an example: one was asked to do a trial of void on a patient, which meant that they had to take a catheter out, and when someone asked how they were going, the patient was actually emptying their urine into a bottle, and the nurse was scanning the bladder, however, she failed to recognise the catheter was still in! The patient had had a catheter for a long time, so it was his regular routine. So they don't know what they don't know; they need someone supporting them for a long time.

In that instance, team nursing is the ideal way to go, but when you've got grad. EN's, with 95% of our patients being on IV AB's, they can't. That means an RN or another nurse has to pick up that responsibility, so they can't just be doing something else in that team. So you're putting nurses under a lot of pressure.

The 4-hour rule- you know the push is to get things going even quicker but it's not always possible. We are stressed and it's hard to

support your team without feeling stressed and take on board what they are experiencing and try to make it better.

Current work issues pour out of Jade like a flood. She rubs her tired eyes and her story continues unedited:

We were talking yesterday about the issues of the ward and some of the staff said to me, "Do the exec really understand the pressures that we are under?" And I say, "They do but I don't know that they personally understand what it means to be in that constant cycle of stress; but they do listen to that." And you know I then went back to my manager who I was meeting anyway and I said we really have to do something about this. I suppose it's not frustration; it's about making sure I can give that message as clear as I can, so you know it does get listened to. But I have limited [authority]. I don't have the ability to make those changes, so I need more to help me. I feel frustrated because it feels like they don't listen, really.

Jade's introspective capabilities seem well honed as she reflects and tells me more of the story she wishes to convey. I take on the mantra of story listener, open in my chair, tape recorder on and pen in hand. She muses:

I always try to look at everything positively. It's not always possible, but I try and look at everything positively and I do like the idea of stimulating the brain and learning something different. So it's the feasibility of how that works. At a recent change meeting we had I sat down and

talked about study and as a change member you may have to sit down and assist them with their study and the requirements of their role and all the other requirements which we have.

I have on my list about 10 other things that I'm involved in - the redevelopment and change team, my wards. I also feel that I'm an advocate on that committee for other managers and I said that we have to be realistic about what we asked other people to do. I find that I do speak up a lot- it might be career limiting- but I have to do what I believe in and that's what I see as my role as well. So I mean my directors are there, because they have been a part of the change committee, the team; we're all together and I felt we all had to be heard, and that we need to be realistic about what we are asking people to do.

Jade acknowledges she is in the hierarchy of nursing yet works hard at making the voice of individual nurses on the floor or at the coalface heard; she recognises the painstaking work of nursing care and the effort needed to provide it well. She gives the nurses who perform it the respect and the profound attention they deserve. She regales:

We are all here because we love it, and we do it with the best ability that you have, the best way possible. I will often say the thing I like about my role is to keep all the balls in the air at one time and do all of these things; that's where I really get my satisfaction. I really miss the bedside

nursing! I don't know how I ended up in this management position, but this is where I am.

I've worked out how long I've been in nursing - 38 years. 38 years is a long time and I've travelled around Australia with nursing and I've seen lots of different things and I don't think I have ever felt like leaving at all- not once … I never wanted to do anything else. When I was about 9 or 10 I got my arm stuck in the rollers of a Simpson washing machine and I had to go every second day from school and have dressings until it was ready for a skin graft. I've no nursing in my family at all but I think that's where my exposure to nursing came and it was after that I decided that's all I wanted to do and as soon as I left school that's what I aimed for and decided to do. I trained at Whyalla, South Australia, a 250 bed regional hospital.

I trained at the bedside. We had hospital-based training which was invaluable and then travelled with nursing. How you can adapt! I remember at the age of 24 being asked to be in a leadership role, which was quite young, especially in those days. I actually was an after-hours manager… to me that was quite young to be doing that role. Then I travelled back to South Australia, you get a bit homesick, and then did mid. Just looking at that journey, trying to be a sponge, and ended up being here in education and … realising for me that life was short and it wasn't giving me what I really needed. That probably was that adrenaline thing and I was actually asked to manage one ward, then asked could I do ortho

ward as well? And I said, "I don't know how to do one, so give me two and I'll see how I go". So maybe I am an adrenaline junkie; I do like a challenge I know that; I do like a challenge! I've got the two busiest wards in Perth!

I don't have any support family wise, and I have a 13 year old, so it's a big challenge. I've got really good friends; I think that's important when you don't have family here. I have good friends, and staff and people I work with.

I have 250 e-mails at home because I don't want to go on my computer. I do take some work home, rosters, things like that. Some things I do. But you really must have that divide and the divide is not giving all that you have to give at work, and not having anything left to give at home. I've recognised that.

We've done some leaders' summits and some of the exercises that they had were: How much do you have? And what have you promised? And I promised to put up the Christmas tree last year with my daughter, but by the time I got home I was just too tired to do it and realised then that you can't continue to do that. I have to have a happy balance and I try to do that. I pick her up from school one day a week and that's my day to pick her up. It's hard to get out of the place but that's my commitment that I made to her. I stay home in the mornings to make sure she gets to school on the bus. That's an issue for me and that she's going to be there; she's

not a morning person you know. I have to change what I do, but luckily in the role I have, I can do that.

So Jade is part advocate, part nurse, part manager, part teacher, but whole mother and the list goes on. It must require enormous powers of concentration, ingenuity and energy to juggle all these responsibilities, keeping "all the balls in the air at the same time", I query: she answers:

I never thought I was quite a lateral thinker, but I surprise myself that I've come up with a different way of maybe doing what we are doing now, but it's whether or not it would be accepted by the rest of the executive team. Say the 5 beds we took off ortho, giving them back to ortho but maybe putting medical patients back in them because they're struggling with getting staff to manage 12 patients. But it's easy to manage 17 patients with 4 staff and back onto the med. ward so they could have that support ... Trying to think of how to problem solve and then that needs to be passed by the exec. which says the yes/no.

I have an issue here each year with the Christmas leave because I have both my wards generally combined and with redevelopment this year it's going to be a different scenario again. I've been waiting for updates as Christmas rosters are being talked about from July and I approached my exec. about that but it's not really their fault. They don't know the answer, but how can we manage that best? How can we plan? Because I'd like to get the Christmas roster sorted but I'm being held back making decisions ...

By October I'd come up with my own decision because they failed to get back to me in enough time to plan. I'd effectively tell them what we were doing but I can't do that this year because it's such a different kettle of fish. With a new nursery being put in, new wards, theatres only closing 1 week not 2 weeks, and I don't know how many surgeons are going to be away; so it's really hard to plan. That's really one of the biggest frustrations.

Actually I am part of the change management team for the hospital and so that involves trying to roll out change with our re-development within the whole hospital. The professional development course for all the managers, that starts this month, is a twelve month course. I've done two similar courses but this one is going to be relevant to what we do here, so we're taking on study now as well as new wards.

Part student as well! What else I ask?

We have conflicts occasionally with a large environment of females and that's certainly been something that I've learnt to manage proactively. Sometimes … I get a call from someone with issues and then someone calls with the same issue. So you hear both sides of the story, then bring them in together and talk about it. It's best to talk and for it to be dealt with straight away; if you can't do that then you need to help them.

I think people who know me know that they will hear the truth and maybe I might speak out of turn, but … it started a long time ago when

someone said to me, "You're good at communication!" Yet I have been told in my personal life I was terrible at communicating. So it was like: How come I can do it at work but not at home? So it is good to get feedback at how you manage or what you're like as a leader. That again can be positive and you can go for it!

I try to have fun when I am not at work. Drinking is involved sometimes, but also picnicking and camping, I've got good friends. I went to see the funniest movie last night because a bit of humour is always useful, just to put a different perspective on things, and I walk the dog at 5.30 in the morning- it's the only time I've got. I read and go to the movies and sit on the couch sometimes!

I think I am the communicator; that's my way of knowing. I'm communicating with everybody! There are only 4% of nurses these days full time, so the ability for them to be at a meeting … (They can come if they want), but I roster all the late people off that shift to attend. So at least you get some quota. The AM people can come in if they can. I do get together every second month with the Clinical Nurses and every second month with the night staff as well as each ward. We do that at the same time so I can produce my newsletter. That way they can be kept up to date. Even casuals say, 'I love reading your newsletter as I know what's going on.' It's trying to keep that communication up.

The Newsletter, that's what I was working on till midnight last night! Staffs don't read memos, and bits of paper all over the place. Once a month after my ward meetings I give a summary of what's happened … and what is to happen for redevelopment. Anything really that happened, and then I print off to each staff member with their time sheet and … then I know they have read it. I've been doing that since 2002! Would you believe that? That surprises me; it's just another thing to add to my workload!

Chief communicator and wait … there's more!

Last year we were the highest fund-raiser, $12,800 for cancer from just one ward! We did "Relay for Life" to raise funds; our events are all consuming! This year they decided they didn't want to do it, so we're doing a hospital one re donating organs.

A great team approach to everything we do, nipping any issues early in the bud and maybe just listening to them helps … I am not a perfectionist, no - nor an overachiever. Nothing's too hard to do with a positive spin on it and they have to love what they do, otherwise they wouldn't be here.

Jade's words speak for themselves, yet her issues have ominous undertones of trouble brewing with the issues that she has mentioned. But she leaves me to attend another meeting and as she strides purposefully

off down the corridor she turns around waves, grins and salutes me and then continues on her way.

Conclusion

In the presentation of the portrait gallery, my journey as researcher is evident. My voice in the portraits moves between vigilant description and concomitant analysis, attempts to make sense of what I observed and heard, yet still being able to create and hold the reader's attention within the ambiance or spell of 'storytelling'. This technique is central to Portraiture research methodology where the art of telling the story propels the readers' imagination into a new way of understanding experience.

The rendered portraits are documents described by Lawrence-Lightfoot & Davis (1997, p.4) as being "a haunting paradox, a moment of time and of timelessness". The 'life drawings' are 'still' at the moment of creation, capturing space and time, connecting the nurse and the organisational culture, yet in years to come, remaining a vital reflection of what was, at this time, 2008-2012.

In telling their stories the nurses are able to do many things. They are able to take time to be still, to identify their priorities, to describe their relationships, to make meaning of their successes and reflect on their challenges, and to consider their work life whilst contemplating their resilience. Their stories told, reflected back, heard and described via Portraiture are relived and retold in a new way. Here were the stories of ordinary nurses preserved.

Each nurse is an individual. Each had a varied nursing background to bring to the canvas. Each was extremely interesting and each was a jewel in my crown as a novice researcher because of their willingness to be a subject in my portraiture landscape. But what is evident is that the nurse/participant stories, although being told from different nursing backgrounds and settings, merged and overlapped even when at first they seemed so unlike.

The following chapter reviews the themes that emerged from the data and discusses the interpretation of those themes in relation to the portraits.

CHAPTER SIX – INTERPRETATION

Revealing the brush strokes- shades and themes

"All meanings, we know, depend on the key of interpretation."

George Eliot (Daniel Deronda, 1876)

Introduction

The portraits of April, Ginger, Grace, Jade, Lucky, Maggie, Jean, Mary-Anne and Vivien were drawn in chapter 3. Each portrait represented each participant's perceptions of working life in the West Australian healthcare system. Perceptions are coloured by personal, unique and shared experiences, forming each participant's view of the world. Each tells a story which showed courage and determination in their personal struggles and work life as a nurse.

Eight emergent themes or brush strokes, common to each narrative, coloured the portraits and illuminated the attributes and qualities of resilience shown by participants. For convenience the eight themes identified can be discussed under two major categories. The categories however, are not in reality mutually exclusive. First, those themes which can be associated with personal attributes of the participants; the five key themes encompassed: managing self; focusing on the positive; valuing social support; paying it forward; and a passion for the profession. The second category, attributes of resilience was expressed related to environmental and organisational influences; the three themes are taking on of challenge; experiencing adversity and growing through it; and leadership.

In keeping with the ontological substance of Portraiture, the discussion of the portraits presents a tapestry for success rather than of failure. This knowledge is significant to the health of the nursing workforce and to a health care system facing many hardships. Lawrence- Lightfoot (1983) captures the essence of looking for the positive saying, "it is almost as if there is a cynical, complaining edge to much of social science investigation that begins by asking what is missing, wrong or incomplete, rather than asking what is happening, or even what is good" (p.313).

Personal Traits

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Theme 1:   Managing self

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The first theme to be discussed concerns the management of self through self-control and self-care. Self-control is defined as "the overriding or inhibiting of automatic, habitual or spontaneous action tendencies, urges, or desires in order to ensure an unimpaired realisation of planned, purposeful behaviour"(Schmidt, 2010, p. 356). Although the participants speak of different circumstances within healthcare settings which lead to frustration and stress, they do not act disruptively. Rather than acting out their frustrations, they possess the self-control, self – management skills and self-awareness that allows them to reflect and recognise a better way to handle stressful situations (Reeves, 2005).

Each of the participants in this study can be said to have through their conversation, demonstrated emotional intelligence (Goleman, 1998) by having insight to their own needs and the needs of others in the workplace setting. Seligman (2004) has emphasised that human experience is defined by peaks and valleys with Goleman (2002) deeming the ability to cope with such changes in experience as a measure of 'emotional intelligence', which he feels is essential for life and for working lives. Furthermore, Goleman (1998) averred that emotional intelligence refers to the "capacity for recognising our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships (p. 318)." Participants in the study were frontline healthcare workers and as such were involved in emotional work. Emotional work is fundamental to healthcare delivery. Bar-On (2005) notes that emotional intelligence is required in healthcare as it "determines how effectively we understand and express ourselves, understand others, relate with them, and cope with daily demands (p. 3)."

The historical development of nursing as a profession has been linked to the military and religious orders (Borsay, 2009; Wall, 2010). This has meant that nursing

has inherently been a disciplined profession with a central tenet of hard work and with an ethos of restraint and self-control (Claffey, 2006; Manion, 2005). The notion of regulating what one feels and does in nursing is embedded in the history of nursing development, and is strongly reflected in the curricula of hospital-based training. Self-control was a determining factor for participants in this study as eight of the participants were educated in this way, with only Maggie being educated in the tertiary environment. The concept of self-control is almost juxtaposed with emotionality in the healthcare setting as Bar-On (2005) emphasises this aspect of nursing work. Hence a 'nursing cultural trait' embedded within the participant's personal reactions and thoughts become almost an involuntary work habit and/or response for self-control. Nurses in hospital programs were taught to be well mannered, patient, and industrious. Showing emotions, 'speaking out'' was not tolerated. Borsay (2009) and Wall (2010) say nurses were not expected to be rebellious, headstrong or overtly critical or arrogant.

Mary-Anne discusses being careful about voicing her decisions and her next moves concerning issues that worried her in her residential aged care environment. She says:

> *My tension … with … issues and … with the paperwork and the paper*
> *work has mounted up and I still don't feel convinced that it is all going*
> *to work out yet. I've just got to wait and see* (Verbatim).

She speaks of the special challenges for residential aged care nurses who care for frail old people, usually with care tasks mostly provided by patient care assistants, with nursing care being provided by a smaller number of Registered Nurses in today's health care context. Mary-Anne, demonstrates personal self-control by her ability to manage her tension and to maintain a 'wait and see' approach. This is, again, highlighted when she tells of her angst over the issue that profits appear to be put ahead of patient care. This issue creates a personal anger in her which she must control to stay in the job and advocate for the frail elderly. Mary-Anne's need for self-control is compounded as this situation is also an ethical dilemma for her. She says:

In aged care you are dealing a lot with AGfee (Australian Government) which is a funding that the government provides for aged care which means there is a pressure for nursing staff to achieve high dependency levels to get or maximise their funding. And I certainly do not feel that my duty as a nurse is to be a fundraiser ... so that's made me very disillusioned at the moment with aged care.... responsible for 40 high care residents plus 35 low care and it was becoming ... the low care was becoming more and more demanding, so that it felt like that I was basically in charge of 75 people. I've been thinking of (moving on) perhaps for a few reasons - that they've decided to move all the registered nurses out of residential care except for myself, so I would become like the monarch who signs, the figurehead, who signs off on everything ... I was feeling quite exposed I suppose that ... just different ideas that might help a resident and I just felt a very huge sense of responsibility, like a burden of responsibility to be able to think of every option and trying to be everything to everyone (Verbatim).

Again Mary-Anne demonstrates self-control by maintaining care of patients and doing endless paperwork that she feels is not her role. April also confronts her frustration and her need to maintain self- control. This is reflected in relation to managing complaints and the threat of litigation. She manages these stressors by:

I try not to take it; I used to take it very personally. (She laughs ruefully). *Now I try and sort of diffuse it, and look at it not as a personal thing. It's a team thing really. It makes you a bit more aware, makes you a bit more ... you double-guess before you say anything ... you know, all that sort of thing* (Verbatim).

Lucky discusses self-control and the way in which she has been able to hone this skill over time. She states:

I suppose for me is having a situation that you're probably not that comfortable with and finding ways to deal with it, and to you know

look at different angles of. When you're much younger you barge through it, don't you? You barge. Barge, that's such a stupid idea that you just barge through and do whatever you like, but as you get older and more experienced you can see two sides of the coin, you sort of tend to be a bit slower at making a decision in terms of how you'll deal with it and you deal with it more logically I think, as you get older rather than barging through or pushing people over as you do it.

Healthcare professionals often report a mismatch between their professional practice goals and the requirements of bureaucracy or organisational imperatives, noting the disequilibrium between their personal goals and the self-control needed to meet workplace demands (Schmidt, 2010). The delivery of high quality practice is often the goal of nurses who exhibit self-control so as to meet both the demands of the organisation and their personal need to achieve their own work goals. The mismatch between personal goals and organisational requirements among aged care nurses was studied by Baumeister, Vohs & Tice, (2007), who noted that these nurses often require high levels of self-control due to their role incongruence as they set their highest personal goals towards caring, whereas the organisation focuses on economics. Regular exertions of self-control can improve the personal repertoire to continue to exhibit the trait; the direct influence of high self-control predicted a positive correlation in their ability to stay in work (Baumeister et al., 2007). However, the exertion of continual self-control could eventually deplete coping ability in the long-term due to the detrimental effect of unresolved goal conflicts.

The participants' raise the issue of patient care becoming increasingly complex with the associated extra pressure placed on RNs to provide care; and, in the case of the nurses working in the University, coping with student demands. This is reflected in the literature as a contemporary problem for Registered Nurses (Archibald, 2006; Duffield et al., 2010; Twigg et al., 2010) and in the literature concerning tertiary education (Deceglie, 2010; Gaberson & Oermann, 2010). The contemporary healthcare setting and its model of rapid turnover for economic

rationalist ideals equates with 'patients in beds' and the newly created 'four-hour rule'. This rapid turnaround of patients often means that nurses may have three to four different patients in one bed in one day (Archibald, 2006; Hegney et al., 2006; Twigg et al., 2010). For nurses who are already working under difficult conditions and have a mindset of patient's restorative and recuperation needs, a rapid turnaround time forces them not only to manage complex patient needs, but also to manage their reaction to their work routines (Holland et al., 2012). The participants in this study have developed nursing habits which in the past have allowed them to see the recovery of patients, or simply the "fruits of their labour". Jade explains the need to keep her emotions in check because she never feels that her nursing work has any positive patient outcomes. Jade notes:

> *Patients are sicker, more acute, for example 2 TPN* (Total Parenteral Nutrition) *patients on the ward- in years gone by they would never be on a surgical ward, and they would have been special in a nurse specials or in a special area. So we've got a lot more complex patients managed on the ward, plus the flow-through- say an appendix- is come and gone within 24 hours, so the turnover is very quick. So it's not unusual that a nurse will see 3 patients in one bed in a day, with the morning person going home and another surgical patient going home. We also get others very diverse...here accommodating orthopaedic patients; we're accommodating medical patients and surgical patients* (Verbatim).

Jean echoes:

> *There are more acute patients on the ward- sicker. We have a big DPU* (Day Procedure Unit), *so small surgical things are constant and the patient gets discharged. So what we are really getting are elderly really sick patients and a very high amount of medical patients. The wards have people in their 80s, confused, difficult to look after, so I would say that that has changed definitely. We get the quick turnaround and more acute* (Verbatim).

Twigg et al., (2010) assert that the rapidly changing structure and organisation, and the changed financing of health care is leading to a shift in the latter's delivery because of the redesign of staffing patterns, and the organisation of care. There is downsizing and engaging in various patterns of substitution of personnel to stay economically competitive and viable. Archibald (2006) contended that patients are entering hospital sicker than in previous years and, as a consequence, the intensity of care required has increased.

There is also general consensus that workplace change in healthcare is now no longer an aberration but rather a constant. The imperative of change is the norm for healthcare with whole organisations now required to adapt to competitive and volatile economic times while keeping pace with technological advances and competing with business acumen.

With change comes uncertainty, but how people and organisations react to the change, looking for success in the midst of what could be perceived as a system out of control (or in disarray), is important (Porter & Tiesberg, 2006). The Bennis (1989) classic theory of change management proposes that people can be subservient to external events; or can take charge of their own response, a response wherein each individual has control by choosing their attitude to change. The more the change, uncertainty, chaos and disarray, the more potential for development for each person is on offer, if they have the means, emotional, educational, and social, to cope with such change (Peters, 2010). The participants in this study have shown the positive aspects to dealing with changing models of patient care and the apparent economic mandates that are seen to impact 'good' patient care.

Self-control and self-management are enhanced by a personal 'self-belief' that the nurses, as individuals, can cope with change. This 'self-belief' allows a participant to reframe the work stressors occurring in healthcare because they are able to maintain their locus of control.

The participants revealed they are constantly faced with the need to evaluate their role in terms of professional practice and what the workplace expects of them. They are supposed to be caring, professional and supportive, constantly giving, always able to cope, and to be all things to all people. They are still equated with the stereotypical nurse who is an astonishing person with boundless energy, enthusiasm, and devotion to duty, who must, although they are tired and weary in these times of rationalisation, budget cut-backs, bed closures, understaffing and issues requiring a mixture of skills, cope and be resilient.

Even though a few of the participants perceived a loss of control at some time and acknowledged that the cumulative effect of this caused stress, it was felt that their ability to be self-caring and self-managing enhanced their capacity to cope, even with hurtful and emotionally draining situations which had the potential to cause mental turmoil which would impact on self-esteem and weaken coping mechanisms (Jackson et al., 2007).

Jade and Vivien did mention words of discouragement, frustration and even outrage about difficulties they were having within their work place; however, these feelings were not projected onto others in their surrounds, as their negative behaviours were muted by the critical regard in which they held their peers and their profession and the self-control in which they held themselves as professional nurses and emotionally intelligent individuals. The participants may internalise their dismay at workplace issues; however, they are able to 'bounce off' their peers and 'bounce back' for more work. Participants had their own way of looking after themselves and shared their methods of self-care. Jade explains:

> But you really have to have that divide and the divide is not giving all
> that you have to give at work, and not having anything left to give at
> home. I've recognised that (Verbatim).

Whilst Jean notes:

*I can split the two up. Sometimes it's a welcome break to cook and
clean* (Verbatim).

Further, this transient perceived lack of control over events has the potential
to hinder personal growth and fulfilment, and a sense of personal satisfaction with
work. The feeling of being in control may only return by adopting a strategy of
avoiding further hurt or by removal from that environment. This may be viewed as
an exaggerated or inappropriate defensive mechanism, but Grafton & Coyne (2012)
maintain that defence or protection of self is most crucial in maintaining locus of
control. Maggie shares her despair and recovery of locus of control after not being
supported in her work role but her self-awareness and sense of self-worth allowed
her to manage the situation:

> *When I told my parents, I remember I went up and told them I had
> resigned. It's not a very nice thing to have to tell people that
> something like that's happened and they were really supportive of me
> and everything. I know I could of, I really could have, walked away and
> not really gone back to it (nursing) because it was quite horrible ....
> And you realise as well that you've got to look after yourself because
> people are so quick to discard you. ... I did withdraw initially but just
> having time out and then going out with friends, spending time with
> family and just doing stuff, doing stuff that I wanted to do.*

> *But that was probably one of the lowest points I've ever been in my
> life, and after it happened, I just felt so humiliated, and I didn't know
> what to do with myself. I mean just spending time with them, and
> because I suppose all I was thinking about was work, and what had
> happened, and I couldn't get my mind off it and I was feeling anxious
> all the time and thinking about it all the time, so I needed the
> distraction. I mean one of the first incidents I remember after it
> happened was I was in my room.*

I remember being upstairs in my house and crying and stuff and two of our nursing friends came over and we just had a laugh and we mucked around and stuff. I had a laugh and that was the best thing because I realised that life can on and there's much more to life than just work So ... Yeah friends are definitely very important. I felt so anxious, and I've never felt like that before, apart from when that happened to me. I felt so anxious about everything and I was in a very bad place (Verbatim).

Maggie's reflections not only show the importance of maintaining her locus of control but also the importance of maintaining family and friendship connections to bolster the professional self in times of threat. This awareness allows the ability to seek refuge, comfort and support. The notion of a work-life balance was significant to all participants in assisting them with their ability to self-control and self-manage. Although the participants are committed to their nursing work, the adage "work to live, don't live to work" (Cipriano, 2007, p.10) is evidenced by their comments to the researcher. This reflects that the participants were able to evidence strong involvement in their work without being over-involved; to be able to give and take; and to self-manage and self-care in order to adjust and move on. The ability that the participants revealed to adjust to a situation through the use of emotional intelligence and therefore self-control and move on is a central tenet of resilience theory (Bjarnadottir, 2011). All of the participants recognise the need for work-life balance but often this need was preempted by work being taken home and affecting the family. Vivien attests:

Sometimes I worry about what's going on during the weekends. I have to make sure it's covered as they all are very experienced ... I spent my days off on the weekend still thinking about it, not so much the patient situation, but how I've handled it, how I would handle it in the future, what I've got to do now. ... I got cross on Friday. I try to show that I am fairly static here, but at home, I'm just evil, very short tempered, very tired. I'm starting not to socialise, not exercise, my diet is out the window, but at work, I am absolutely fine. My children don't

see a great deal of me, certainly not quality time. My husband gets fed
up with my moods and my coming home late quite badly really
(Verbatim).

The struggle to find a balance between the spheres of work and home echoes in their stories and reflects the contemporary challenge faced by most working men and women. Cameron and Brownie (2010) contend that the conscious recognition of the need for work and family integration, and work-life balance is a powerful acknowledgement and an important determinant of resilience.   Vivien continues:

I try, I do recognise it … I'm studying. I've dropped my hours a day a
week because I've got a core of people filling in for me so I'm becoming
much better than I was (Verbatim).

Grace echoes:
In order to survive and not take your work stress home to your family
so that it doesn't impact on your personal relationships (Verbatim).

Koen, Van Eeden and Wissing (2011) note that striking this balance is a part of constructive coping, often being seen as a characteristic of resilient people who make an effort to self-manage their trying situations.   This is echoed by Jade and Jean when they state:

I do take some work home, rosters, and things like that. Something's I
do. But you really have to have that divide and the divide also not
giving all that you have to give at work, and not having anything left to
give at home. I've recognised that (Verbatim - Jade).

So often you give to others. I suppose pottering in the garden helps
but there are not enough hours in the day. There are times when you
think- what about me? I would like to have time to walk along the
beach. At home I would say I get stressed because of stuff to do at

home and of course stuff to do for work. I can split the two up.
Sometimes it's a welcome break to cook and clean (Verbatim - Jean).

These examples indicate that the participants took it upon themselves to use their own self caring behaviours as a form of self- control and self-management to achieve better outcomes for themselves as individuals and also as workers. The use of self-caring behaviours provided them with an arsenal of control strategies to keep workplace stress in its place.

Displaying attributes of caring for self in the work environment has the potential to decrease stress and job burnout, not only increasing the likelihood that these nurses will remain working, but also assisting them to cope both professionally and personally giving support to and augmenting their therapeutic capacity (Brown, 2009). It is evident that the participants believe that having a work-life balance is a useful self-management strategy, and they 'work' toward achieving that balance through physical, emotional, and spiritual aspects of self-care.

This personality trait allowed them to moderate workplace stress by buffering themselves with other choices reflective of seeking a better work-life balance. They have appraised their work situation and evaluated how they can cope with the demands of work, and they have self-selected actions that can assist them to cope (Koen et al., 2011). This focus on care of the self allowed each of the participants to become stronger both personally and professionally as individuals and as nurses, giving them the opportunity to be role models for others (Brown, 2009).The feelings of having self-control can provide comfort in stressful times; so too can a feeling of connectedness with spirituality and the belief that another *being* is in control (Gall, Charbonneau, Clarke & Grant, 2005). Tugade and Frederickson (2004) acknowledge the importance of a belief system that provides existential meaning while Cockell and McSherry (2012) note the importance of spiritual attachment (connection) to God as a key factor in driving the religious coping process. Belief systems allow individuals to construct meaning out of their

adversity, act as a buffer for coping, and provide for a more hopeful and optimistic attitude thereby decreasing distress. Grace, although the only participant to discuss *connectedness*, shares the spiritual connection she feels that helps her cope at home and at work:

> *Well I suppose my belief in God, my faith is such that I try to live my life according to the principals in the bible and according to what I believe is good and right and proper and do to other people what you'd expect them to do to you. I have a conscience, a social justice conscience and like to do what's righteous and correct and therefore if that doesn't marry up then that just doesn't fit with me and then I lose my peace and that's when I get stress filled. ... I have what I believe, is a fortunate life, in that it has been filled with experiences that I may not have wanted, but they have actually turned out to be some of the biggest blessings because of what has happened afterwards* (Verbatim).

Religious coping, in particular, has demonstrated associations with a variety of social, personal, and situational factors, as well as links to psychological and physical health (Cockell & McSherry, 2012).

Grace listens to her inner guide, remaining spiritually attuned, imbuing her relationships with family, colleagues and students with her spirituality and sense of social justice. Spiritual coping behaviour is a frequent response to severe stress and can be a great source of emotional comfort for spiritual individuals, encouraging inner strength, empowerment, and optimism. Notably, spiritual coping has predicted well-being beyond the contribution of general coping both cross-sectional and longitudinal dimensions (Cockell & McSherry, 2012; Gall et al., 2005; Hsiao, Chien, Wu, Chiang & Huang, 2010).

By maintaining a focus on the management of self, through the use of self-control, self-care, and in some instances expressing a belief that a higher being is in control is important in the context of other choices that nurses may make to

promote their own well-being and resilience (Hsiao et al., 2010). The participants' evidence self-controlling, self-managing and self-reliant skills. They voice the positive aspects of their work situations and settings, remaining optimistic rather than reflecting negatively or cynically on the problems with healthcare today. This is evidenced in the theme to follow.

Theme 2:   Staying positive
(The ability to reflect, the choice to have hope, and the use of humour)

The second theme relates to the ability of participants to stay positive in the healthcare setting. Three important sub-themes underpin this theme: the ability to reflect; the choice to have hope; and the use of humour. These intertwined sub-themes are synonymous with remaining positive or stoic in the face of adversity as expressed by Epictetus (341–270 b.c.e.), "it's not the accident that distresses the person, because it doesn't distress another person; it is the judgment which he makes about it"(Johnson & Johnson, 2010, p.221). This perspective taking involves the ability to reflect upon what is happening and allows the focus to stay positive through choosing hope and using humour.

Reflection

Reflection involves re-evaluating practice while continuously adapting to reflect the lessons learned from experience which has the ability to transform understanding and provide a deeper level of learning (Alliex & McCarthy, 2005; Gaberson & Oermann, 2011). Ginger demonstrates this reflective practice, concentrating simultaneously on remaining positive in the workplace. She notes the importance of contemplating all of her options before making a decision within the academic setting. She speaks of letting her accomplishments and successes speak for themselves, and prudently allow that truth will surface eventually. This evidences self-control, but also a marked use of reflection. She says:

> I have learnt that there are two sides to every story … I'm very open to
> people at all levels, and I am more aware of issues (Verbatim).

Ginger's reflection reinforces findings from a study conducted by Barrett and Yates (2002) with Australian nurses. They suggest that personal reflection and perception of workplace stress has a buffering or balancing effect on burnout. They contend that reflection allows a review of options; and, that the judgments made from that review of challenge or adversity offers the ability to 'short-cut' or diffuse the tense emotions that occur with response to adversity or stress. Thus, being reflective of or mindful of circumstances may be ameliorative. That is, the individual then has the ability to respond, rather than react, to stress-inducing situations. This reflective appraisal of situations, or reflection and judgement upon an issue can become habitual and gives credence to one's ability to increase awareness of the present moment or situation, and concentrate and reflect upon it. Johnson and Johnson (2010) attest that this appears to offer a useful antidote to a flight and fight reaction to stress-dependant problems. Jade says:

> *I never thought I was quite a lateral thinker, but I surprise myself that*
> *I've come up with a different way of maybe doing what we are doing*
> *now … Trying to think of how to problem solve … But how can we*
> *manage that best? How can we plan? … By October I'd come up with*
> *my own decision* (Verbatim).

This concerted use of reflection and introspection by the participants involved reviewing what had happened to them and trying to consider and analyse how events or situations at work, or at home could have been handled better. This allowed the exploration of issues to be reflected upon and looked at in an individual light by the participants who then could modify their responses in the future and self-console or self-manage the stressful occurrence by putting it into perspective (Yoder, 2010). April states:

> *I just try taking each day at a time* (Verbatim).

Jean also relays the importance of taking time to reflect as a strategy for staying positive:

> *Nurses are very good at reflecting. I think it's the vast majority of*
> *nurses who think like that and I think that. I know I feel like that or you*

wouldn't stick at it. When girls go home or I go home you'll think what
a shit of a shift; but you think we'll sort that out tomorrow. They [the
staff] are resilient; it would be just being able to, or a big part of it is
being able to reflect on the challenges of the previous shift. That's my
idea of resilience: taking it on the chin-and the ability to go back for
more and feeling that, accepting that you didn't do something very
well, but you will do better next time (Verbatim).

This habitual reappraisal and evaluation of situations to focus judgment on the stoic choice is a form of learned optimism as typified in Seligman's (1991) seminal work *Learned Optimism*. Links have been established between attributions for positive events and well-being (Peterson & Seligman, 1987) as optimists engage in more active problem-solving types of coping, and optimism has been associated with good mood, perseverance, achievement, health, and longevity by Seligman. In addition, this reflective stance may be useful in helping to explain the ability to stay positive or optimistic further.

Hope

Hope has been described as the ideation of successful goal-directed thought and planning to meet goals, as well as a belief in the capacity to accomplish and achieve, even in the most difficult situations (Snyder, Lopez, Shorey, Rand, & Feldman, 2003). April working in residential aged care says:

You do have to be fairly resilient because on occasion it can be a very
ploddy job ... Being able to keep going, even though you are not seeing
any changes, and just keep going and hoping for that change ... People
don't think there are many highlights in it, but there are. Your day is
always full (Verbatim).

Hope has also been suggested as an attribute of emotional intelligence by Johnson and Johnson (2010) who say that that men and women are equally hopeful, although women may report high hope for the goals they perceive they are 'allowed' to have. Some of the participants in this study remain hopeful of achieving

work related goals. Jean says, *"It will be better tomorrow,"* expecting that it will be better tomorrow, or in the future, and that improvement will happen. She continues optimistically:

> *We all think tomorrow I'll do a better job. I didn't do that very well but*
> *next time I'll do better. Next shift will be better, that keeps them there*
> *(Verbatim).*

Participants hoped for a better day tomorrow. These reflections show that the participants have hope that things will improve - either that they or the work that they do will improve because of the time spent at work. Rose and Glass refer to this as a trait in positive people who through cognitive reframing, grounding, hope and optimism are able to work against issues and constraints that seek to "diminish (their) inner balance" caused by workplace stress in clinical or academic nursing environments (Rose & Glass, 2009, p. 167). Jade is of the same mind when she says:

> *Stressed; it's hard to support your team without feeling stressed and*
> *take on board what they are experiencing and try to make it better ...*
> *valued ... that goes back to resilience - why we are all here because we*
> *love it ... the best ability that you have ... the best way possible*
> *(Verbatim).*

Resilient people are able to draw upon some form of positive emotion or hope even in the midst of stress and hardship (Frederickson, 2004; Jackson et al., 2007; Tugade & Frederickson, 2004). Morrow (2006) states this hope is essential in the development of resilience as it engages individuals to envision an "optimistic view of the future...to hang on" (p.4), while Gall et al., (2005) affirm that hope assists to ameliorate the effects of stress, assists coping, and is linked to aspects of physical and mental wellbeing. Levi et al., (2012) opine that the resource of hope builds cumulatively upon experience and reinforcement, modifying until it reaches a mature, reflective, rational stance on its limitations Individuals with high levels of hope tend to find meaning or gain in situations of difficulty and trauma (Turner & Stokes, 2006), and are able to remain motivated and focused on their goals or

purpose as they feel more positively according to Levi et al. They have more positive thinking than those with no positive sense of hope.

Maggie states:

The knowledge that I'd got them through accreditation, that first cycle of accreditation, and that I hadn't had the training, and I was understaffed, and when I left they put on more staff, carried me through (Verbatim).

The contemporary dynamics of change have dramatically affected the healthcare system of Western Australia and the participants encounter a number of varying situations on a daily basis including: suffering; ill health (Bush, 2009); swings from mundane tasks to intense no-second-chance situations; perceived threats to one's physical well-being; nurse-patient and nurse/doctor relationships; nurse/student relationships; nurse/facility relationships; the emotions involved in caring (Grafton & Coyne, 2012); problems encountered with an ambiguously defined nursing role; lack of support staff; conflicts of responsibility; promotion/development conflicts; roster/workload difficulties; funding, management and leadership hierarchical difficulties; and the physical and mental demands of nursing (Squires et al., 2010). The nurse's role therefore, involves a high level of multi-skilling and multi-tasking, much of which is unrecognised within their job description or by the powers that be (Archibald, 2006). Within all of their healthcare roles, managing the changing face of their work and themselves as a consequence is evident.

One of the ways the respondents managed change in their work environment was through the use of humour. Coupled with hope often is the need for humour. The nursing fraternity is said to take joy in small pleasures and find humour in the disarray of the workplace and often the sadness and stress of the healthcare environment. Humour may provide the link between hope and hoping things will change. The researcher feels that this is integral to developing and maintaining resilience. This aspect ties to the Rose and Glass (2009) concept of cognitive reframing, wherein, order makes the mundane and the horrific bearable.

Humour

The participants are mindful of actively searching not only for hope but also for novelty, fun, joy and laughter at work. Humour may often be considered trivial or unprofessional; however, the plethora of literature supporting the sustaining value of humour proves it is neither of those. Humour enhances team work, emotion management and the maintenance of human connections; it serves to assist collaboration and co-operation, relieve tension, develop emotional flexibility; and has the ability to 'humanise' the healthcare environment (Adams, 2007; Dean & Major, 2008; Rose & Glass, 2009).

Evidencing the use of humour in her work-life Ginger boasts:

I will disrupt my colleagues to entertain myself and I'll drag them off to be naughty with me and that can be a frustrating point with me because it builds my energy but it probably stresses them a little bit! It does, but being naughty and having fun puts things into perspective. It's childlike and playful. I think people would say when I am work they all know that I am here because I'm noisy. I'm not noisy because I'm stressed or tired though. They always comment 'the passageway is quiet', so I think being noisy and silly rejuvenates other people. I actually feel when I am being noisy it rejuvenates me and I think when running around being noisy that brings energy around the place and makes the place more fun to be in (Verbatim).

Ginger ponders her wish for fun and her ability to embrace her silly side. What is reflected is a chance of returning back to the meaning of childhood and those carefree childhood days 'playing' with others (Walter, 2003). She believes that fun, laughter and play should not dissipate with age. April reveals humour of a different ilk when she says:

I know it sounds horrible but my husband and I were close to her as well ... my husband's mother passed away just before Christmas, and we were trying to you know jolly each other along, and I said, 'oh I had

better ring up work and let them know a bed's available at her nursing
home'. So you know … the look on his face, was just absolutely you
know … I could have crawled under …. I thought it was quite funny
but he did not appreciate it at all! (Verbatim).

Humour is multifaceted and some humour and its use may be elusive. For example, nursing humour may be only relevant to the nursing profession itself as it may have subtle understandings with metaphors and illusions that only nurses may understand. A non-nurse may miss the joke entirely and feel like a foreigner listening to a strange language, but it is the language of nursing. April exemplifies this when she explains:

You know make a comment, you see some really gross wounds and
you know you liken it to foodstuffs or bowels motions and yeah people
just don't really appreciate that sort of description or whatever. But I
think that because we are dealing with things that most people don't
have to deal with, and they are, some things are very upsetting,
especially some wounds that we have had here … we always have
somebody who likens a bowel to foodstuffs, which puts you off food
for a little while which I suppose is quite good. … but not for long at
all! (Verbatim).

The participants often used humorous events as they recalled and recounted their resilient experiences. They looked on these events with fondness believing that humour could alleviate hard times, and transcend what is at times, the extremely hard and oft-times dirty work of nursing. For example Maggies says:

Sometimes the things the residents do, the people with dementia, you
do have to laugh … We tell stories, oh we don't tell stories, but you do
tell some of the strange behaviours that happen, that kind of thing … I
mean we were laughing out here … saying how this man was homeless
and he was so bad that we had to soak his socks off, and we were
laughing a bit about that, even though it's not really what you really
should be laughing about. He had alcohol abuse and he's a little bit

delusive, so we don't quite really know what he's saying is true or not.
He's quite an intelligent man, so they think some of its quite strange
that he's ended up like that. He is in another care awaiting placement
facility and he had absconded from somewhere else ... some of the
strange things they do. Strange things happen every day. A woman
who lost her teeth, we couldn't find them anywhere, and she put them
somewhere internally and when we were washing her we found them -
just awful, absolutely awful ... which wasn't really funny really ...
you'd have to laugh or you'd cry. You do see some funny things. I think
with every nursing you have to (laugh) you know, because some of the
things you have to see are a lot worse (Verbatim).

The interviews too were often punctuated by laughter with the participants using laughter as a means to lighten the tone of a 'formal' research interview. For example, April shouted across the outdoor area at her colleague:

Hello Jane! (Laughs) *Yeah! She finally got me... the bitch! I'm being*
interviewed ... with the paparazzi (laughs) (Verbatim).

April used humour and laughter effortlessly throughout our meetings as she was constantly changing roles between interviewee/carer/teacher/clinician. She was playful, ready to laugh and ready to share laughter at any appropriate opportunity. She is overt with others about being happy to be interviewed and her positive affect creates the urge to play and be playful in the broadest sense of the word, kidding other workers that she was being 'interviewed by the paparazzi'. Fun and joy at work can have the incidental effect of building an individual's physical, intellectual, and social skills which can be drawn on later, long after the instigating experience of joy has subsided (Frederickson, 1998). Mary-Anne notes:

It's great when you work with team members who have great wacky
sense of humour and who can really set the ball rolling and suddenly
you're all feeling so much better (Verbatim).

Play is a vital sign of a healthy work environment and is often fundamental to humour (Walter, 2003). Ginger uses work time as an opportunity for intellectual play, and engages in tomfoolery as she bemoans the limited scope for engaging in play due to the rigid confines of a heavy curriculum and workload, this making her work setting seem less fun. The pleasure of 'inspired exchange' so as to be alert, engaged and responsive provides the spark of stimulation for which Ginger is yearning, and she takes it upon herself to fill that requirement (Frederickson, 1998). Ginger says:

I know that I'm the kind of personality that would get easily bored, and perhaps I'm easily bored here, not stimulated enough here by people around me which makes my bouncability back hampered. But as long as I keep myself entertained with things that challenge my mind I'll probably function .... If I share a common sense of humour, they see fun in the things that I see as funny, and they have a particular mindset that I can have a conversation with them, that they are intelligent (Verbatim).

Humour is a buffer with 'healing' properties (Adams, 2007; Bethea, 2001; Wooten, 2005) and the participants like to laugh and tease their patients, colleagues, student's family and friends. Again, Mary-Anne verbalises:

The gentleman who I said deteriorated recently with the PSP; he has had skin cancers lesions on his head, which he a skin graft done from his leg to his head about 4-5 months ago. They didn't heal very fell he has had ongoing problems with infection and we had to bandage his head up … without using tape on his skin because the tape was pulling his skin off. I said, "Yes you look like Lawrence of Arabia with that bandage on your head" and he said "Bring me my camel" very slowly, but eventually he got the words out. And he has very long eyelashes and I always tease him that cows would be jealous … I think humour in or when you're working with dementia residents is very useful as it often transcends words. We have got a lady who sits at the dining room table with a very loud voice, who is deaf herself and she says,

"Oh look, here comes that big man" meaning me, especially when I am wearing trousers, so I do gestures to show big breasts etc. I am six foot, so I sort I wriggle my hips around. That gets her laughing! (Verbatim).

The conversations with the participants abound with explosions of laughter and release, suspending time for a moment and giving a rare opportunity for frivolity that the interview time allowed in the contemporary nursing environment. Grace regales with tales of working in two different nursing environments and using contextual humour in both. She pronounces to students in the academic clinical setting:

Just remember, a baby may suck your finger during a vaginal examination but a bum will not! And, remember! A foetus is like a corkscrew; otherwise it would end up in a knot! (Verbatim).

And when describing her nursing work within a forensic setting she recalls:
I used to wear an apron that had mushrooms on it and I'd put that on over my nursing uniform so it wouldn't get dirty and we used to talk a lot (with the prisoners) about my magic mushrooms! The prisoners would be asking often for my magic mushrooms and where were they and why was I advertising magic mushrooms so it was a bit of ... an ice-breaker is probably the word that I'm looking for. The new prisoners they'd see me walking around in this prison in this little pinafore with colourful mushrooms all over it and even though it may appear to be a little bit childish it really was an ice-breaker and something we could talk about. It then gave me a bit of opportunity to do what I needed to do with the prisoners and the, the word of mouth went around was 'Oh here's the magic mushroom lady! (Verbatim).

A component of humour is that it is a mature defence mechanism which allows individuals to cope with, and grasp the perspective of, difficult situations by

minimising but not trivialising the negative emotions that may occur with difficult nursing care scenarios (Adams. 2007; Dean **&** Major, 2008).

Using humour in this way is a choice of attitude which may sometimes be considered bravado; however, humour can pull people together 'just for a laugh' and it is often this laughing encounter that gets them through. People 'pulling' together is echoed in the theme to follow.

Theme 3:   Valuing support

The valuing of social support was the third emergent theme. Social support refers to the various types of assistance that people receive from others whether it is by emotional or physical aid (Seligman, 1998). Emotional support is often evidenced by the things people do to make one feel loved and cared for and boosts self-esteem; this type of support frequently takes the form of non-tangible types of assistance such as words of encouragement, positive feedback and talking over a problem (Bonnano, 2004). By contrast, physical support refers to the various types of tangible help that others may provide such as assistance with workload and provision of transportation or money.

 In this study, each participant spoke of the value of support from others. They spoke of the valuing of relationships which were professional, supported participan**ts'** decision-making and provided a like understanding of what it is to be a nurse. Valuing support also referred to the valuing of personal friendships with work colleagues, and those personal relationships outside of work, family and/or partners. The importance and empowering potential of these personal relationships and the collegial interactions with others, especially at work, is given great credence and value by the participants. Mary-Anne says, echoing the writing of Cash (2000):

> *It's great when you work with team members who have great wacky*
> *sense of humour and who can really who set the ball rolling and*
> *suddenly you're all feeling a so much better* (Mary-Anne -Verbatim).

We've got a really good team here, very, very good, and everyone does back each other up very well so that's all good … I certainly have fun when I'm down in the office, down that office in residential, and I'm with the RNs and ENs and we have a good laugh (Maggie-Verbatim).

The team here is wonderful to work with. On the majority of occasions I enjoy coming to work and being part of a team. You know it makes a huge difference. It can be very isolating out in the community like this and it's really good to have a team that you can bounce things off, you can laugh with, or you can bitch with! (April-Verbatim).

It makes me laugh and also interacting with my colleagues, the ones that I know really well and if they have a funny situation and obviously I laugh about that (Grace-Verbatim).

The team I was working with was the only thing that actually kept you sane because they had lots of experience with different areas and lots of knowledge and forethought (Lucky-Verbatim).

I surround myself with people I like because they bolster me of course (Ginger-Verbatim).

The people, the ICU nurses have a different sense of humour. We can laugh in the darkest time and I think there might be something we're really pissed off about or at a member of staff and we have a laugh at their expense (on the quiet). I think it's about being with people at their most vulnerable- building up a relationship with people- at that time. It allows me to function and socialise better with my family, I am more tolerant (Vivien-Verbatim).

It's the people you work with- I've a lot of good caring friends (Jean-Verbatim).

I do for my staff; I look after them so that's why I'm here; I'd like to make a difference. I've got all those cards and things (points to greeting cards and boxes of chocolates along a ledge to her left). Because of what my staff says I do about my job, and that's where I get my resilience from (Jade-Verbatim).

The role of clinical handover in which a patient, resident or student care is 'handed over' to another nurse, is mentioned by a number of the participants as an invaluable time for social support and interaction. Handover sees nurses coming together to discuss their work and increases the potential for humourous dialogue and laughter which assists in building relationships and social support, strengthening the team and equipping them to discuss and build a repertoire to withstand stressful situations (Macdonald, 2010). Jean explains:

*Sometime you just get things of your chest, especially after a shit shift. You get to sit down and tell someone who is actually listening **to** what it is. Usually someone says something and you just feel better (Verbatim).*

These oft seen innocuous conversations are deemed "crucial interactions" for nurses to support themselves and each other (Macdonald, 2010, p. 20). The sharing of their experiences whether it be during handover or by them seeking out their colleagues and friends, assisted the participants in "transforming their stressful experiences of adversity in their work life into opportunities for increased growth" (Gillespie et al., 2007, p. 124), building intangible, collaborative capital that they can use at a later time via recall to sustain them in times of stress (Beyerlein, 2005). Maggie states:

Certainly with like the RNs and ENs at handover and things and we have a bit of a laugh. Like you say when something particular happens you have a bit of a laugh or you muck around with your colleagues. I wouldn't say it was fantastic or anything but I mean I have I certainly

have fun when I'm down in the office ... and I'm with the RNs and ENs
and we have a good laugh.

I have a good relationship with them cos we used to share an office,
actually this is a bit rude actually, the other day we were down there
and Dr X one of our GP's rocked up. One of the ENs said to an RN
actually, "I'll do your medications, you go do Dr X," and she went, "I'm
not going to do Dr X", and went all red because of the sexual
connotations and then Dr X laughed. That happens all the time, the
interactions between us. It's more of that type of stuff that we laugh
at. Probably not always appropriate! (Verbatim).

These interactions allow time for the participants to learn about each other
in a safe environment as well as providing space to engage about their work. These
interactions also succour group or team cohesiveness by generating bonds
between the subgroup in attendance (Beyerlein, 2005). These opportunities to be
revelationary to each other also allow the participants a time for reflection on any
difficulties or successes they are experiencing at work. McGee (2006) proposes that
nurses enhance their care for the self by sharing experiences of adversity and
resilience thereby helping them and others to reflect on those discussions and
mimic or model the approaches discussed when they are faced with similar
situations in the future.

Friendship and collegiality are mentioned by the participants as having a
great effect on whether they enjoy their work setting. Ulrich et al., (2009) report
that 'colleagues' were the main factor influencing retention, in a 2009 survey of
critical care nurses, whilst Hannon, (2006) found that people who have their 'best
friend 'at work are seven times more likely than those who do not to be engaged in
their work and their organisation. Jackson et al., (2007) reiterate the moderating
effect that peer relationships have on the developing and maintaining social
relationships believing them to be crucial for nurses. This peer support or social
support network that the participants speak of is their professional support system.

They speak of their friends, family and colleagues who can be called upon in times of stress or crisis. Mary-Anne says:

> *I had a lovely tea/coffee with my mum last week and we had a good chat last week ... Yes ... having haircuts, getting together to have a coffee with people helps (Verbatim).*

Jean reiterates:

> *You shrug it off and say, they don't understand the job. I often say, get them to do the just one of these shifts and we won't get another complaint. You talk to yourself or someone else about it and have a couple of glasses of wine, talk to my husband - he always backs me up. I think that's how you deal with it. There is another manager who gets agro and gives them a good telling off; another after hour's lady gives her support. We meet for lunch sometimes because a laugh's the best way. We quite often see the funny side (Verbatim).*

The literature also attests to the perceived support when referring to the belief that a participant can obtain help, guidance and support when needed, thus promoting psychological ease (Koen et al., 2011). As Epicurus (341 - 270 BC) the Greek philosopher is said to have uttered: "It is not so much our friends' help that helps us as the confident knowledge that they will help us". Jean gives evidence of these wise words when she says:

> *They don't understand the job. I often say, get them to do just one of these shifts. ... You talk to yourself or someone else about it, and have a couple of glasses of wine (Verbatim).*

April also shares the importance of working collegially with others, reporting:

> *The team here are wonderful to work with. You know ... it makes a huge difference ... it can be very isolating out in the community like this and its really good to have a team that you can bounce things off,*

you can laugh with, you can bitch with …. I think it's very important

for nurses to be able to banter with each other (Verbatim).

Bruce and Sundin (2012) note the availability of a caring person at difficult times has the consequence of assisting resilience. A simple gesture, just a phone call or flowers for April is a huge symbol of support. She states:

Oh I got a Beautiful bouquet of flowers from one of the clients who

went home, thanking me personally, which I thought was really lovely

… We are not here to be thanked but it is nice to be thanked every

now and again (Verbatim).

Jean's words also support the sentiment of Bruce and Sundin (2012) on having a person in whom to confide or to have contact with family and friends both at work and outside work who assist in one's surviving critical incidents and crises within work life. Jean says:

It's the people you work with. I have a lot of caring friends. I talk to my

husband- he always backs me up. I think that how you deal with it …

[With another manager's] support. We meet for lunch sometimes

[because] a laugh's the best way; we quite often see the funny side

(Verbatim).

Ginger agrees, speaking of the esprit de corps that grows out of collaborative nursing work and the sense of sisterhood and bonding that nurses have. Ginger reflects:

I surround myself with people I like because they bolster me of course.

If I share a common sense of humour, they see fun in the things that I

see as funny; they have a particular mindset that I can have a

conversation with them (Verbatim).

Ginger feels supported by a group of like-minded colleagues who support her, offering her a strong sense of kinship and camaraderie. This notion of 'bolstering' or reciprocity, the giving and taking of support when needed has a

buffering effect; it has also been linked with an overall effect on health (Bogossian, 2007). Vivien imparts:

> *It's important to be very supportive of staff members because by doing that, helping them, it also makes yourself feel better by debriefing with them* (Verbatim).

Thielemann and Connor (2009) suggest that, with the demands, burdens and excessive workloads of nurses, there is an increased requirement on nurses to have the 'luxury' of someone with whom to talk: a luxury that is now seen as a necessity in modern society.

The social support of colleagues is especially needed for nurses working with residential aged care as they habitually operate as a lone registered nurse in a whole facility or a wing of a facility. They are frequently isolated professionally and find it difficult to access the collegial support required (Jackson, Mannix & Daly, 2003). Mary-Anne tells:

> *I just felt a very huge sense of responsibility, like a burden of responsibility to be able to think of every option and trying to be everything to everyone ... there is a registered nurse on every alternate weekend day shift and the beauty of that was that she got time to, in a day shift, to catch up on paperwork, to do all the weights and referrals to the dietician and speak to the speech pathologist ... that's now fallen on my shoulders.*

> *Except for myself now ... we have got two enrolled nurses; one does night shift so that she very limited in what input that she can put into problems and the other enrolled nurse ... Stress has really gone up for me ... and this enrolled nurse who has carried a lot of the burden has been on leave for five weeks as well so it's basically fallen on my shoulders.*

I have been asking them and asking if we could get a clinical nurse replacement. The manager thought initially that it might be ok but then she said no it is not in the budget and then just this week she said she hopefully she can get someone to come in for two shifts per week hopefully to look at the paper work with me. The major problem is that all the care plans need to be signed off by a registered nurse and I need to be looking at all the assessments that are being done and relating the care plan ... it makes the whole situation difficult at times (Verbatim).

Mary-Anne offsets her professional isolation by developing 'relationships' with her long-term residents. She speaks with warmth of developing long-term relationships with her residents and her sense of purpose in providing holistic care, relating:

It was one of the saddest funerals I have ever been to because she had no next of kin whatsoever; it was only those of us who cared for her at the funeral ... I went on my day off (Verbatim).

She recalls:

I would say there are moments during the day and afterwards I suppose at the end of the day that you do feel that you've have accomplished something, but often I don't feel that I've accomplished much. You do feel that you've made a difference I suppose, especially when you've been away on leave or off for a few days and then staff and residents say, "Oh it's good to see you back"! It's a feeling of appreciation of being part of a team and making a difference in someone's day I suppose (Verbatim).

Here, Mary-Anne celebrates the small success of accomplishment that she feels. Celebration of small achievements or perhaps the development of long-term, meaningful relationships with residents enhances the resilience of those nurses working with them and, interestingly, the effect of those relationships is reciprocal

in nature (Cameron & Brownie, 2010; Fuller-Iglesias et al., 2008). This reciprocity is echoed in the next theme, not only as evidenced in relationships with colleagues, friends, family and residents/clients, but via other means.

Theme 4: "Paying it forward"

The fourth theme is "Paying it forward". This theme's label is taken from the movie 'Pay It Forward' which is an American film made in 2000, based on the novel of the same name by Catherine Ryan Hyde. The basic premise of the novel and film is to 'pay forward' or complete acts of kindness to, or for others with deliberate intent and no recompense, but rather a focus on gratitude, giving, and gladness.

Lucky and Vivien enjoy the healing power of gratitude and giving by *"paying it forward"* or *"sharing the luck"* which enables them to connect and focus on people other than themselves. They then give whether it is by nurturance or by wealth, thereby finding replenishment, strength, gladness and resilience. Lucky says:

Then when you get to the position of getting it all sorted out, you think, God I was lucky, gee I was so lucky, that I was able to do all this, then I'm going to give my luck to someone else, hence when you're travelling and you meet people that need help, you respond to that help from your abundance. I am not a rich woman by any means but I am richer than 90% of the people that are out there. So I feel very blessed and very lucky. I don't feel as though I've been hard done by (Verbatim).

Grace concurs:

Do to other people what you'd expect them to do to you, and too, I have a conscience, a social justice conscience and like to do what's righteous and correct … I have what I believe, is, a fortunate life, in that, I, it has been filled with experiences that I may not have wanted,

but they have actually turned out to be some of the biggest blessings because of what has happened afterwards.

When I was 8 I had a Sunday school teacher and she believed in me, and because of that, I came to believe in myself and so that has set up in place another chain reaction whereby I have the ability to look beyond, I believe what is going on and see that in a person, and believe that everybody has a purpose and a destiny and it's my, my role in life to assist them along their life's journey to achieve their destiny and their purpose (Verbatim).

This 'other-regarding' (Basu, 2012, p. 189) behaviour is often described as altruism whereby the goal is to increase the welfare of another individual by sharing, giving and co-operating, whether it is for personal reasons or feelings of social justice. By acting altruistically people gain perspective on their life and work situations finding strengths within themselves they did not know they had. These strengths allow them to achieve more in work and life as they find, even in times of stress, that if they are doing good acts for others, this giving is returned to them in a cycle of reciprocity and even happiness. Wallis (2005) reveals that a major source of happiness of 75% of the individuals surveyed about how they find happiness in their own lives showed that "contributing to the lives of others" was their major source of happiness (p.2).

Social psychology research (Ballanger-Browning & Johnson, 2010; Johnson, Haigh & Yates-Bolton, 2007) suggests that altruism can engender positive emotion not only in the giver but also the receiver of assistance, and also a feeling of gratitude in the person who receives help. This can often create the urge to reciprocate and thus form the basis for an ongoing relationship and social support (Seligman, 2002).

The participants found many ways to 'pay it forward'. Some found that being a mentor to others whether clinically, managerially or academically was like leaving

a legacy for the future. Each participant speaks of their nursing experience and of their desire to be able to provide wise counsel to others. Mentoring either on a formal or informal basis can show remarkable improvement for those mentored both academically and socially, and can also have positive effect on the mentor (Myrick, Yonge, Billay & Luhanga, 2011). Grace says:

> *I did education as well as administration and always thought if I could just inspire one person like … (she) … inspired me then I would have arrived on my journey* (Verbatim).

April also wants to 'pay it forward'. She explains:

> *I'd like to be remembered as doing my very best for the people that I have been made responsible for. I hope I've improved their life or maintained their life or contributed to their life and their relatives and friends* (Verbatim).

Vivien too wants to leave a legacy and explains:

> *I stay in nursing because I want to make a difference, and it's cheesy but I can see lots of things to improve outcomes for patients. I like to think I can lead by example that I've been doing it a long time and that there is no substitute for expertise* (Verbatim).

Several of the participants voice their opinion that happiness is not about making or having money; it is more about contributing to the lives of others. April says:

> *I just … I went to my bridesmaid's funeral, and the things that she'd done in her life for the community were just absolutely amazing and I thought to myself well I need to do something too! … she has done this huge amount of work for the aboriginal community and she'd done this, that and the other thing … Hopefully somebody will find something to say for my funeral … I'd like to be remembered as doing my very best for the people that I have been made responsible for, I hope I've improved their life or maintained their life or contributed to*

their life and their relatives and friends and I'd also like to be
remembered as a good team member as well (Verbatim).

April and the other participants stories resonate with the interpersonal strengths that Peterson and Seligman (2004) describe as being the befriending and tending of others through kindness, love and social intelligence which reflects the humanistic view of the world. Humanism in nursing is not new; rather it is a strongly held value of the profession (Benner & Wruebel, 1989; Leininger, 2001; Watson, 1988). Many of the earliest nursing theorists described nursing as humanised, personalised or care of each unique person that is holistic and connected (Nightingale, 1946; Peplau, 1965).

April and Lucky openly express gratitude for their personal lot in life. They appear to appreciate the small things that occur around them as well as the larger issues affecting their lives. Their stories reflect their appreciation of nature, beauty and excellence and that they are aware of and thankful for the good things that happen to them. In the midst of April telling her story of her work in interim care she exclaims:

> *It is a great delight to walk watching the gardens beds and smell the*
> *roses when they are out and blooming, but I did not choose this facility*
> *for the gardens* (Verbatim).

The contentment in life and work and in current life circumstances describe**d** as 'flow' by Csikszentmihalyi (1990) and noted in connection with joy as being "when the flow episode is over, one feels more 'together' than before, not only internally but also with respect to other people and to the world in general" (p. 41-42).

Mary-Anne, who cares for her disabled husband at home and is an active nurse by profession, speaks of the little things that she enjoys when she says:

> *Having haircuts, getting together to have a coffee with people. What I*
> *would really like to do is go out walking more because I do love space*

and nature, plants and gardening. I have a lot to do in the garden this weekend. It gives me time ... when you work all day with people you often don't want to be with people at the end of the day and pulling out weeds and killing snails is very cathartic! (Verbatim).

Previous research suggests an altruistic orientation is not only associated with happiness, but with well-being and good health (Ballanger-Browning & Johnson, 2010). In addition, involvement in altruistic activities may be associated with a more meaningful life (Csikszentmihalyi, 1990; Seligman, 2002).

Theme 5: Passion for the profession

The fifth theme related to personal attributes emerging from the portraits was passion for the profession. Participants spoke of their sense of professional pride and value of their nursing role and their satisfaction with career choices made despite the literature related to the unfriendly culture of nursing (Sauer, 2012; Yoder, 2008).

In this study, the participants professed a strong belief in nursing and a passion for the profession; and, what it is to be a nurse and what being a nurse meant to them. All participants said they found something inherently rewarding about being a nurse, being intensely committed to the profession. Participants' worried about, and had a passion for, their profession's destiny, so much so, that the researcher gained the impression that one of the driving motivations for the nurses to tell their story, was to tell of their love of the profession, their love of nursing. This was supported by their commentary which is summed up by Jade:

I've worked out how long I've been in nursing- 38 years. 38 years is a long time and I've travelled around Australia with nursing and I've seen lots of different things ... I never wanted to do anything else ... we are all here because we love it! (Verbatim).

Grace explains her passion:

It was what I wanted to do, I did nursing to become a midwife and so once I found myself again or trusted myself again then within that I came to trust the essence of who I was and who I am is a nurse a midwife - a caring person (Verbatim).

April adds:

I graduated in 1978. I do still get some enjoyment from it. I think there's joy at work. On the majority of occasions I enjoy coming to work and being part of a team … I enjoy caring for the elderly. I found it very challenging and sometimes a rewarding role (Verbatim).

Vivien describes her feeling about patient care:

A life of nursing, it is the number one thing in my life. I think it's about being with people at their most vulnerable, building up a relationship with people. It allows me to function and socialise better with my family, more tolerant … I have never thought about leaving nursing, never (Verbatim).

Lucky continues:

According to my family I was always a nurse; from when I was three years old I'd be around making people eat things, taking their clothes off and checking their stomach. I got a nurse outfit when I was about four and apparently wore it until I could no longer manage to wear it … now I have been nursing for over 30 years, mainly in midwifery, because I find that's my passion … I feel passionate about changing the system … in terms of making … getting change happening (Verbatim).

Ginger adds another perspective:

I suppose my nursing career has been about working in education and in education roles or in fairly senior jobs for 20+ years ... I think the biggest thing for people who work in the sector is to remember you're here because you actually enjoy nursing and you enjoy the students (Verbatim).

One of the participants, Maggie, was sure she was going to be a nurse from an early age:

I knew it what was what I wanted to be. I've always been sincerely interested in the welfare of people and I've always felt a particular connection to older people. I ended up loving gerontology (Verbatim).

Jean and Mary-Anne also explain:

All I can say is, I don't think just anyone can do what we do ... but it is my passion; I love ICU and I love being able to get patients through a cardiac crisis ... I couldn't work anywhere else- there is not enough challenge. Nursing is a challenge; I am an adrenaline junkie. I love it when the shit hits the fan ... nursing is my whole life (Jean-Verbatim).

I also wanted to do something in a caring profession ... My mum and my grand-mum were also nurses, it runs in the family, yes and in fact my great grandmother as well, she was one of the first ... She trained at the Johannesburg hospital as well, where I trained at. It was the late 1800's I think that's right wearing those terrible uniforms ... I have I have always felt for aged people they have come to the end of their life or coming to the end of their life and they've got ... It's almost like a castle; you just get glimpses of what its former glory used to be. You've got to try and understand their life and where they are at and then to make those last few days pleasurable. It's a real privilege (Mary-Anne-Verbatim).

The seminal work by Herzberg (1959) outlines the view that work may be viewed in three ways. For some it is a job that is just a job, something one does, and has to do, to exist and to survive. For some, work is being part of a profession where the individual is able to find joy and pride in what they do. For others, work may be seen as a 'calling'. That is, work as a calling has the ability to become an over- riding need and equals life, although nursing has moved away from this terminology. Further, the participant's thoughts may be traced back to Herzberg's (1959) Motivation Theory which claims that if the work matches the individual, then this gives meaning or meaningfulness to their work, in part, providing the vitality and zest to carry on, and be engaged with the work even under difficult working conditions.

Engagement with work is defined as the positive opposite to *burnout* and is characterised by involvement, competence and zest for the job at hand (Maslach & Leiter, 1998). Furthermore, Cowin and Hengtstberger-Sims (2006) suggest that self-belief is enhanced when individuals identify with their chosen work, this often being a strong predictor of retention.

From the reading of the participant's stories it is evident that they are absorbed in their work and find nursing an intrinsically rewarding experience. In a study by ANA (2009), 65% of nurses surveyed stated they were satisfied with being a registered nurse; and, in two surveys commissioned by the AACN (2006, 2008), 88% to 90% of survey respondents said they would definitely or probably recommend nursing as a career, whilst 65% said they would definitely recommend it (AACN, 2008).

Many of the participants spoke not only of the love of their profession, but also with positivity about their current nursing employment. The following excerpts from participants' stories support this sentiment:

> *It's taken a long time to get to this to work to the position I'm in at the*
>
> *moment. I really enjoy the students. I really enjoy teaching them in the*

classroom now and doing lots of clinical workshop-type things (Lucky-Verbatim).

It's not very often you win … You maintain people generally, or watch them deteriorate, you don't see many of them improve, but every now and again you get that, that … hmm you get that … ooh I don't know what you'd call it, every now and again somebody improves or they either go home or something happens and yeah they can resume their quality or their life outside of residential care … a rewarding role (April-Verbatim).

I think people are receptive to change. I've worked very briefly in the public system; here if I want to make a change, I'm empowered to do it. I think that's very positive, whereas in the UK hierarchy – what you had to go through! Here is much more open to change- so it's a pleasure in that respect sometimes (Vivien-Verbatim).

April and Maggie speak of the image problems associated with caring for the frail elderly, *"It is not sexy"* in Aprils words. However, they discount this view that caring for old people is boring and without reward (Rego, Godinho, McQueen & Cunha, 2010) as they tell of the love of their role. April continues:

There are some people who don't find caring for the aged … ahm …'classy enough' I suppose you would call it or 'high tech' enough. I think there is still a stigma associated with caring for older people. I don't think people are aware of the complexities of caring for an older person, in that it's a far more holistic care that you have to provide for an older person than what you would do in an acute setting. You'd only be looking after that person for a specific period of time, then sending them home to whatever and not really looking at the person as a whole (Verbatim).

Mary-Anne further champions her elderly residents when she says:

I have always felt for aged people they have come to the end of their life or coming to the end of their life and they've got ... It's almost like a castle; you just get glimpses of what its former glory used to be. You've got to try and understand their life and where they are at and then to make those last few days pleasurable. It's a real privilege. Because with acute care you are trying to plug holes in the dyke, you know you are often only doing stop-gap measures, like give antibiotics to cure the infection but in aged care you are actually trying to make those last bits of life happy and enjoyable and get the most out of life (Verbatim)*.*

This positive view of work has recently been termed "harmonious passion" in organisational literature (Vallerand, Paquet, Philippe & Charest (2010 p. 289) and influences an individual's satisfaction with work. Rather than an "engagement gap" with work (Rivera, Fitzpatrick & Boyle, 2011, p.265), nurses who have passion for their work benefited from increased satisfaction, resilience and ultimately this passionate and harmonious engagement affected retention of those nurses (Kearney, 2010). Uplifting remarks concerning the love of nursing work as evidenced by the participants play a critical role in assisting nurses to stay working in trying times in whatever organisational context they work.

Environmental/Organisational Characteristics

The discussion thus far has related the personal traits and attributes brought to bear by participants on a daily basis for sustenance in often difficult times in difficult work environments. The discussion now takes a turn to encompass how those personal traits seem to have been internalised by each participant to re-frame cognitively their personal capacity to remain in the workforce as it relates to the environmental and organisational characteristics which enhance resilience.

Three themes emerge as important: first, the acceptance of challenge; second, experiencing adversity and growing through it; and third, the significance of leadership.

Theme 6:   The taking on of challenge

This theme relates to the taking on of challenge. Challenge is defined as 'to make demands on, or prove testing to' and challenges are 'specific, detailed and actionable' (The Oxford English Dictionary, 2010). From the discussion of participant's personal resilience traits, it is clear that each participant recognised and voiced demands and issues that tested them on a daily basis in the workplace. However, instead of being overwhelmed by the problems of the healthcare system, the participants chose to 'take on' the challenges at hand. They show interest, motivation, and excitement when they believe they have the ability to solve a perceived testing problem or challenge at work and take action to do so. For April there are never enough hours in the day to be able to care for the elderly in her care. She says:

> *I found it very challenging just getting your work done* (Verbatim).

Vivien works in management in an acute care setting and echoed the same concern when she explained:

> *My workload is such that achieving one thing in a day gets me through*
> *to the next day … It is a hard slog; I've never worked so hard. … I do*
> *feel overwhelmed every day. Overwhelmed by the management load*
> *and the added responsibility for patients and staff … that's the way I*
> *am … I just knuckle down and I do the work. I work my arse off and*
> *get it done. That's hard work it is* (Verbatim).

Grace recounts challenging experiences in the workplace in the very early stages of her career when she made a decision related to covering the ward for ethical and legal reasons. Grace remains emotionally charged by this experience as she describes the challenges she faced in standing up for what she believed to be good nursing care; she felt she had to get through the challenge alone with little or no organisational support. Grace muses:

I've had some situations that have been stressful to me but I've bounced back ... because of that part within me that just won't give up. I had a situation when I was just, I'd only just started working ... and there's a part of me that really is an advocate for social justice, an advocate for rights of people and I was working at a health facility where the night shift finished at five-thirty in the morning and the day shift came on at six-thirty.

I was working night shift and I just could not marry in my head the fact that these women on the anti-natal and post-natal wards would be left for an hour without anyone to care for them so they could haemorrhage or anything could go wrong ... so because I couldn't marry this stuff in my head and it just wasn't ethically correct I would stay for an extra hour and did that continuously when I worked nights.

One night when I came on at 9.30 p.m there was the Director of Nursing waiting there for me and said, "Don't expect to get paid" and I said "Well look I'm not really expecting to get paid but you can be guaranteed that I will not go home early; it's not ethically correct." She sacked me on the spot and that was devastating. I was twenty-two years old, and thought that I was a good nurse and a good midwife and thought that was I was doing was right and it was almost like my whole world shattered underneath me and I did find that that really knocked me for a while ... it was something that shook the essence of my being(Verbatim).

The contemporary healthcare system in which these nurses find themselves includes issues pertaining to ageing populations, longer life expectancy, an increasing shortage of skilled and qualified nurses, high workloads, and increased patient throughput (Holland et al., 2012). The participants in the residential aged care setting were challenged by all the issues mentioned above. For Maggie it was the lack of

trained staff, dealing with complaints and managing the performance of difficult staff members. She articulates:

> *We are very short of trained staff, very short. For example my old position is still not replaced, so I'm doing, not as much now, but I am still doing a bit of both roles, and we've still not replaced that person - my position.*

> *Complaints are daily events … I suppose the complaints are about the site here and the care given normally. I do still find it difficult because obviously you are defensive about what you do here and you think everyone here does a great job … performance of difficult staff members as well which I find quite stressful … some days are really bad* (Verbatim)*.*

Mary-Anne feels the same burden of responsibility because of the management decision to have only one registered nurse on site in the residential aged care facility for sixty-six clients, twenty-two residents in one section and forty-four in another, and all there on a temporary basis awaiting permanent long-term residential care placement**.** She says:

> *So my clinical nurse has left to take a different position and then we have been told, I think because for financial constraints, we have been told that there is to be only one registered nurse on site- in other words for sixty-six clients and some of them, twenty-two are under my section and forty-four of them are there on a temporary basis.*

> *Except for myself now, we have got two enrolled nurses, one does night shift … stress has really gone up for me … and this enrolled nurse who has carried a lot of the burden has been on leave for five weeks as well so it's basically fallen on my shoulders and she is going away again soon for another two weeks leave and I have been asking them and asking them if we could get a clinical nurse replacement. The manager thought initially that it might be ok, but then she said no it is*

not in the budget! (Verbatim).

Jean who also works within a management role in the same acute care setting disclosed the challenge of nursing management saying:

The nurses - they can't do what they want to-do for each patient. There is huge stress and other huge responsibility from fire, engineering, clinical, security issues, complaints, staffing and other issues, and the continual interruption. You cannot hold a five minute conversation especially on late shift because of constant phone calls; it's just constant! Just crisis management and the continual problem solving and staffing issues. (Verbatim).

The recent study by Holland et al., (2012) and the Health Workforce Australia 2025 Report (2012) notes that the shortage of skilled nurses is the worst for the past 50 years and that the crisis of attraction and retention in nursing is a problem likely to continue for some time. The added pressure of unskilled staff creates a flow-on effect to those who do stay working as their workloads and responsibilit**ies** increase. This results in a less than satisfying work experience and has the potential for losing many experienced nurses through turnover adding to the increasing shortfall (Holland et al., 2012).

Grace for example, describes her reactions to these issues; however, she relates a feeling of pride in that she was able to get through frustrations and continue working in the healthcare environment. This attitude is captured when she says:

But I bounced back from it and then went to the country, consolidated my midwifery and really started to get back to where I was at before really … it gave me the ability to trust my own instincts and to know that I am a good nurse and midwife and when I came back it even gave me more fire in my belly to stand up for what's right and what is wrong, so really I stood up for the women who couldn't stand up for themselves (Verbatim).

The pride displayed is a phenomenon that is termed 'survivor's pride' as described in the seminal work by Wolin and Wolin (1994) who emphasise that it is through suffering and perseverance, and encompassing that struggle to work through obstacles and challenges, that those difficult experiences become integrated into one's sense of self and makes one resilient.

Survivor's pride is the well-deserved feeling of accomplishment that results from persisting in the face of hardship or adversity. A bittersweet mixture of pain and triumph is usually under the surface, but is sometimes readily visible in many youth and adults who have gone through difficult circumstances. It develops over time in the course of a struggle that typically goes unnoticed in professional and lay circles, being more likely to document problems and deficits in people than their strengths. Survivors develop a "survivors' pride" from which they draw strength when they are challenged. Wolin & Wolin (1993) state that a dysfunctional environment can become a "breeding ground for uncommon strength and courage" (p. 108).

Meeting the demands of the workplace was viewed as being about having a particular attitude. This attitude meant being able to rise up, even thriving and 'profiting' from overcoming the daily organisational challenges encountered in the workplace. Each participant gave voice to their attitude that they often loved a challenge. Jade in particular, said she thrived upon it, saying:

> *I was actually asked to manage one ward, then I asked could I do ortho* [orthopaedic] *ward as well? And I said, I don't know how to do one, so give me two and I'll see how I go. So maybe I am an adrenaline junkie; I do like a challenge; I know that ... I could be called; I do like a challenge!* (Verbatim).

April echoes:

> *I still get enjoyment from it* (nursing). *It's still a challenge I enjoy* (Verbatim).

Jean exclaims:

They only see what's not done, not what has been done. But that's the
lovely challenge of it! (Verbatim).

LePine, Podsakoff and LePine (2005) found that challenge stressors are positively related to attitudinal outcomes including increased productivity and the potential gains related to performance. Specific pride in accomplishment and general well-being are evoked by the positive potential of challenge. In psychology it is also termed 'interest' where interest sparks a feeling of wanting to become involved, or extend or expand the self by incorporating new information and having new experiences (Arnaud, 2007). Being motivated and challenged may be associated with feeling more animated and alive, making one feel more open to new ideas, experiences and action**s,** and able to seek and explore new information which broadens an individual's repertoire of knowledge (Podsakoff, LePine & LePine, 2007). This is illustrated in the following excerpts from the participant's stories:

Vivien says:

All the education I've bloody done over the years - I'm a perpetual
*student - from practice to challenges to Uni higher education **is** all so*
interesting (Verbatim).

Grace agrees:

I think the rewards far out-weigh the horrible stuff that goes on. It is
all been so interesting; it's kept me going (Verbatim).

Frederickson (1998) contends that interest then is the "primary instigator of personal growth, creative endeavour, and the development of intelligence and resilience" (p. 306). This claim echoes the classic work of Csikszentmihalyi (1990) who warns that people must seek a balance between interest and challenge **as** to 'best fit' for each of us. Further, if the demands of work are too overwhelming and

unreasonable, people often feel a sense of failure and an inability to cope; they just want to give up as success does not feel within reach. Conversely however, a job that does not challenge can cause people to lose interest, skills become denuded and creativity flags. This type of workplace may also cause people to leave due to lack of engagement.

All of the participants were interested in taking on the challenge of mastering new knowledge either within new domains of nursing or acquiring new knowledge to meet the challenges within their work setting, a setting which changed almost daily, thereby requiring up-to-date knowledge and skills just to keep pace with their work. Lucky, for example, who had been nursing for 39 years, had taken on the new role of educating nurses in academia. Lucky has found it challenging to relinquish the expert clinician role and begin again as a novice academic. Although Lucky had numerous years of teaching patients, she was not prepared for the role of educating nurses in the University sector. She exclaims:

> *I can't say I've been totally enamored by it, it's taken a long time to get*
> *to this to work to the position I'm in at the moment. I really enjoy the*
> *students. I really enjoy teaching them in the classroom now and doing*
> *lots of clinical workshop-type things. But that's taken me a good 18*
> *months to get to this position. Mainly that's again sort of being unsure*
> *of my own abilities in this sort of aspect because it's a totally new role*
> *and also I've never done anything like this before* (Verbatim).

With this change in role or the need for mastering new knowledge to become the 'experts' in their role, the participants showed emotional strength when faced with new challenges and the necessary steps to accomplish the goals they and the facility set them, and again accepting challenge.

Vivien voices her concern to continue to develop personally and to keep up to date professionally. She takes on the challenge to do her best, to be the best, to make a difference. Vivien harkens to the ideas of Seligman (2002) which proclaim

that if people believe their work makes a difference, then they as individuals feel that they have made a difference. Vivien contends:

> *My role is developing practice, policy affecting patient care, weaning protocols, work practices, updating … I feel really bad because it's not evidence based …It's the academic level that I'm trying to bring, to brush it up to A1; yes that's the way I am. I've very high standards both good and bad because I don't settle for second best!* (Verbatim).

Nurses working in academia, despite having a 50-60 hours per week academic workload are required to manage with teaching, marking, community engagement, professional service, research, clinical practice and student care (Brady, 2010). They appear to enjoy being a role model for students and they provide support for large numbers of students. They accept the challenge inherent in the academic theory and clinical setting. Grace explains:

> *There's probably a lack of understanding of what goes on behind the scenes. We use a workload model and I don't really believe it fully captures what is actually done and that in itself then frustrates me because I know that I work hard and I know the people around me, … do work hard as well, but it doesn't equate to a, a numbers game. What we do is more than numbers! You can't put it all on a little grid and say this is what I did today. There's lots of liaising with the public; there's lots of supporting of students. How can you put that into numbers? It doesn't equate to a one hour lecture but it's a lot of the job that you do. It is that support and trying to role model for nursing and midwifery and that's what I believe is my job here, to role model what it is to be a nurse, and what it is to be a midwife. So hopefully that someone will remember that, because they'll forget the theory, but if they remember what and how they were made to feel within, then they will carry that on* (Verbatim).

Grace turns her focus from the self to selflessness as she re-frames the challenge and frustration of the excessive workloads and expectations of her role.

Ginger reveals more when she says she is happy with being a role model despite her work demands and the need to justify work activity through an organisational points system. She says:

> *I think workload is significant because I think one of the difficult things to do is you have to equate your work hours with workload points and justify your workload. You never experience a sense of completion and achievement. I have a book with lots of squares in it and often the squares don't get ticked. Often you go home and you don't know what you've achieved in the day. We might have achieved 60 things but there are 90 more things to achieve. So you never experience, "I've achieved this; it's complete! There is also the demand of being a good teacher, a researcher, a publisher and answering 65 phone calls ... As long as I am a good role model for the students and the other academics I am happy with that* (Verbatim).

Each of the nine participants in this study had completed some form of postgraduate education and some studies suggest that nurses who complete post-graduate programs have a higher stress level than those that have not. Brady (2010) contends that the more a nurse studied and was aware of nursing research and evidence, the more stress was experienced by the nurse. Lucky reveals thoughts about the challenge and stress of being expected to undertake further study whilst working. She says:

> *I enjoy reading for the sake of learning something but having to actually do assignments and that sort of business is probably the most stressful thing in this job* (Verbatim).

Although study and/or further post graduate education may be adding more work to an already heavy workload, many of the participants voiced their love of learning something new, as echoed in the thoughts of Jade:

> *A professional development course for all the managers ... starts this month; it's a twelve month course. I've done two similar courses but this one is going to be relevant to what we do here, so we're taking*

on study as well as new wards. I've got the two busiest wards in
Perth, so all of these things ... it's a big challenge ... but I do like the
idea of stimulating the brain and learning something different
(Verbatim).

Hill (2010) suggests that cultivating career-long learning or maintaining openness to ongoing education was a key characteristic in predicting 'wisdom-related' performance as the mastering of new knowledge and the strength that it entails to pursue and conquer that knowledge; it reveals an open-mindedness to take on a new challenge. The respondents demonstrate the understanding of the potential inherent in learning/education. It is a mature view of learning which comes from understanding in a wider context, and thinking towards what the long-term goals of achievement and mastery of the new knowledge or task can bring consistent with educational theory (Gaberson & Oermann, 2010). For example, each participant lists evidence of achievement, noting to themselves and the researcher the visible and invisible markers of progress, the completion of this course or that competency, or the undertaking of new knowledge to meet with the challenges of today's nursing settings, be they clinical, education related or management focused. For example, April said:

I studied Gerontology ... post grad. yeah, and I've just done a
continence assessors course ... and I found that hugely stressful ...
that really bought me out of comfort zone (laughs) ... you think to
yourself: how the hell did I do that and still maintain my sanity, but I
was very well supported here. You know my manager supported me
and it was really quite good. I would like to have the opportunity and
time to use the skills ... I don't know how ... I'm just running from one
job to another putting a finger in a pie not really looking at an overall
plan and being able to implement it (Verbatim).

Gaberson and Oermann (2010) note that self-development is a key **to** promoting and strengthening personal resilience and providing an avenue for novelty and challenge. Ginger craves this type of challenge when she calls for more

responsibility on committees which should create another interest for her and provide her with the potential for increased interaction with a new network of colleagues. This allows her to grow as a person and as an academic nurse through the gaining of insights and the reflection on educational and practical experiences that new knowledge can bring in accord with Gaberson & Oermann. She reflects on this saying:

> *I'm easily bored here, not stimulated enough ... But as long as I keep myself entertained with things that challenge my mind I'll probably function (Verbatim).*

This mature view also relates the challenge directly related to the multiplicity of changes occurring within the Western Australian healthcare system and, with it, recognition of a changing perception of what they, the participants could achieve, and what they should aspire for within the system. They remained interested in the changes occurring and the experiences they would have throughout, because of, and beyond those changes. They engaged in thinking things through, reflecting on and examining the changes from all sides; they assessed the current and potential obstacles to overcome, the challenge of making order out of chaos. They all offered criticisms of the system in which they currently worked. For example Jade covered a number of the current issues in healthcare when she observed:

> *Challenges come from all angles. Currently there is an increased workload. My surgical ward is a 25 bed ward, but by the time you get your admissions, your day cases that will come and go in a day fed from DOSA (day of surgery admission), we've got out ED dept, we've got demands from intra ward that need to change to different areas, so by the time you see all the patients, on average you see 40 patient changes a day.*

> *The other challenge is found in the junior work force, grad nurses, RN's and EN's. It's a very difficult environment to get them up to speed when they come to the wards. They've just changed in February and now we're October and you'll find that they are not up to the speed,*

so they need a lot of support. But even seniors coping with that workload struggle and are finding it a challenge as well. Patients are sicker, more acute, for example two TPN patients on the ward in years gone by they would never be on a surgical ward, and they would have been special in a nurse specials or in a special area. So we've got a lot more complex patients managed on the ward, plus the flow-through, say an appendix is come and gone within 24 hours, so the turnover is very quick. So it's not unusual that a nurse will see three patients in one bed in a day, with the morning person going home and another surgical patient going home. We also get another very diverse area here accommodating orthopaedic patients; we're accommodating medical patients and surgical patients and from an experience level that's a difficult scenario for staff adjustment (Verbatim).

For the participants, challenges ranged from workplace dilemmas to workplace dramas while for others the challenge was just getting their nursing work done to their satisfaction. However, the entire research cohort was unanimous in their enjoyment in the taking on of challenge. In essence, the lack of stability, the flux, and the possibility of further problems within their work environment, challenged this group of nurses rather than dismayed them.

Theme 7: Experiencing adversity and growing through it

The seventh theme extends from meeting the challenge and focuses on the personal growth of participants through workplace and other adversity. Adversity is defined as: "a state of hardship or suffering associated with misfortune, trauma, distress, difficulty, or tragic event" (Jackson, Firtko & Edenborough, 2007, p. 3). These authors view workplace adversity as: "any negative, stressful, traumatic, or difficult situation or episode of hardship that is encountered in the occupational setting" (p. 3).

The healthcare workforce is in a period that may arguably be considered the most chaotic and adverse to recall (Holland et al., 2012) with fewer nurses working harder to manage the same or ever increasing workloads; and this problem only is predicted to increase to a highly significant shortage of 109,000 nurses by 2025 (Health Workforce, 2012). Average weekly working hours for a nurse in Australia have increased; this is likely to have an effect on sick leave in the short term, and burnout, premature retirement and decisions to leave nursing in the long-term (AIHW, 2010). Reflective of this, each participant had stories of adversity faced in the healthcare setting as well as reminiscences of past adversity.

> Maggie tells of one of her experiences:
> *I got promoted to the manager of the facility and I was very young. I was probably just a couple of years out of uni and I messed up ... I didn't really have the skills to do the job. And it was an awful. An absolutely awful time ... I really could have, walked away and not really gone back to it (nursing) because it was quite horrible ... you realise ... that you've got to look after yourself because people are so quick to discard you* (Verbatim).

'Nurses eating their young' is the commonly used terminology to describe this 'sink-or-swim' approach to survival of the fittest in nursing. This 'throwing in at the deep end' is often seen as a rite of passage for new nurses and is somewhat akin to an initiation into the profession. Research suggests that often a nurse's exposure to this type of stress has a devastating effect on self-confidence and morale (Araujo & Sofield, 2011; Baker, 2012). Maggie does not become a victim however, as she was able to work through adversity due to her belief in her own hard work and capability.

> *But the knowledge that I'd got them through accreditation, that first cycle of accreditation, and that I hadn't had the training, and I was understaffed ... carried me through ... you know, you weren't given enough training and support, just given the role, and set up to fail really ... I just didn't have the skills to do it, I really didn't know exactly*

what I was supposed to be doing really ... with work, I am a bit of a perfectionist, and I like to do everything really well, but I just didn't know what I needed to do. That was the problem (Verbatim).

The feeling of coping alone with her professional trauma or being discarded from her career makes Maggie insulate herself as a defence mechanism and as a means of protection from more pain and further damage to her self-esteem. She places some blame for her feelings on the organisation when she declares that she was "*set up to fail*". This disturbing syndrome is exposed within the work of Manzoni and Barsoux (2002) who reveal that managers often place workers in situations where potential 'star' performers lose self-confidence and drive and 'recoils' from work. The result is that the leader or manager begins to micro-manage and the unwitting result is that the employee loses morale, lives down to expectations, rather than living up to their true potential. The flow on effect goes well beyond the lost productivity of a few individuals; rather it can mitigate the derailment of potentially great careers.

This disconnect from work is identified by Shean (2010) as the displacement of anger and the negotiation phase of recovery to resilience, those affected believing that this response emerges as the second part of a three stage model following victimisation. Stage one equates with impact; stage two equates with recoil; and stage three equates with reorganisation. The authors reveal that most victims of crises successfully negotiate these three stages to recover to resilience. Peterson and Seligman (2004) align this with the emotional strength that involves the exercise of will power to accomplish goals in the face of opposition. This process of reaction to adversity, developed through some personal reflection, enables insight, letting go, and then recovery which leads to self-worth (Shean, ECU unpublished thesis 2010). It also leads to a celebration of one's own resilience with a reinvesting in skills and knowledge gained through previous adversities, and a mobilising of resources enabling response and adaptation, and a making sense of and managing the challenges that are presented. This demonstrates resilience, by

showing the ability to adapt successfully in the face of stressful or negative work events (Low, Stanton & Bower, 2008; Ungar, 2008). Maggies says:

> *I didn't experience doubt or loss of confidence with my nursing skills as such, but certainly as a person I did. I suppose it was because I was in a managerial position not really a nursing one … but I went back to nursing … and the job … was just wonderful: my passion* (Verbatim).

Grace illustrates the ability to adapt to occupational adversity when she tells of her experiences:

> *When I was pregnant, I worked in child health and I loved child health. I had my own child health centre. It was great, the mums really loved me and they were excited that I was pregnant and that I was going to experience some of the things they were experiencing. So I went to the person in charge, and this almost seems like issues with people in charge of me, and said that I was pregnant and I'd like to have maternity leave. Well there was no such thing as maternity leave and I was told I could come back … if my baby died. So that was very understanding I thought, not at all, and that was just, really awful and I thought, "How dare they say that to me? I've been loyal to this organisation* (Verbatim).

When an individual is challenged by adversity, personal growth may often follow as the adversity often leads to them discovering talents and strengths that they did not know they possessed, or had not developed fully prior to the adversity (Hogan, Greenfield & Schmidt, 2001). Currently, there are a variety of theories of how people benefit from experiencing adversity, often termed 'benefit finding', 'post-traumatic growth' or 'stress-related growth' (Snyder et al., 2003). This perseverance in the face of adversity or the struggling with hardship and not giving up, denotes a process and a trait of hardiness which allows a person to face stress and to grow from the adversity that is encountered (Maddi, 2006). Grace demonstrates this in the continuation of her story:

After that, I wasn't sure if I was going to return to child health. It was like do I want to work for them again? So that was another crisis thing in my life but I did go back to child health and in fact … I didn't go back immediately but I actually got phoned by child health offering me a job … It did have a huge impact on me and it's had an impact on my teaching because I've spoken with students about that and I've relayed that incident and how I felt at the time and how it made me dig my little heels in (Verbatim).

Ginger also replicates this growth with her story. She says:
I've recently shown a lack of judgment re my colleagues about their trustworthiness … and generally I'm the kind of person who doesn't trust anyone. You have to prove yourself to me and when I have been more trusting sometimes I've been disappointed with this cut-throat world.

Where I have given someone the benefit of the doubt and trust and where I've supported them, they have turned around and misused that trust, or not even misused it, but the fact that I've helped them, that I've been in the background … it's one upmanship. There are people, some people, that I've worked with that probably don't see the world as I do in that you don't step on others to get where you are, or you don't ignore the people who helped you along the way. There are a lot of people that I've worked with that tend to forget the people who've helped them … I wipe off my knees and keep going despite adversity … I come from a family that taught me you just need to move on and get on with it (Verbatim).

The outcome of adverse work environments, inclusive of adverse interactions with other members of staff, often leads to an uncomfortable work climate, yet all of the participants had adverse events or crises in their work life and still remain. Although these related events made up a large part of their story, they

were discussed as something to recover and grow from. In reality, the participants juxtaposed their adverse events with the positive experiences they were having in their current workplace.

Much work has been done on positive environments in the workplace. For example, the positive impact that a healthy work environment can have on staff satisfaction, retention, and both personal and organisational performance is a well-established phenomenon (Aiken, Clark, Sloane, Lake & Cheney, 2009; Shamian & El-Jardali, 2007; Sherman & Pross, 2010). Sherman and Pross (2010) reiterate, stating that a healthy work environment requires a work setting in which policies, procedures, systems and culture are engendered so that employees are able to meet organisational objectives and achieve personal satisfaction and accountability in their work. However, the participants in this study have revealed that despite the omission of these attributes in their workplaces they have survived and in all cases demonstrate personal and professional growth. It is here contended that new research perhaps should focus on developing resilience traits and characteristics to harness success in the workplace.

The AACN (2005) emphasised nine characteristics that establish, support and sustain a healthy work environment for nurses. These are: skilled communication, collaboration, effective decision-making, a culture of accountability, appropriate staffing, meaningful recognition of nursing and the profession, professional growth and development, and authentic leadership. All these characteristics are able to be learnt and equate in some way to traits possessed in resilient people and also applied to the workplace (Brady, 2010).

Another strategy used by participants to work through adversity was to seek and harness mental stimulation available to them. Whether the nursing setting is academia or a clinical environment, nurses want a stimulating work environment which encourages and supports professional growth and development (Koen et al., 2011). Ginger says:

I find happiness and joy when I am writing and publishing (Verbatim)

Ginger finds the appropriate levels of stimulation within her current academic environment by the pursuit of academic ideals as does Vivien who is struggling to deal with the lack of evidence-based practice within the clinical setting. She speaks of her role and tells that she wants to bring her area to be "A1". She says:

My role is developing practice; policy affecting patient care, weaning protocols, work practices, updating everything. The girl in quality keeps ringing. I feel really bad; it's not evidence based ... It's the academic level that I'm trying to bring by brushing it up to be A1 (Verbatim).

By the participants working through adversity they have demonstrated positive development in the face of challenge, pushing for mastery to combat negatives within their work environment. This gives them the ability to self-develop, imbuing the 'survivor' with pride in their own ability to continue. Tapping into these strengths becomes part of a leadership role, looking for and developing resources within people so that they respond actively within workplaces; this will be discussed within the next theme.

Theme 8:   Leadership

Viewing personal strengths as a resource to be further developed is the foundation of good leadership. In current leadership and management literature, leaders of organisations are viewed as designers, stewards and teachers with a responsibility for building their organisations and the people within them (Peters, 2010; Porter & Tiesberg, 2006). Leaders are expected to 'grow' themselves and the capability of their colleagues; they should make clear their vision and 'inspire' the organisation and others, as well as enable their staff to cope productively with the problems and crises they may face within their work (Senge et al., 1999).

Hill (2010) notes that one of the essential components of a good nursing work setting is strong, reliable and motivated leadership, especially when it is required to guide a changing workforce. In a time of great organisational challenge, it is suggested that every nurse leader within contemporary nursing settings should treat their staff with the respect that professional nurses deserve. Leaders must understand themselves in order that they become credible, competent, and visible leaders (Hill, 2010). Leaders also play a crucial role in creating hopeful work environments (Avolio, Gardner, Walumbwa, Luthans & May, 2004) while Coomber and Barriball (2007) and Hill (2010) contend that the negative effects of working under a ineffective leader or a leader that does not meet the requirements of a leadership role, or who may not have been competently prepared to assume the mantle of leadership, may contribute to nurse dissatisfaction with their work, and ultimately cause them to leave the workforce.

Notably the participants in this study did not believe that leadership was only up to others. Each participant took on the role of leadership in whatever capacity they could and saw leadership as part of their nursing role. For example, Vivien states:

> I try to make the right decisions. I try to lead by example. I feel like I'm doing that anyway. I feel like I am a reasonable manager … I am not conscious of it, but I do it naturally anyway … I said to the boss I will not compromise the patients; I am very worried about opening the floodgates. I wasn't comfortable. If it was affecting patients, I would go; I would have to make a stand, make a protest if the care is not optimum for the patient (Verbatim).

Lucky too restates:

> I'm not really the sort of person or nurse that likes to be told what to do and certainly if I see things that aren't really how I'd like to do them it's very frustrating for me, especially if it's on a higher level. So those sorts of crises, I don't like to be the underling or feel powerless I guess … You're made to feel as though you can't really change the system

because the policy's written as such or 'this is how we've always done
it at this hospital' and you do feel frustrated. I think my way of dealing
with those sort of things was to make light of it but eventually you
actually leave that system don't you because if you feel you can't
change it from that position you move on to somewhere where you
can feel comfortable with your work (Verbatim).

Participants made comment on the problems associated with a leadership role and on leadership issues in healthcare settings. These nurses expect to provide input into decision-making, and explanations for the rationale of the decisions made; however, they often felt a power disparity in not being able to exert any influence within their area of work. English and Chalon (2011) assert that cynicism with work is often a diffusing mechanism to release frustration. Ginger described cynically an exaggerated power discrepancy between nurses/leaders and followers where she was sometimes made to feel like a child. She says:

A lot of the time in this particular unit you have to play dumb in order
to be crazy and play dumb in a unit which is supposed to be a place of
higher learning. I find that very frustrating (Verbatim).

Ginger believes that professional latitude which includes autonomy and entrepreneurship makes her job interesting, and participation in clinical decision-making contributes to her satisfaction with her role. Ginger believes that when others recognise what she does, it makes her feel valued and leadership is essential in displaying and making over this valuing. She says vehemently:

The amount of work is irrelevant as long as you feel supported and
valued in what you do (Verbatim).

Shirey (2006) believes that nurses are more tolerant of an increased workload if they feel they are being treated fairly and that their work is valued. Ginger craves exactly this. She enjoys leadership roles and she wants to feel part of something that is larger than herself - her way really of leaving a legacy, or leaving a mark on the institution, saying basically, 'I was here and I had input into these

decisions!' She mentions the potential for promotion and advancement opportunities having a strong impact on her satisfaction and intention to stay in the nursing profession, rather than any motivation from workload or pay (Freeney & Tiernan, 2009). The AACN (2005) noted that recognition of the value and meaningfulness of one's input into an organisation's work is a deep-seated need and important for both professional and personal growth. The acknowledgement of the work and contributions of staff is also a key leadership responsibility according to Sherman and Pross (2010), and echoed within the recent work of English and Chalon (2011).

Jade too expresses the value she feels when she solves her problems at work, articulating:

> I said we really have to do something about this …. I always try to look
> at everything positively. It's not always possible, but I try and look at
> everything positively and I do like the idea of stimulating the brain and
> learning something different. So it's the feasibility of how that works
> … I never thought I was quite a lateral thinker, but I surprise myself in
> that I've come up with a different way of maybe doing what we are
> doing now … trying to think of how to problem solve. By October I'd
> come up with my own decision (Verbatim).

Richardson and Martin (2004) found that over 50% of the aged care nurses in their study felt under pressure to work harder and were dissatisfied. Mary-Anne, Maggie and April tell of this when they comment on their inability to provide the care that is needed for their residents, but also spoke of how they were able to develop relationships with patients and the bolstering effects this had in improving their work life. This sense of meeting their own professional and personal work standards, and to provide the best care possible to the residents in their care, leads to joy at work despite most aged care nurses feeling tired and burnt out (Cameron & Brownie, 2010; Glasberg, Eriksson & Norberg, 2007). Mary-Anne says:

> I have always felt for aged people. They have come to the end of their
> life or coming to the end of their life and they've got … It's almost like

a castle; you just get glimpses of what its former glory used to be. You've got to try and understand their life and where they are at and then to make those last few days pleasurable. It's a real privilege (Verbatim).

Mary-Anne's use of the metaphor of ruined castle and past good days of the elderly in care indicate that beneath her narrative is the reflection upon the life-essence of the people in her care; she leads by example, transforming the interactions with the elderly in care from daily work into daily 'privilege'.

The participants' stories reveal the problems, with which they are faced, the lack of quality leadership, and management shortcomings. They feel caught in the maelstrom of today's health care environment -powerless and devalued (Araujo & Sofield, 2011; Hutchinson, Vickers, Wilkes & Jackson, 2010). These participants sometimes feel impotent in the face of the bureaucracy that is nursing. They have not left their current nursing position yet, but if their feelings of overwork and powerlessness continue they may retreat to a less demanding role and lower their personal and professional aspirations as a means of coping (Schaufeli & Enzmann, 1998; Maslach & Leiter, 2005). This is exactly what Maggie did:

I don't think I handled it particularly well, but I was young. I was only, I can't even remember how old I was then, early twenties, and I was supposed to stay on and hand over to the next manager that was taking it on, but I … just basically resigned and left, so that wasn't very professional really, the way I handled it. But I just couldn't face going in really … I know I could of, I really could have, walked away and not really gone back to it (nursing) because it was quite horrible. I realised I was so young but now I look back and I realise … that you've got to look after yourself because people are so quick to discard you. But the knowledge that I 'd got them through accreditation, that first cycle of accreditation, and that I hadn't had the training, and I was understaffed, and when I left they put on more staff, carried me through. … Even my old boss … there was a major restructure and he

was made redundant and I was promoted up two positions, and he

was very supportive after I left. He rang me quite a few times and said

to me 'that you know, you weren't given enough training and support,

just given the role, and set up to fail really' (Verbatim).

Ginger tells of the *"Decided lack of ego stroking in the academic environment - or praise"* which she seeks despite other available rewards of working in an academic setting**,** including travel opportunities for conference attendance; study time allocated within workload; and the receipt of sabbatical leave. The lack of positive reinforcement for work and the lack of a culture of respect are indicative of a lack of good leadership, which in the literature is termed 'joy stealing'; this may wear a nurse/participant down and add to their frustration with work (Heinrich, 2007).

Many of the nurses communicate nostalgia for previous times when respect and honour for a nurse's work were universal. Nostalgia it may be with the idealised past being wished for**;** Jean relives the past when a nurse was a revered and respected figure. Jean reminisces:

*I love it from years ago but wouldn't do it now***;** *it's a lot harder now*

and not the same respect for nurses now. Police would give you a lift;

bus drivers wouldn't charge you a fare. Patients are more demanding

and patients are unaware of how busy we are and patients are savvier

re litigation and being internet savvy (Verbatim).

Of course this romantic idealised version of the past will only offer feelings of disappointment and disenchantment in the present day, yet the participants are allowed to feel this way - remembered in their stories as exemplified in April's refrain:

But nursing is still the best! (Verbatim).

Conclusion

This chapter has identified and developed discussion around the themes within the participant's portraits. This data had been analysed with reference to appropriate seminal and contemporary scholarship and literature. The stories of April, Ginger, Grace, Jade, Lucky, Maggie, Jean, Mary-Anne and Vivien have been explored first in relation to their personal characteristics revealed within their stories and also from the perspective of the environmental/organisational issues which affected their decision to stay working in their current nursing setting.

The clinical nurses are coping with the frail elderly who are living longer with chronic conditions. They are presenting to hospitals in increasing numbers, 48% of people in hospitals now are elderly (Department of Health and Aging, 2003). The nurse academics are dealing with consumer-savvy students who are questioning their teachers and their teachings like never before (Brady, 2010; Gaberson & Oermann, 2010), and residential aged care nurses are working with frail elderly and often cognitively impaired residents on a daily basis; this work load is associated with high levels of carer stress (Brodaty, Draper & Low,2003).

The following chapter will offer a reflection and discussion on the findings of this study, offering recommendations and arriving at conclusions for the practice of nurses, the education of the profession, the employers of nurses and suggestions for further research.

CHAPTER SEVEN – CONCLUSION AND RECCOMMENDATIONS
The Frame and Signature

"Narratives exist at the everyday, autobiographical, biographical, cultural, and collective levels. They reflect the universal human experience of time and link the past, present and future … Narrative gives room for expression of our individual and shared fates, our personal and communal worlds … We should value the narrative".

Laurel Richardson (1990, p. 22)

Introduction

This chapter revisits the methodology, methods used in the collection of data, key concepts illuminated the study and makes recommendations for future policy and research. This study has illuminated qualities of resilience shown by nurses who have chosen to continue their work in the Western Australian nursing workforce.

Nine registered nurse participants shared their stories, thoughts, and experiences of resilience so that the characteristics and personal traits of their resilience were revealed. In addition their narratives revealed contextual organisational issues which develop and support these traits.

Current review of the literature in Australia shows limited reports on nursing resilience at a time of such possible consequence for Australian healthcare, particularly from a qualitative perspective. Findings from this study may assist in the development of strategies that influence policy making and funding processes to enhance the provision of coping skills training through ongoing professional development for nurses. There is increasing attention being paid to how coping in adversity can aid retention of a stressed workforce (Walker, Gleaves & Grey, 2006). Employers of nurses, in any setting, may consider using the insights illuminated by this study to develop programs and interventions to enhance resilience of their workforce.

Research has evidenced the implications of a stressful work environment experiencing constant change and its effect on the workers within it (Maslach & Leiter, 2005). There is general consensus that nursing workplaces are inherently stressful, yet the portraits demonstrate that stress and disarray contrary to encouraging these nurses to leave the profession, rather, motivates them to stay.

Herzberg's et al., (1959) seminal work into motivation examines and reveals the factors that motivate people positively at work; these are different to and not simply the opposite of factors that cause dissatisfaction and cause defection. The theory proposes two main areas that enhance motivation: 'hygiene' or food; warmth and shelter, engender the need to 'grow psychologically' or be truly motivated. Herzberg et al., assert that once the first needs are satisfied humans require further motivation, such as responsibility, achievement, development, recognition and advancement which are at a deeper level of fulfillment and personal satisfaction to reach full human potential.

Work to some people is not a grind, but rather part of their purpose and their life, and the happiest people at work dream of achieving something that is special to them as individuals. The psychological need to be competent, autonomous, accomplished and powerful motivates people to find meaning and purpose with their life and work (Csikszentmihalyi, 1990). This aspect has been so for the participants in this study. Given that challenge and change can be positive and motivating (Bennis, 1989; Herzberg et al., 1959; Peters, 2010), the participants assert that they learn from modeling behaviours around them. The supports, opportunities and experiences that provide the context of nursing work and the culture that is nursing, they argue, have a positive effect on their ability to cope and stay within the system. Participants value good leadership in the bureaucracy of healthcare and look toward it for assistance in times of chaos. Often within the participant's narratives, reaction to work is culturally expressed, with nursing culture situated within the overarching context of the health care system, and across various institutional settings. These settings include: residential aged care

facilities; acute tertiary hospitals; and academic institutions, each of which has a set of unique contextual environmental stimuli and experiences.

If the contemporary problems of healthcare previously discussed are a given, the narratives demonstrate dissonance between the participants wanting to tell the researcher the 'best story' about their work. That is, the participants may be putting 'a good spin' on things, and masking the reality with a denial of how bad things actually are and whether they and/or the system are more vulnerable and closer to despair/defeat than they want to show. They may have chosen to present idealised pictures and overly optimistic images; these may draw attention away from the facts and camouflage the reality of the change, conflict and problems inherent within their nursing settings. Nevertheless, they told their stories their way, with the gallery showcasing nurses who thrive despite difficult, adverse and strenuous personal working conditions.

What was most striking about the findings was how clearly the themes paralleled the work of Peterson and Seligman (2004). Within this work the authors list the personal traits and psychological strengths of people which are considered to be universal. Their list consists of two dozen character strengths, grouped into six broad areas of virtue. The six core virtues correlate with the seven virtues of the Christian tradition of: self-control, fairness, courage, practical wisdom, humanity, and hope. Each trait is asserted to be socially valued in its own right, regardless of culture, and capable of enhancing a person's well-being, correlating with life satisfaction. The participants spoke of taking on a challenge, their love of learning, self-control, hope and being a leader. These qualities relate to the virtues and strengths discussed above.

The work of nurses is stressful. Nurses are vulnerable to burnout and stress from heavy workloads, heavy responsibilities and workforce changes, impinging on their ability to be resilient. The findings of this study have recognised that some personal traits are crucial to the participants' ability to remain in the nursing profession. Moreover, these personal traits, whilst possessed by most nurses, have

been honed and enhanced by the nurses in this study; possibly due to previous life lessons.

The methodology

Portraiture allows for a richness of description with the portraits fashioned highlighting the positive stories of the participants resilience and strategies they used to enhance coping in times of stress and change. The findings of this study contribute to resilience research by providing a greater understanding of professional nurse's well being and the impact of resilience.

Involvement in the study and the ability to reflect upon their stories drawn by the researcher allowed the participants to think about the challenges their nursing work and workplace have posed for them. They are the experts of their own reality and the portraits enabled an authentic connect between past and present experiences of resilience to emerge and be shared through the positive view of success that the portraiture recommends.

The opportunity to include nurses within Western Australian healthcare settings, and the stories collected and developed into nursing portraits provide a rare and valuable insight of what resilience means to these nurses at this moment in time. This study has employed a methodology to study nurses and their practice.

Findings

The portrait of each participant demonstrates the constant interplay between memories, identity and work life, and resilience within their work and home life narrative. Bruner (1987) contends that "a life as led is inseparable from a life as told — or more bluntly, a life is not 'how it was' but how it is interpreted and reinterpreted, told and retold" (p. 16). The participants' stories illuminate a number of fascinating dimensions in their lives through narrative, many of which the researcher would have never come intuit without an in-depth analysis of the structure and content of their stories as they told them. The tools of narrative analysis, therefore, allowed for an image of each to emerge from the data, along

with an explanation and description of what appears to be most important to them. These pictures of each participant as a resilient survivor simply could not have been achieved with many other types of analysis, nor without the Portraiture approach being employed; however, achieving a balance between the subjective and the objective, that is, presenting the personal voice of the participants (subjective) and remaining true to the research aims (objective) was difficult. Ultimately, it is this fuller understanding of the contextual knowledge of their work and the private knowledge of their life experience that allows for a multi-faceted understanding of the participants' resilience and their tremendous ability to cope at a number of different levels.

The distinguishable personal emergent themes within the portraits are indicative of personal strengths or attributes that each participant has within them, yet may remain invisible to onlookers unless they are voiced by means of the portrait. A framework of resilience and the language of human strengths is the scaffold that these participants build upon to cope with the disarray and the contemporary system in which they work. Resilience is associated with personal optimism, hope and positive changes, and adaptations made to learn from and move through challenge and adversity. Coping skills foster the ability to adapt to change within different contexts of nursing, allowing the participant to develop or build on their resilient qualities and traits while becoming more resilient through the process. Resilient characters are proactive learners who learn from success and setback to innovate, be more creative, and to get things done. They focus on their strengths rather than their weaknesses, and make the most of the here and now (Park, Peterson & Seligman, 2004). Resilience theory views these strengths and resilience as not fixed traits, but as attributes that can be learned and developed in various forms and within various contexts as the individual progresses through life and work (Peterson & Seligman, 2004). This is most significant to developing plausible education packages for the nursing workforce to promote resilience.

The nurses who participated in this study show that they are not overcome by the challenges they face within their work because of the social support they

receive from colleagues, friends and family, and by their belief in the substance of their profession. They are encouraged when they have fun, and they try to remain optimistic in most circumstances of their work. The participants voiced or displayed certain personal characteristics which buffer against the negative effects of stress and which are said to be indicative of or build resilience which is consistent with the literature (Brady, 2010; Cameron & Brownie, 2010; Letvak & Buck, 2008; Manion, 2005; Seligman et al., 2005). Resilience is viewed as a vital attribute for nurses because it augments adjustment and balance in challenging and volatile clinical environments; it assists nurses in adapting their behaviours to perform effectively in any given stressful situation for the benefit of themselves and others (Frederickson et al., 2003; Sherman & Pross, 2010). As indicated in my introduction, I was endeavouring to reflect upon the role of resilience in nursing and offered a simple visual depiction in Figure 1.1. That figure has now been augmented with the personal traits and organisational characteristics reflected within the scales creating a 'balance' between stress and coping, and resilience (See Figure 7.1).

Figure 7:1. Theoretical framework: creating a balance

The nurses in this study have not only demonstrated resilience within the workplace but also share resilient experiences within their home lives as well. Some told of adversity experienced through divorce, and the illness or death of a loved one. Similarities were identified with respect to how resilience is constructed by each nurse in each different experience in differing locations. Each experience also

provided an affirmative view of the participant's resilience which seeks, as Portraiture requires, stories of success and positivity. The participants' stories concerned incidents occurring in moments of stress, crisis or adversity which, upon retelling, helped them to make sense of the experience;   contributing to broadening and building of their previous gains around resilience. The nine nurse participants in this study represent nine different individuals: some quiet and introverted; others extroverted and loud, yet all were able to relay their stories of resilience in spite of their experiences of adversity, and all were able to be woven into a mosaic of nursing resilience.

The major themes uncovered by the nine portraits included personal qualities of self- control, focusing on the positive with perseverance and hope, trust and a love of learning. The sense of accomplishment that comes from the confronting a challenge, the importance of "paying it forward' and the related volunteerism and opportunity for involvement to help and assist others. This is achieved with a sense of humour, with robust assertiveness, self-regulatory skills, peer group belonging and strong personal beliefs; it makes the reader aware that this was a research cohort which uses the experiences of its members to harness a desire to succeed or to advocate for change or to help someone else. These qualities in turn, help others to be, or become resilient, and display positive outcomes in spite of the often chaotic healthcare setting in which they find themselves, be it clinical practice, management or academia. The participants' stories were creative yet authentic accounts of their work context with incidents and experiences of resilience highlighted for the reader. Some stories were happy whilst others were quite moving; but taken as a whole the analysis of those stories questioned "What else are those nurses really saying?" (Kucera, Higgins & McMillan, 2010).

The portraits highlight a sometimes imperceptible theme of resilience within nursing. These nurses are resilient; they rely on the social support of colleagues and family and friends to continue to bear the mantle of responsibility to keep working. They take pride in their work and their accomplishments and give to others

altruistically. They like to laugh and they love nursing and they keep the needs of their patients, clients, residents or students foremost.

From the themes uncovered, the value of encouraging professional and social interactions among nursing colleagues, such as promoting nurses to take advantage of organised peer support activities could assist their resilience repertoire. Nurses are never more needed for the maintenance of safety and quality within healthcare (Buerhaus et al., 2009; Twigg et al., 2010). The onus is on the profession to keep nurses working in the industry and not lose any of those that educators are preparing for future work. Mentoring programs for new nurses, coping skills education, leadership skills training for management and support for nurse educators under stress are all needed to explore additional avenues for support for students and staff in their charge. Highlighting resilience education and related qualities in education programs could assist students and nurses to flourish in busy, dynamic workplaces (Mc Allister & Mc Kinnon, 2009).

Implications and practical applications

The findings of this study will be of importance to many groups, both inside and outside of nursing education and practice. There is evidence suggesting that nursing students are often not adequately prepared for the work that is nursing; and that the cost of caring and its emotional and physical outlay which correlates with nursing work weighs them down, leading to stress, burnout and ultimately causing them to leave the profession (Gillespie et al., 2007). Moreover, Hodges et al., (2005) challenges nursing educators "to better prepare nurses for sustained professional resilience" by providing strategies for developing resilience in nursing students (p. 548).

For nursing educators and nurse leaders the testimonials of how the participants report their levels of work stress, their happiness in their work, their job satisfaction or discontent, and their intent to stay or leave their role, will be of interest. The participants' details of the power of their human strengths and positive qualities, such as hardiness and self-control will also be of interest to policy

makers and curriculum designers as they are related to the practical application of resilience education and training, where those qualities can be learned and enhanced.

Although there has been a burgeoning of research concerning resilience and positive psychology, complete understanding of each model has not yet been reached. However, related literature has demonstrated positive examples of both, attesting to their assistance in coping with challenging situations which are especially applicable to nursing work. Resilience and positive psychology education improves self-empowerment which has a considerable effect on psychological well-being at work and increasing job satisfaction. Practically, the approach to apply positively oriented resilience training that can be developed and effectively managed for performance improvement and enhancement of resilience should have positive organisational benefits (Seligman, 2011).

Nurse occupational settings will always contain elements of stressful, traumatic or difficult situations and episodes of hardship because such challenges are inherent in the very nature of nursing work. Resilience therefore is a quality necessary for nurses and nursing because the everyday work conditions can be so adverse (Jackson et al., 2007). The ability to display resilience is considered an asset to an individual's psychological health as it assists their life's journey through its protective value, its preventative ability for coping with future stress, and its promotion of wellbeing (Revich & Shatte, 2002). If nursing leadership, system management and nurse educators are able to put in place polices to augment known strategies of resilience building, surely it is timely to explore resilience education and training as a matter of priority. Further resilience research within nursing settings is vital. Organisational change is needed to entrench a resilience-based approach to early intervention and the application of strategies for learning resilience as a key component of all curricula for all health professions (Seligman, 1994).

While the research is being conducted in Western Australia, it is a timely undertaking with further healthcare change mooted by federal politicians on a near daily basis (Howard & Abbott, 2007). The findings of this research will have broader implications that will inform all educators both nationally and internationally, and contribute to the global healthcare knowledge base of strategies which may promote resilience among nurses which may, in turn, affect the high attrition rate of nurses leaving the healthcare system. Thus, this research makes an original contribution to knowledge and may in some way assist in addressing problems associated with the variable Western Australian healthcare system and may have significant implications that may be applicable to a wider Australian audience as well as to audience of other cultures. Nurses everywhere within the present healthcare climate are at risk of developing stress and burnout, and those who are unable to build resilience in undergraduate education thereby enhancing it whilst maintaining their working lives are more likely to leave the profession (McAllister & McKinnon, 2008).

In the midst of a world-wide shortage of nurses in all nursing settings, examining the respondents' stories and then applying suitable interventions to relieve workplace stress is necessary. The evidence in the literature concludes that resilience training is a buffer and protective factor in preventing the negative consequences of stress. Given the shortage of qualified nursing academics and clinicians across the country, it has never been more important to retain the nurses we have, and to put in place tolls that can improve and sustain the healthy functioning of nurses within the current healthcare system, as well as protecting the nurses we need for the future (Wong, 2012).

This may be accomplished through the designing and implementation of training tools to provide the best support for the nursing workforce with a mixture of positive psychology and resilience skills with the intention to improve communication, positivism, a sense of group identity, coping skills and a feeling of hope in the midst of disarray (Wong, 2012). With the support of nursing hierarchy,

each nurse has the potential to develop resilience if they are given the preparation, support, and skill sets to do so.

Limitations

The participation of subjects is confined to three workforce settings and all the participants are female nurses who have been in the workforce for five years or more. It could be conjectured that other settings and the participation of male nurses could provide different insights and experiences; however, this study cohort has provided a collection of first-hand, expressive and valuable data that has allowed for a description of issues relevant to the quality of resilience within contemporary Western Australian nursing settings.

While the number of nurses participating in the study is sufficient for this methodology, the depiction of more portraits could have been beneficial. The nine portraits have allowed an in-depth analysis of the issue which is the subject of this study; however, generalisability is limited to the participants' experiences. Many of them volunteered to participate in the study which can introduce the bias of 'self-selection', where these volunteers may have characteristics that non-volunteers do not. For example, they may be more hard-working, and dedicated than others; or may be more submissive towards outsiders (the researcher); or maybe they were more available.

Although these portrayals are not representative of all nurses they have extended thoughts and perceptions with regard to the immediate and longer term needs of nurturing resilient qualities in undergraduate education for potential nurses, and support for nurses immersed in clinical practice and those engaged in any context of the tertiary education and healthcare systems.

When examining the nurses' stories it becomes evident there are many complex issues affecting their desire and ability to remain working with the current healthcare system. The problem may be one of being able to cope with the dynamism that is nursing today, the major concern of which is the number of nurses

who have experienced stress previously and are experiencing it currently. This may have a profound impact on the profession with the incumbents' ability to cope in the future if their resilience is further tested. Although this study has provided insight into the nurse's stories of resilience, the findings need to be interpreted with caution. This study took place between the years of 2008-2012 and may be a product of a specific social, historical, cultural, economic and political time in space. The findings of the study may not be applicable to other locations. The collected data might not be fully trustworthy because the participants might not have disclosed aspects of their resilience experiences for various reasons. However, the answers provided were assumed to be an accurate reflection of the feelings and perceptions of resilience of the participants and the portraits fashioned from those replies.

The methodology utilised celebrated the participant's stories of resilience. It is hoped that the stories of April, Ginger, Grace, Jade, Lucky, Maggie, Jean, Mary-Anne and Vivien, the convenience sample of the study cohort, have been truthfully depicted and created an experience for the reader to be immersed in the participants' stories. Each had a powerful story to tell which was related using Portraiture as the research methodology, a methodology which looks for success within its frame and gives this success voice; the nine portraits demonstrate clearly the inextricably linked, successful themes which assisted the cohort to tackle and cope with nursing and its challenges in Western Australia in 2008-2012.

Recommendations

Recommendation One: That resilience education should be included in all beginning nurse education programs. Resilience factors are associated with emotional intelligence, critical thinking, and problem solving ability. These factors fit well with Australian Nursing & Midwifery Competency (ANMC, 2006). These competencies are already assessed and coupling this with resilience would increase the depth of nursing curricula and increase the portfolio of nursing skills.

Often as much as a third of one's life is spent at work, and work often sets the context of the greater portion of people's lives, livelihood, and the concept of whom they are (Fragar et al., 2010). Nursing leadership must strive to meet the demands of the future where the issues of rapid change in technology, skill mix, and acuity of patients is likely to continue; thus healthcare staff need to have personal tools to fall back on in times of crisis, and mechanisms of support they can use in times of adversity. It is the responsibility of the nursing/healthcare hierarchy to prepare and support groups of nurses to cope with what they perceive as stressful for them, and to provide ongoing resilience education. I recommend investment in resilience education in the short and long-term which will benefit patients, staff, the organisation and the profession, as it promotes self-engendering optimism and security, thereby improving job satisfaction and retention.

Recommendation Two: Ongoing professional development within nursing practice settings should include the recognition and enhancement of those traits required to maintain resilience. This is not seen as a major change to continuing nurse education programs, rather an enhancement of the programs provided.

Recommendation Three: There is a clear need for more research in differing nursing populations and work settings around positive psychology and resilience education within nursing. Researchers need to consider the qualities of resilience, and whether the skills and practice of resilient approaches such and emotional intelligence to clinical decision making and problem solving are inherent or may be developed in nurses.

Recommendation Four: Further application of Portraiture methodology into the study of nurses and nursing would be useful as it reveals the "human archaeology" (Lawrence-Lightfoot, 1997, p. 15) of people and professions. The richness of the layers of human experience are revealed by the employment of this method which illustrates in words people at work in a variety of settings; the resulting word picture aids reflection whilst illuminating themes of importance and informing the reader.

Conclusion

This study should encourage continuing debate on the preparation and preservation of a settled, professional and happy workforce. If, to paraphrase Shakespeare, stories are the stuff that data is made of, then the participants' stories offer unique, individual views that are illustrative of their personal meanings and experience of resilience.

Ancient verbal storytelling is the precursor to modern-day narrative which is the very essence of teaching and learning. Conversing and involvement with others to learn their stories, and the telling of those stories, is the seminal work of the researcher (Mello, 2002). The portraits presented of the nine study participants are not intended to be definitive depictions of nurses but are presented to offer an experience of a new language of qualitative methodology which is innovative in its perspective, yet structured in a way that is not romanticised. The repeated refrains of the nurses' resilience themes resonate coherently and evidently to the reader through the finished portraits, the result of the aesthetic process of Portraiture. This is their story and it is crucial to remember what is often said, "There is nothing as resilient as the human spirit".

As I reflect upon this research experience I ponder many of the facets and emotions of the research journey: the vulnerability of the student; the privilege of sharing intimate moments of the participants' lives; the support of my supervisors and my university colleagues; and the long-held breath of friends and family concerning the never-ending question of, "How is the thesis going?" The answer is, "The thesis is complete but the journey is only beginning as future portraits surround me just waiting to be etched".

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APPENDICES

APPENDIX 1

Participant Information Letter - Observation

Dear Participant,

I am currently a student at Edith Cowan University completing my PhD. Part of my degree involves research for which I am asking for your help. The aim of the research is to try to understand what your perceptions are of humour and resilience and your thoughts, beliefs and understanding of its effect on you and your practice.

The Edith Cowan University Human Research Ethics Committee has approved the study and the Ethics Committee of your place of work.

You are being asked for your permission to participate in the observational stage of the study. Your participation will involve being observed in your usual place of work as the researcher aims to identify research participants who may show evidence of using humour and laugher whilst at work. Should you be identified as a potential candidate for the research study, further information will be given to you at that time.

Please note that you have a right to say no to your participation in this research and if at any time after you initially said yes, you can say no.

Any questions concerning the study entitled "Portraits of resilience among nurses: Listening for a story" can be directed to the researcher or supervisors as listed below.

Researcher
Vicki Cope
Edith Cowan University
Room 452, Building 21
100 Joondalup Drive
JOONDALUP WA 6027
(08) 6304 3509
▮▮▮▮▮▮▮▮

Supervisors
Dr Bronwyn Jones
Associate Professor
Edith Cowan University
▮▮▮▮▮▮▮▮

Dr Joyce Hendricks
Senior Lecturer
Edith Cowan University
(08) 6304 3511

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

Research Ethics Officer
Edith Cowan University
100 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au

Should you be willing to participate please sign the Consent Form and complete the Participant Inventory attached and return it to the researcher in the stamped and self addressed envelope provided.

Once the research is complete and it has been examined and edited, I promise to send you a copy of the study.

Thank you for your consideration.

Yours sincerely,

Vicki Cope
PhD student
Edith Cowan University
JOONDALUP

APPENDIX 2

Consent Form - Observation

<div align="center">INFORMED CONSENT</div>

I …………………………………………………….. have read the information sheet and any questions I have asked have been answered to my satisfaction.

I agree to being observed within my clinical setting for the purpose of this study. I further understand that I can withdraw my consent at any time.

I agree that the research data gathered for this study may be published and/or used for presentation at conferences provided that I am not identifiable in any way.

Participant: Date:

Researcher: Date:

APPENDIX 3

Participant Information Letter - Interview

Dear Participant,

I am currently a student at Edith Cowan University completing my PhD. Part of my degree involves research for which I am asking for your help. The aim of the research is to try to understand what your perceptions are of humour and resilience and your thoughts, beliefs and understanding of its effect on you and your practice.

The Edith Cowan University Human Research Ethics Committee has approved the study and the Ethics Committee of your place of work.

You are being asked for your permission to participate in the study. Your participation will involve an interview where you will be asked to talk about the things that are humorous and made you laugh at work. The interview will be tape-recorded and the information then used to study the themes that may emerge in comparison with other nurses and their stories of humour. After this information has been collected, the tapes will be transcribed, kept in a locked cupboard within the researcher's home for five years and then destroyed. What you talk about will be used for a research report, and possible conference presentations; however, no one will know who said the things that are written in the report. All names and any other information that tells people who you are will not be used in the study although I will collect some demographic details to compare participant attributes (see attached Participant Inventory). You do not have to participate in this study if you do not wish to, you can also inform the researcher during the interview that you would like the tape turned off and to not participate anymore.

Please note that you have a right to say no to your participation in this research and if at any time after you initially said yes, you can say no.

Any questions concerning the study entitled "Portraits of resilience among nurses: Listening for a story" can be directed to the researcher or supervisors as listed below.

Researcher
Vicki Cope
Edith Cowan University
Room 452, Building 21
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Should you be willing to participate please sign the Consent Form and complete the Participant Inventory attached and return it to the researcher in the stamped and self addressed envelope provided.

Once the research is complete and it has been examined and edited, I promise to send you a copy of the study.

Thank you for your consideration.

Yours sincerely,

Vicki Cope
PhD student
Edith Cowan University
JOONDALUP

Consent Form - Interview

<div align="center">INFORMED CONSENT</div>

I ………………………………………………………… have read the information sheet and any questions I have asked have been answered to my satisfaction.

I agree to this interview being audio recorded and to participate in this study. I further understand that I can withdraw my consent at any time.

I agree that the research data gathered for this study may be published and/or used for presentation at conferences provided that I am not identifiable in any way.

Participant: Date:

Researcher: Date:

Participant Inventory

Demographic details	
Age:	
Gender:	
Highest level of education:	
Years of work since registration:	
Specialty clinical area:	
How long have you worked in the Western Australian healthcare system?	
How long have worked in your current clinical environment?	
Pseudonym/portrait name of your choice:	

Aide Memoire

Some of the questions that might have been asked are:

- Can you tell me about your understanding of being resilient?

- What is the relationship between resilience and your professional nursing practice?

- Can you tell me about nursing today?

- Why do you stay in nursing?

- What do you feel is the relationship between resilience and working within (insert the nurses relevant setting here) the Western Australian healthcare system?

- Does working here have problems?

- Tell me how you have been feeling lately at work. Have you felt happy at all, have you generally been in good spirits? Do you laugh?

- What strategies do you use to deal with the obstacles you come across daily within your work?

- What made you choose nursing as a career?

- Are you happy in your work? Is this the way you feel right now?

- Everyone has a life story. Tell me about your life.

- Are there milestones/crises that stand out in your nursing career?