Becoming resilient; how do student nurses develop resilience for nursing? A study using Interpretative Phenomenological Analysis.

By Laura Ann Strumidlo

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School of Education
College of Social Sciences
The University of Birmingham
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Abstract

Aim: This thesis explores resilience in nurse education from the perspective of student nurses. It is the first study to do so in the United Kingdom. Essential to exploring the lived experience of becoming resilient was to find out why resilience was needed for nursing? What aided resilience development, identify useful educational strategies and explore how this phenomenon was understood?

Design: A qualitative case study with seven final year adult nursing students, using Interpretative Phenomenological Analysis (IPA).

Findings: Participants articulated an overall process for becoming resilient made up of the following three parts. Experiencing the tests of resilience, utilising a resilience toolbox and reflexivity for resilience. The tests essential for resilience work were cited as the emotional labour of nursing, practice learning, academic failure, attrition, life events. It was clear that resilience development was highly individual. Simulation and reflection were named as the educational interventions useful for resilience building. A Resilience Framework was used to explain aspects of resilience development within this group.

Implications for theory, practice and policy in nurse education: This thesis contributes to a theoretical understanding of the cognitive and mental activities that enable recovery from adversity in a new context. It adds new knowledge to educational theory with respect to how simulation aids resilience. On a practical level the findings have informed the development of new curricula and may influence nurse educational policy at a local and national level. There is utility in considering IPA for future nurse and health care professional research.

Dedication

This thesis is dedicated to my mum and dad, Pat and John McGinty, who have consistently role modelled resilience throughout my life. Without your ongoing support, encouragement, wise words and gift to me of tenacity, this work would not have been possible.

To team Strumidlo, my husband Adam and children Niamh and Danny; I've done this for you and us. You equally demonstrate resilience and I thank you for your understanding, common sense advice and patience over the last six years. Particularly kind of you were the donation of a horse and dog during my Doctoral journey. Willow and Toby have indeed become key tools in my resilience practice.

To my sisters, Helen and Jo, I am eternally grateful for your friendship, laughter, wine, gin and ongoing support. I owe you….

To the Selly Oak nursing family that I have known for over 30 years leading the next generation of nurses and young people to be compassionate, caring and resilient individuals. I treasure our ongoing friendship and support network.

When I try and explain resilience to student nurses, two inspirational people that I had the good fortune to know, are my working examples; this thesis is also dedicated to the memory of Rosie Abbott (forever 15) and Louise Orucu (my nursing role model).

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CHAPTER 1: INTRODUCTION TO THE THESIS

1.1 Context for the thesis

> *"It is difficult to believe that the vast majority do not enter the nursing profession wanting to deliver compassionate care to patients or that they would wish to do less throughout their careers.*
>
> *Many of those who fail to reach the high standards required do so not because of inherent character flaws or an absence of fear of sanctions against lapses, but because of a lack of resilience in the face of mounting systemic pressures." (Sir Robert Francis, 2017, p 5,)*

This quotation notes the importance of resilience as a quality which may enable delivery on the vocational component of nursing. It is poignant, having been written by the author of the inquiry into preventable patient deaths at Mid-Staffordshire NHS Trust (Francis, 2013). That report lamented the absence of key values as demonstrated by many practitioners, including nurses, which impacted patient care negatively. Reassuringly his commentary above introduces a more recent study, which found that such professional behaviours are still valued by nurses, including students (Kristjansson et al, 2017). Whilst examining the factors that challenge their ability to stay true to these in the delivery of contemporary nursing care, such as resilience (Kristjansson et al, 2017). Hence it is important to explore how exactly resilience is developed or broken down during nurse education. Moreover understanding resilience is fundamental to nurse education as the term has gained prominence within new nursing standards (Nursing Midwifery Council, NMC, 2018a). Indeed resilience has been a core value measured within all health care education at my university in the aftermath of the Francis report (2013).

This thesis uses an Interpretative Phenomenological Analysis approach (IPA; Smith, Flowers and Larkin, 2009) to investigate the term resilience from the perspective of student nurses, nearing the end of their three year pre-registration BSc Adult Nursing course. In this introductory chapter I highlight the importance of resilience for nursing and nurse education. I also cite the relevant professional body requirements which mandates that resilience is

essential to nursing (NMC, 2018a). The scene is set with regard to contemporary knowledge of resilience both within nursing and in a wider context. As these findings are vital for setting up the research questions. For much can be learnt from previous resilience studies conducted within other disciplines and populations (McAllister and Lowe, 2011).

Recently the role of values based education in developing resilience, as part of professional care values, has gained prominence and is thus briefly explored (Curtis, Horton and Smith, 2012; Health Education England, HEE, 2016, 2018; Kristjansson et al, 2017, Jubilee Centre for Character and Virtue, JCCV, 2017). The main research questions are introduced and explained, alongside the key aims of this study. An overview of the organisational structure of this work provides clarity with regard to content and I outline the relevance of each section. Finally, a summary will draw together the pertinent points which introduce this work.

This is practitioner research which encompasses many benefits such as utilising expert knowledge, pre-existing relationships with participants and draws on my relevant research skillset (Finlay, 2011). It is a type of research which offers an opportunity to cross the bridge between the realities of practice and research (Finlay, 2011). I am in a position now to add to theoretical understandings of resilience and evidence-based practice both locally and nationally regarding nurse education. Indeed such insider insights are often useful in interpreting the context of statements made by participants (Smith, Flowers and Larkin, 2009). In this instance regarding the curriculum, educational strategies used and understanding the worlds within which the students' transition. Here, the practice learning environment (PLE) and the Higher Education Institute (HEI). As within each environment it is mandated that student nurses must undertake 50% of the course, to achieve the required 4600 hours to register (NMC, 2018b).

It draws on my 30 years as an experienced nurse, with 21 years in clinical practice, predominantly in critical care where resilience was required on a daily basis. More recently, with 10 years as a nurse educator at an HEI, where I now lead the education of future nurses. I would wish for all of the nursing students past and present that I have taught and registered, an equally long career. Including the successful maintenance of their wellbeing, through resilience, in order to deliver on the essential healthcare values (NMC, 2018c; McCann et al, 2013). As I have seen first-hand the damage that burnout and emotional exhaustion can result in with colleagues.

Throughout my professional career I have contributed to both clinical and research ethic, following the completion of an MSc in Health Care Ethics. Therefore it was essential to me to design a robust and ethical piece of research, investigating an often controversial phenomenon (Traynor, 2018), from the students' viewpoint. For "*inquiries into people's lives are always an exercise in ethics"* (Agee, 2009, p440). However equally measured was the need to consider the challenges of insider and phenomenological research (Finlay, 2011).

1.2 The research questions

This research aims to explore, from a student nurse perspective, how resilience is developed within a values based curriculum thought to be essential for the protection and retention of nurses in the current workforce (International Council of Nurses, ICN, 2016, World Health Organisation, WHO, 2017). Preparing students adequately for both the rigours of academic study and practice learning, in the real world of nursing, is also important. Establishing an understanding of the multi-layered influences on the student experience (McLinden, 2017), here in relation to nurse education, is of equal importance in exploring resilience development. As resilience has also been noted as important for the transition of students with protected characteristics from compulsory education to the HEI setting (Hewett et al, 2018).

To date the lived experience of student nurses in regard to resilience has not been captured in the UK. Therefore more research is warranted (HEE, 2018). In order to "hear" the voice of 3rd year student nurses, IPA was chosen, as a form of hermeneutic phenomenology. Within which the role of the researcher is to interpret data generated from semi-structured interviews, analysing the participants' making sense of their existential experience (Finlay, 2011). Thus a rich and unique picture of the individuals understanding of the phenomenon, in this instance of resilience, is built (Darbyshire, 2015).

The following research questions, were constructed after reviewing the nursing and nurse education resilience literature as part of undertaking earlier research and educational theory modules for the Doctorate in Education (EdD). As part of these assessments I performed a concept analysis (Earvolinez-Ramez, 2007), exploring what is known about resilience in nurse education. Drawing on the conceptual work of Stephens (2013), this mooted that nurse education is stressful and must be overcome. This is the overriding theme in all resilience research, which states that adversity, or challenges are a prerequisite for resilience development (McAllister and Lowe, 2011; Southwick and Charney, 2013). However, positive coping strategies may enable completion of the course and transition into the nursing workforce, whilst delivering compassionate care (Curtis, Horton and Smith, 2012). Responses by the participants, as part of this research, further refined the wording for question one which was changed from how is resilience challenged, to acknowledge the 'tests' involved as part of nurse education. It is quite common within qualitative research to develop or amend questions during or following data analysis (Agee, 2009).

1. When and how is resilience tested during nursing education?

2. What aids the development of resilience in student nurses?

3. Which, if any, educational strategies, currently within the curriculum, support resilience formation?

4. On completion of the course how do student nurses understand the term resilience in nursing? Do they see it as important?

In order to understand the context for these questions a short narrative of nursing in the 21st Century is now provided followed by a summary of resilience knowledge in nursing and the wider research literature.

1.3 Nursing in the 21st Century

There are multiple reasons why health care environments in the 21st Century require nurses, including students, to be resilient. Entry into nursing in the UK is guided by both academic attainment, suitable care experience and values based recruitment (HEE, 2016). This aims to ensure that candidates with the appropriate values gain access to programmes. Whilst nurses study and register within a specific field of nursing; adult, child, learning disabilities or mental health- all nurses are expected to care for people across the lifespan within varied care settings (NMC, 2018a). This may encompass provision of nursing care for those with complex mental, physical, cognitive and behavioural care needs throughout their lives.

However multiple stressors have also been noted which affect the resilience of nurses and students daily (Crombie et al, 2013). These include caring for an ageing population who are living longer and experiencing chronic illness with complex co-morbidities. Decreased financial spending on health, after austerity cuts, and increased expectations on the nursing workforce to do more with less resources (ICN, 2017). Changes to the environments in which nurses' work, since the introduction of performance measures to improve efficiency, has impacted the amount of time that nurses feel that they can devote to patients. Thereby affecting the quality of care delivered (Maben and Griffiths, 2008; RCN, 2018; Kristjansson

et al, 2017). Conversely many health and social care policies appear to pay no attention to the potential damage that the chronic nature of stress within current health care environments can inflict upon nurses. Demands on resources, role conflict with other professions, shift work and work overload can impact on a nurse's ability to self-care (Yilmaz, 2017). As the ICN (2017) recognise, how can nurses care for others if they cannot self-care?

The emotional burden of sharing others' suffering on a daily basis can also be difficult to deal with (Smith, 2012, Theodosius, 2008). The emotional labour of nursing is well documented due to the ongoing exposure to the suffering of patients and their family (Smith, 2012; Delgado et al, 2017). However the expectation of the public and government is that nurses must remain emotionally invested in their patients (Cummings and Bennett, 2012; NMC, 2018c). Even though the link between nurse burn out, exhaustion, fatigue and patient outcomes is well documented (Rees et al, 2015). Conversely a recent National Institute of Health Research study (Ball et al, 2019) recognises that hospitals particularly, are understaffed on a daily basis. Indicating that safe staffing levels have not increased as recommended since the Francis Report (2013). This is at a time of new global health challenges from anti-microbial resistance, new pandemics, emerging infections, armed conflict and increased numbers of migrants with specific health needs (ICN, 2016).

A relationship between nurse wellbeing and patient satisfaction is also duly noted in research studies (Maben et al, 2012a). Therefore, it is in society's interest that both nurses and students are well, resilient and able to perform complex roles in contemporary health care environments (Maben et al, 2012b). Yet by 2030 it is predicted that there will be a 9 million deficit in nurse numbers globally (Burdett Trust, 2020). Indeed the Chief Nurse for England launched the Year of the Nurse/Midwife 2020 with a call to address workforce concerns and enhance pride in the profession by raising perceptions of nursing as a high value career option (NHS England, 2020). This is with the aim of attracting more people into nurse

education. Thus resilience is thought to play a role in retaining both nurses and student nurses once recruited (Stacey and Cook, 2019).

1.4 Resilience in nursing

Resilience is a complex entity, initially in nursing it was described as "*a phenomenon known to buffer the negative effects of stress"* (Reyes et al, 2015, p438). It is a professional requirement in nurse education which student nurses must demonstrate during and on completion of their three year course. In order to register and transition into the nursing workforce (NMC, 2010). The professional standards regarding resilience have been strengthened in recent radical nurse education reforms (NMC, 2018a). These now encompass; defending complex decision making, effective communication and supporting those who are emotionally and physically vulnerable. Nurses and students must also;

> *"be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support."* (NMC, 2018a, p3)

Although, this demand for increased complexity in enacting resilience coincides with new factors that could adversely affect resilience, including increased levels of attrition from pre-registration undergraduate nurse education (HEE, 2018). The loss of student bursaries (Foster, 2016) causing financial hardship, resulting in declining applications to nursing courses and low morale in nursing generally as vacancies remain unfilled (RCN, 2018). Indeed Ball et al (2019) argue that the main cause of short staffing levels in hospitals in England, is due to the decreased numbers of student nurses completing their courses. Resilience is therefore increasingly thought to be significant for the successful completion of nurse education and hence transition into the workforce (HEE, 2018).

Therefore in the new standards, upon completion of nursing curricula, the Nursing Midwifery Council (NMC, 2018a) now state that student nurses must be able to*:*

> *"Demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations."* (NMC, 2018 a, p9, 1.10).
>
> *"Acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others.* (NMC, 2018a, p23, 6.11)

Unfortunately there is no clarification as to how this attribute is defined or guidance on how to assess nor develop it (RCN, 2017). This articulation appears to promote a rather individualistic approach to resilience which does not consider the wider effects of outside factors on the ability to develop resilience (ICN, 2016). Nor is the role of emotional intelligence or literacy defined in relation to resilience within a nurse education context. Although emotional intelligence is stated to be the ability to manage our own and others emotions demonstrating the requisite interpersonal skills (Goleman, 1996). In turn emotional literacy is described as an ability to read others emotions to enable the enactment of appropriate behaviour (Sharpe, 2001). To date the link between these attributes and resilience in student nurse education is undetermined. Yet it could be surmised from the NMC's (2018a) perspective that they are associated correlates of resilience.

Over the last few decades there has been an increase in resilience studies in health care settings due to an increased recognition of the above stressors (Richardson, 2002). However, these have on the whole focused on research within the qualified health care or nursing population. Conversely there are few UK studies and a paucity focusing explicitly on student nurse resilience (McGowan and Murray, 2016). Yet other values have also been mandated as vital to nurse education.

1.5 Values based education

A values based recruitment and education framework was a response to poor care cited in recent inquiries mentioned earlier in the chapter (HEE, 2016). In response to societal demands, an increasing drive to improve standards of care experienced by patients is noted in moral and

professional body codes (NMC, 2018c; Curtis et al, 2017). This is as a result of negative patient experience and systematic failures of institutions to support nurses to deliver quality care (Sawbridge and Hewison, 2013; Francis, 2013). According to Francis (2017) though, training in ethical decision making is equally required for nurses in order to maintain their resilience and hold fast to the requisite values as cited earlier in this thesis.

Others argue though, that by promoting such outdated traits and moral character or virtues, this keeps nursing rooted in the past and undervalues the profession, making nurses invisible (McIlroy, 2020). Moreover it is also mooted that the situation at Mid-Staffordshire was caused,

> *"not by a failure of compassion…but a series of contextual factors that are known to alter social cognition. These factors cannot be corrected or compensated for by teaching ethics, empathy and compassion to student nurses"* (Paley, 2013, p 1452).

Acknowledging the organisational responsibility for promoting environments which support the delivery of values based health care agenda. Conversely both nurses and the public alike appear to agree that certain values are required for professional practice (Maben and Griffiths, 2008; Nuttall and Pezaro, 2020). Yet Kristjannson et al (2017) maintain that pivotal to delivering on good ethical or values based practice, is resilience. Of interest is other work, in which it is explained that resilience may be an instrumental feature in delivering on values as part of a wider Character Education Framework (JCCV, 2017).

Nurse educators are tasked therefore with creating curricula which purports specific values throughout the course. Appendix One identifies Institution specific values, including resilience, based on professional requirements as core capabilities and the curricula activities associated with values based education and recruitment (HEE, 2016).

1.6 The wider context of resilience research

Consideration of the existing wider evidence base for resilience allows for analysis of convergence and divergence with nursing and later, in Chapter Two, nurse education research

findings. Resilience has been investigated particularly in the disciplines of psychology (Southwick and Charney, 2013) and neurobiology (Robertson, 2016). Although socio-cultural (Richardson, 2002) and ecological perspectives have recently added to the knowledge base (Ungar, 2015). Resilience has been investigated mainly through a biomedical and positivist framework (Aburn, Gott and Hoare, 2016). This could result in potential gaps in the literature regarding the lived experience of resilience and is of note to my study.

The concept is described as dynamic and a bio- psychosocial, cultural and ecological phenomenon which requires investigation from many differing scientific lenses (Southwick and Charney, 2013; Ungar, 2008). The populations of interest initially, for resilience research, were those of vulnerable children, adults with mental health illness, adults with chronic ill health and survivors of disasters and trauma (Hart, Blincow and Thomas, 2008; Hart, Blincow and Cameron, 2012). It remains to be seen whether the findings of these studies can be of use when studying resilience within UK student nurses.

Resilience research is stated to have occurred in *"The Three Waves of Resilience Inquiry"*, with the first investigating character traits that protected different groups of vulnerable people from adversity (Richardson, 2002, p308). Whereas Hart et al (2016) now describe a further Fourth Wave. Table 1 summarises the phases or waves of research for clarity. This is noteworthy as nursing resilience research has mirrored these same waves.

Table 1-Waves of Resilience Research

Resilience Research	Richardson (2002)	Hart et al (2016)
First Wave	Resilience qualities, individual characteristics	Correlates of resilience qualities
Second Wave	Resilience process- how resilience qualities are acquired	Associations of correlates, mitigators and mediators of adversity
Third Wave	Innate resilience- what motivates individuals and groups to foster resilience	Developing and testing interventions that build resilience- role of context and culture
Fourth Wave		Investigating sophisticated multilevel and multidisciplinary contextual models of resilience

Studies from the positive psychology movement explored the children of parents with mental health issues and found that, despite an increased risk to their mental health, the majority were warm, competent adults (Garmezy, 1991). Masten (2001) described this ability to withstand adversity as *"ordinary magic".* Her work heavily influenced others such as Hart, Blincow and Cameron, (2012) in creating a Resilience Framework, based on their work with 'looked after children' and later adults, see Appendix Two. I first discovered this, when exploring the resilience literature, six years ago and immediately thought it useful for nursing and nurse education. This is because it draws together the findings of previous resilience research into one place, as a practical, accessible tool to guide resilience practice. Exploration of this framework was very helpful to me in understanding resilience, particularly during the data analysis phase in my study.

The second wave moved towards exploring various associations or correlates of resilience which could identify risk and protective factors to moderate adversity (Hart et al, 2016).

Identified as Third wave research, was that which involved the design and testing of interventions for resilience building, in order to form contextual and cultural understandings of resilience (Hart et al, 2016). Richardson (2002), states that multi-disciplinary cross-field work is of great importance to further understandings and strengthen future applications of research. Hart et al (2016) cite the need for multi-level and systems research in a fourth wave which would develop more sophisticated understandings of resilience. The concept has evolved from one of individual resilience to community resilience.

1.7 Nursing resilience research

The next section will focus on what is known about resilience in nursing and place this alongside findings from other disciplines. As stated previously nursing is demanding and can affect nurses' psychological wellbeing, in that stress and burn out results in many leaving the profession (Rees et al, 2016). However, resilience research in occupational settings is still in its infancy (Grant and Kinman, 2013a). Conversely adversity is a necessary prerequisite for developing resilience both within and outside of nursing (Earvolino-Ramirez, 2007). Studies within nursing highlight the importance of sleep, healthy eating, exercise and work/life balance as key to resilience (Andrews, Tierney and Seers, 2019; Thomas and Asselin, 2018). This resonates with the Resilience Framework which outlines the components in an individual's life that could precede the state of resilience. Basic needs such as housing, finance, safety, healthy food, fresh air, sleep and work/life balances are essential (Hart, Blincow and Thomas, 2008). Prior to moving on to other aspects of self-care and wellbeing as part of resilience practice.

Within nursing resilience research, three broad categories of interest have been identified– wellbeing, social support and self-care (Thomas and Asselin, 2018). These are inextricably linked to being resilient in nursing. Multiple resilience factors are linked to wellbeing such as decreased likelihood of post-traumatic stress disorder, depression, burn out and emotional

exhaustion (Manzano Garcia and Ayala Calvo, 2011; Rees et al, 2015). Social support from colleagues, family and friends is identified as important, as is self-care in maintaining a work/life balance (Andrews, Tierney and Seers, 2019). In view of the global issues with attrition and burn out in nursing a growing research focus is evident on the effect of the workplace on resilience (Rees et al, 2015; Thomas and Asselin, 2018). Although as students transition through multiple workplaces, as part of their course, their experience is likely to be different to that of nurses per se, based in one setting.

Strategies such as reflection in practice, written journals and resilience training have proved useful in building resilience in nursing (Jackson, Firtko and Edenborough, 2007; Mealer et al, 2012). McAllister and McKinnon (2009), in a study with healthcare professionals, recommended that all pre-registration healthcare courses should contain teaching on resilience. Specifically stating that practitioners should have the opportunity to reflect and learn in practice. Highlighting professional cultural generativity, which involves learning from more experienced staff through role modelling, mentoring and coaching, as supportive of resilience (Grant and Kinman, 2013a). However this assumes a willingness on the part of staff to do so and that they are 'good' nurses.

Until the last 10 years, the experience of student nurses explicitly regarding resilience had been omitted from most previous studies, especially from a qualitative perspective (McGowan and Murray, 2016). Therefore studies which utilise a qualitative approach are likely to provide new and original knowledge to add to the small but growing body of resilience knowledge in nurse education.

1.8 Theoretical aims of this study

This study has theoretical and practical aims which are aligned to the research questions. Few studies seek to identify the importance of resilience in nurse education in the UK. Yet

understanding resilience from the student's perspective may contribute to the development of resilience theory within a nurse education context (Stephens, 2013). Given that resilience is thought to be developed in response to stress or adversity it is therefore vital to identify the particular triggers of student stress during their nurse education, as per research question one.

1. When and how is resilience tested during nursing education?

Comparing these findings to resilience theory in other disciplines could allow for greater understanding of the mechanisms through which resilience works (Richardson, 2002). A further theoretical aim of the research is to establish what aids resilience development in response to adversity, as per research question two.

2. What aids the development of individual resilience in student nurses?

Additionally, defining theoretical aspects of how resilience is developed on an individual and group level is key to the outcomes of this study, as per research question three. Acknowledging the educational theory underpinning useful strategies for building resilience is often omitted in the current literature (Stacey and Cooke, 2019).

3. Which, if any, educational strategies, currently within the curriculum, support resilience formation?

Whilst resilience is a professional requirement in nursing and nurse education (NMC, 2018a), it is not known whether students in the UK rate resilience as important or recognise this as fundamental to them in nurse education or their future nursing practice, as per research question four. Theoretical knowledge on resilience development within the student nurse context may then be added to, by identifying the actual process of working through adversity fundamental to resilience development.

4. On completion of the course how do student nurses understand the term resilience in nursing? Do they see it as important?

The findings of this study are liable to be of use to other nurse educators, students and potentially policy makers (Porteous and Machin, 2018). A further theoretical aim of the study is to consider the use of IPA within nurse education research.

1.9. Practical aims of the research

1. When and how is resilience tested during nursing education?

By identifying when and how resilience is tested or challenged during the course, preparation for predictable triggers of stress may be improved at key points of the programme (Li et al, 2015). Arguably with the advent of VBR and selection for the ideal nursing characteristics, the first wave of resilience research in nurse education may have been performed in a UK context. Therefore locating the tests was thought to reveal more about resilience itself. It is also likely that from this initial recognition of the tests, individual or personal resilience practices could be articulated by the participants that enabled the formation of their resilience.

2. What aids the development of individual resilience in student nurses?

It is hoped that through locating individual efficient resilience practice, within and outside of the course, that sharing of knowledge in this area may occur for future students. Barriers that obstruct resilience could then be minimised through the influence of policy and practice (Rose and Abi-Rached, 2013). By moving from identifying the individual to the group level strategies, the evidence base for resilience practices can be better understood (Stephens, 2013).

3. Which, if any, educational strategies, currently within the curriculum, support resilience formation?

A more formal evaluation of group level interventions which aim to promote resilience, is required to plan for implementation of the new standards and form part of the educational quality assurance processes (HEE, 2018).

4. On completion of the course how do student nurses understand the term resilience in nursing? Do they see it as important?

The aim of this question is to explore the participants' understandings of resilience in-depth and to clarify whether existing student knowledge on resilience aligns with the aforementioned professional body standards.. Through reflection on personal accounts of resilience, pivotal information on resilience formation within nurse education may be gained and compared to the existing literature.

1.10 Organisation of the thesis

The presentation of this thesis comprises six chapters including this introductory part and is structured accordingly:

Chapter Two –Literature review

An overview of relevant national and international studies is presented, collated by scoping the literature (Sanderson and Brewer, 2017), which seeks to define and explain what is known to date regarding resilience in the context of nurse education itself. The process of conducting the literature review is described in keeping with best practice (Gerrish and Lacey, 2015). It discusses and identifies gaps in the literature, comparing nurse education research to that of other "*waves of resilience research",* in order to contextualise the research questions.

Chapter Three – Methodology

Within this section the methodological approaches, underpinned by the work of Hannah Arendt (1981; 1988) and choice of the IPA research approach as part of a qualitative

research design is justified (Smith, Flowers and Larkin, 2009). The second part of this chapter explains the research methods or tools, such as the recruitment strategy and data collection tools, including in-depth iterative one to one semi-structured interviews. Purposive convenience sampling was utilised and seven students in the final stages of the course were recruited via an advert on the online learning platform (Gerrish and Lathlean, 2015). A critical appraisal of the data analysis process, incorporating the Six Step Framework for IPA, is given for transparency and defended in light of recent criticism (Smith, Flowers and Larkin, 2009; Paley, 2017). Cognisance of ethical considerations is demonstrated throughout, yet focused on; informed consent, a disclosure agreement and in maintaining confidentiality by the use of pseudonyms. The limitations are acknowledged and I reflect on the advantages and challenges of practitioner research (Finlay, 2011).

Chapter Four – Findings

The resultant overarching or superordinate themes and subthemes are outlined at a group level and results are arranged around the core themes identified. I found an overall process for becoming resilient, once the data was analysed, which was made up of three main parts. The tests of resilience, forming part one of the process, is outlined across three areas or a triality of the participants' lives - the PLE, HEI and home settings. A resilience toolbox of resources for support; involving self and others in these life areas are discussed, as the second part of the process. This includes an evaluation of group level educational strategies. Finally as part three of the process, an understanding of resilience from the participants' perspective and their assessment of its importance for nursing is considered. Presented as reflexivity for resilience, in support of the predominantly internal processes involved in resilience work.

Chapter Five – The Discussion Chapter

The key findings above are then considered in the light of the existing literature recognising those that confer or diverge with current knowledge. Some findings appear to add to the knowledge base, whilst others reflect new findings. Thus contributing to theory construction in relation to resilience in nurse education (Tomkins and Eatough, 2010).

Chapter Six –Conclusion and Recommendations

This section presents a synthesis of the main findings and their contributions in terms of theory, practical implications for the nursing curricula, future research and policy recommendations. Most important is the need to understand the challenges for students traversing the three areas of their lives; PLE, HEI and home. Evidence-based teaching practices are thus required to address the gaps between nurse education and nursing practice concerns (Dwyer and Revell, 2015). I consider the highlights and sum of the learning garnered in undertaking this project. The importance of reflexivity for nursing practice and nurse education research is discussed. Finally IPA is also considered in terms of this project and nurse educator research.

1.11 Summary

This chapter has introduced the importance of resilience for nurse education and nursing practice at a student, nurse, patient and societal level. The demanding nature of nursing, challenges to workforce retention and role of the nurse as fundamental to global health targets, dictates that resilience is important. Exacting professional body standards regarding resilience have been outlined. These stipulate the mandatory need for strength of character in order to make robust decisions in stressful situations, yet promote a need to develop practices which support the maintenance of resilience for life.

Research questions constructed for an IPA study have been described. Key to providing relevant appropriate support and debrief to retain students, prevent attrition and secure wellbeing, is to construct an understanding of the concept from their perspective. Identifying efficient individual practices for sharing with others, minimising inhibitors to resilience formation and evaluating educational strategies at a group level is also essential. The structure of this thesis has been outlined and now progresses with Chapter Two, a literature review, which aims to define resilience within the context of nurse education by conducting an overview of research to date in this field.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter seeks to locate the current knowledge regarding resilience in nurse education which has influenced this project. Informed by a comprehensive review and appraisal of the resilience literature within nurse education, it aims to present an overview of the relevant empirical studies. In order to identify gaps in the evidence, justify the research questions for my study and leads onto the methodological approach as described in Chapter Three. A comparison with wider resilience literature draws on the "*waves of resilience research*", (Richardson, 2002, p308) outlined in Chapter One, explaining further how this has shaped the research questions. It also serves to present my thoughts on resilience in nurse education for transparency, to enable bracketing of my thoughts so as not to influence presentations of the participants' views in Chapter Four (Finlay, 2011). It begins with a synopsis of definitions of resilience to date drawn across disciplines (Southwick and Charney, 2013).

2.2-Defining resilience

There is no consensus agreement on the precise meaning of the term resilience both within nurse education, nursing and in other populations (Hart et al, 2016). It is also apparent within the resilience literature that multiple terms are used for what appears to be one concept with disciplinary specific nuances (Richardson, 2002). These include 'psychological resilience' (Southwick and Charney, 2013), 'stress resilience' (Pines et al, 2012), 'emotional resilience' (Robertson, 2016), 'personal resilience, systems and organisational resilience' (ICN, 2016). For the purposes of this thesis and to incorporate all elements of this concept I will refer, as the wider literature does, to the phenomenon as resilience (Hart et al, 2016). The goal of researchers, therapists and wider society appears to be to understand how stressful life events and continuing adversity can not only be dealt with, but that positive outcomes are also achieved (DoH, 2009). The consideration of a working definition should therefore provide

clarity and transparency where there is often ambiguity related to the term (Grant and Kinman, 2013a).

Most definitions of resilience involve mention of *"bouncing back"* or even *"up"* from adversity, utilising personal and external resources in order to grow from the experience (Hart et al, 2016). However, resilience is also defined as *"the ability to maintain personal and professional wellbeing in the face of on-going work stress and adversity"* (McCann et al., 2013, p 61). This requirement to be resilient in both life worlds of home and work is akin to the NMC's (2018a) standard, upon which student nurses are measured.

My thoughts on resilience are influenced by the work of Hart et al (2016) which defines *'Boingboing resilience'* as the capacity to locate and navigate resources to overcome adversity in order to thrive. I use this concept though within a new context, for my study, that of nurse education. This recognises the effect of the environment on the vulnerable, here student nurses, with the goal of empowering individuals and organisations to challenge inequalities in support at every level. Thereby promoting a less individualistic notion of resilience (ICN, 2016).

Indeed McAllister and Lowe (2011), as nurse authors, describe resilience as the ability of nurses not just to overcome adversity but to grow stronger and learn from the experience or survive and thrive. The American Psychological Association (2014) state that resilience is

> *"The process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress..."*

Aburn, Gott and Hoare (2016) note that more research is required within the context of nursing to fully understand the term. Windle, Bennett and Noyes, (2011) and Glass (2009), though, do highlight the need for resilience in everyday life for healthcare professionals as it is impacted by chronic and acute stressors recognised as part of such work environments

(Rees et al, 2015). Several authors define the resilient practitioner as one who can successfully care for themselves as well as those for whom they are treating (Hart, Blincow and Thomas, 2008). This definition, from counselling children and young people, has much synergy with nursing and the attributes of a nurse as stated earlier by the NMC (2018a).

Controversy still exists over whether resilience is a predetermined feature within an individual, or one which can be developed (Hart et al, 2016). Such a trait would be fixed, innate, possibly inherited and genetic in origin (Davydov et al, 2010). Whereas behaviour can be taught, developed, nurtured and is of more interest to educators hoping to understand and apply relevant interventions in practice (Fox, Leech and Roberts, 2014; Southwick and Charney, 2013). However, in health care education it is stated that resilience is not an innate, fixed characteristic but a complex and multifaceted construct not easily understood (Grant and Kinman, 2013a). Terms such as fluid, fluctuating and dynamic describe resilience, implying that people may be resilient in one sphere of their lives but not in others (Southwick and Charney, 2013).

To that end this thesis aims to add to an understanding of resilience within the context of nurse education, by exploring understandings of resilience with student nurses as part of a values based curriculum. Starting with isolating the tests of resilience, as whilst there is no agreed definition of resilience, there is consensus that adversity is fundamental to resilience development (Hart et al, 2016). Thereafter seeking to identify internal and external factors that affect one's ability to be resilient, whilst recognising the potential for individual and organisational responsibility for promoting strategies to nurture this state (DoH, 2009). Above all though, it is generally an accepted position in the field of healthcare and other professions that to be resilient is advantageous (DoH, 2009). Therefore resilience is viewed as a vital component for practice, education and further research (Windle, Bennett and Noyes, 2011).

2.3 A scoping review of the literature for resilience in nurse education

By critically appraising others' research, following a comprehensive scoping of the literature, the phenomenon of interest can be put in the context of what is already known (Thomas, 2013; Finlay, 2011). This can include disputes and convergences of ideas (Robson, 2011). I chose to utilise a scoping review outlined by Arksey and O'Malley (2005) and demonstrated by Sanderson and Brewer (2017), as a method for searching the literature to summarise and synthesise the existing nurse education literature. This followed previous reviews I had performed as part of the concept analysis on resilience, mentioned in Chapter One and the EdD research proposal, for which I had only included qualitative studies. Feedback on that work advised me to widen the scope of the literature to include quantitative studies as well, to map the full extent of the literature that exists (Gerrish and Lacey, 2015).

This approach is ideal to capture all material, especially where there is a paucity of information to provide a context for the research design (Arksey and O'Malley, 2005; Sanderson and Brewer, 2017). Unlike systematic reviews, which usually report on the effectiveness of treatments and procedures from quantitative studies or other review frameworks which focus purely on qualitative data (Gerrish and Lacey, 2015). I applied the recommended scoping review four step model (Arksey and O'Malley, 2005), as follows:

Step 1, began with formulating my review question– 'What is known regarding resilience to date in nurse education?' A search strategy tool called SPIDER (Cooke, Smith and Booth, 2012), was applied as below, to my search. For it is considered more inclusive for searching qualitative and mixed methods research. As it is less restrictive and offers more breadth than other tools such as PICO; quantitative focused, or SPICE; qualitative focused (Cooke, Smith and Booth, 2012).

S- Sample: student nurses

P-Phenomenon of **I**nterest: resilience, wellbeing or coping must be in the study title or a key word

D-Design: any primary research, written in English, to encompass key databases known to contain nurse education research; CINHL, MEDLINE, PsychInfo and EMBASE were all selected for the review (McGowan and Murphy, 2016).

E- Evaluation: of the papers carried out by applying the JBI appraisal criteria as per Appendix Three and highlights presented in Table 2.

R-Research: Qualitative, Quantitative and Mixed Methods.

Step 2, identifying relevant studies- any primary research regarding resilience in nurse education. Time limiters were not applied due to previous searches identifying a small pool of studies.

Step 3, study selection- see search strategy results below, Figure 2.1.

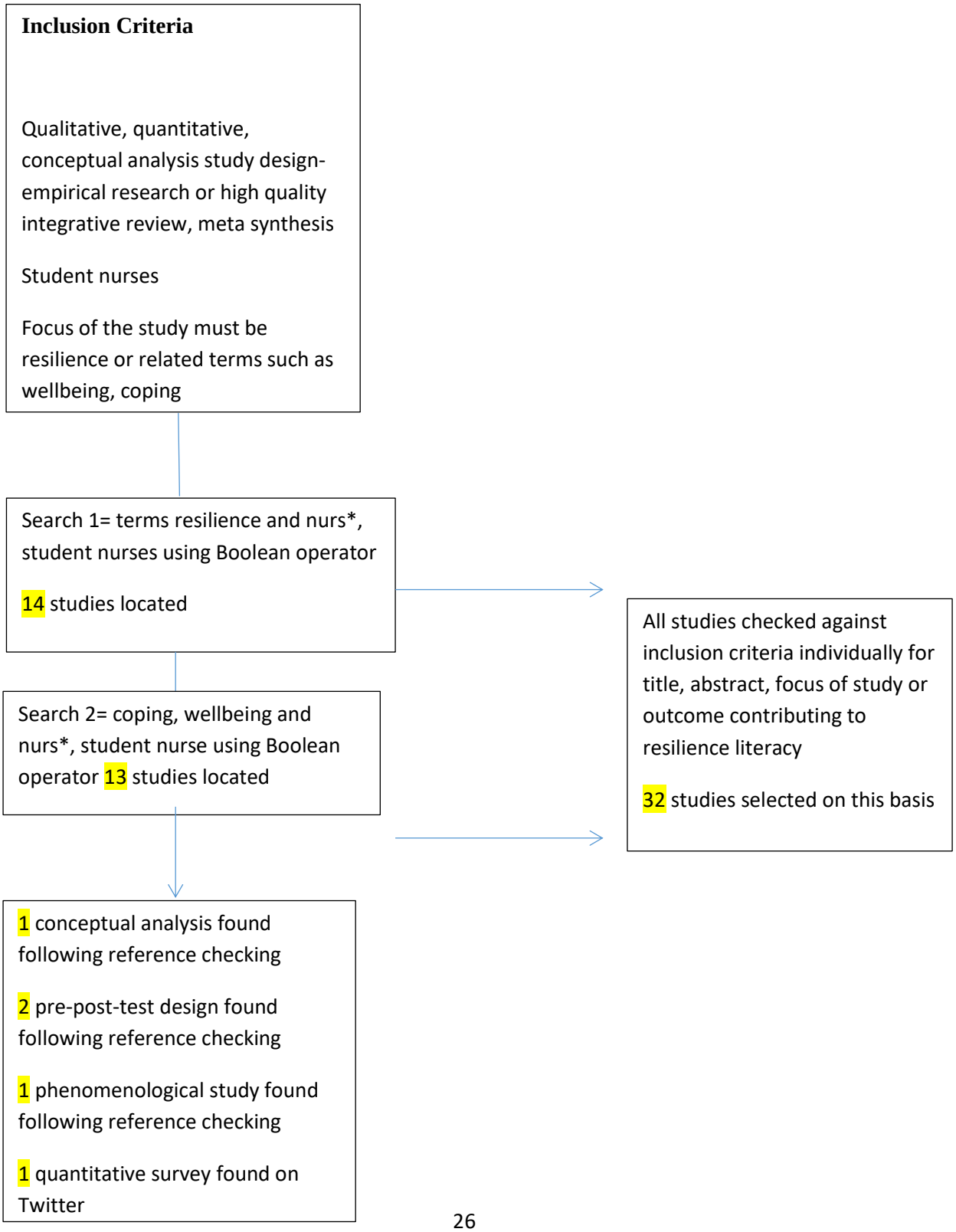
Step 4, charting the studies- see Table 2 and ensuing summary of key findings, drawing on the Joanna Briggs Institute criteria (JBI, 2017).

The first key search term I used was ‘resilience’ and ‘student nurses’, as I knew this elicited some studies from previous work. However a further search using the term ‘wellbeing or coping’ instead of resilience was executed as these concepts are often conflated with resilience within nursing and nurse education, as in other disciplines (Thomas and Asselin, 2018; Richardson, 2002). The Boolean operator “and” was used to combine search terms as per best practice to narrow the search limiters (Gerrish and Lathlean, 2015).

Unfortunately techniques for searching databases for qualitative research in a rigorous and systematic fashion are thought to have low precision and sensitivity which could hamper results (Robson, 2011; Centre for Review and Dissemination, CRD, 2009). Qualitative designs are not always labelled as such and databases historically have been more geared towards building search engines for quantitative studies primarily (Bowling, 2009). Therefore conducting a search in this type of research can prove challenging (Robson, 2011). Any empirical research related to resilience, either as the main focus or as a keyword regardless of methodology, I considered appropriate for this review. As previously there has been a paucity of work exploring this concept in nurse education (Thomas and Revell, 2016). I augmented the review by scoping the contemporary and historical nurse education resilience literature. Also through performing reference checking for key articles, exploring the grey literature and reviewing Twitter feeds of resilience experts, conducting a google and HEI library search (Beecroft, Booth and Rees, 2015; Thomas, 2013). I also utilised the results captured by a six year Zetoc alert on several key nursing journals through Proquest, with the results outlined in **Figure 2.1.**

Figure 2.1 – Search Strategy

Relevant Databases searched = CINAHL (Cumulative index for Nursing and Allied Health Literature), Proquest, PsychInfo, Medline (PubMed), Embace.



All of the studies found were of reasonable quality, as rated by the Joanna Briggs Institute Critical Appraisal Checklists for Qualitative Research (JBI, 2017) and Analytical Cross Sectional Studies (2017) as judged by the criteria in Appendix Three. Whether an appraisal tool was warranted in qualitative studies is debated with some arguing that prescribed formulae cannot rate the quality nor relevance of such a piece of research (CDR, 2009; Beecroft, Booth and Rees, 2015). However I found these tools of use when performing **Step 4** of the scoping review (Arksey and O'Malley), in order to present the studies in a table for ease of reading.

Table 2 summarises essential research appraisal information such as the findings of the studies, to concisely collate key points for synthesis following evaluation of the studies (Agee, 2009). The phenomenon at the focus of the study, research design, sample size, country where research was conducted, were focused on to aid analysis of validity, reliability, generalisability (JBI, 2017; Gerrish and Lacey, 2015). However these terms apply primarily to quantitative research; whereas rigour, target sample, phenomenon of interest and other key determinants are equally important in order to evaluate qualitative research (Arksey and O'Malley, 2005; JBI, 2017). Hence the subheadings of **Table 2** provide a transparent and consistent method of presenting the review studies, ready for discussion (Sanderson and Brewer, 2017; Arksey and O'Malley, 2005). All studies demonstrated congruity of methodology, research methods and findings with the phenomenon of interest, resilience (JBI, 2017).

According to Kossek and Perrigino (2016), there has been an explosion of work illuminating resilience development over the last two years. I found 31 primary studies that have investigated student nurse resilience and one concept study. Although as different data collection and analysis methods were undertaken in most of the designs, synthesis and comparison of findings is complex in this situation (CDR, 2009; Davydov et al, 2010).

However the multiple perspectives are also encouraged when researching resilience due to the complicated nature of the phenomenon (Southwick and Charney, 2013). Indeed such an array of research designs is in keeping with the wider resilience research (Aburn, Gott and Hoare et al, 2016).

Table 2 Summary review of the studies

Authors	Phenomenon	Research Design	Sample size	Country	Findings
Abiola, Olorukooba, and Afolayan (2017)	Resilience and relationship to wellbeing	Quantitative-descriptive cross-sectional study	71	Nigeria	There is a positive link between resilience and wellbeing.
Aloba, Olabasi and Aloba (2016)	Testing the 10 Item Connor-Davidson-Resilience Scale Among Student Nurses	Quantitative-descriptive cross-sectional study	449	South West Nigeria	The scale is a valid and reliable measure of resilience in this population. No linear correlation between resilience and sociodemographic variables
Carroll (2011)	Exploring resilience in nursing students through a phenomenological study	Qualitative- Interviews and analysis Heideggerian philosophy and coding of themes Giorgi (1994)	10	US	Student nurses in the study were equipped with internal qualities supported by external forces that promoted academic resilience which may be of use in decreasing attrition

Chamberlain et al (2016)	Quantitative-Dispositional mindfulness and employment status as predictors of resilience in 3rd year nursing students	Quantitative-observational successive independent samples survey design was employed	240	Australia	The predictive model explained 57% variance with resilience linked to mindfulness. Working outside of the course could be a protective factor contributing to resilience
Cleary et al (2018)	Promoting emotional intelligence and resilience in undergraduate nursing students	An integrative literature review	14 studies	International	A positive relationship was found between resilience and performance in undergraduate studies including professional experience placements. While some studies observed an important role for emotional intelligence for nursing students, there is currently insufficient evidence to conclude that emotional intelligence improves nursing students' communication,

					academic success and retention.
Crombie et al (2013)	Factors that enhance rates of completion for nursing students: What makes students stay?	Qualitative- ethnographic and focus group interviews	50, 2nd year students	UK	Student identity, the organization, fostering resilience and clinical support affect retention
Cuadra and Famadico (2013)	Male nursing students, emotional intelligence, caring behavior and resilience	Quantitative- Descriptive correlational design	186	Philippines	There is a significant relationship between male nursing students' emotional intelligence and caring behavior, emotional intelligence and resilience and caring behavior and resilience
Curtis, Horton and Smith (2012)	Compassion	Qualitative-Interviews, grounded theory analysis	19	UK	Students worry re: emotional work and lack of preparation, student well-being and vulnerability discussed
Froneman, Du Plessis and Koen (2016)	Effective educator–student relationships in nursing education to strengthen nursing	Qualitative- World Café Method, content analysis	40	South Africa	The following five main themes were identified as important in resilience building and

	auxiliary students' resilience				included: (1) teaching–learning environment, (2) educator–student interaction, (3) educator qualities, (4) staying resilient and (5) strategies to strengthen resilience.
He et al (2018)	Assessing stress, protective factors and psychological well-being among undergraduate nursing student	Quantitative-Cross-sectional descriptive survey	538	Australia	Resilience is a key factor in sustaining well-being. There is a need for specific curriculum preparation to promote positive coping strategies
Lekan, Ward and Elliott (2018)	Resilience in nursing students	Mixed methods online questionnaire	27	US	Only 33.3% of the sample was considered resilient. Nurse educators must help nursing students develop resilience to better prepare them for academic success and ensure a smooth transition into their professional nursing role.

Li et al (2015)	Nursing students' post-traumatic growth, emotional intelligence and psychological resilience	Quantitative- cross-sectional questionnaires	202	China	Post-traumatic growth was associated with emotional intelligence and psychological resilience.
Lopez et al (2018)	Does building resilience in undergraduate nursing students happen through clinical placements	Qualitative- focus group interviews, content analysis of data, 3rd and 4th years	19	Singapore	Students reported that they were stressed while facing challenges head-on during their first clinical placements, mainly due to a lack of peer and clinical support. Gradually, students built resilience overtime and were able to adapt to the ward culture through peer support and reframing coping strategies.
Mathad, Pradhan and Rajesh (2017)	Correlates and predictors of Resilience among nursing students	Quantitative-descriptive correlational study	194	India	Resilience is significantly correlated with mindfulness, perseverative thinking and empathy in nursing students.

Meyer and Shatto (2018)	Factors which influence resilience and transition to the workforce	Quantitative- descriptive correlational study	17	US	Resilience fluctuates during the first year of qualification with only 57% of participants feeling adequately prepared for the realities of practice. Interventions which increase resilience should be included within curricula
Onan, Karaca and Barsal (2018)	Evaluation of a stress coping course for psychological resilience among a group of university nursing students	Quantitative- Pre-test and post-test design Using a stress self-assessment checklist and psychological resilience questionaire	78, 1st year student nurses	Turkey	An improvement in self-perception and social resources posttest More attention needs to be given to the role of psychological resilience in dealing with the inevitable stress involved in nurse education
Pines et al (2012)	Stress resiliency, psychological empowerment and conflict management	Quantitative- correlational study Intervention involving simulation	166	US	Students scored in the high range for focusing on their deficiencies in conflict situations. Empowerment scores were significantly

	styles among nursing students				correlated with stress resiliency scores.
Pines et al, (2014)	Enhancing resilience, empowerment, and conflict management among baccalaureate students: outcomes of a pilot study	Quantitative -Pre-test and post-test design	60	US	Integrating conflict resolution opportunities throughout the curriculum can aid preparation for challenging heath care environments and resilience.
Rees et al (2016)	Predicting Burnout among student nurses-exploring the ICWR-1 Model of Individual Psychological Resilience	Quantitative-correlational study. As well as several key demographics, trait negative affect, mindfulness, self-efficacy, coping, resilience, and burnout were measured.	422	Canada and Australia	Resilience had a significant influence on the relationship between mindfulness, self-efficacy and coping, and psychological adjustment (burnout scores)
Reyes et al (2015)	Nursing students' understanding and enactment of resilience	Qualitative - a constructivist grounded theory study	38	Canada	The process of 'pushing through' was based on a progressive trajectory, which implied that nursing students enacted the process to make progress in their

					academic lives and to attain goals.
Rios-Risquez et al (2018)	Connections between academic burnout, resilience, and psychological well-being in nursing student	Quantitative-A longitudinal study	218 students at T1 survey 113 students at T2 survey	Spain	Emotional exhaustion was the most relevant dimension of academic burnout when predicting psychological well-being, resilience has an important positive effect on psychological well-being
Sigalit, Sivia and Michal (2016)	Factors associated with nursing students resilience: communication skills course, use of social media and satisfaction with clinical placement	Mixed methods online questionnaire	149, 2nd year students	Israel	Positive correlation between the use of social media and personal/group resilience. No link to the communication course.
Smith and Yang (2017)	Stress, resilience and psychological well-being in Chinese undergraduate nursing	Quantitative- a cross-sectional study and statistical analysis	1538	China	Psychological well-being appears impaired in Chinese nursing students. Globally more attention could be given to the resilience training in nurse education

Stacey et al (2017)	A case study exploring the experience of resilience- based clinical supervision (RBCS) and its influence on care towards self and others among student nurses	Qualitative- Exploratory case study using social constructivist theory to analyse the data Focus groups as data collection method	3rd year student nurses T1- prior to intervention (9) T2- end of intervention period (8) T3- 6 months post intervention (4)	UK		RBCS has the potential to help individuals to develop resilience Mindfulness was also effective in raising self-reported levels of resilience The many variables involved in the development of resilience do not permit a direct link between RBCS and resilience
Stephens (2012)	Increasing resilience in adolescent nursing students	Quantitative - experimental pre-test and post-test intervention using Twitter	71	US		The use of Twitter to provide support to students when in the PLE increased resilience in the short-term but led to no statistical significant increase in resilience in the long-term.
Stephens (2013)	Developing a conceptual analysis of	A conceptual analysis Theory building	Not applicable		US	All student nurses are vulnerable to stressors in their training, protective factors can

	resilience in student nurses				be enhanced through education, need for more research including from the students' perspective
Thomas, Jinks and Jack (2015)	Finessing incivility in placement	Qualitative- Longitudinal study, diary entries, grounded theory	26	UK	Transition into practice challenging, students face adversity and develop resilience, coping mechanisms noted for dealing with dissonance
Thomas and Revell (2016)	Resilience in student nurses	Integrative literature review	9 studies	International studies Authors US context	Resilience not well defined, support an important factor of resilience, role dissonance experienced, reflection may be of use, educational strategies require evaluation, clear definition of the concept requires research

Van der Hoek, Portzky and Franck (2019)	Influence of socio-demographic factors, resilience and stress reducing activities on academic outcomes of undergraduate nursing students	Quantitative -A cross-sectional study	554	Belgium	Resilience was the only factor that significantly predicted the three academic outcomes: intention to leave, academic success and dropout. Known predictors of academic outcomes such as young age, gender, previous education, nationality and caring for family members were not confirmed in this study.
Van der Riet et al (2015)	Effectiveness of a mindfulness intervention in stress management	Qualitative- Focus group interviews, thematic analysis	14	Australia	Some students found the intervention useful in the short term, much critical feedback gained to inform future delivery

Wahab et al (2017)	New graduates nurses' accounts of resilience	Qualitative- A study using photovoice in focus group discussions with thematic resilience	9	Singapore	Four themes emerged; resilience is persevering and overcoming obstacles. Resilience is fulfilling professional duty, adapting to new situations and taking control of one's own learning.
Zhao et al (2016)	Peer caring and its association with resilience among nursing vs medical students	Quantitative-cross-sectional survey design	426 nursing students 336 medical students	China	Peer caring and resilience improved the subjective well-being of both sets of students

2.4.1 Key Findings of the Literature Review

The findings of the studies and methodologies employed to explore resilience to date, summarised in Table 2, will now be considered as part of justifying the research questions previously outlined in Chapter One. This is in terms of what is already known about resilience in nurse education. These include the following themes; measuring resilience in nursing students and identifying key constructs of resilience; citing multiple stressors of resilience; interventions and personal meanings of resilience.

Measuring Resilience - As can been seen from Table 2, the majority of studies were quantitative in nature, employing cross-sectional surveys utilising an array of validated tools or scales searching for the key variable or socio-demographic characteristic which could predict resilience. So-called second wave research (Richardson, 2002). Most employ comprehensive statistical analysis in order to test various hypotheses exploring links between constructs (Salkind, 2011), from the field of psychology. Identifying this "Holy Grail" could enable targeted educational interventions for vulnerable populations with low scores in corresponding components of resilience (Windle, Bennett and Noyes, 2011).

Conversely these studies found no confirmation between sociodemographic information and resilience. A few studies claim a statistically significant association between maturity in terms of age as a protective factor (Chamberlain et al, 2016; Mathad, Pradhan and Rajesh (2017). However, He et al (2018) contradict the assumption that life experience enables students to deal better with adversity. Citing increased competing demands outside of the course on mature students as negatively affecting resilience. This is supported by Lekan, Ward and Elliott (2018). Whilst Aloba, Olabasi and Aloba (2016), alongside Cuadra and Famadico (2013) cite males as having higher resilience scores in their studies drawing on some supporting literature. Yet this contradicts the rest of the empirical findings, possibly as respondents in the

majority of studies are mostly female, which is in keeping with the overall demographic of the nursing profession globally (Aburn, Gott and Hoare, 2016).

Yet the resilience measurement scales favoured in many such quantitative studies are not validated within the UK student nurse population, but often within the therapeutic communities of mental health settings, chronic ill health and children and young people (Windle, Bennett and Noyes, 2011; Lee et al, 2013). Athough from Table 2, it can be seen that these have been validated in some student nurse populations in other countries (Sanderson and Brewer, 2017). This is of significance for future mixed methods research (Thomas and Revell, 2016).

Nevertheless in these quantitative studies there is also divergence of findings in terms of predictors of resilience. Perhaps due to the array of tools used in the data collection. As most studies utilised at least 3-4 different scales to measure various perceived factors affecting resilience aside from social demographics. Such as emotional intelligence (Cuadra and Famadico, 2013; Li et al, 2015; Cleary et al, 2018) and wellbeing (Abiola, Olorukooba, and Afolayan, 2017). Additionally burnout (Rios-Risquez et al, 2018; Rees et al, 2016) conflict, empowerment (Pines et al, 2012), peer caring (Zhao et al, 2016) and empathy (Mathad, Pradhan and Rajesh, 2017). See Table 2 for all study details. Psychological wellbeing as an outcome of resilience (He et al, 2019; Rios-Risquez et al, 2018; Smith and Yang, 2017; Zhao et al, 2016), was measured too.

Stressors in nurse education- What is of interest, is that most of the findings apart from one (He et al, 2019), acknowledge that nursing students have lower than average resilience scores compared with other student populations. Leading to higher risk of burn out, psychological distress or illness and increased rates of predicted drop out or attrition from the course (van der Hoek, Portzky and Franck, 2019). This means that potentially student nurses globally are more vulnerable in comparison to other groups of students. Although Rios-

Risquez et al (2018) applied a very narrow definition of burnout to academic stress whilst investigating resilience as a protective factor in a longitudinal study. They sampled respondents on two occasions, only 18 months apart with almost 50% attrition of the cohort, which has limitations for their findings. Though this study did find that resilience was a protective factor against academic burn out. Whilst the ideal for informing an empirical knowledge base in this area would be a longitudinal study, it is noted that they are expensive and resource intense (Kristjansson, 2013).

Zhao et al (2016) also cite peer caring as protective against stress associated with nursing although this is a comparison study including medical students which, whilst of interest, does not fully account for differences within the groups' resilience scores. The studies showed that academic factors, the emotional aspects of nursing and practice learning were sources of stress for student nurses. The academic workload on the Bachelor of Nursing undergraduate course is stressful due to several factors. Globally most nursing students are also working to meet financial needs around university course requirements or shifts in practice (Carroll, 2011; He et al, 2018; Sigalit, Sivia and Michal, 2016). Academic overload or bunching of assignments can further increase the risk of fatigue and burnout (Lekan, Ward and Elliott 2018). The effect of this combined workload on resilience is currently missing from a UK context.

My review found that the emotional burden of nursing and reality shock of nursing work is experienced for the first time in the PLE with death and dying, navigating conflict and dealing with communicable diseases all cited as stressful by students (Curtis, Horton and Smith, 2012; Lopez et al, 2018; Reyes et al, 2015; Stephens, 2013; Stacey et al, 2017). The 'dirty work' (McMurray and Ward, 2014), of nursing equally brings a unique set of challenges to student nurses, for which they must be prepared as it challenges resilience daily (Thomas and Revell, 2016). Moral distress was cited when dissonance was experienced by

nurses including students, in relation to a lack of professional behaviours witnessed from qualified colleagues in clinical practice (Stacey et al, 2017). Or, when care values were compromised by an output driven system, the effect of which should not be underestimated (Young and Rushton, 2017). Internationally the potential for nurses to become emotionally fatigued or burnt out is indeed well recognised and thus students are vulnerable too (Jack et al, 2018).

Thomas, Jinks and Jack (2015) and Crombie et al (2013) found that students were negatively affected by the culture of an area as this meant having to navigate those unsupportive of their learning or deal with bullying. Resilience was required to cope with the adverse socio-cultural areas of the PLE where students perceive that they are not always treated well (Thomas, Jinks and Jack, 2015; Wahab et al, 2017). Pines et al (2012) noted the widespread experience of conflict in relation to practice environments and that lack of preparation for this impacted resilience in their study. It was also recognised that if Faculty and practice learning staff understand, support and engage with students emotionally then a more conducive learning environment may develop (Carroll, 2011; Curtis, 2013; Reyes et al, 2015; Wahab et al, 2017). Whilst others found that family support was essential to completing nurse education and aided resilience (Carroll, 2011).

Few studies though acknowledged the PLE outside of the UK explicitly (Curtis, 2013; Thomas, Jinks and Jack, 2015; Stacey et al, 2017). Moreover the existing literature does not focus on individual resilience strategies or practice. Indeed resilience research in nurse education is in its infancy (Thomas and Revell, 2016). Therefore more research is required to explore this feature of resilience development in a UK nurse education setting.

Interventions - Several of the studies in this review focused on evaluating the impact of educational interventions aimed at improving resilience scores. The third wave research. Van

der Riet et al (2015) explore the use of a strategy for stress relief thought to be of use in resilience building, mindfulness. However it appears as if the intervention itself was the main focus of that work rather than theory construction to understand the concept of resilience. Mixed results were found in this study with some short term positive benefit cited by some students and much critical feedback was gained to inform future delivery of the intervention (van der Riet et al, 2015).

The importance of dispositional mindfulness, the ability to separate oneself from emotion in order to think clearly and operate in stressful situations, was also noted as an important feature of resilience in Chamberlain et al's study (2016). With others (He et al, 2018; Mathad, Pradhan and Rajesh, 2017; Lopez et al, 2018; Rees et al, 2016 and Carroll, 2011) also citing the potential impact of this practice/ability on resilience. The wider literature supports further investigation of mindfulness or recommends the use of this intervention in resilience building (Curtis et al, 2017; HEE, 2018; Clarke et al, 2015; Brennan, 2017 and Morley, 2016a, 2016b). The evidence base underpinning these educational strategies to enhance resilience is very small though and more research is needed (Thomas and Asselin, 2018).

Sigelit et al (2016) tested the use of a communication course and social media support for students during practice learning. The peer and group support gained on social media was rated highly and increased resilience scores. Stephens (2012) used Twitter to provide messages of support to students when on placement. For the experimental group this worked in the short-term but not thereafter. Pines et al, (2014) used simulation to improve resilience scores in nursing students focusing on conflict management and empowerment skills with short term improvements. Whilst Stacey et al (2017) in the UK, explored the use of Resilience Based Compassionate Clinical Supervision (RBCS) with student nurses and qualified nurses. From pre-intervention to post-intervention focus group discussion, students reported some benefits from debrief and reflective discussions. The emotional aspects of

nursing were dealt with and peer support gained. However due to the many variables associated with resilience development, no clear link with RBCS and increased resilience was demonstrated (Stacey et al, 2017). Thus more research from the students' perspective is required to understand other educational features supportive of resilience formation within a UK context.

Meanings of Resilience - The ideal study design to investigate students understanding of resilience is a qualitative approach. However this review found less qualitative studies than quantitative informing the knowledge base on resilience in nurse education. It is worth noting too that in many of the empirical studies resilience was not the main focus of interest. Often resilience was mentioned through the voice of the student nurses themselves or identified as a theme in the data analysis or discussion phase of the research (Thomas, Jinks and Jack, 2015; van der Riet, 2015; Curtis, Horton and Smith, 2012). Nursing scholars across all of the studies defined resilience as a response to the presence of a stressor or adversity, as determined by a set of personal characteristics and resulting in a coping outcome (Thomas and Revell, 2016).

Few actually investigate a conceptual understanding of resilience prior to testing interventions. Reyes et al, (2015) present a progressive model for resilience as a result of a qualitative grounded theory analysis based on interviews with student nurses in Canada. They outline the process of students' "*pushing on through*" adversity after "*stepping into*" new and stressful experiences which were often balancing academic workload versus personal life. "*Staying the course*" was enabled through seeking the support of peers, faculty and nurses in practice. Holding onto their beliefs and values was essential. Resilience was described as an active process which requires work and often purposeful disengaging from others to deal with issues and acknowledging resilience was key to growth.

Carroll (2011) undertook a phenomenological study in the United States with Associate Degree Nurses in a community college. She identified personal strategies which may prevent attrition, enable fulfilment of academic requirements of the course and focused more on completion of the course than resilience per se. Carrol (2011) applied her construct of resilience as identified in the findings in Table 2, to 10 nursing students. She found the themes of hope, autonomy, perseverance, optimism, support, empathy, sense of purpose, and honesty of importance. Thereby providing first wave research findings in nurse education. These concur with findings noted within the wider literature (Southwick and Charney, 2013) and also form part of the Resilience Framework for Adults (Hart, Blincow and Cameron, 2012).

Stephens (2013) was one of two researchers within this review who created an operational definition of resilience which purports that all student nurses face significant stress and adversity at some point in their training. However there are many protective factors that can be utilised to build resilience through resources internally and externally located. This has synergy with the wider literature, particularly Hart et al (2016). This applauds the paradigm shift from a deficit model of resilience to strength or asset building (Richardson, 2002) and resonates with my own thoughts on resilience for nurse education. Though Stephen's model is a result of conceptual theorising and has yet to be tested empirically. Therefore more research is required which explores understandings of resilience at an individual and group level.

2.4.2 Gaps in the Literature

The resilience literature, in nurse education, is in its infancy but replicates the first, second and third wave wider resilience research (Rees et al, 2016). Although narrowly focusing on individual characteristics or measures of how resilient this group are. Often

alongside interventions to improve resilience, with limited understanding of the phenomenon within a nurse education environment. I sought therefore, to add to the existing knowledge base regarding an understanding of resilience from the perspective of the students, particularly within a UK context. Hoping to prepare, further down the line, for a fourth wave or more sophisticated understanding of resilience on many levels (Hart et al, 2016), within a nurse education setting.

Indeed not all of the research designs in this review set out to focus on resilience. Although most studies do cite resilience in the title of the papers. However terms are conflated such as psychological resilience, stress resilience, or simply resilience. Initially I set out to focus on emotional resilience but soon realised that within nurse education there is the potential for resilience to encompass all aspects found. Other surrogate terms such as coping and stress management are used. Ambiguity and confusion over concepts can lead to misidentification, incorrect labelling and inaccuracies in respondents' answers, which affects the veracity of the body of knowledge on the subject (Rogers, 1989).

Much of the work here is not only exploring other related phenomena but investigating resilience as a protective factor against emotional exhaustion, academic burnout or attrition. Or as a key component for other attributes such as wellbeing, compassion, socialising in professional practice or academic success. This though, is in keeping with the wider literature and second wave research on the topic of resilience. With resilience articulated and approached differently across disciplines as identified earlier by Richardson (2002). Due to few qualitative studies in the field of nurse education, any knowledge if applied with caution may be of use in exploring the phenomenon (McGowan and Murray, 2016).

Indeed personal meanings of resilience in other "helping professions" have been found to be extremely varied (Grant and Kinman, 2013a). These researchers found that 2nd year student social workers identified resilience as innate, fixed, uni-dimensional and self-

protective, but that their definitions lacked clarity (Grant and Kinman, 2013b). Clohessy, McKellar and Fleet (2019), found with six, 3rd year student midwives, that resilience was indeed triggered by exposure to adversity and articulated as the ability to bounce back and move forward with optimism. Being confident was key to the resilience process. These participants believed that it can be developed and that education providers are vital to enabling resilience development.

De Witt et al (2019), in a cross-sectional online survey with Occupational Therapy students in South Africa, identified that whilst stress levels were high and younger students living away from home were more vulnerable to mental health issues, resilience training could benefit all. Finally, a focus group of physiotherapy students in Hungary, voiced that resilience is needed to cope with increased demands of their training aligned with decreased support from University (Biro, Veres-Balajti, Kosa, 2016). Conflict with peers provoked a need for resilience, alongside decreased family/leisure time and financial issues. Above all, this group appeared to lack techniques and skills to cope with the stress of the course and resilience building. Yet personal meanings of resilience are very limited in nurse education research to date.

A further limitation of the quantitative survey approach, favoured by the majority of the studies, is the self-reporting nature of the data collection tools which could enable respondents to inflate or deflate scores. However all of the researchers acknowledged this issue and a risk of bias is present in all research designs except perhaps ethnographic observational research (Bowling, 2009). Little information was given in some studies though regarding ethical considerations of the research designs, particularly as to whether this was insider research and if appropriate measures were taken to mitigate potential researcher coercion or bias within the qualitative studies (Mercer, 2007).

Lekan, Ward and Elliott (2018) and Sigalit, Sivia and Michal, (2016) did include an open ended question at the end of their surveys to obtain qualitative data related to resilience building. Acknowledging the requirement where possible for a broader mixed method approach to resilience research (Richardson, 2002). This type of research therefore presents a snapshot of how the students were feeling at the time they completed the study. Although it is not a rich in-depth exploration of resilience of the type that I am drawn to (Finlay, 2011).

It needs to be recognised that three studies did not focus on undergraduate nursing students as this may impact on the findings in terms of a difference in experience of academic stress, challenges in practice learning and leadership development. Carroll's (2011) population were associate degree nurses; Froneman, Du Plessis and Koen (2016) concentrated on nursing auxiliary training and Meyer and Shatto (2018) concentrated on newly qualified nurses. These are focused on different populations and roles, although still part of the wider nursing family. Whilst there are other routes into nurse education in the UK, such as the part-time apprenticeship route or nursing associate then transfer onto BSc course, by far the main route is via the pre-registration undergraduate degree which is University or HEI based (RCN, 2018; HEE, 2018). Whilst Zhao et al (2016) undertook a comparative study between nursing and medical students which could impact the data analysis and findings by conflating the two groups' results. Despite these differences the topic and findings were thought to be of use in this small pool of research studies when creating my research design.

The empirical work in this review was conducted in different countries with diverse cultures which most recognise, limits the relevance of the results outside of that environment (Ang et al, 2018). This could affect transferability of findings to the UK setting which appears to have the most exacting standards in terms of practice learning hours to be achieved within three years, 2300. Larue, Pepin and Allard (2015), note that practice education requirements for nurses in the U.K. are among the highest in the world. This is important

given the challenges in nursing environments highlighted earlier in Chapter One which could affect student nurse resilience.

There were just four studies conducted in the UK with only one (Stacey et al, 2017) focused primarily on resilience. Crombie et al (2013) investigated attrition, Curtis (2013) explored the concept of compassion, and Thomas, Jinks and Jack, (2015) finessing incivility in practice learning. All were investigating issues in learning in clinical practice settings unlike most of the other studies in this review. Moreover this attention to practice learning is under theorised in the literature (Sanderson and Brewer, 2017). Therefore with 50% of the course in the UK situated in PLE's, this experience needs greater focus in future studies. This combined with academic challenges may be why rates of stress and depression were high in some cohorts (Smith and Yang, 2017), as outlined in Table 2. The net result of these factors affects resilience and can lead to significant attrition. It is of concern to nurse educators, practice colleagues and patients alike that when students fear for their emotional wellbeing some disengage from compassionate practice as a coping strategy, thus potentially adversely affecting patient care (Curtis, Horton and Smith, 2012; Maben et al, 2012a, b).

Hence more research is needed in a UK context to understand the tests of resilience from the students' perspective. The students lived experience of the tests is minimally covered in the global literature with only Carroll (2011) previously investigating this phenomenon. As per research question

1. When and how is resilience tested during nursing education?

Davydov et al (2010) and Ungar, Ghazinour and Richter (2013) note the conceptual discrepancies and lack of a unified definition which render it difficult to quantify and develop appropriate measures across cultures to investigate resilience. This could further limit comparison and evaluation of studies. However key themes were developed in all of the

papers which concur with findings of research in my previous scoping. Without exception every study recognises resilience as a potential protective factor in combatting the multiple challenges for nursing students. They all challenge nurse educators to build curricula that includes resilience training, given that the importance of developing emotionally supportive curricula and promoting the wellbeing of future nurses to deliver healthcare is highlighted globally (McGowan and Murray, 2016; Grant and Kinman, 2013a; Fessey, James and Pengelly et al, 2016). Indeed the period of training for professionals has been suggested as more stressful than qualified practice (Grant and Kinman, 2013a). Yet it is not understood what enables resilience on an individual level both within and without the course. Thus the formation of research question:

2. What aids the development of resilience in student nurses?

Awareness of how resilience is fostered is likely to help students to thrive in their future careers (Grant and Kinman, 2013a). Grant and Kinman (2013b) have undertaken research in the "helping professions" including 200 social work students, through qualitative questionnaire and thematic analysis. They later applied findings to trainee midwives, nurses and social workers training to become healthcare professionals. They found that emotional intelligence and emotional literacy were key components of resilience.

Research undertaken by Health Education England (RePAIR project, 2018) explored attrition and retention in nurse training with a view to promoting best practice in this area. The trend of increased attrition impacts the future workforce numbers for nursing in the UK (RCN, 2018). Thereby perpetuating the cycle of a lack of capacity for supporting future students in practice learning if not addressed. This report recommends resilience development as part of the nursing curriculum in a bid to prevent attrition and retention but only highlights mindfulness as a possible intervention (HEE, 2018). A better understanding of resilience could also inform strategies to build resilience (Gillespie et al, 2007). Moreover it is deemed

to be a moral obligation to explore strategies which may protect neophyte nurses at the start of their career (Cusack et al, 2016). From my review it is clear that more research is necessary within a UK context to explore what within existing curricula helps with resilience.

3. Which, if any, educational strategies, currently within the curriculum, support resilience formation?

There are few studies which seek to understand resilience from the students' perspective particularly in nurse education. Therefore the aim of my research is to focus explicitly on understanding resilience through the lived experience of student nurses within the UK. Enabling their voice to denote resilience and the importance of this in nursing education. As per the research question,

4. On completion of the course how do student nurses understand the term resilience in nursing? Do they see it as important?

My study adds to the existing nurse education literature in several ways. By illuminating the tests of resilience in new settings, as this is currently missing in a UK context. By citing aids or a toolbox for the development of resilience at both an individual and group level. Through the identification of reflection and simulation as educational strategies useful to resilience development. Thus for the first time, in a UK context, an overall process by which resilience is built, is articulated which involves reflexivity. Thereby several waves of resilience research have been utilised, albeit in a context specific case study. Above all this thesis seeks to understand resilience from the experience of student nurses.

2.5 Summary

The findings of this review offer some real world insights which are of use in creating and implementing this research design. As there appears to be no one universal definition of resilience for nurse education (McGowan and Murray, 2016). This aligns with current

thinking in other subject areas and previous research regarding this phenomenon have been mainly quantitative (Stephens, 2013). Furthermore little is known in relation to what specifically tests resilience in the lived experience of nurse education. Resilience development has not been fully considered in this population from the student perspective and more needs to be known about the efficacy of individual practices and group level interventions. Finally gaps in the literature exist regarding the student understanding of the importance of resilience in nursing. Chapter Three now explains the research design at the heart of this thesis.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

For the purposes of this thesis, methodology is defined as the overall framework or approach to the research (Lacey, 2015). A research framework was required for this study which could capture the phenomenon of interest, in this instance resilience, as it appears to the subject (Robson, 2011). In this study I draw on an interpretivist paradigm; viewing the world as one to make sense of and understand through the interpretation of others' words or thoughts (Thomas, 2013). This chapter is made up of two parts; the first exploring the chosen methodology, which clarifies my stance on the chosen research approach, including the underpinning philosphy (Smith, 2011). It will be posited that the work of Hannah Arendt (1981;1988) regarding both hermeneutic phenomenology and the human mind was essential to both the ontological and epistemological position of this research. A discussion of the research design or plan then demonstrates how the methodology is enacted in this study. Although often the terms are used interchangeably in research literature (Bowling, 2009). The second part, the methods section, justifies the chosen tools for the study; including the recruitment strategy, data collection instruments and data analysis process (Thomas, 2013, Finlay, 2011).

The overarching methodology draws from Interpretative Phenomenologcial Analysis (IPA) as described by Smith, Flowers and Larkin, (2009). Often described as a type of hermeneutic phenomenology (Finlay, 2011). It was thought that this could provide a vehicle for the research questions below, including the thoughts of student nurses' regarding the concept of resilience (Stephens, 2013).

1. When and how is resilience tested during nursing education?

2. What aids the development of resilience in student nurses?

3. Which, if any, educational strategies, currently within the curriculum, support resilience formation?

4. On completion of the course how do student nurses' understand the term resilience in nursing? Do they see it as important?

Ethical considerations are discussed throughout this thesis, though particularly here, as key to the design phase of the research (Johnson and Long, 2015). Limitations of the study are acknowledged accordingly at the end of the chapter.

3.2 Methodology

As demonstrated in the current literature discussed previously, the dominant discourse driving research in this area to date has been concerned with positivist frameworks (Thomas, 2013). Measuring the presence and levels of resilience among qualified or student nurses (Sanderson and Brewer, 2017; Stacey and Cook, 2019; Aiken et al, 2012). Literature reviews consistently identify the prevalence of quantitative studies including the utilisation of resilience measurement tools within this population to search for associated correlates of resilience (Hart et al, 2016; McGowan and Murray, 2016). Alternatively to test the efficacy of interventions designed to enhance resilience (Chesak et al, 2015). This preference for quantitative research is common in nursing (Melia, 1982). However for this project though, such an approach was not appropriate for several reasons and such approaches were thus ruled out on the following basis.

A positivist, quasi-experimental design was not appropriate as there was no hypothesis to test nor one theory or intervention under investigation (Thomas, 2013). The variables are multiple and cannot be controlled for in this real world setting (Robson, 2011). The educational strategies or support mechanisms to enhance resilience within the curriculum are many (simulation, Mental Health First Aid, personal tutor system, staff in practice learning

settings) and may not be accessed by all students equally (Galbraith, Brown and Clifton, 2014). Additionally a positivist methodology was not preferrred here as these often lack the depth and richness of qualitative or interpretivist frameworks (Gerrrish and Lathlean, 2015). Above all not enough is known about resilience in nurse education yet to enable theory or hypothesis testing at this stage.

An approach which can attempt to investigate this dynamic, fluctuating requirement from a pyschosociocultural perpsective, is ideal (Southwick and Charney, 2013). There are already useful relevant examples of robust phenomenological qualitative studies investigating the meaningful experiences of nurses dealing with the emotional work of students and nurses in the real world of practice (Jack and Wibberly, 2014; Jack, 2017). Although there is no one approach or framework which will provide definitive answers in any research (Robson, 2011; Thomas, 2013). Yet Interpretative Phenomenological Analysis was considered the preferred option for this project for multiple reasons.

Alternative qualitative frameworks, such as grounded theory research (Galvin and Holloway, 2015), were not chosen as no theory construction was thought possible given the small nature of the project. I also considered it too early to generate theory from small data sets due to the lack of previous conceptual studies on resilience in nurse education (Dunne, 2011). Moreover grounded theory studies tend to use larger numbers to present an overall description of a phenomenon. This lacks the detail and idiographic importance favoured in IPA, which values each particpant's experience equally (Smith, Flowers and Larkin, 2009).

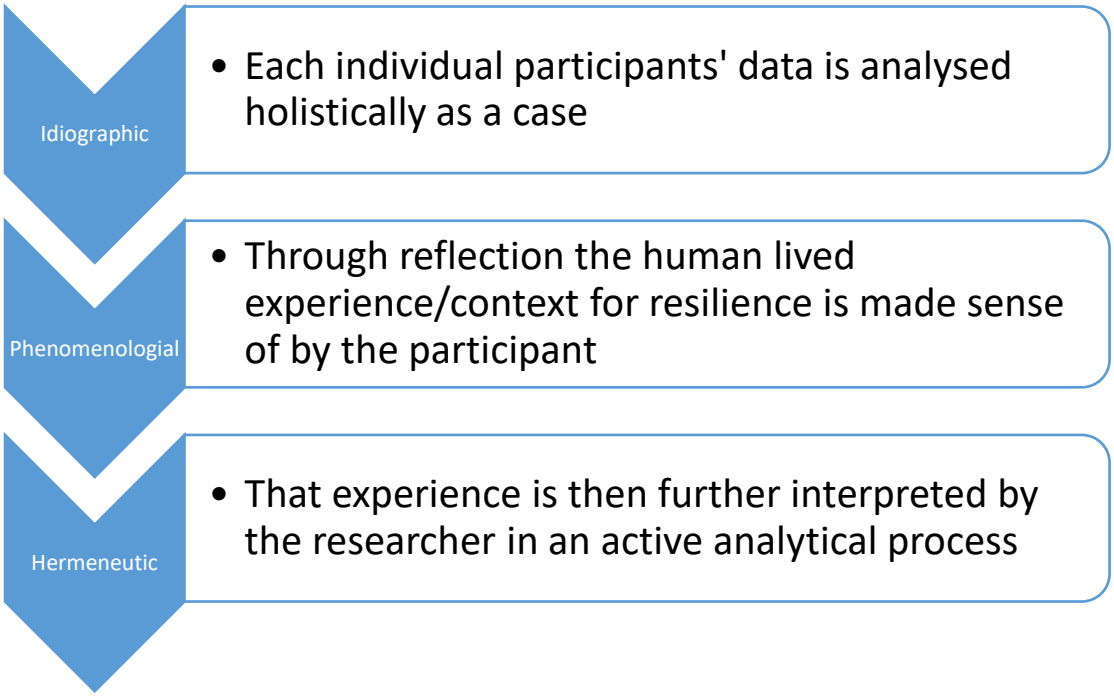
Narrative inquiry enables participants to share their stories of an experience or incident (Freshwater and Holloway, 2015). At face value this appears similar to IPA. However IPA goes beyond the traditional methods of qualitative thematic analysis (Blank, Finlay and Prior, 2016). As it features the interpretative active role of the researcher who applies rigour and

analysis, through the application of the hermeneutic circle, constantly, to the data to look for hidden meaning (Clancy, 2013; Smith, Flowers and Larkin, 2009). Hence a phenomenological approach may enable the unearthing of previously intangible concepts by acknowledging explicitly the intertwined relationship between the participant, researcher and their worlds (Blank, Finlay and Prior, 2016).

It is not easy to investigate matters of the mind and emotions (Malabou, 2012; Rose and Abi-Rached, 2013), yet IPA can enable the exploration of just such personal experiences usually through a transition or meaningful life event (Smith, Flowers and Larkin, 2009; Wagstaff et al, 2014). In this instance this would be of the student nurse transitioning through the course on their resilience journey to that of a qualified professional (Jack and Wibberley, 2014). The reports or stories involved in the telling of this are then interpreted or analysed by the participant making sense of their experience as it "appears" to them (Arendt, 1981; 1988).

Phenomenology incorporates a double hermeneutic or interpretation as both participant and researcher are engaged in making sense of the world (of the student nurse) (Smith, Flowers and Larkin, 2009; Borren, 2013). This is both a dynamic and iterative process with the particpant working to reveal and interpret their lived experience whilst the researcher seeks to contextualise the narrative, identifying themes that may emerge in the data as it appears to them (Miles, Chapman and Francis, 2015). Thus a case by case or idiographic representation of the phenomenon is built up (Smith, Flowers and Larkin, 2009). This process is explained in Figure 3.1

Figure 3.1 The IPA Approach



This framework is ideal for exploring resilience as IPA has been tested effectively within health care settings exploring both psychological and sociological concepts (Smith, Flowers and Larkin, 2009). Phenomenology has also been considered of use in exploring the world of the student nurse both in the past and more recently (Melia, 1982; Carroll, 2011). Temporality is also important to IPA in that both the meaning of present and past experience is explored in regard to the focus of the research (Finlay, 2011). This is accounted for in the research questions and objectives for this work in accessing what the participants use now to enable resilience and what has helped shape them in the past. Indeed others have found that participants appreciate discussing current and historical issues, such as the emotional challenges of learning in practice environments (Jack and Wibberley, 2014). Especially if this is in a non-judgemental setting with someone who would actively listen, as in that study.

Another aspect of this chosen framework is the consideration of embodied aspects of experience and phenomena (Finlay, 2011; Blank, Finlay and Prior, 2016). As was argued earlier, the expectation is that student nurses will immerse themselves in the emotive, mental

and physical dimensions of people's care (NMC, 2018a). Resilience itself is very wrapped up within an individual or community's state of mind and wellbeing too (Hart, Blincow and Cameron, 2012; Hart et al, 2016). Thus this particular type of phenomeonology is thought to be appropriate for all of these reasons.

3.2.1 Underpinning Philosophy

As part of the earlier EdD modules, I had been introduced to the works of Hannah Arendt, amongst other writers, as part of philosophical theory underpinning research (Robson, 2011). The more I read of 'The Human Condition' (1988) and 'The Life of the Mind' (1981), the more I was drawn to her style of hermenuetic phenomenology and essentially, study of people. I found her writing accessible, understandable and in keeping with my interpretivist lens (Robson, 2011; Thomas, 2013). I began to see possibilities for accessing seemingly intangible concepts from participants, by exploring their thoughts on resilience in order to better understand objects as they appeared to them as people (Arendt, 1981).

Arendt (1988; 1981) considered the following important in exploring phenomena; reflection on every day experiences in order to interpret them, the use of metaphors to bridge the gap in investigating phenomena, consideration of time, context, space and emodied aspects of life. All very much in keeping with phenomenology and IPA (Smith, 2011). Equally, I admired her life story, which appears to show her as a resilient human being. Indeed for IPA, the philosophy underpinning the research design is as important as the chosen design selected to undertake the actual research as it informs the holistic approach to the project (Smith, Flowers and Larkin, 2009). This is achieved by researchers engaging with the appropriate philosophy and theory to inspire their research (Eatough and Smith, 2017).

According to Borren (2013), Hannah Arendt has more than any other phenomenologist explored the intersubjectivity of 'being in the world'. However it is the context and content of that lived experience which it is important to recognise (Borren, 2013). This thesis aims to

explore an understanding of resilience through the use of IPA and is informed in its philosophical approach by the thoughts of Arendt (1988;1981). This fits both the methodological stance and the object of interest (resilience) which could be stated to reside in the mind of the participants. It is noted that IPA draws on an interpretation of data to make manifest what has previously been hidden (Wagstaff et al, 2014). This interpretative methodology can be utilised to gain access to the inner cognitive world of the participants if applied carefully (Biggerstaff and Thompson, 2008). As most resilience work occurs in the mind, this appears appropriate (Robertson, 2016).

Arendts' background is of interest from a resilience and research perspective as she was a German Jew who studied with one of the forefathers of phenomenology, Martin Heidegger (Peterson, 2001). A seemingly resilient survivor, as a displaced person residing later in America. Her work on understanding the experience of others in hermeneutic phenomenology and in exploring the 'Life of the Mind' (1981), or inner psyche are of interest here. In this instance, in terms of accessing the thinking processes involved in understanding and formulating resilience. IPA is often interested in matters of thought and/or emotional experiences (Eatough and Smith, 2017).

Arendt (1981) questioned whether phenomena are ever truly quantifiable or empirically measurable especially in relation to matters concerning thinking, willing or judging, as such attributes reside within the hidden unseen life of the mind. Her work consistently values the sense making experience of thought, observable only in a given *'space of appearance'* after interpretation by the observer (Borren, 2013). Therefore the discourse with participants in this instance would create the space of appearance encouraged by myself as researcher. For it is only through the disclosure of self and others that reciprocal recognition of experience and being human, can associated meaning occur (Arendt,1981; 1988). Hence the IPA process

influenced by some of Arendt's work appears appropriate here, to explore what aids the development of resilience, especially in participant and researcher discourse (Peterson, 2001).

For me, it is actually within this existing relationship and through the documentation and interpretation of the experience that the plurality of stories or multiple perspectives on events can be captured (Vasterling, 2007). IPA celebrates both the unique or singular experience but searches for any collective or shared commonality within these accounts (Smith, Flowers and Larkin, 2009). Consequently new knowledge may be generated which can be applied to theory development or practice. Phenomenological research acknowledges the very subjectivity which was derided by a more traditional science paradigm as it was exactly that which was sought- a unique, meaningful disclosure regarding a complex phenomenon (Arendt, 1981; Borren, 2013). As every student nurse's experience is different this approach searches for the unique and shared experience.

Arendt (1981) warns though that the mind itself may try to keep some inner thoughts or things hidden or masked from both the self and others. This I consider as unavoidable, needs acknowledgement and is a feature of all research involving self-reports (Cleary et al, 2018). Afterall everyone is concerned with self-presenting a favourable impression of themselves which affects behaviour, especially if what is expected of them is mandated by societal or professional norms (Leary, 2003). A researcher therefore needs to be mindful of this, but through sensitive communication, disclosure may be more frank and honest (Smith, Flowers and Larkin, 2009).

Ultimately though, through application of the double hermeneutic cycle, the researcher's interpretation ultimately awards meaning in IPA, which could be at odds with a participant's intended meaning (Wagstaff et al, 2014). Although Arendt was adamant that the rights over one's own life story are not solely the property of the author (participant) (Borren, 2013). It is

more so that we are shaped by the world, of education and practice here, whilst shaping it (Borren, 2013). In doing so, we are recognising the symbiotic nature of our relationship as beings in the world (Arendt, 1981); or student nurses undertaking their pre-registration nursing course in this instance. Indeed in IPA, the researchers' perspective is a legitimate part of the enquiry (Biggerstaff and Thompson, 2008). To counter researcher bias though, reflexivity through critical self-awareness of one's position on topics, here resilience, is part of every step of the research process (Finlay, 2002). Reflexivity is a requirement of professional practice and therefore this type of methodology lends itself to practitioners in both health care practice and education (Finlay, 2011).

This project could be viewed as an opportunity for student nurses to articulate the lived experience of nurse education, particularly in terms of resilience strategies which have shaped them, assuming that they have been. Thus informing the future development of other education frameworks via curricula development (Stephens, 2013; Carroll, 2011).

3.2.2 Research Design

The research design is a "*superstructure that governs the way that research proceeds"* (Thomas, 2013, p 187). This case study (Robson, 2011), was targeted at final year student nurses who had experienced the six practice modules and all theoretical components of the course. Appendix Four is an example of the nursing course plan within my own Institution which demonstrates the theoretical and practice requirements across each year for the participants in this thesis. Moreover this ensured that the participants would have experienced all aspects of the course and that they were successfully completing all components, which would be suggestive of resilience formation (Carroll, 2011).

At the heart of the research design was the aim of understanding resilience from the student nurse perspective and how they ascribe meaning to their experiences (Biggerstaff and Thompson, 2008). At the design stage there were several ethical issues that needed to be

addressed in order to protect potential participants when investigating sensitive topics (Davydov et al, 2010). This is especially true when the researcher was part of their world or Faculty (HRA, 2017). Essential to this research design was that adult nursing student representatives guided the development of the study from a participant perspective. These were volunteers who responded to an advert on the online learning platform in order to listen to an outline of the purpose of the study, chosen methodology, design and methods (Thomas, 2013). Thereby potentially aiding reflexivity in the pre-research phase of the project by enabling me to sense check any bias in the design and bracket my thoughts on resilience to one side, so as not to lead the direction of the study (Finlay, 2002). This approach was considered as best practice when conducting research with potentially vulnerable people (HRA, 2017; Grant and Kinman, 2013a). A steering group of student nurses could thus mitigate against any researcher power imbalance or bias in developing the design (Smith, Flowers and Larkin, 2009; Robson, 2011).

Another feature of this research design was aimed at aligning with the research/teaching strategy of the University (2015-2021). Also noting wider best practice in HEI research teaching by offering an opportunity for students to be active participants in research by critiquing teaching and learning approaches (McLinden et al, 2015). Hopefully increasing their research knowledge and experience through inclusion in a research project, thus in keeping with professional body guidance in this area (NMC, 2018a).

Some may argue that it was not ideal for a nurse educator to be conducting research with one's own students, however it is also noted that practitioners, with the requisite interpersonal skills, are used to dealing with the thorny problems of real world research (Robson, 2011). Indeed an IPA researcher should aim to enter the life worlds of the participant rather than simply just investigate it (Eatough and Smith, 2017). It was imperative that this particular unique values based curriculum and support mechanisms, which Faculty believe are creating

compassionate yet resilient practitioners, was accessed to investigate this phenomenon. This is due to the fact that it is the curricula at my own Institution that I can influence in response to the findings. I am a former critical care nurse who was used to breaking bad news to grieving relatives and a professional who deals with some emotive student issues on a daily basis. Therefore, I believed that I had the necessary skillset to undertake this part of the research (Tweedlie, 2013). For an IPA design, it is often preferred that the researcher has knowledge of the area to be investigated and emotional experiences are one of the most prominent prevailing themes in the literature in this field (Smith, Flowers and Larkin, 2009; Wagstaff et al, 2014). My previous relationship with the targeted cohorts was deemed to be favourable by the steering group and became an advantage in creating the open space necessary for open and honest dialogue (Bondi, 2016; Finlay, 2002).

Essential to the research design was the plan or timeline for enacting the various stages of the research. Please see Appendix Five for dates and more detail regarding the exact timeline. It was an academic requirement of the EdD to undertake a research proposal outlining the research methodology, design and methods (Thomas, 2013). Indeed, this was a vital point of the planning phase allowing for feedback and clarification from supervisors and second markers which would inform the final project (Gerrish and Lacey, 2015).

To build on this work the steering group of student representatives was then held. This was vital to deal with ethical components of the work, as discussed, only once the design and research methods were amended post group review, was ethical approval sought. Appendix Six details the requisite approval which then allowed for data collection to commence. This work actually underwent two ethical approval processes. The initial being through the awarding academic institution and the second in the institution where the researcher accessed the participants. By undertaking the ethical review processes the integrity of the research design should be assured (Macfarlane, 2009).

Interviews took place across an eight month period and these ran concurrently with transcription, which I performed alongside initial analysis of the data. During this time I attended an IPA advanced data analysis workshop conducted by Adele Dickinson and Paul Flowers (2017), which was invaluable to performing the in-depth data analysis over a further year or so.

3.3 Methods

The next section will outline the research tools or methods utilised as part of the research study. These include the recruitment strategy, data collection tools (Appendix Seven) and data analysis phase. However, to summarise for transparency, I conducted the research as follows; participants were recruited from an advert via the HEI online learning platform. They consented to semi-structured interviews which were conducted, audio-recorded by digital dictaphone and transcribed by myself. I began early analysis whilst transcribing, noting initial thoughts as per the Six Step Approach (Flowers, Smith and Larkin, 2009), later outlined. Transcription sheets were then amended into the template as described by Dickinson and Flowers (2017), examples below and in Appendix Eight.

Analysis was done by hand, by writing thoughts on description, language and analytical interpretations into the templates. Photographs were taken by mobile phone throughout this process to audit the journey, as per Appendix Eight. From each participant's analysis a document was drawn up summarising the main findings on a case by case basis, using Smart Art images and tables per interview question (Appendix Nine). I then cut up each document and collated responses per interview question on display boards in a room at my HEI (Appendix Ten). This allowed for collation of the data across cases or participants and enabled me to spot the overarching subthemes (Biggerstaff and Thompson, 2008). I wrote these up on white boards and took photos to later write up as the key findings. Throughout, I checked and re-checked the transcripts for accuracy throughout the analysis and write up

phase of the project (Tomkins and Eatough, 2010). I now articulate and justify each of these methods.

3.3.1 Recruitment Strategy

The recruitment strategy (Bowling, 2009), focused on purposive sampling aimed at recruiting 6-8, 3rd year adult student nurses from two different cohorts who had experienced most of their course and had the opportunity to engage with all of the available educational strategies. In keeping with qualitative studies, which aims at collecting and analysing rich in-depth data, the numbers aimed for were small (Gerrish and Lathlean, 2015). This is recommended for IPA studies where the focus is on detailed idiographic interpretation of small case studies of people experiencing the same phenonmenon (Smith, Flowers and Larkin, 2009). Institutional requirements of the thesis also affected the amount of data that could be analysed and presented for this work (UoB, 2018). Similar methods have been used to good effect with such numbers previously and more recently in nursing and midwifery educational research (Melia, 1982; Clohessy, McKellar and Fleet, 2019). Particularly where there is only a paucity of information known regarding the phenomenon (Finlay, 2011).

To avoid coercion, recruitment posters advertised the opportunity to potential participants via the online learning platform. However, the requirement to obtain gatekeeper approval, to access the participants also served to protect them from unethical research. Homogeneity of the group was encouraged as they would all be at the same stage of their course (Smith, Flowers and Larkin, 2009). Homogeneity was thought to support cohesive theme and theory building from the findings of the research (Miles, Chapman and Francis, 2015). However, it is also argued that homogeneity can never be achieved (Wagstaff et al, 2014). Indeed it is the multiple perspectives on a phenomenon that is celebrated in IPA (Larkin, Shaw and Flowers, 2018). Moreover the adult nursing cohorts are very diverse in terms of culture, age and socio-economic background. Despite this they are homogenous in their exposure to the same

education framework and PLE locations. Their unique perspectives are still important to this design as it was a plurality of voices as described by Arendt (1988), which was sought to understand the meaning of their lived experience.

Specific demographic details regarding participants though were not collected for two reasons. Firstly in order to protect confidentialty in a small group of participants (HRA, 2017; King, Horrocks and Brooks, 2019). Secondly as this design did not seek to establish any relationships of co-variants or any correlates of resilience (Rees et al, 2016). This has been the focus of previous research. However in order to aid understanding of the participants' 'life worlds' a 'pen portrait' for each participant follows. Providing this level of detail aims to make the participants *'more alive and present'* by contextualising or personalising the write up of their data (King, Horrocks and Brooks, 2019, p189). Pseudonyms are allocated to the participants to protect confidentiality (Gerrish and Lathlean, 2015). It was key to establish what proximal (factors close to the students) influences the participants faced as part of their experience on the course (McLinden, 2017).

Sarah, an end of 3rd year student on the BSc Adult Nursing, was a mature student who has already obtained a first degree and worked in the marketing sector prior to changing career. She was not born in the UK but has lived here for several years. She has undertaken care work to support herself during the course.

Martha, an end of 3rd year student on the BSc Adult Nursing, was a mature student who has children and previously worked in a care home prior to commencing the course. She was not born in the UK but has lived here for several years. She had to undertake extra academic qualifications to meet the entry requirements of the course.

Cathy, an end of 3rd year student on the BSc Adult Nursing, was a mature student who previously worked in the financial industry prior to commencing the course. She had to

undertake extra academic qualifications to meet the entry requirements of the course. Cathy worked in the health care sector in order to provide herself with financial support. She lived in a different area and travelled a distance to the PLE and University.

Jayne, an end of 3rd year student on the BSc Adult Nursing, was a direct entrant from sixth form onto the course. She had moved to the area, living in student accomodation, for the duration of the course. Her family and partner lived a significant geographical distance away.

Natasha, an end of 3rd year student on the BSc Adult Nursing, was a mature student with a family. She had to undertake extra academic qualifications to meet the entry requirements of the course. Natasha has worked in other jobs including health care support work prior to and during the course.

Julie, an end of 3rd year student on the BSc Adult Nursing, was a mature student with a family. She was a qualifed nurse for 10 years in her home country and moved to the UK a few years ago, where she had undertaken care work since starting the course. She had to undertake extra academic qualifications to meet the entry requirements of the course.

Lorna, an end of 3rd year student on the BSc Adult Nursing, was a mature student with a family. She had previously commenced a first degree and has worked in other jobs including care work prior to and during the course.

3.3.2 Data collection instruments

I utilised a semi-structured interview as the primary data collection method which encourages the particpant to reflect on and attribute meaning to an experience (Hart, Blincow and Cameron, 2012). The existing relationship between researcher and participant was harnessed to create a dialogue to enable this research conversation (Heyman, Webster and Tee, 2015). The researcher then further translates, interprets and analyses the meaning of the

spoken word from a digitally recorded interview and thus the transcribed word following documentation of the interview recording (Denscombe, 2010).

Whilst there is no predicated ideal number in terms of optimal sample size in IPA research, in practical terms a sample size of 6-8 was initially aimed for (Smith, Flowers and Larkin, 2009). This is in keeping with this type of qualitative research which generates large datasets in the form of transcripts (Finlay, 2011). The rigour and depth of analysis required for each participant's dataset is fundamental to this methodology (Wagstaff et al, 2014). As each idiographic case is dealt with in its entirety prior to moving onto the next participant, the transcription must be meticulously accurate (Biggerstaff and Thompson, 2008). Therefore for every one hour of interview, seven hours was spent on transcription on average by myself (Smith, Flowers and Larkin, 2009). Seven participants volunteered to participate in this study. Each spoke freely regarding their resilience journey with apparent honesty.

The fact that the researcher was well known to them appeared to augment rather than inhibit this process (Heyman, Webster and Tee, 2015). This allowed for the requisite plurality of meaningful experience to be captured whilst being achievable within the academic framework of this study (Clancy, 2013; Blank, Finlay, Prior, 2016). The participants appeared to make the most of the research opportunity afforded to them in order to articulate their experiences of the curriculum to influence future educational strategies. They had a real desire to improve the nurse education experience for others.

Due to the potentially sensitive and emotive nature of the topic to be explored; disclosure, signposting to support and anonymity was explictly dealt with in the particpant information sheets, consent forms and interview process itself (HRA, 2017). Specificity was also required regarding at which point it was practical for the particpant to withdraw, as once data was

anonymised, analysed and incorporated into the findings and presented as the thesis, this becomes more difficult (Smith, Flowers and Larkin, 2009).

The questions used in the semi-structured interview were developed based on current resilience knowledge and in partnership with the steering group which facilitated the discourse on resilience. This can be found below in Table 3. The group did change one or two questions on the interview schedule into more familiar language. In doing so they stated categorically that they felt other students would feel comfortable speaking about the topic with myself, due to the existing relationship. A finding recognised in previous field or insider research (Clancy, 2013). Additionally, in order to protect against potential positional power bias prior to interviews commencing, it was also agreed that a researcher statement was read out. The purpose of this was to remind the participant that I would be appearing before them in a different role, that of researcher, with a different purpose, for transparency (Jack and Wibberley, 2014). Previous supervisor and marker feedback on the research proposal, which contributed to the research design, also helped formulate the questions in alignment with the overall aims and objectives of the project. This was the case for question number 7, in particular.

Table 3 Interview Schedule post steering group input and supervisor feedback

Question	**Prompt**	**Mapped to Resilience Research Waves and thesis research questions**
1. What do you think is meant by the term resilience in nursing?	Why is this needed?…	Fourth wave- RQ 1 and 4.
2. How do you think this can be developed?	Any challenges to maintaining this?	Fourth wave- RQ 1 and 4.
3. Is there anything within the course that has helped you in terms of your resilience?	Either in practice or theory (PLE or HEI setting)	Second wave- RQ 2, 3
4. Is there anything outside of the course that has helped you in terms of your resilience?	Family, friends- what helped you?	Second wave- RQ 2
5. What will you use in the future to stay resilient?	Current coping mechanisms, support from peers,	Third wave- RQ1-4
6. What other support could be provided on the course to promote resilience within student nurses?	Any interventions particularly From other Institutions/fields of practice or disciplines	Third wave- RQ 3
7. On a scale of 0-10 how resilient would you score yourself now?	What do you normally run at?	Fourth wave- RQ 1-4

The reason behind exploring the participants' current state, in a more numerical score, was to create a discussion point to check whether resilience was static or fluctuates and where they were on their journey in terms of resilience near the end of the course. Obviously the score is a basic quantitative measure of resilience (Windle, Bennett and Noyes, 2011). However it was used in this instance as a trigger to further explore what resilience means to them, in a qualitative sense, in order to capture their feelings on their experience (Jirwe, 2011). In terms of whether the participants are resilient individuals at the end of the course or their journey, the scores spoke to the fact that they can articulate how resilient they felt at a point in time (at interview here). Successful completion of the course and transition into the workforce would be another measure (Rees et al, 2016; HEE, 2018). Questions 3, 4 and 6

were also designed to consider those proximal (close to the participant) and distal (situated away from the participant) influences on the participants' experience at various levels within and outside of their control (McLinden, 2017).

Interviews took place within the University in pre-booked small meeting rooms to provide a mutually convenient accessible location which was conducive for a research conversation (Thomas, 2013). The data collection period occurred over an eight month period and interviews were undertaken at the participants' convenience. On reflection the interviews felt like a conversation and flowed easily with little, if any, prompting with the questions acting as a focus for that discussion. Perhaps the prior relationship made this process easier but I found the level of rich detail provided and personal nature of the information shared very humbling (Finlay, 2002). The interviews were conducted as an ongoing dialogue and afforded many opportunities to check my understanding of the points made. Strategies such as member checking, continuous self-reflection and outsider checking were used (Dowling and Cooney, 2012). This was in order to counter any false assumptions likely in insider research where both the participant and researcher have pre-existing knowledge of each other (Asselin, 2003).

Confidentiality was protected and participants could withdraw up to one month from interview. Transparency regarding all aspects of the research was deemed to be clear in the participant information and consent forms by the University Ethics Committee who reviewed the research proposal (Economic Social Research Council, 2015). General Data Protection Regulations (Information Commissionaires Office, 2018) guidance on storage of research material both identifiable and anonymised has been adhered to.

Key to protecting the participants was to provide debrief at the end of the interview to allow participants to ask any questions about the study and to be provided with support

should they need it (Finlay, 2011). Often we talked further about some of the more traumatic incidences that they experienced, but with my role moving from researcher back to that of nurse educator, encouraging reflection and learning from these episodes to aid their nursing practice. Whilst being mindful to signpost to counsellors, chaplains or mental health advisors as required (HEE, 2018).

3.3.3 Data Analysis- Application of the IPA process

The next section will demonstrate the application of this method to the data in order to provide transparency, which is criticised by some as lacking in this type of research (Paley, 2017). This is both part of an audit trail for clarity and to demonstrate my journey in undertaking IPA. Those using a phenomenological or indeed any qualitative approach are often charged with being less than clear as to how the analysis phase was conducted (Pringle, Hendry, McLafferty, 2011).

Reflexivity is a fundamental component of the analysis phase (Biggerstaff and Thompson, 2008). This practice enabled emotions and decisions at the thematic analysis stage to be accounted for whilst performing the hermeneutic circle of interpreting further the participants' understanding of the experience (Finlay, 2011). Therefore a reflexive diary was kept by myself, throughout the process, to aid suspension of critical judgements and engagement with the data at the transcript stage (Biggerstaff and Thompson, 2008). Distancing was also used in the form of stepping away from the analysis and write up phase for periods of time (Clancy, 2013).

Detailed descriptions of the application of IPA from the researcher's perspective are scarce possibly because this is a relatively new research method (Wagstaff et al, 2014). The application of the methodology has also been criticised at length by John Paley, (2017). For example by encouraging a lack of accuracy by the researcher and for quite simply of "*making things up"* from transcript to findings. Paley (2017) also disputes that findings *"emerge"*

from the data arguing that phenomenological researchers implant themes based on pre-read theories. To that end both an idiographic and the group analysis process will be presented in this chapter with specific concrete examples to illustrate techniques (Blank, Finlay and Prior, 2016). To be clear I used theory, in the form of the Resilience Framework (Hart, Thomas and Blincow, 2012), in the final analysis and writing up phase of this thesis to further an understanding of resilience from the participants' perspective, but not in the initial analysis phase (Robson, 2011; Smith, 2011).

This method differs from other thematic analysis in that it is the idiographic case that is important initially (Biggerstaff and Thompson, 2008). However, there is no one preferred method of performing IPA. Text from the interviews in terms of quotes will be utilised in Chapter Four to demonstrate how conclusions were reached regarding interpretation of the participants' narrative (Smith, Flowers and Larkin, 2009). Those using IPA also attempt to place an interpretation of the participant's voice within the wider context of social, cultural and theoretical issues (Wagstaff et al, 2014). These will be addressed in the findings and discussion chapters.

Whilst there are many different ways to analyse qualitative data (Robson, 2011; Thomas, 2013), the non-prescriptive themative analysis involved in IPA was chosen for its relative flexibility and ease of use for the first time researcher using this method (Smith, Flowers and Larkin, 2009; Finlay, 2011). Authenticity of the particpants' experience is recognised in this approach (Miles, Chapman and Francis, 2015). Yet the prior knowledge and context of the researcher in terms of the education framework in the curriculum is also recognised in this methodology and accounted for (Smith, 2012). A detailed six step narrative analysis of the transcripts and presentation of verbatim quotes will add to the veracity of the work and claims regarding identification of themes (Smith, Flowers and Larkin, 2009). As a novice in this type of research, it was reassuring to follow a process (Dowling and Cooney, 2012;

Finlay, 2011). This approach is outlined below in Table 4 in terms of the data analysis process.

Table 4 The Six Step Analyis Process

Steps for Analysis	**Details of the process**
1) Reading and re-reading the data	All transcriptions were performed by myself and involved repetition of listening to the participant's voice and then checking for accuracy
2) Initial noting of the transcript	Informed by attendance at Dickinson and Flowers (2017) workshop; description, language and analysis formulae utilised **Examples provided in this chapter and Appendix Eight**
3) Developing emergent themes	Initial word documents drawn up per participant, using images and tables in relation to the interview schedule **Example provided in Appendix Nine**
4) Searching for connections across emergent themes	Per interview question, frequency of language used and resultant analysis **Examples provided in Appendix Eight**
5) Moving to the next case	Above process repeated for each participant after interview
6) Looking for patterns across cases	Use of a room at the HEI with display boards to visulise all word documents, all word documents deconstructed per research question and then collated themes displayed via white boards **Evidence provided in Appendix Ten**

Data analysis is described by Thorne, Reimer Kirkham and O'Flynn-Magee (2004) as the most complex part of phenomenological research. When moving to the identification of patterns across cases this can leave the researcher with a dilemma as to which themes to include and which data to exclude (Wagstaff et al, 2014). This is the stage that took the most time and over which I agonised as to whether I was being true to the participants' lived experience. However using reflexivity to bracket off my thoughts on the curriculum and frequently revisiting the transcripts for accuracy, enabled me to make decisions on which were the most powerful shared themes (Clancy, 2013; Smith, Flowers and Larkin, 2009).

Management of data, in terms of organisation, was key as this type of data collection can result in lengthy transcripts. This can leave the researcher with a sense of a 'deep bowl of spaghetti'(Wagstaff et al, 2014) and hence difficult to analyse. Whilst software does exist to aid narrative analysis and data management (Thomas, 2013), my preferred learning and writing style involves being close to the literature immersed in the data and not potentially at a distance (Robson, 2011). Smith, Flowers and Larkin (2009) do not recommend computer programs for the novice researcher unless it is a preferred working style. Whilst interpreting the text I needed to surround myself physically with the material (transcripts) once anonymised so that nothing remained hidden from my mind (Arendt, 1981). The reflective processes required to analyse and present the findings was enhanced by this approach too (Kolb, 1984). For I too needed to protect myself by working to my strengths (Petre and Rugg, 2010).

I found that it created some issues in terms of analysing the data, as there was a copious amount, I felt conflicted as to how to give equal voice to the participants throughout this thesis (Smith, 2011). Each of the participants are valued in this work and their voices are of equal importance to me in terms of understanding their experiences of resilience during their nurse education. Thereby providing a particular instance of a lived experience in the

spirit of phenomenological research (Huff et al, 2014). In order to demonstrate the approach undertaken in both phases of the research process, one participant's interview transcripts are shown below to demonstrate the process. Examples of others can be viewed within the appendices. My IPA skills had probably developed by this point and there are several poignant passages which make it easier to demonstrate the link between analysis and findings. Perhaps my interview technique had also been refined by this stage (Robson, 2011). Or the researcher-participant conversation was developed based on previous knowledge of each other (Thomas, 2013).

The interview with Lorna (the transcript example below) was my final one and lasted 1 hour and 6 minutes. Although not the longest, the data was rich in providing the details (Braun and Clarke, 2006) of the lived experience of a student progressing through their nurse education. It also demonstrates how honest Lorna appeared regarding challenges to her resilience during the course. Lorna was very articulate and able to express her lived experience when sharing her observations without prompting. The interview progressed more as a conversation, with the interview schedule serving as a basis for discussion as the narrative developed throughout the interview (Thomas, 2013). I share Lorna's response as I reminded her of the consent and participant information at the beginning of the interview to illustrate the context of the interview in terms of openness,

"I trust you implicitly…" (Lorna; transcript 7, page 1, sentence 1).

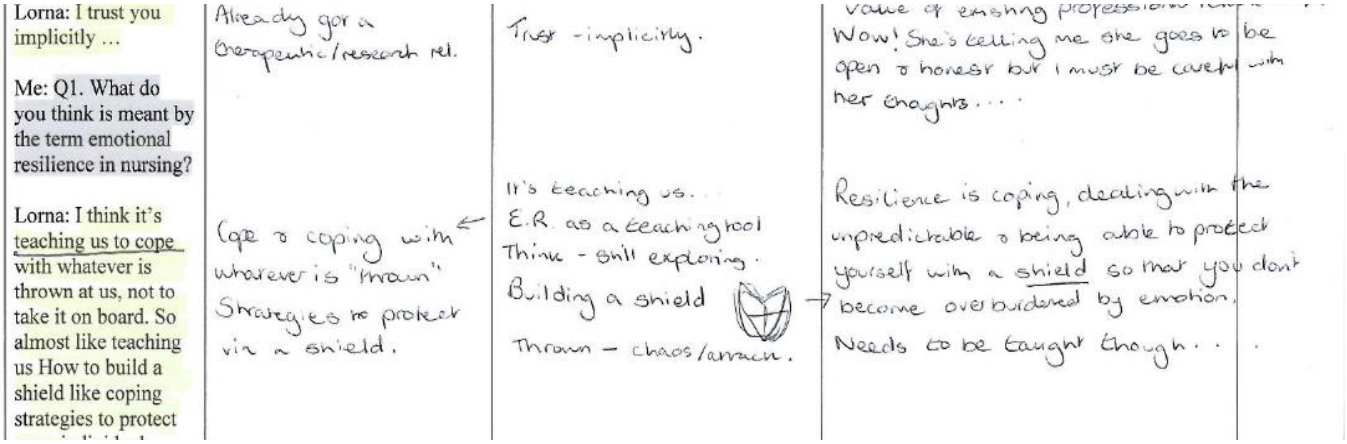
This set the scene and allowed a rapport to develop whilst demonstrating trust and an appreciation of the opportunity for Lorna to tell her story (Biggerstaff and Thompson, 2008). It enabled her to talk through the issues associated with developing or maintaining resilience from her past and within the course. From a reflexive point of view this made me very aware

of my duties to Lorna and all of the participants in terms of protecting confidentiality and respecting their perspectives.

For coherence I used the template suggested by Smith, Flowers and Larkin (2009) for all of the analyses which reduced the written transcripts to the descriptive, key language noted and analysis components in three columns**.**

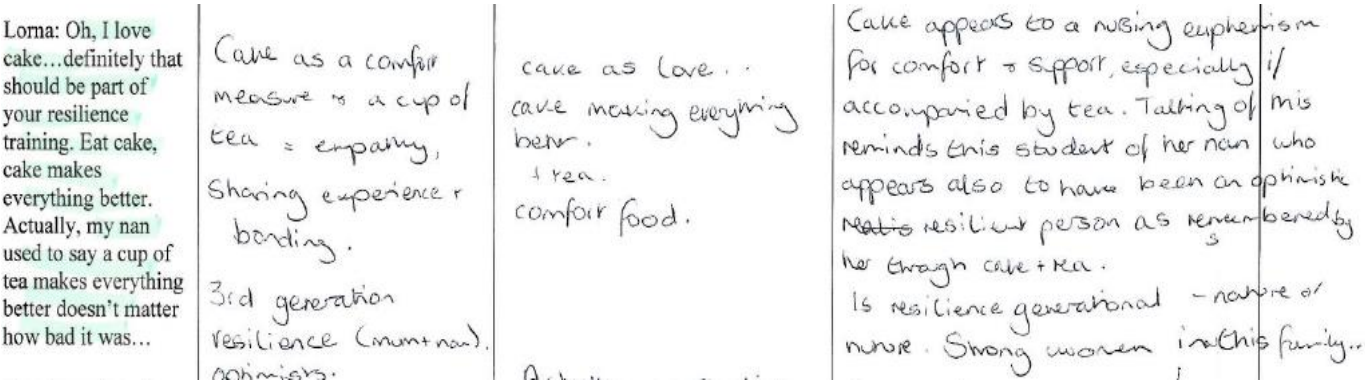
Extract 1.0 Lorna's understanding of resilience

Transcript Description Language used Analytical interpretation

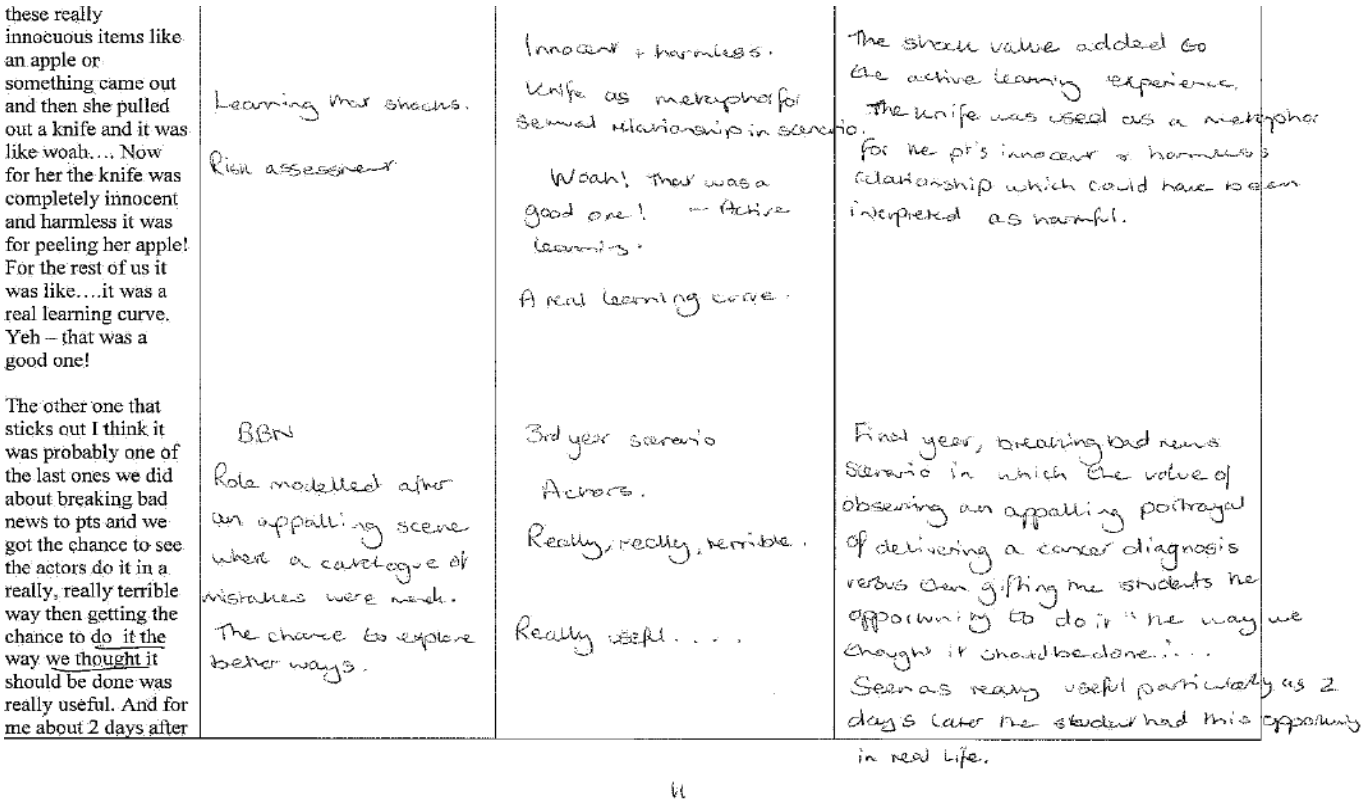


Extract 1.1 Lorna- Cake as comfort

Transcript Description Language used Analytical interpretation



Extract 1.2 Lorna-Immersive Simulation with actors



Transcript	Description	Language used	Analytical interpretation
these really innocuous items like an apple or something came out and then she pulled out a knife and it was like woah…. Now for her the knife was completely innocent and harmless it was for peeling her apple! For the rest of us it was like….it was a real learning curve. Yeh – that was a good one!	Learning new skills. Risk assessment	Innocent + harmless. Knife as metaphor for sexual relationship in scenario. Woah! That was a good one! – Active learning. A real learning curve.	The skill value added to the active learning experience. The knife was used as a metaphor for the pt's innocent + harmless relationship which could have been interpreted as harmful.
The other one that sticks out I think it was probably one of the last ones we did about breaking bad news to pts and we got the chance to see the actors do it in a really, really terrible way then getting the chance to do it the way we thought it should be done was really useful. And for me about 2 days after	BBN Role modelled after an appalling scene where a catalogue of mistakes were made. The chance to explore better ways.	3rd year scenario Actors. Really, really, terrible. Really useful….	Final year, breaking bad news scenario in which the value of observing an appalling portrayal of delivering a cancer diagnosis versus then giving the students the opportunity to do it "the way we thought it should be done…"…. Seen as really useful particularly as 2 days later the student had this opportunity in real life.

In these three examples the analysis is broken down into a description of the data, the language used and then the analysis. These examples serve to highlight the process that was applied to each participants' data. Steps 1 and 2 were relatively straight forward but time consuming. As I transcribed all interviews, I listened and re-listened as well as read and re-read the transcripts whilst typing them up. Constantly checking and re-checking for accuracy of the words, inflections, tone and meaning took time but was an essential part of this process (Smith, Flowers and Larkin, 2009; Biggerstaff and Thompson, 2008). I became fully immersed and my familiarity with the data grew accordingly (Robson, 2011). By examining the transcript for emerging themes, Step 3, question by question as per the interview schedule, this subsequently generated key themes.

I then collated the main themes by research question into a Word document per participant in order to scrutinise the text, step 4 (Chenail, 1995). As part of this process, as a visual learner, I began using tools such as Smart Art as well as tables to present the connections across themes. This non-standard, creative approach to collating the data is encouraged with regard to IPA (Wagstaff et al, 2014; Smith, 2011). A spatial representation of the discourse enabled super-ordinate and sub-ordinate themes to be identified using abstraction and subsumption as some themes overtook others (Smith, Flowers and Larkin, 2009). In the participant specific collated word document, speech bubbles were used for poignant quotes and images were used to represent key points made by each participant. I used imagery as a visual learner and thought such symbols may be effective if used in each idiographic data analysis to enable comparison across the group when the time came (Chenail, 1995). Please see appendices for evidential record of this process.

I was looking for the "hidden or secret gems" (Smith, 2011, p6) in amongst the overwhelming data which could symbolise the meaning of the experience to the participant. Often not visible on first reading, summarising key points in tables and illuminating quotes in speech bubbles enabled the status of the phenomenon revealed to be defined in terms of its importance (Smith, 2011). In contrast to the "shining gem" (Smith, 2011, p6) which was explicitly mentioned, or the "suggestive gem" (Smith, 2011, p6), which was partially revealed by the participant.

3.3.4 Collating the findings

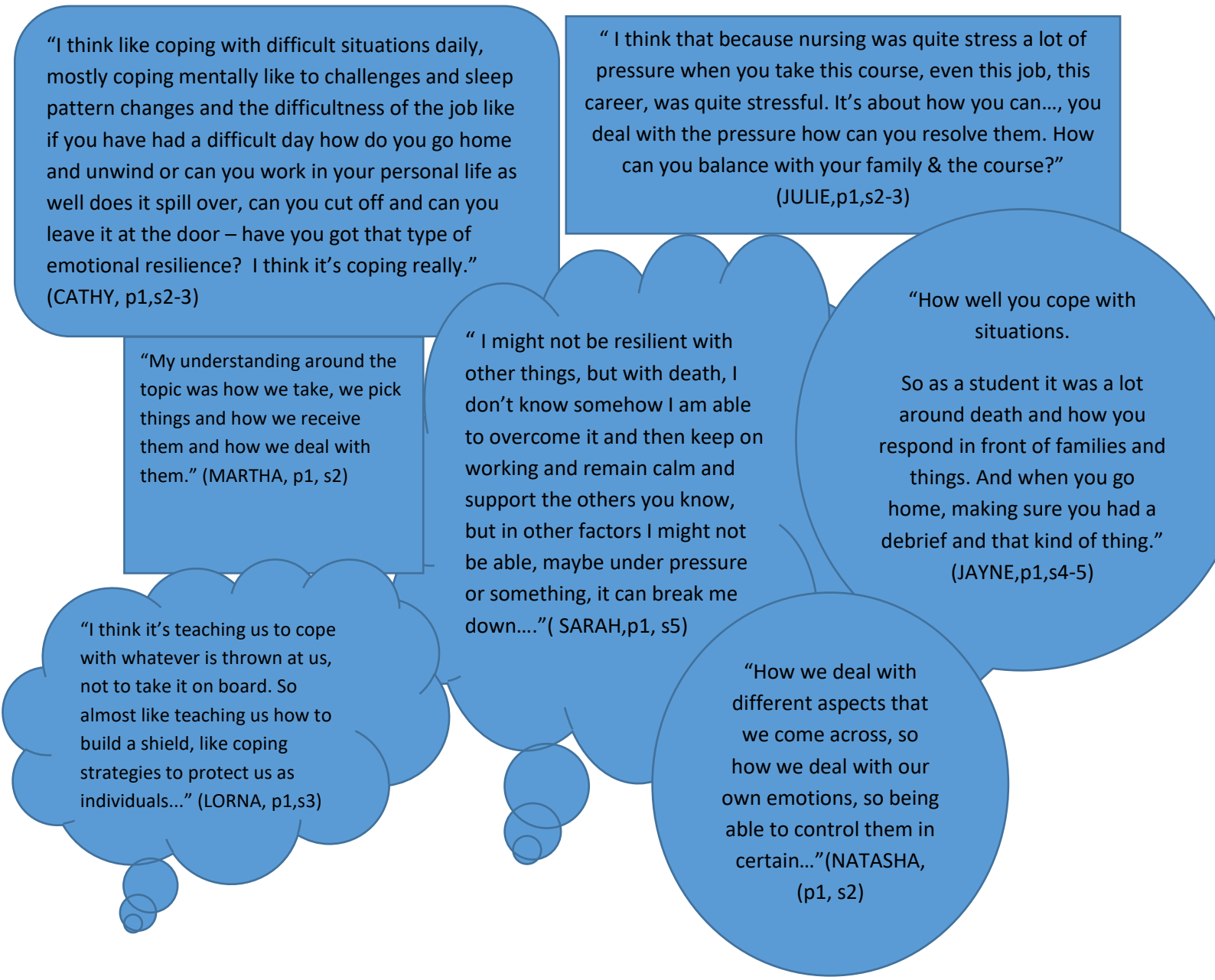
By summarising the analysis in this format I could draw all of the Smart Art figures and tables together to extract the superordinate and subordinate themes across the individual datasets for Step 6 (Smith, Flowers and Larkin, 2009). To progress this stage a room at the HEI, within which I work, was booked and display boards were used to enable a visual synthesis and creation of themes per question. This resulted in superordinate themes

represented in diagrams on white wipe boards. Digital photos were taken of this work at various stages via my mobile phone (see appendices for evidential record). This approach allowed for transparency, an audit trail of the method employed and helped with data construction to highlight key themes (Chenail, 1995).

I was able to visualise the key points, made by the participants as individuals, and interrogate the descriptive elements through interpretative analysis (Smith, Flowers and Larkin, 2009). This enhanced the identification of shared themes and locating differences within the participants' experience. Figure 3.2 illustrates the technique undertaken to collate data across the group.

By presenting these quotations it is hoped that transparency, for the method of analysis regarding the participants' understanding of resilience, is outlined (Thomas, 2013). However in order to check for accuracy and contextualise the wider articulation of this phenomenon, I delved into the transcripts more deeply to identify other instances where the participants talked about resilience throughout the interviews (Robson, 2011). This rigorous interrogation of the data was necessary to quantify the exact use of language and prevent my prior conceptions steering the direction of theme development (Paley, 2017). Anonymity in quoting from transcripts was protected by allocating a pseudonym to participants (Bowling, 2009).

Figure 3.2 Understanding resilience using the voices of all of the participants



Paradoxically, by reconsidering the participant voice, this further allowed for application of the hermeneutic circle by adding more interpretative analysis to their personal meanings of resilience. The language used in the interviews was carefully considered. As stated earlier, this was key to hermeneutic interpretation and analysis (Arendt, 1981). This approach was taken throughout the collation and further analysis process.

3.4 Limitations

There were key challenges to using this methodology such as the amount of resulting data created by the idiographic approach. Also as to whether I was doing justice to each participant's journey in terms of equally valuing their input by choosing quotes in a representative manner (Smith, Flowers and Larkin, 2009). In addition to this, the process required time, energy, attention to detail, application of reflexivity and as part of this, dealing with feelings of guilt regarding weighing the value of each participant's response (Bondi, 2016). Despite this, the themes in both the idiographic and group findings tell powerful stories which are open and honest, demonstrating their professional values. I believe this shows the potential use of IPA in future nurse education research. Self-doubt, regarding the application of the methodology, was also experienced. However, excellent support was received from supervisors, colleagues and experts in the field of IPA. The time and attention invested in the analysis phase of the research has resulted in useful data which reveals how an understanding of resilience may be of use in educating student nurses or other health care professionals.

This is a small scale project conducted at one UK University which investigated the lived experience of just seven individuals exploring resilience in relation to a pre-registration nursing programme. The findings therefore may not be transferable to other people, contexts or communities (Finlay, 2011; Blank et al, 2016). The aim of the research though, was to explore unique understandings of resilience, including the barriers and the aids to building resilience in a specific time and place. Establishing ways in which resilience was taught and experienced within the curriculum has enabled some theory building for future curriculum design which may be of interest to other educators.

Since this research there have been major changes implemented in nurse education with the advent of the new frameworks (NMC, 2018b) and fee paying status for all health care

professional undergraduate students. It is predicted that the financial difficulties experienced by the future student population, including attrition, is likely to be worse than those faced within this study (RCN, 2018, Foster, 2016). This means that the findings may not be as relevant. Although, this research does provide a platform to plan other larger scale research to check the theory and findings developed as a result of this work (Gerrish and Lathlean, 2015). It is worth noting that the participants often appeared to speak in a wider sense for their peers and friends, almost as a collective. However their perceptions may not be that of their colleagues and their points cannot be verified other than through statistical information in the public domain such as National Student Surveys, evaluations of practice modules and other quality metrics undertaken at this time.

Interestingly though, my memories of the cohorts and students of that time do chime with many of these perceptions. The issues that they raised were in alignment with global research conducted in this area as outlined in Chapter Two. Perhaps therefore, there is then a shared synergy with others experience of nurse education that makes some of the findings key for the current and future curriculum planning. In light of the paucity of UK focused resilience research in nurse education, it is thought that the ideas and framework appraised within this thesis may also be of interest to other nurse educators (Porteous and Machin, 2018). This is because the evidence base underpinning resilience interventions is limited (Hart et al, 2016), especially within nurse education.

The participants within this research did not include any male student nurses as none offered to take part in the research. Within resilience nursing education research, males are consistently underrepresented (Cuadra and Famadico, 2013). Further research is needed thereafter to understand their perspective to address any potential marginalisation and not forget this group, who may have a different experience of resilience. However my study in

the spirit of phenomenology was concerned with the experience of resilience generally and did not seek to explore variations by population group (Beecroft, Booth and Rees, 2015).

This was insider research and although I tried to mitigate against any potential power imbalance, the participants may have answered with some bias, or underplayed issues with some areas of the course in order not to offend (Jack and Wibberley, 2014). The dialogue within the interviews though did flow and appear more as a conversation due to the pre-existing relationship and participants stated that they were more than happy to speak with me in preference to a stranger. It is hoped that the amount of transcript excerpts in this work, particularly in relation to the application of IPA, will in some way provide transparency as to the credibility of this study.

The difficulties in conceptualising and investigating resilience must be acknowledged, as this phenomenon is sometimes intangible and could evade evaluation (Hart et al 2016; Richardson, 2002). People can wear a professional mask and act out the required emotions of nursing but may not actually be resilient at all behind closed doors (Smith, 2012; Theodosius, 2008; Delgado et al, 2017). However the growth in studies over the past decade shows that researchers are determined to try and learn more in relation to this complex phenomenon (Stacey and Cook, 2019).

With regard to the participants in this study they were successfully completing the course and had met the requisite measures of resilience. Their stories and behaviour within the interview also consistently demonstrated a level of resilience (Li et al, 2015). Indeed by witnessing resilience daily in my work by staff and students I am convinced that this phenomenon does exist and is actually all around us (Southwick and Charney, 2013). Due to the duration of the research, the participants had left the course prior to the sharing of key findings. Member checking with IPA research is not a requirement, particularly due to

potential disagreements over findings around the double hermeneutic and final researcher interpretation (Smith, Flowers and Larkin, 2009). However during debrief, I asked them to email me for dissemination of publications or presentations if wished for.

The existing literature on resilience, as outlined in Chapters One and Two, has located the importance of the emotional labour of nursing (Delgado et al, 2017). It is more than likely that discussion regarding this phenomenon was liable to evoke the memories of emotional experiences for the participants. Therefore protecting the participants and myself through support was a vital component of this research. There was emotional work for both of us during and after the interviews in terms of processing feelings evoked by some of the topics under discussion (Bondi, 2016). However being a nurse with considerable clinical experience I actually found prior exposure to the emotional labour of nursing an asset when interviewing. I could empathise and visualise exactly the types of issues that they had coped with daily.

Smith, Flowers and Larkin (2009), have described the process of hermeneutic empathy as useful in meaning or sense making of the participants revelations in the analysis stage as part of the double hermeneutic cycle. I had to be careful though to bracket off my feelings to ensure that their experience emerged in the data, not mine, and enable the questioning or suspicious phase of the hermeneutic circle (Biggerstaff and Thompson, 2008). Yet Bondi (2016) argues that for too long the place of emotions within research has remained hidden and that overtly acknowledging the emotional work of research is significant for several reasons. In order that researchers continue to be sensitive to particpants and co-construct their data, emotions need to be processed or supported (Bondi, 2016). Emotions can be particularly of use in the analysis phase if the emotional dynamics of the topic are recognised and reflexivity plus insight was used by myself in interpreting this rich data (Wagstaff et al, 2014; Bondi, 2016).

The validity of this data does rely on the researchers attention to detail at every stage of the application process especially in insider research (Gerrish and Lathlean, 2015). It is hoped that by a transparent recounting of the design and application process that, whilst perhaps descriptive, there is an accuarate and convincing audit trail (Paley, 2017). Thus I have read widely regarding the pitfalls of such methodology and applied the required reflexivity to balance and account for my bias as an experienced nurse and nurse educator/researcher (Tomkins and Eatough, 2010). Constantly checking transcripts and detailed discussion of presenation of results with supervisors has attempted to ensure that this thesis presents as valid a set of results as possible (Wagstaff et al, 2014). This was important given that the very nature of this type of research relies on subjective interpretation and the double hermeneutic to allow for interpretative analysis (Smith, 2011). Attending the Flowers and Dickinson workshop (2017) and performing exercises in comparing analysis of transcripts also honed my skills in IPA.

3.5 Summary

This chapter has outlined the chosen methodology, research design and methods which were utilised for this research project. An interpretivist, qualitative approach utilising IPA, was thought appropriate to answer the research questions exploring resilience from the student nurse perspective. This drew on the philosophical theory of Hannah Arendt regarding hermeneutic phenomenology and the human mind. The research design or plan has been outlined in detail with ethical considerations. Research methods have been described and justified including the recruitment strategy, data collection and data analysis. An audit trail for the important and often criticised key stages of IPA at an idiographic and group level has been provided. The advantages and challenges of using IPA have been considered and reflexivity demonstrated.

The next chapter will now present the main research findings with regard to the research questions as a collective body. However individual participant quotes are provided, which demonstrate the key themes regarding the tests of resilience throughout the course, individual aids for developing resilience and their understanding of resilience. The educational interventions aimed at building resilience are also appraised through the participants' lens. There is synergy within themes but also anomalies which stand out from the rest of the group. This speaks to the fact that resilience may have shared components but is also unique on an individual basis. There are divergences from the literature which suggest new findings and convergence regarding established knowledge around this topic.

CHAPTER 4: THE FINDINGS; BECOMING RESILIENT

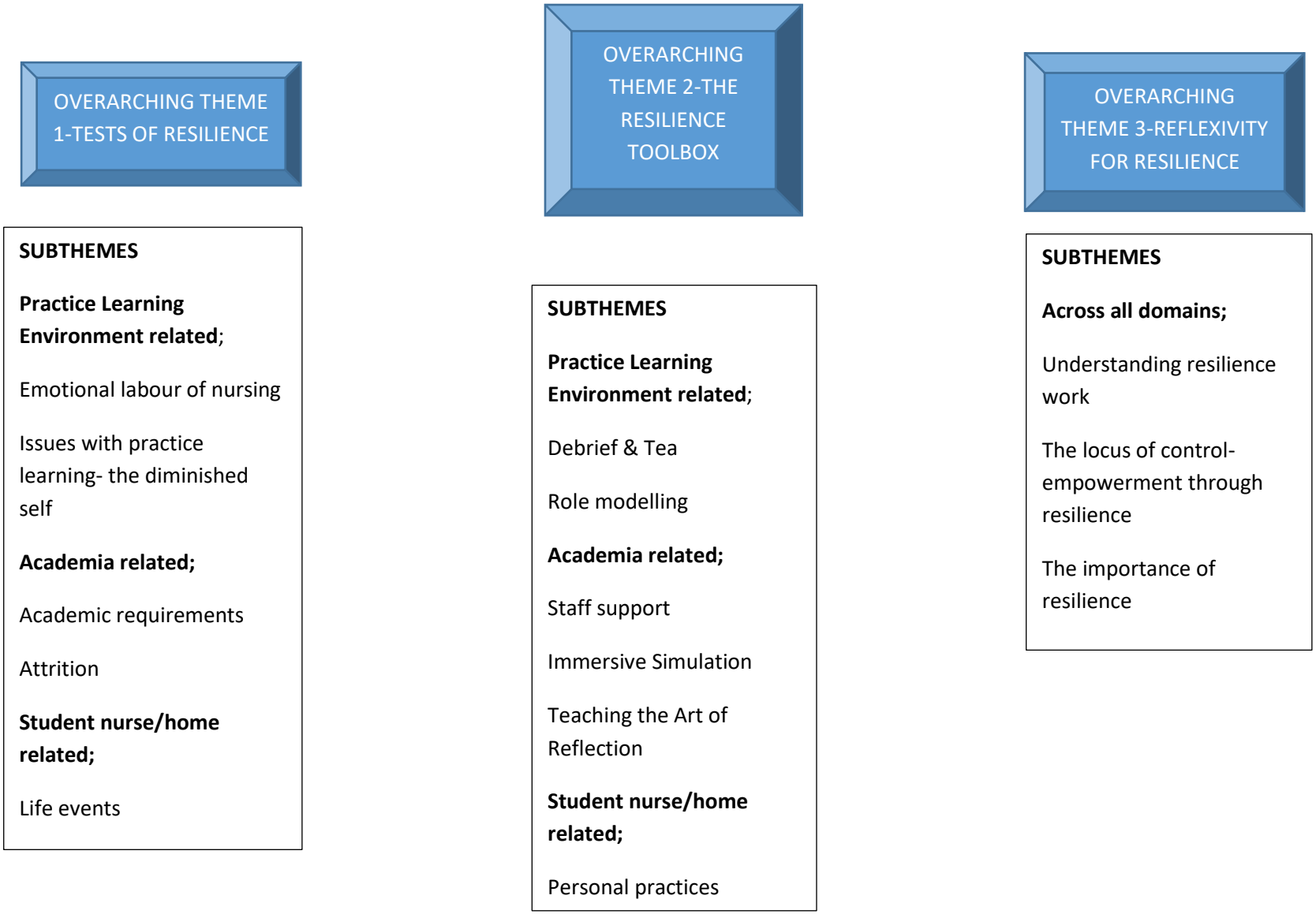
4.1 Introduction

The main finding of this study outlines an overall process for becoming resilient within the context of nurse education. This can be explained through the metaphor of a resilience journey, as described by the participants, which summarises the experience of adversity faced and overcome during their nursing course. In order to explain the process of becoming resilient, I identify three themes which form the main headings with associated subthemes found from applying IPA to the data. The first part of the process explains the tests and trials for resilience in nurse education that require the development of resilience. A resilience toolbox is then outlined which is symbolic of the varied support mechanisms utilised, involving self and others as required, to overcome the tests. Finally, reflexivity for resilience is explored, in order to locate the mental or cognitive processes fundamental to the participants end goal of being resilient.

Of note is the fact that the participants appeared to require resilience on several levels or in the separate domains of their life, adding another level of complexity to an understanding of resilience. These are the PLE, HEI and home, through which each transitions whilst on the course. A successful use of the resilience tools on an individual and organisational level led to the development, maintenance or enhancement of resilience. This has been done with the professional values of nursing at the heart of the participants' narrative. Recommendations by the participants for how to become resilient and improve resilience support within the curriculum were highlighted by all. Figure 4.1 serves as a visual representation of the themes and subthemes shortly to be discussed with quotations in evidential support from each of the participants.

Figure 4.1 also presents the process for becoming resilient summarised as three overarching main themes, named as such across the top of the diagram. These are ‘the Tests of Resilience’, or triggers of adversity essential to the beginning of resilience formation. Any mention of resilience led automatically to a discussion of these tests. As without the tests experienced on the course, participants stated that they would not know if they were resilient or not. The ‘Resilience Toolbox’ was needed then for participants to delve into, in order to acquire resilience. ‘Reflexivity for Resilience’ explains how participants moved from adversity towards becoming resilient. Underneath each of these overarching themes are the subthemes associated with them. However for some, subthemes were experienced in boundaried or specific areas of participants’ lives. For example the tests occur in the PLE, HEI and home, so subthemes are further labelled under the setting within which they were experienced. Reflexivity for resilience was a theme found to encompass all domains or life worlds and therefore the subthemes are not labelled or attributed as occurring within specific areas but across all of these.

Figure 4.1- Overarching Themes and Subthemes identified as part of the resilience journey

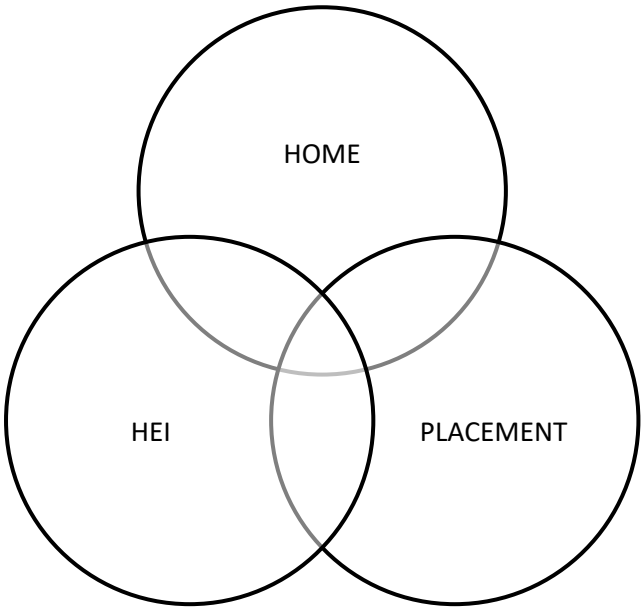


4.2 The Tests of Resilience

The tests of resilience affected all three domains and were articulated within the practice learning environment as two subthemes. These were; an exposure to the emotional labour of nursing alongside issues with practice learning, which left some participants feeling diminished in terms of confidence, competence and self-worth. Academic requirements and attrition in the HEI setting also triggered a need for resilience. On a personal level, tests were experienced as challenging life events associated with their home lives. Appendix Ten provides a table of quotations which summarises the tests per participant.

The triggers for stress during the course requiring resilience were multiple in number for most. These impacted their ability to deal with challenges and at times progression on the course. Tests often occurred simultaneously in the domains depicted below. Not only is resilience understood on an individual basis but the stressors which test it appear to impact some, yet, not all of the participants. This is suggestive of a personal threshold, or capacity, regarding the three boundaried and conversely potentially blurred areas of their lives; home, HEI and practice setting. If all three were under attack then adversity is felt in this group.

Figure 4.2 the areas of life within which resilience is tested and required.



The participants' individual tests were identified as per Appendix Ten, which also provides evidence from the transcripts of the subthemes named as the Tests. The practice learning environment appeared most challenging as it was spoken about at length. Equally testing though, in the sphere of the HEI, were academic failure and the impact on the participants of attrition with the loss of peer support. Major life events were experienced by nearly all, such as bereavement or serious illness and affected resilience performance in the other domains often impacting their ability to engage in nurse education.

Whilst there was synergy with shared experiences, exceptions were noted which contradict the group findings. For instance death and bereavement, in the PLE, did not unduly affect Julie, as she had previous exposure from many years nursing in a different country. This is suggestive that repeated exposure to a test may help in building resilience. Sarah found that reading about resilience for academic work empowered her in some areas of life and vindicated some of her many resilience practices.

> *"So I will go and learn more about that thing that happened to me. That's another thing to me, I still go and dig more, I like to learn more."* (Sarah, p1, s18).

In light of this comment resilience knowledge or literacy may be protective. Likewise Lorna had no issues in her practice learning experiences, enjoying them all as *"excellent experience"* (Lorna, p45, s 285).

Martha actually embraced the emotional labour of nursing celebrating the positive comments she received from patients. She had come to terms with the fact that *"You can't save them all"* (Martha, p10, s100). Professional identity was also very important to Martha and was protective against tests in other spheres of her life. Martha did not experience tests in all spheres of her life as no major issue in her home life was declared. Therefore that which tests one person may be an area of strength to another. However most participants had many tests

in all three areas of their lives which impacted on their ability to perform at different times on the course.

The most frequently described area of stress for the participants occurred in practice learning settings or placements. These were exacerbated by the unpredictable nature of health care settings, exposing participants suddenly to the emotional requirements/labour associated with nursing. This was as well as difficulties experienced with mentors or the culture of placement areas which impacted practice assessments comprising 50% of the course.

4.2.1 Emotional labour of nursing

An ability to deal with the situations of adversity was recognised as important for nursing and required emotional labour from participants to maintain a professional 'face' whilst feeling like a novice. Cathy's statement below, when asked what tested her on the course, showed synergy with others indicating the daily occurrence of several simultaneous stressors on placement.

> *"Anything, if you have had a challenging situation with a patient, whether that's if they become really ill, if you have had a difficult family situation that you've come across ermm you know if they've become aggressive or upset or they're unclear and you've got to kind of work that out with them- ermmm. If there's not enough staff on, if the shift has run over, if you can't get hold of a doctor or the right person or anything that doesn't follow what you would expect to happen."* (Cathy, p1, s 5).

Dealing with the emotions of others and trying to resolve organisational issues such as suboptimal staffing levels or accessing treatment for patients, created stress. Building a therapeutic bond with people required emotional energy. When these same patients suddenly deteriorated and died unexpectedly this was clearly recognised as traumatic. Accounts of first exposures to cardiopulmonary resuscitation (CPR) and withdrawal of treatment were cited quite graphically as if the participants were still in the moment.

> *"It's not like you see on the tele…it's completely different. She's got vomit coming out of her mouth, they are trying to suction her, they are trying to put a cannula in cos obviously they had taken one out earlier. There was blood all over the place…"* (Natasha, p4, s18-20)

The reality shock and highly intimate nature of nursing resulted in an exposure to very adverse situations. These included managing aspects of death for which many felt unprepared, under confident and helpless, all of which impacted their resilience.

> *"There were things that happened at last offices that wouldn't normally be happening with his body, like the skin coming away in your hands when you're moving them and the body leaking everywhere…"* (Natasha, p3,s11)

Coping with their own emotions and dealing with the natural empathy felt for relatives and patients was also hard at times. Lorna described her feelings of helplessness during an episode of patient care. This was heightened by the presence of relatives who were witnessing CPR and ultimately watching their family member dying.

> *"I could see the son just looking almost pleading as if to say "please just fix this". And it was just so draining, so heart breaking"* (Lorna p3, s11).

Jayne also highlighted the sudden or unexpected nature of events including CPR as the most challenging for which students have variable preparation and exposure, resulting in feelings of incompetence.

> *"Yes, some people go through their whole training without seeing this. Then all of a sudden it can happen 6 times in 1 day. I didn't see this til my 2nd year… went to a placement and they said that never happens here, then we had 1 on the first day and 3 the next. They were all older people and it was kind of expected but still….and that was it then for the whole placement."* (Jayne, p 20, s217-219).

A lack of opportunity to rehearse very complex skills within the HEI setting, prior to learning in practice environments, was a barrier to preparing for unexpected incidents. This often resulted in feelings of inadequacy for participants. There appeared to be a dichotomy for some between the promise of equipment and resources shown on Open Days at the HEI to support such learning, versus the realities of the course. As Jayne, Natasha and Lorna had experienced harrowing incidents in this area they thought that an increased use of simulation for cardiac arrest scenarios would help. Further discussion or watching documentaries was also suggested.

A lack of debrief following traumatic incidents in practice was noted which led to feelings of moral dissonance between the desired support and that available in busy placement areas.

> *"I do think the environment plays a key part in support. On a ward you haven't got the time for this. To debrief like that. The ward with the CPR was renowned for being short staffed anyway the staff ratio and even hca ratio was 1 nurse to 1 hca for, per sort of 12 patients and it was a respiratory ward where most of them were all care and there's not the time, they are all very sick. It depends who you're with too…"* (Natasha, p7-8, s47-50)

Natasha also raised the long-term impact of this test on her emotions after the events she experienced on placement. This presented as a lack of sleep and constantly thinking about the incident. The longevity of resilience work or potential for post-traumatic stress must not be underestimated and possibly feelings have not been resolved for some. For several of the participants in this study the examples given demonstrate the emotional labour of nursing, including traumatic life and death situations. However both Jayne and Cathy noted that dealing with others anger could be stressful. Whereas for Julie the professional requirement for empathy almost encourages students to immerse themselves in all aspects of the patient experience. Thus vicariously experiencing their pain, providing psychological and social support which is stressful and for her initially uncomfortable. *"Yes like placement – you are dealing with personally with stuff with pts*" (Julie, p2, s13). Yet she acknowledges that, *"Relationships with patients and staff are more, its better more therapeutic"* (Julie, p3, s30).

Natasha also stated that she thought families and patients also required empathy to be enacted in order to know that you were not emotionally closed, thereby recognising the professional requirement for compassion as an emotional component of nursing. *"Obviously some patients do want to see that you are not emotionally shut off!"(Natasha,* p1, s4). She continued with a specific example whilst nursing a young patient through withdrawal of treatment resulting in the patient dying. During this experience, she actively controlled her emotions in the situation as much as she possibly could.

> *"I did cry a little bit, but not a full on cry, just so that the tears were there and I think in a way the family kind of feel that it's nice to see that you're not closed off, that you do care."* (Natasha, p2, s6).

This appears to show a level of complexity to the emotional labour of nursing in accordance with professional and public expectations.

Lorna explained the triggers for emotional labour for her as follows, indicating that those who remind her of her own grief test her resilience the most,

> *"We all get closer to some pts, more than others and it's hard when somethings don't work out the way you want it to for the patient"* (Lorna p6, s7)

> *"their situation was going to strike a more personal chord with what was going on in your own personal life as well which was another time when you're gonna need resilience"* (Lorna p6, s30)

The spatial or boundaried aspects of the tests were emerging as twofold here. In that when two domains of life, here home and practice learning are painful, this was when participants are most vulnerable and resilience is needed.

For some though there were positive aspects to the emotional labour of nursing. Martha found strength in the affirmation of her skills that this type of emotional work with patients can produce. She enjoyed delivering compassionate care and felt appreciated by the response from her patients. This is then a challenging but a necessary part of nursing according to their experiences. Whilst often the reason that many entered the profession in the first instance, to feel valued and partake in a rewarding career. Therefore exposure to some tests can also help develop resilience too.

> *"You know the appreciation you get from some of the patients you look after tend to like make you forget the negatives, they overrule the negatives, so that's where I get ermmm, I develop my resilience"* (Martha p4, s33)

4.2.2 Learning in practice: the diminished self

Transitioning through this environment was testing due to the impact that placements had on the participants' sense of self in terms of diminishing their identity, confidence and competence. This was felt to be more notable in year one of the course.

> *"But first year you go back to being a child and it's like I don't have the right to ask this, because they are of such authority and I am no one and I can't do anything."* (Cathy, *p8, s51).*

Both Cathy and Sarah had left well paid jobs in order to undertake their chosen profession. They had been competent and valued in their previous work environments, yet now experienced dissonance with the way they felt in their new novice nurse role in some practice settings.

Martha summarised her feelings regarding adversity in placement several times. She gave an example of challenges she had faced when integrating into a new practice learning setting. Coping with this involved work in evaluating her own perceptions of her performance or *"signal reading"* (Martha, p1, s6), related to interactions with qualified nursing staff. These revolved around feedback from an assessor in practice highlighting her shyness and possible anxiety. Yet for Martha this provoked feelings of being prejudged or depersonalised. There was much synergy between this discussion and the interview with Sarah, who became very quiet when discussing a near fail of assessment in placement. Her shyness also appeared to affect her learning and ability to demonstrate competence,

> *"Somebody who has been in a place for 20 years and you are there one week you might never, never, not, no never, never it's unlikely to be on the same level. You try to find your base but you cannot reach their level, but they want you to be on their level. I know I'm shy, I need to work on that, now I am able to talk and face this."* (Sarah, p5, s97).

Here she appears to express her frustrations with the unrealistic expectations placed on students. A phrase she used appeared to summarise her experience in relation to this aspect of the course. *"It's a painful journey- it's been fine."* (Sarah, p4, s89) Yet there appears to be discord between the statement of experiencing pain but coping and being fine on her nurse education journey. Alternatively this could instead be a pragmatic acceptance that adversity will be experienced as a result of nurse education. The fact that Sarah manages all three life areas impacted by the course and supports others is suggestive that this is indeed the case.

Julie focused on the feeling of abandonment on transitioning from University out into placement, particularly with regard to her perceived isolation. This surprised me given her previous nursing experience, however this is testament to the impact of culture and context on resilience.

> *"I found this leaving Uni hard, you feel alone and you deal with a lot whilst feeling sometimes not supported. Sometimes the mentors have strong characters, some students too. But year 1 was hard, quite stressful for nursing students, they don't know what to expect. Some do quit cos of placement, they can't deal with the stress, the relationships in practice."* (Julie, p5,s53-56).

Julie moves from talking about *"you"* to "*they"* making it unclear which feelings were personal and which she felt vicariously on behalf of others. She does mention though that the people who left the course tended to regret it. Acknowledging that they had other issues or life events in progress highlighting again the link between facing tests across the domains of life.

Julie and Jayne both highlighted the need for well-developed communication and interpersonal skills as testing of resilience in placement. For Julie the culture shock of working in a different country in a second language was very challenging. She cited that critical thinking skills, underpinning patient treatment, were expected to be developed to a higher level, alongside increased expectations of nurses in the UK healthcare system.

> *"I don't know, I found it strange, I think in my own country I knew what to do…Here if I got the communication wrong it just broke!" (Julie, p3,s 22-23).*

This was not every participant's experience though, as Jayne explains that in her view in year one the mentors are "*soft on you*". It was in year two you need to *"up your game* (Jayne, p8, s79)!" She did though reveal some dissonance or moral distress with an example of when her nursing values were tested. She narrates an episode of care for a group of patients where her mentor was rushing and not allowing for time to talk to the patients whilst performing clinical procedures and basic nursing care.

> *"and especially in year 2, as you are just starting to come into your own, getting your confidence with what you're doing and then somebody tries to change the way you do things"* (Jayne, p13,s145).

> *"I think it's almost harder too the amount of empathy type things you have in Uni, then when you're working with people like that but you've been taught one way, they are doing like that, you almost think am I doing it wrong, which was the right way? Should I change the way I work to match theirs…but you don't feel like yourself and it makes you feel all funny again."* (Jayne, p12 s137-138)

Jayne decided that she would not adopt the negative attitude of this practitioner but opted to apply for jobs in other areas with a more supportive culture for self and patients. She not only dealt with this test but learnt from it. Aside from, or often on top of issues experienced in placement the academic component of the course also proved stressful for some.

4.2.3 Academic Requirements -Failure

This was less boundaried often spreading into the practice learning environment when academic work was a requirement whilst on placement. Lorna and Cathy both experienced a fail of an academic piece of work which affected their perception of self and made them doubt their ability to complete the course.

> *"I'm not a stressy person….It stressed me when I failed an assignment, cos I didn't expect to fail, but then I kind of expected to fail it as I left it too late, I hadn't put the effort in that I should have…*"(Cathy, p21, s174)

Clearly the fail raised conflicting feelings for Cathy who was a mature student with financial responsibilities. Indeed it was actually home or life issues which left her short of time to complete course work. Acknowledging that due to financial difficulties, which required her to undertake care work, she was left with minimal time to study on that occasion. Some tests were recurring in nature though and not easily resolved. For example whilst reflecting on the course as a whole, Cathy summarised her experience of wrestling with managing her time and finances, hinting that when the stability or planned home life alter, there are serious consequences.

> *"That work/life balance was hard. You have to prepare yourself on this course to miss out on life. But it's hard as an adult, when you've already got a functioning adult life, you've made your commitments to an adult life, a certain life then it falls out."* (Cathy, p24, s208-210)

Lorna too found her academic fail stressful whilst experiencing major home life events around this period of the course. *"One fail resulted in missing out on a first classification"* (Lorna, p30, s151). Her desire to keep going, achieve the end goal without delay and be resilient meant that she also took a chance and submitted an essay, instead of seeking an extension which resulted in the fail. The consequence of this affected her in all domains of her life. As it, *"Knocked my confidence because it was a really stupid fail."* (Lorna, p30, s153).

Others, such as Julie, also felt pressure between managing the academic requirements of the course and home life responsibilities, yet dealt with the competing requirements of both domains. All though were very aware of their peers experiencing unresolvable difficulties in practice, home or/and academia.

4.2.4 Attrition-The Lost…

Many of the participants mentioned the negative effect of losing peers from the course as a significant test of their own resilience. This was due to the loss of peer support. It challenged their own sense of self or position on the course. They felt helpless too with regard to how best to advise their colleagues. Specific examples were cited as below;

> *"It really helps when you have somebody to talk to and there is hope then you continue with the course, because so many people who have left the course because of so many things that they struggled with individually you know, so I don't know if there is something that can be put there to support more students to stay on the course even when things are outside the course"* (Sarah, p3, s51)
>
> *"…sometimes when we find out later why people left it feels sad that they couldn't access that help from school, so if it is there, maybe we contain at least 4 out of the 10 who left*." (Sarah, p3, s60)

Sarah even quantifies how many students she perceives could have been *"saved",* yet she did not articulate the reasons as to why particular students left, just that the majority had issues/life events outside of the course. However, so did most of the participants within this study too, all of whom stayed? Maybe they were more resilient or had better developed coping mechanisms and resources to draw on in the first instance.

> "*I think resilience comes in different ways, I think if I wasn't resilient enough then I could also have dropped a long time ago."* (Sarah, p 4, s76).

Perceptions regarding what is an appropriate space in which to seek support across all three areas of life may hinder signposting to relevant support mechanisms. Jayne insightfully noted that many placement absences were not due to issues with practice assessments but due to home issues affecting the students' ability to cope on placement. Normal support channels, such as speaking to Practice Educators and links to the University were not deemed suitable as it was not the PLE that was the problem.

> *"If you contact them you don't want the ward staff to think there was an issue with them. Sometimes it can be quite difficult from that perspective knowing who and where you go to…" (Jayne,* p110, s113-114).

Equally, Jayne stated that some students did not wish to approach University for a non-related problem either. Lack of knowledge regarding how to access counselling/wellbeing or financial support was expressed as a barrier to participants and peers when seeking support for issues. They appreciated that information was given in Fresher's week but highlighted the need for repeated signposting as a reminder. There appears also to be a stigma regarding accessing some services though, possibly still perceived as the domain of those mentally ill.

"But you don't really think it's for you." (Natasha, p11, s74; p15, s115)

"*Well a bit more signposting really- we do the Mental Health First Aid but that isn't for us, it's for patients."* (Natasha, p11, s74; p15, s116)

Likewise Sarah appeared unsure of where specialised help could be sought but stressed that she did not identify as requiring such. This is interesting given that she mentioned suffering from low moods which debilitated her at times throughout the course.

> *"I don't know if there is somewhere where we can access this help? I think we have, I have never accessed it. Where if you have bereavement and stuff like that, for struggling and stuff not academic or anything else?"* (Sarah, p 3, s 48-50).

Natasha explored the complexities of seeking support which seem to suggest that peers act as a filter and signpost each other to support services. This appears to give an insight into the number of life events occurring within this population, including how this impacts on the ability of participants and fellow students to successfully complete the course.

> *"There are many here going through some real tough times. It's not always not knowing about what you can tap into but about wanting to,…Sometimes it's easier not to speak to anyone, but easier to speak to your friends because you don't want to admit that actually this is bigger than you can handle. So if someone wants to get something off their chest, even if it's just verbal diarrhoea, so we all get together. But sometimes we say look you need to speak to someone else and get support…."* (Natasha, p18-19, s150-153)

4.2.5 Life events

As mentioned earlier most of the group also had major life events occurring in the third area of their domains; home or personal life, whilst on the course. These ranged from Lorna's very recent bereavement and Sarah's loss of multiple members of her family since childhood. There was also the breakdown of a significant relationship experienced by Cathy and Sarah's battle with low moods or depression. With Natasha there was an episode of becoming seriously ill and in need of medical treatment which led to her transitioning as a patient through areas where she had been a student. For Cathy it was exposure to financial difficulties as a result of undertaking her nurse education journey, indeed, leaving a well-paid job to do so. Jayne had to adapt to living away from vulnerable family members and Julie had to resettle in a new country. This affected their resilience at different times on the course though none of them mentioned thoughts of leaving the course. They all managed to utilise different support mechanisms that enabled resilience and in some cases examples of growth.

Above all, through the discussion on the tests of resilience the students not only demonstrated resilience they also provided examples of proficiency with regard to other requisite nursing values. Courage, honesty, caring and compassion were all evident in their responses. An ability to deal with adversity and seek some support was demonstrated by all when dealing with the tests.

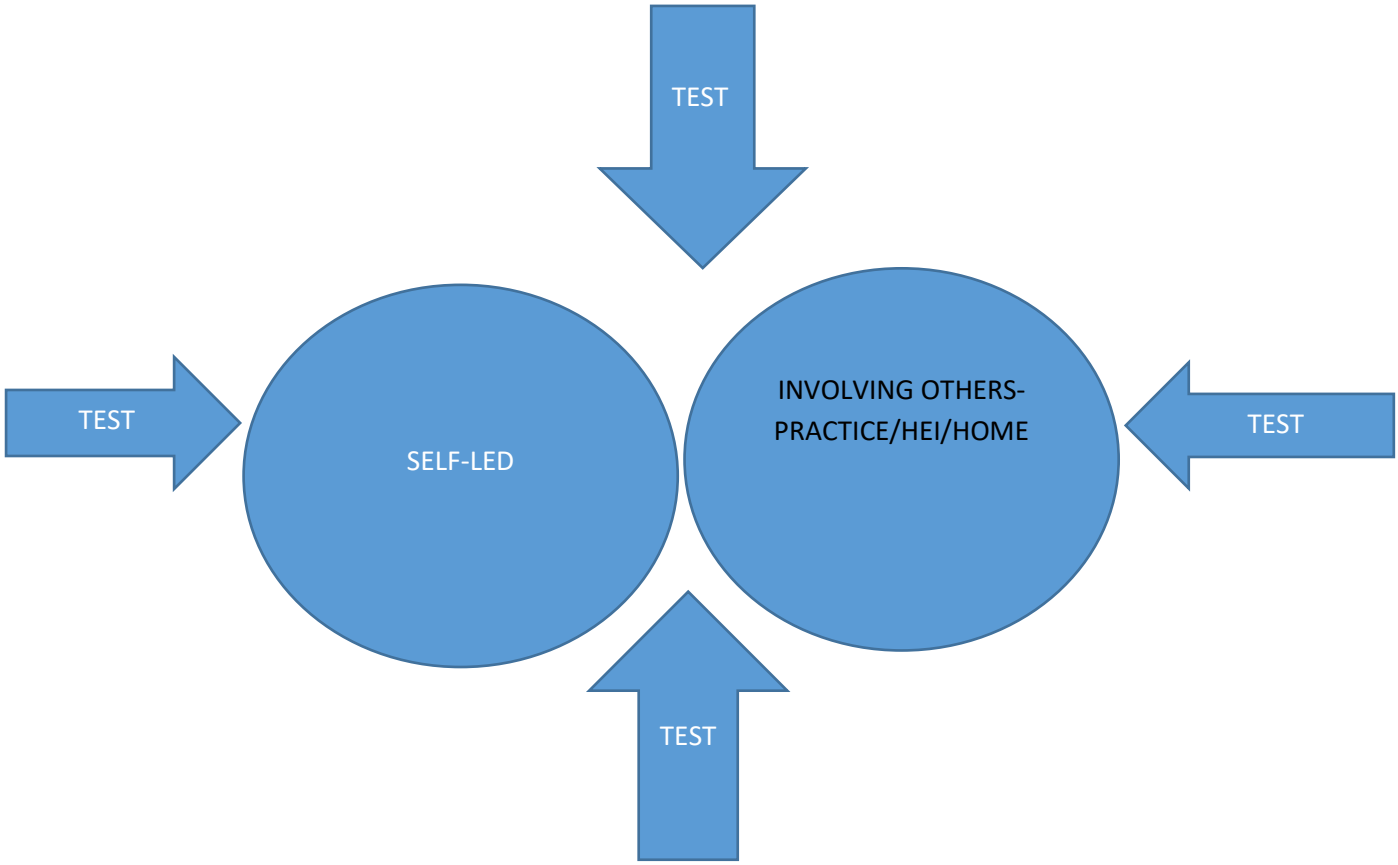
4.3 The Resilience Toolbox- resources to support resilience development

As part of becoming resilient a toolbox approach using an array of tools to support resilience development took place across the domains to mitigate the effects of the tests. This was the next stage of the process involving resources or support mechanisms which the participants used, or navigated, to deal with the tests. It was an essential part of their journey to the end destination of being resilient. Forms of support were either self-led or provided by others and multiple strategies were required in order to develop resilience. On a self-led level, these were identified as individual practices and seeking peer support. In practice learning through debrief with staff who often offered tea and sympathy to denigrate the emotional labour of nursing. There were also opportunities through role models who demonstrated how to be resilient in difficult situations. Formal activities within the course such as staff support, simulation and reflection were cited as essential but not always unproblematic. Figure 4.3 depicts the way in which these appear to protect participants against the tests just outlined. Additionally these resources are found in the three domains of the course/life of the participants; PLE, HEI and home. Participants stated very clearly that different approaches will work for different students or the same student at different times.

> *"I think the best way that this can be taught is by giving students- 'this is what worked for me, this is what worked for so and so', by giving them a whole range of tools and plans and things that they can work out through trial and error what works for them." (Lorna, p7, s33).*

Subthemes for resilience support were noted as debrief and role modelling in the PLE. For the HEI staff support, simulation and reflection and at home personal practices enabled the tests to be dealt with. Peer support was often provided in all three areas of the course and will therefore be appraised last. I will present each subsection accordingly supported by quotations.

Figure 4.3 Identifying the locus of resources for dealing with the tests of resilience



4.3.1 Debrief - Tea as empathy in the practice learning environment

Staff debrief following a traumatic episode of patient care in practice learning was cited, on several occasions by different participants, as supportive of their resilience. Where this did not occur, recovery from the tests was more difficult. Tea or cake was symbolic of the offering of a caring gesture, nurturing a neophyte member of the profession and supporting their basic needs such as food and therapeutic conversation. Jayne mentioned this custom as being helpful in dealing with the emotional work in relation to breaking bad news to the family of a patient who had died. Tea appears as code for self-care vital to resilience, or helping others to be resilient and implies acceptance into the profession.

> *"The first time it happened she went & I watched while she did the family thing and then we went had a cup of tea and talked about it."(*Jayne, p3,s28).

Lorna and Natasha cited wider support through debrief from other non-nursing professionals in clinical practice which they valued. This support fulfilled the need to discuss traumatic incidents almost immediately and was crucial to dealing with the emotional labour of nursing.

> *"I went with a doctor that had to break bad news to a patient with pancreatic cancer, by the time that is discovered they don't have long. After the Consultant doctor had spoken, the junior doctor took me to one side and asked me how I felt about that, they thought they would give me a little debrief which I thought was nice."* (Natasha, p8, s 51-52)

Debrief though also originated from participants in response to experiencing difficulties with practice learning and assessment. After communicating effectively with practice staff, Sarah and Martha felt empowered to feedback to mentors on their experience of learning in that area. Albeit this was once they had successfully completed the assessment. They dealt with this particular test by trying to improve the culture of certain areas and educate mentors as to the impact of practice learning on students. In doing so, clearly demonstrating growth and role modelling resilience for peers and practice staff.

> *"What I do before I learn that person, I cry, but then I get to know them, we laugh, we cry together. I give them feedback…we are individuals and see things differently"* (Sarah, p5, s94-95).

4.3.2 Role modelling in the PLE

Role modelling by mentors and other practice staff was mentioned as essential to developing resilience and negating the tests in practice learning for several reasons. Being able to view these revered professionals as human and observe how they dealt with emotions and made robust *"good"* decisions was valued by Lorna. When Lorna became upset the role models demonstrate coping behaviour which she strives to emulate and they provide debrief too. Acceptance of such adversity is recommended as part of this support,

> *"I cried all the way between the two theatres, between A & E and theatres rather and the person I was with just talked to me and gave me a hug and said 'do you know what, this is just how it is…..' And just that talking, that being able to off-load to him was the help that I needed"* (Lorna, p4, s15).

The opportunity for more exposure to senior students or recent alumni now qualified was treasured and should be increased according to most. Cathy, Natasha, Lorna and Jayne all

welcomed talks by former students in Fresher's week as seminal in making the end goal seem achievable. Tips for dealing with the tests of resilience were gained from another source outside of the usual team. As these role models have only recently shared a similar experience by undertaking the course, they are deemed more authentic by some participants.

> *"People you can visualise where you're gonna be. You can understand what type of learner I am?! When you can see people, you believe in what you're doing. It just realises everything for you, sets it all in place. You need to see it- that's a support, it's a better learning ..... Its different hearing it from newly qualified. You find out how their training was and how they coped."* (Cathy, p15,s 103-107).

However the support from other role models within the HEI setting such as academic staff was also valued on many levels.

4.3.3 Staff support – resilience support within the HEI

All of the participants cited academic staff support as key to their resilience building. This came from many areas such as the Course Director, personal tutors, seminar leaders, and dissertation supervisors. Approachability, availability and accessibility however were all fundamental requirements for this support mechanism. Synergy was noted in responses regarding University personal tutor support. On the whole this was very positive but could be a barrier depending on the approach of the individual. Some personal tutors were more proactive in booking meetings for academic and pastoral support with students, whilst others waited for the student to book appointments. Some conducted group meetings which many found useful, others wanted more individual support. Again this highlights the variable nature of resilience support.

> *"Yeh- it's just knowing that actually you can approach others; markers, supervisors, seminar leads, anyone will support you. It's the opportunities for the 1-1 that is short with the APT." (Jayne, p 20, s226-227)*

> *"To do with APT's some are approachable, some are not this, they are formal, if you have taught us I can engage with you- I can bring my problems to you. Personal tutors should be part of the journey for all 3 years".* (Sarah, p6, s 126-127).

For Sarah it was important that staff show empathy and identify with student issues. She qualifies this statement by adding that instead of talking to counsellors, for some, better personal tutor support could suffice. Communicating flexibly and in a timely manner via a variety of means such as email, phone and face to face was required as well, according to both Lorna and Cathy, otherwise issues were exacerbated.

> *"I know they had a pretty much an open door policy, so if I had an issue or a problem, I could go and be able to pop in or email or phone and say "I've got a problem can I come?" So for me that's what worked."* (Lorna, p8, s94).

> *"I've never, ever, knocked on anyone's door and been turned away for anything and it could be something really stupid. I'm the type of person that if you…, I speak to someone that second, I'll just ask you one question you answer and I'll feel reassured"* (Cathy, p7, s44-45)

Martha (p10-11, s108-110), though, became quite vocal regarding how much support is already provided appearing to recognise the importance of self, alongside others in resilience development.

> *"You are doing everything you have to do – comparing to the training from the newspapers and what I hear from friends doing this course back home you don't get this. I get so angry when students complain on the course, you do enough. You offer it to us and sometimes the reflections we write may look as if we need support but we get the offer of support I don't think there is much else you can do?"*

Clearly, preferred tools for developing resilience vary on an individual level but if not dealt with then resilience is lowered to the point that attrition from the course may occur. Participants also cited two formal educational interventions within the course as supportive of resilience building as part of the toolbox approach. Immersive simulation and reflection were the focus of animated discussion for all of the participants and cited as particularly helpful in mitigating the tests of resilience experienced in the PLE.

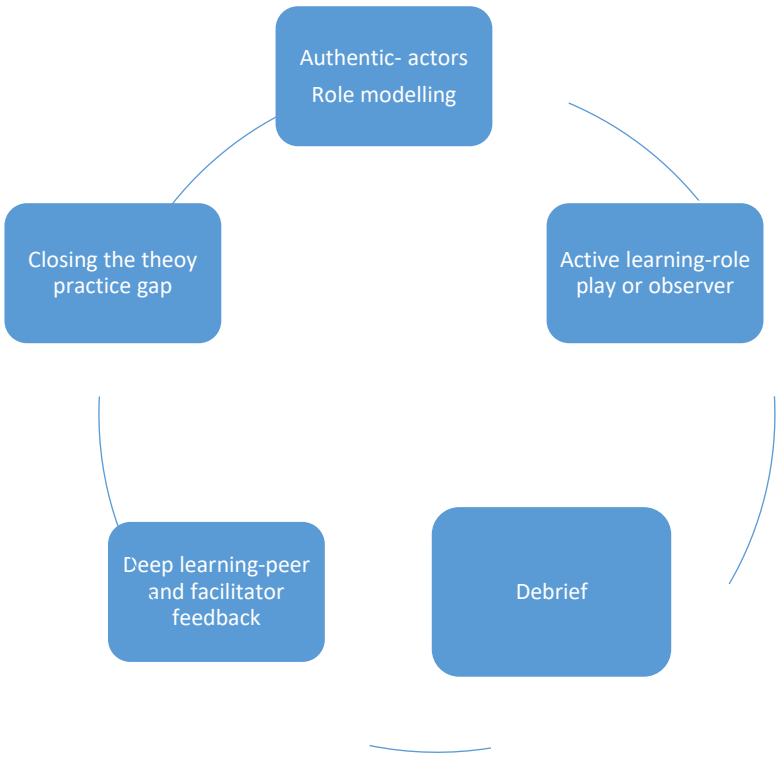
4.3.4 HEI tool- Immersive learning in interpersonal skills simulation

Every participant in their interview explicitly mentioned this type of learning as being of value in their resilience formation. This was stated to be due to the reasons summarised in the flow chart below (Figure 4.4).

> *"It gives us the tools, it's a way of teaching us the tools, again going back to my lovely phrase of different perspectives. One person will do something one way and you think oh yeh, ok, I wouldn't have done that, but I can see why you've done that. So it gives you a different exposure into other peoples' way of dealing with things. You might not choose to use it yourself, but you've got it at the back of your mind, so if something similar happens in future, perhaps it will, this one will work. Yes I can see the link between giving us different things, different ideas and tools to use" (*Lorna, p19, s92-96).

An overlap between subject matter covered in this teaching activity and the tests of resilience was also observed. Through exposure to certain simulated traumatic scenarios, techniques for dealing with the tests of resilience were learnt. Indeed many of the tests of resilience also require the interpersonal skills role modelled in simulation to deal with the tests. In conjunction with accessing other relevant resilience resources.

Figure 4.4 Key benefits of simulation



Simulation helped with preparation for the tests, increased competence and decreased feelings of helplessness in some areas. This often provided exposure to certain aspects of nursing which are harder to gain across the fields of nursing.

> *"The one with the child- the Gillick competence one. Refusal of chemo? Because we don't have paediatric placements, it's not something you really see. This was really helpful. In practice we do still deal with children and young people and their parents, siblings etc… I don't feel there was so much dealing with children and teenagers, ' cos in adult you could be with an adult reaching the end of life who only has a 16 year old, and you might think I can't talk about these things but you have to."* (Jayne, p17, s187-191).

The participants remembered sessions on ethical decision making, resilience and protecting the vulnerable patient. They commend the fact that challenging issues such as breaking bad news, self-harm, safeguarding and end of life care were discussed in this safe environment. All participants called for more simulation opportunities in this deep learning experience. At the beginning of each simulation day students are encouraged to reflect on concrete experiences in the *"real world"* of clinical practice which they have encountered. Particularly those relating to the theme of the day- for instance resilience. Thus it enables the linking of theory to practice which is helpful when experimenting with solutions for the tests of resilience,

> *"So when we got to do it in simulation, it gives you that chance to run through, it gives you that bit of an insight, so as you're going on through the course, with what we are covering in lectures, with simulation and going out into placement, it is being slowly developed"* (Natasha, p9, s60-61).

Most of the participants acknowledged that some peers did not value the exercises due to a dislike of role play and *"getting up in front of the class".* Yet they also commented on the fact that as much learning was gained from observing scenarios and problem solving as a group, by supporting those taking part. Peer learning is key to this activity and at the heart of becoming resilient.

> *"The whole session with conflict resolutions and stuff like that, when we were discussing it really helped people and me also deal with stuff in placement, because in placement is where actually things happen practically. So the whole session where we were able to discuss and you know scenarios and us sharing our opinions and I could learn from others and also*

> *learning that I wasn't the only person going through something, others are going through things*." (Sarah, p3, s41-42)

Another professional requirement for nursing, which simulation explores and tries to enable, is that of reflective practice.

4.3.5 Teaching the Art of Reflection

Reflection was taught on the course as an important mechanism for learning in practice and as a professional requirement. Therefore several participants recommended reflection as a strategy from previous experience of using in order to develop resilience, with Cathy stating

> *"I think you do cover quite a bit about coping, how to cope. I think encouraging reflection, which you do anyway, on the course and you're all quite big on reflecting. I think that is big with emotional resilience in this job, isn't it actually reflecting and actually thinking it's ok that didn't go as expected because next time we'll know that you do it this way. I don't know what you could do more?"* (Cathy, p 21, s164).

However, she did qualify this statement in terms of a request for help on how to reflect as part of evaluating one's own positive attributes. Although Jayne felt there were issues with the way reflection was taught. She hints that reflexivity also needs to be explored within the course, enabling them to act unconsciously, learning and reflecting in the moment through habituation.

> *"I think with the coping mechanism thing, with reflection, it would be a good idea if we were taught it doesn't have to be great big long essays it can be short pieces. This is how you reflect within minutes. It would help in the future with revalidation too. It is worth knowing that reflecting on something really small is good ' cos all the little things can add up to a big thing. It could be 2 mins of scribbling in a note book, as a team we did this, I felt that or next time I would do…*
>
> *You spend too long writing a 1000 words and getting a percentage, instead of seeing the value in it, they are not the easiest things to write anyway"* (Jayne, p14-15, s156-160)

Jayne explored the need for more flexible individual strategies such as drawing, scribbling, and texting without breaching patient confidentiality, for a more student-centred approach to building resilience. Yet Sarah interpreted the requirement for confidentiality as impeding resilience building. This appears to have forced her into more self-sufficient strategies as,

> *"We are not supposed to talk about it, so I will do music. I will try to engage with different activities or watch a movie or something different, though I still am always coming back to it"* (Sarah, p1, s17)

The fact that she reports still dwelling on tests of resilience may be due to the solitary nature of her resilience building strategies. These may work with less complex stressors but inhibit resilience building with more traumatic events. To counter this Jayne observes that

"And I think once you learn how to not break the confidentiality and things it's easier to talk to other people. Whereas in 1st year and first half 2nd year, you're still learning what you can and can't say without potentially breaching somebodies… so then you don't always feel like you can talk about it without accidentally breaching. But once you've learnt, then it's easier to talk to somebody– so even if it's texting your mate on the bus on the way home. "Oh I've had a bad day because of this….", and then they'll say this, then you can have a conversation about it without having to talk to someone directly involved, or in the same environment." (Jayne, p23, s254-257),

It appears that the proximity of support to aid reflection is important to optimise resilience building. Cathy too mentioned the immediacy of support required to aid reflection. By texting a friend or family member on break from a clinical shift this could help with resilience. In their narratives/transcripts the participants clearly demonstrate the ability to use reflection and/or reflexivity to build their resilience. It appears then that the strategies within the curriculum, whilst successful to a point in promoting the skill of reflection, could do with a review. Especially as many of the participants appeared to be relying on their own individual multiple practices developed at home or through peer support as more self-led strategies for resilience.

> *"We focus a lot during the course on looking at other people's assets, such as the patient's assets, but we don't really look at ourselves as such …*
>
> *By the time you get to the end of the course you can't remember why you were selected."* (Natasha, p18, s147-148).

This is reiterating the negative impact of the course on self-confidence which took work to regain.

4.3.6 Self-led or Personal practices

Interestingly all of the participants had identified numerous strategies outside of the course that worked for them in terms of enabling their resilience. Figure 4.5 summarises the many individual practices as described by the participants. Most undertook several of the activities.

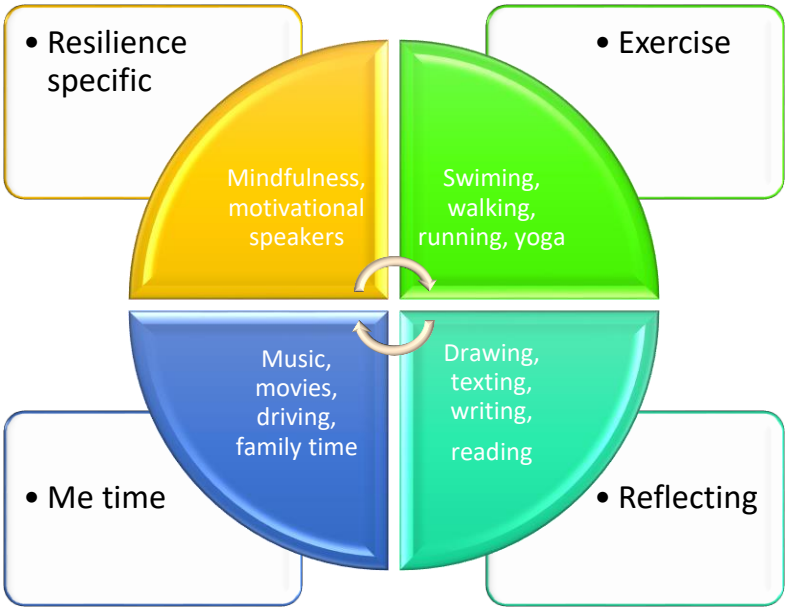


Figure 4.5 Self-led mechanisms for resilience development

Sarah (p1, s4) also outlined the longevity of developing resilience stating that *"Personally to me I have been building my resilience since I was young"*. For Sarah resilience was required when dealing repeatedly with death which she has been exposed to in her own life since childhood. She claims some resilience against the negative effects of this in that she can now support peers or junior students working through their distress. Yet some of Sarah's statements are contradictory. Whilst she repeatedly states that she is fine, the resilience work is constant to keep the powerful emotions at bay. Alternatively I interpreted the statement below to demonstrate that she accepts adversity and actively searches for resilience strategies to deal with her low moods or depression.

> *"If I do exercise then the pain will go away, so I started to swim every week, I do the gym every week. This has really, really helped me with my feelings, I was struggling with my moods so it's really helped me*. (Sarah, p4, s69-70)"

A reverse role model theme continues on a personal level here, with participants demonstrating resilience to children or parents wanting to make them proud and complete the course to demonstrate achievement of goals. This extended to being a role model to peers.

4.3.7 Peer support

All of the students cited peers and friends on the course as fundamental to building resilience. The shared experience of the same curriculum and understanding of nursing made this a key factor in their resilience. Sarah paints a vivid picture of this lived experience.

> *"You listen to your peers, you support each other every day, on the phone at night we cry, we laugh, and then we overcome. Look, here we are now, so…."* (Sarah p4, s76-77),

In Lorna and Natasha's case they keep you on track and support you through the challenges of life. With Cathy and Jayne, they were an unsolicited but useful, immediate resource to offload to. The common goal of completing the course and becoming a qualified nurse was a strong unifying bond. However the participants were clear that these friendships within the group occurred naturally and should not be forced. The sense I gained from the discourse on peer support was of clusters of students working collectively, as part of resilience development, with the participants of this study role modelling the nursing values, including resilience, at the heart of these groups.

4.4 Reflexivity for Resilience- the cognitive processes involved in resilience work

The cognitive or reflexive processes associated with the end goal of being resilient involved an ability to define the concept on a personal and professional level. Key to this is understanding its importance for nurse education and home life, resulting in personal and professional growth. Resilience in nurse education was understood as; contextual, enabling the delivery of empathic nursing care, a work in progress, developed over time in response to adversity or the tests and involved much internal/external work. At the end of their journey

participants could cope, manage emotions and became empowered to the point of helping others on the course. This part of the process required both reflection and reflexivity.

During the analysis phase of this study, I found that certain cognitive processes appear to be associated with being resilient or maintaining resilience. This included understanding resilience and recognising the importance of resilience for nursing and nurse education in order to deal with the tests. The participants all demonstrated a commitment to resilience work throughout their nurse education and nursing careers. A capacity for personal and professional growth culminating in an ability to manage emotions, cope with nursing work and navigate support mechanisms, was also noted. They described resilience work which drew upon the skills of reflection, and reflexivity was demonstrated throughout the interviews. Most explained the locus of control regarding this process across their life domains.

A level of resilience literacy or knowledge was demonstrated in the interviews which is important in terms of exploring this phenomenon from the participants' perspectives. There was similarity in the terms they used providing a shared understanding of the concept as shown in Figure 4.6. The diagram portrays the most commonly cited concepts in order, with dealing with emotions the most popular. Most participants used several of the terms below to explain the cognitive processes involved in resilience work. These can be seen in a table, per participant, in Appendix Eleven.

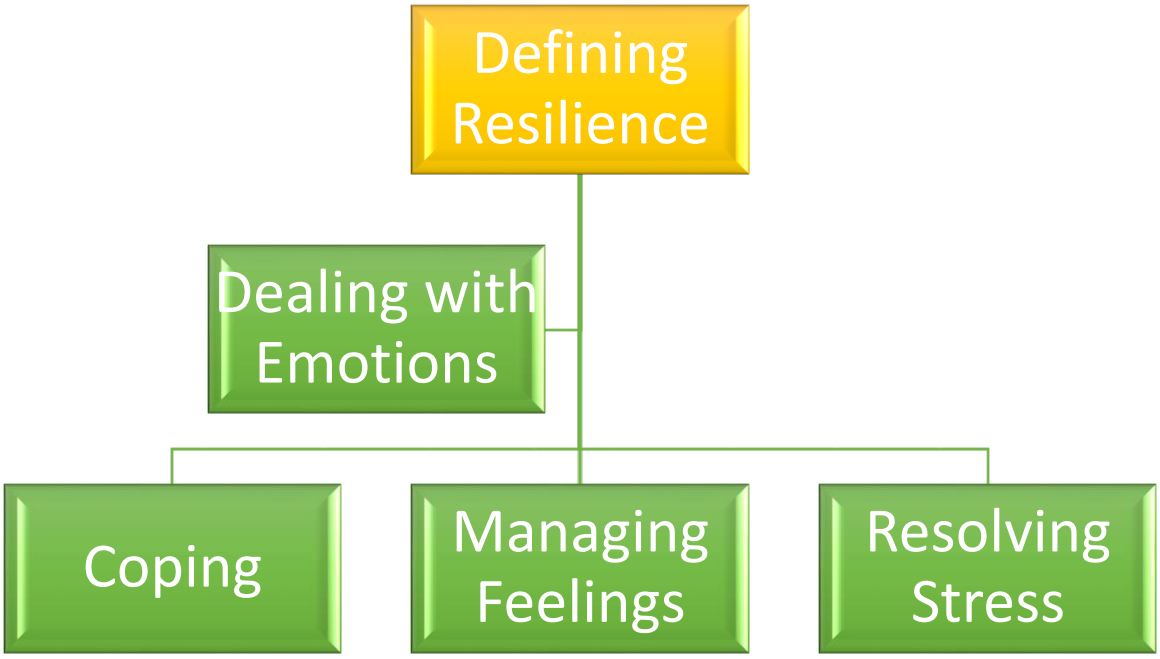


Figure 4. 6 Defining Resilience

Individual examples of resilience work were expanded upon within the interviews to highlight how this process manifests for each of them, as outlined shortly. The subsequent narrative then expands on the participants' thoughts on this work as part of the process of becoming resilient. Whilst described uniquely by each, core themes are identifiable. Through a further consideration of the definitions, the process and purpose of being resilient is revealed.

Several of the participants reiterated how individual or personal resilience was. Sarah even disputed whether resilience could be taught,

> *"But with resilience you can never teach it, it comes with maybe experience, so only when you experience it and that type of experience determines how you'll overcome it. I think so…"* (Sarah, p1, s13-14)

Thereby recognising the place of the tests as essential in developing resilience.

4.4.1 Understanding Resilience work

The descriptions of resilience work provide an understanding of the link between internal, often emotionally driven aspects of work, to control external outwardly presented behaviours.

> "*My understanding around the topic was how we take, we pick things and how we receive them and how we deal with them"* (Martha, p1, s2)

Resilience for Martha appears to separate out external facing work (being a competent student nurse) from dealing with emotions (internal facing work). Yet staff, and to a certain extent peers, are important in verifying and contextualising the resilience behaviour, further informing resilience work.

All participants appear to describe a process which takes ongoing work to achieve and is situation specific. Martha appears to suggest that she is not always successful with regard to emotional work, "*although I bottle things in not telling somebody, or not dealing with them can also be a problem in future"* (Martha, p4, s30*),* or that she may *"cuddle in"* (Martha, p2, s11*).* I found Martha's explanation interesting in that she refers to resilience as a *"topic".* This implies that it has to be learnt, may have been taught (indeed it was in immersive simulation) or explored within the course. However this may mean it was still slightly elusive to Martha and more work is required to deal with the negative emotions.

Sarah revealed quite an interest in resilience and was the only participant who named it as the ability to bounce back.

> *"That ability to overcome challenges, difficulties, to be able to bounce back, continue with your working effectively. So ermm,… examples are like experiencing the death of a patient and how you go about it, your feelings and then, …. that's it."* (Sarah, p1, s2-3).

Yet sometimes returning thoughts need mitigating, particularly with regard to loss and bereavement. If not resolved successfully, she may *'break'*, signifying capacity issues with resilience. So resilience is contextual, evolving and has limits according to Sarah. She also thought that key to resilience was understanding and adapting to the environment or situation related to "*what you are going through*," (Sarah, p4, s71). Additionally resilience was not fixed but a changeable state of being.

She also stated that the character trait of a "*good nurse*" (Sarah, p2, s36) should include the ability to be resilient, referring to the professional requirement or pressure to be so. This could imply that she is judging herself or others if they are not resilient though. For Julie this work was vital in providing a work/life balance and dealing with the pressures caused by the stress of nursing.

Cathy has an eclectic mix of requirements for resilience. It is a very functional definition of resilience for coping with the physical, mental and emotional labour of nursing. She explains that resilience is evident if you can separate work from home life with allusions to the process of dispositional mindfulness or detachment.

> *"I think like coping with difficult situations daily, mostly coping mentally, like to challenges and sleep pattern changes and the difficultness of the job, like if you have had a difficult day. How do you go home and unwind, or can you work in your personal life as well? Does it spill over, can you cut off and can you leave it at the door? Have you got that type of emotional resilience? I think it's coping really". (Cathy, p1, s2-6)*

This appears a priority for all in navigating the three areas of their lives during the course and essential to maintaining resilience. Jayne also cited the protective detachment from the work environment to home, similar to Cathy's definition but she introduces the concept of debrief as key to progressing resilience.

It is of note that most of the participants' responses were explained as several long sentences. This reflects the complexity of the phenomenon itself, implying that it works on many different levels. However, once resilient, participants can function in all aspects of their life worlds; home, HEI and the PLE.

4.4.2 The locus of control-empowerment

Some of the participants used language such as 'we' suggesting that the locus of control for resilience resides with the students. Others, such as Lorna, use the word 'you'. By referring to resilience in the third person, perhaps they are referring to an ideal concept to be aimed at, or to me as Faculty, situating the responsibility back with the organisation. Only

Sarah specifically mentions the term I when viewing the locus for control of resilience. Perhaps Sarah understands resilience as an individual responsibility in nursing or feels alone in developing this. However for Martha this appears more of a collective, peer responsibility for resilience work involving *"we"* the students perhaps, or *"we"* as nurses. Belonging to the professional group is vital to their resilience and is suggestive of a community responsibility for resilience. By recognising a professional responsibility for developing resilience they all highlight the importance of this attribute for nurse education. Control was particularly impacted by new environments, such as placement, for which most resilience work initially was undertaken. By year two participants were more empowered through resilience work and navigating resilience resources in order to take control of their learning in new situations.

4.4.3 Recognising the importance of resilience

These definitions also revealed several associated factors highlighting the importance of resilience; it was transformative, protective, enables the delivery of empathic nursing care and the achievement of the end of goal of successfully completing their nurse education. To that end participants were asked to assess their own resilience levels. This triggered more discussion as to the purpose of resilience revealing the importance attributed to this concept by the participants. Most stated that their levels were just above average at 6/10 with only two participants citing higher levels of resilience. Initially this concerned me until the context of their scores is understood. Martha's comments appear to suggest a personal transformation whilst on the course, which makes her a stronger and braver person.

> *"I would say 6- I have grown a lot….. I see things differently. I have really grown. Talking to you today was a real achievement, I would not have done this 4 years ago…"* (Martha, p11; s111, s114-115).

Julie echoed this sentiment in several aspects of her life with a transformed ability to make *'good'* decisions and rates herself as a 9. Cathy is actively working through adversity in order

to raise her resilience levels back up to her higher normal levels. Cathy's comments reinforce the fluctuating nature of resilience due to life events.

> "*Right now, probably about a 6. But I'm not in the best place of life, so normally I run about 8-9. I'm quite emotionally resilient."*(Cathy, p21, s168-9).

This is due to financial difficulties, the break-up of a significant relationship and fatigue. Despite this she performs well on the course and successfully completes her goal of becoming a nurse with personal and professional growth.

> "*But I say happiness is everything…..I know I make a difference, I know I am a very caring person, I like to be doing that type of work.".* (Cathy, p21, s171).

Natasha too has faced serious adversity as per her statement below and Jayne is adapting to a challenging new role. Both remained on the course and registered as nurses, again demonstrating professional growth.

> *"Normally, an 8-9, not at the moment 'cos of workload due to the course. Not at the moment, due to being ill, ….probably hitting a 5-6 at the moment* (Natasha, p15, s124).
>
> *"Probably a 6. I think if I was in the hospital setting I'd feel better and it would be higher, but I'm adjusting to the new practice setting, so that takes time,"* (Jayne, p30, s341-2).

Lorna self-scored at an 8 but admits that this *"probably dropped to 4 during the hissy fits"* (p76, s435). Lorna's hissy fits appear to be the internal resilience work which helps her deal with adversity and raises her resilience levels. Lorna gave real insight into the possible cognitive process of developing resilience with her hissy fits. Seemingly an essential coping mechanism for her, voiced as part of the rebalance after traumatic emotional episodes both inside of and outside nursing. They start to last longer during major life events, such as up to a week around her mothers' funeral. In addition Lorna appears to emerge even stronger from the *"hissy fits"* (Lorna, p33, s180-182), ready to function and perform pivotal life roles such as writing and reading the eulogy at the funeral (Lorna, p33, s184-186). Although not articulated fully Lorna describes the *"fits"* which occur in the private sphere of her life as wanting to be alone, ranting, arguing with others and being stubborn (Lorna, p33-36). For

her, resilience is protective like a *"shield"* aimed at deflecting the challenges experienced as a result of performing nursing. The symbol of the shield conjures images of attack and defence mechanisms which Lorna returns to throughout the interview.

Sarah stated that she was a 6 and happy with that, yet mentioned many resilience practices that she undertakes to maintain her levels, as do all in this study, which is recognised in their scores. This was a message repeated throughout the interviews; work was constant to maintain resilience throughout the course. This is suggestive that nurse education tests resilience, however, these tests can be overcome.

Table 5 Summary of The findings per research question and area of life impacted

Area of participant life cited in relation to research question	**The Tests (RQ 1- When and how is resilience tested during nurse education?)**	**Resilience Toolbox I (RQ 2-What aids the development of resilience in student nurses?**	**Resilience Toolbox II (RQ 3- Which, if any, educational strategies within the current curriculum support resilience formation?)**	**Reflexivity for Resilience (RQ4- By the end of the course how do students view resilience, do they see it as important?)**
Practice Learning Environment	The emotional labour of nursing. The experience of learning and assessment in practice; the diminished self.	Debrief and tea Role models	Preparation for the tests through simulation Reflection	Enables the capacity to deal and cope with the emotional labour of nursing and delivery of patient care. Facilitates cognitive processes which results in navigation of resilience resources in practice

Higher Education Institute	Attrition Academic failure	Peer support Staff support	Simulation- links theory to practice Reflection	Empowerment to seek support Importance of reflection and reflexivity for growth (techniques taught in the HEI)
Home	Life events	Personal practices	Reflexivity and other mental processes	Achievement of life goal and becoming a nurse

4.5 Summary of the main findings

An analysis of the findings outlines a process for becoming resilient within the participant sample for this study. It appears to be accepted by all in this study that nurse education requires that students deal with adversity. They articulated a process for becoming resilient which outlined the multiple episodes of adversity occurring across the three areas of their lives during the course. I identified that the tests which provided the most adversity were the emotional labour of nursing and assessment of practice in the PLE, academic failure and attrition in the HEI, with life events the most testing in the sphere of home or private life.

Additionally, resilience work in all three areas was often concurrent in order to remain on the course and cope with simultaneous tests across the PLE, HEI and home. This offers insight into the fact that developing resilience is an ongoing process. Consequently this requires utilisation of multiple resources or a resilience toolbox, driven by self and others, which are necessary for resilience and completing the course. Key to the resilience toolbox were debrief and role models in practice settings. For the HEI, staff support and the educational strategies of immersive simulation and reflection were of most help. At home,

personal practices and peer support were vital. These were not the only support mechanisms by far, but the most commonly cited, as resilience development is unique to each individual.

Reflexivity for resilience appeared a fundamental component to the internal process of how participants became resilient. Participants could define resilience well and in essence are reasonably resilient and literate in resilience knowledge. This may then speak to a recognition of the importance of resilience in nurse education at an individual and group level within this study. These findings indicate how the mental or cognitive activities are acquired in order to become resilient within a nursing education context - namely through reflection and reflexivity.

The aim of this research is to understand resilience, from the participant perspective, by locating individual and organisational support mechanisms for resilience development (Hart et al, 2016). These findings appear to add some knowledge in this context which will be considered within the next chapter, which situates the themes and subthemes found within the extant resilience literature.

CHAPTER 5: DISCUSSION

5.1 Introduction

This chapter frames the process that I found for becoming resilient within the wider context of nurse education, both globally and in the UK. I will compare my findings with previous literature, explore new findings and challenge what is already known. I acknowledge the tests of resilience including when and where they occur on the course. I locate practice which develop resilience, analogous to a toolbox of resources involving self and others. I was also able to identify how resilience is formed from the perspective of the participants. In particular the role of reflexivity and other mental activities involved in understanding resilience. Here I incorporate relevant theories of resilience from notable researchers in this and other disciplines. Specifically, where relevant, I utilise some aspects of the Resilience Framework (Hart, Blincow and Cameron, 2012) and *'Boingboing resilience'* approach (Hart et al, 2016). Thus enabling further theoretical interpretation of the findings in keeping with IPA and other qualitative approaches (Finlay, 2011).

5.2 The Tests of Resilience

I found that the tests of resilience occurred in all three areas of participant lives whilst on the nursing course. These appear to have been related to factors mostly proximal to the participants themselves rather than more distal or Institutional/organisational related (McLinden, 2017). In practice settings the emotional labour of nursing and the assessment experience caused stress. For the HEI academic failure and attrition required resilience work. Life events affected almost all involved in my study. The results on the whole concur with other studies yet add a deeper understanding in certain areas.

5.2.1 The emotional labour of nursing

My findings concur with that of others in relation to the emotional aspects of learning how to nurse. As facing the realities of nursing work can leave students traumatised when

recounting their experiences of placements, particularly first allocations (Lopez et al, 2018; Porteous and Machin, 2018). Indeed Crombie et al (2013), in their UK study, found that the most testing part of the course for students occurred in practice learning settings. However Sanderson and Brewer (2017) note a paucity of studies primarily investigating the causes of this. My thesis adds to the small body of knowledge in nurse education which tries to explain what aspect of nursing tests students' resilience in a UK context and why.

The emotional labour of nursing has previously been noted in nursing and nurse education (Delgado et al, 2017; Smith, 2012; Theodosius, 2008). It has been defined as involving face to face contact with the public which produces an emotional state in another (Gray and Smith, 2009). Research in this area seeks to understand how nurses or in this case student nurses manage their own and patients' emotions (Gray and Smith, 2009). It was clear in my study that participants found the emotional work, namely distress at others' suffering, challenging.

Moreover the stress evoked by this test can be exacerbated as there is an expectation that nurses should be emotionally invested in patients in order to provide compassionate care (Kristjansson et al, 2017; Curtis et al, 2017). However, mastering the emotions was challenging to learn. To be resilient involved a level of detachment of oneself from the emotions of patients' (Delgado et al, 2017). In my study, becoming resilient involved stepping back or distancing oneself from the emotional triggers causing adversity. Hence agreeing with others that there is a need to view such situations in an objective, non-judging and self-compassionate manner with greater clarity and insight (Brown, Ryan and Creswell 2007, He et al, 2018).

Nevertheless some argue that extra work in this regard is needed to mitigate the fact that most UK nursing students are taught to hide their feelings under their professional armour (Walker and Mann, 2016). Feelings and emotion are often encouraged to be *"swept under the*

carpet" and protective strategies such as *"erecting a wall"* between patient and self has been noted in some studies (Gray and Smith, 2009, p254). This has synergy with my study as shield building as a protective feature of resilience was cited. Work is then needed to seek the hidden feelings in order for students to re-engage with their "*internal emotional space",* (Walker and Mann, 2016, p188). This is private or hidden work as opposed to public facing work (Arendt, 1981), with feeling rules dictating emotion management in practice settings (Theodosius, 2006; NMC, 2018a). In this context, with the intent of demonstrating the requisite professional nursing values, including resilience (Smith, 2012; Theodosius, 2008, NMC, 2018a, c). This work was evident in my study when participants dealt with empathy and sadness.

However, other types of emotion such as anger, conflict and family distress were also highlighted by participants. Recent reports and empirical research both note the increased horizontal violence that nurses and student nurses are exposed to (RCN, 2018; Pines et al, 2014). This typically involves interpersonal conflict, anger or physical violence from colleagues, patients or family (Wilson, 2016). Whilst much of resilience work is internally located within a person, it is affected by external social factors. Concurring with previous studies, that there is a breadth of emotions such as sadness, frustration, conflict, shock and despair that students have to navigate and learn to process in order to deliver professional behaviour (Smith, 2012).

In apparent contradiction to this theme it appeared that the emotional requirements of nursing could be positive for some though. As finding solace or affirmation in becoming a professional and delivering *"good"* care can be rewarding as most nurses still wish to be emotionally invested in patients care (Kristjansson et al, 2017). Indeed some believe that an expression of emotion may be appropriate in certain situations such as dealing with grieving patients and their families (Delgado et al, 2017). It is believed that there is also therapeutic

value in demonstrating caring, compassionate nursing for self and others (Andrews, Tierney and Seers, 2019; Maben et al, 2012a, b; Gray and Smith, 2009). This is certainly the findings of my study. Although it is important to note, as new insights, that the emotional labour only became an adversity when other life events were also testing the participants or unexpected deaths or incidents occurred.

I found that the sudden deterioration of a familiar patient or unexpected death was testing of resilience which concurs with previous studies, for the unpredictability of health care environments is well documented (Rees et al, 2015). Yet it is within these that students are expected to assimilate into teams, provide competent treatment and manage their emotions (Goodare, 2015). Incidents likely to cause secondary or vicarious trauma to nurses including students, are sudden or unexpected death; witnessing others' pain, suffering and experiences where care delivered was felt to be less than ideal (Kossek and Perrigino, 2016; Weurlander et al, 2018).

Synergy was identified with Loftus (1998) who in her phenomenological study found that students cited cardiac arrests or that of the suddenly deteriorating patient, as the most distressing, as was working with dying patients. Exposure to dying patients, as a trigger for emotional distress, is a finding common in other studies (Weurlander et al, 2018). Students tended to distance themselves from the emotional aspects of the experiences by recounting technical issues or competence related deficits of their own performance instead. This was a finding in my study with participants feeling under prepared for these situations, recounting *"reality shock"* (Williamson, Health and Proctor-Childs, 2013; Stacey and Hardy, 2011). In this instance related to the gruesome nature of the dying process and feeling out of their comfort zone.

Conversely some participants had already accepted that not all patients would survive. However with increased experience of these situations, increased knowledge of palliative care, enabling a *"good death"* for patients could be a goal which mitigated negative emotions (Kossek and Perrigino, 2016). One novel finding from a participant in my study was her ability to titrate emotion/feelings to demonstrate compassion to relatives but within perceived social norms (Smith, 2012). This manifested as controlled crying, releasing just a few tears in response to a patient dying. I have not found this specific response described in the resilience literature to date, although the act of *"mirroring"* patient and family emotions has been described in previous work (Gray and Smith, 2009).

Arendt (1981) surmises that all emotional work is reflected upon internally in *'the Life of the Mind'* and processed prior to the individual showing what they think is fit for appearance. She considers the importance of cognition or thought as part of this process. Named as the ability to control one's emotions as 'self-presentation' (Arendt, 1981, p31). Self-presentation theory (Leary, 2003) has been considered in a nursing context in order to explain behaviours which are acted out in a professional setting in keeping with perceived norms (Wilson, 2016). This learned behaviour then becomes genuine through repeated expression and validation by others (Leary, 2003), thus demonstrating a link between internal and external facing resilience work noted by others in my study.

I found that some employ signal reading to interpret how others' perceive their ability to function in practice settings. This bears similarity to processes outlined previously by Theodosius (2006; 2008). Her theory explores emotion management within a nursing context, where experiences provoked by emotional labour are internalised, as social influences determine the expression of appropriate behaviour. In my study this was in relation to being resilient during practice assessments within the real world of health care.

5.2.2 Learning in practice: the diminished self

I found that learning how to nurse in the real world of nursing was found to be testing, again concurring with the results of previous studies. For participants, stories from placement learning experiences were very vivid in keeping with other studies (Weurlander et al, 2018). These had clearly impacted on their resilience journey. Lekan, Ward and Elliott (2018) found that students were most anxious regarding their clinical competence with a fear of making mistakes. Interpersonal conflicts with mentors was also a concern. Lopez et al (2018) found similar findings in that students in practice felt isolated from support. Whilst others adapted to the ward culture in order to learn and move on. Curtis, Horton and Smith (2012) acknowledge the dissonance felt by students between the care values taught and the realities of those demonstrated by some mentors.

Learning how to behave in professional practice settings is harder to master than crossing the theory- practice gap according to Goodare (2015). This certainly resonated with the findings in my study with participants feeling more vulnerable in practice settings and judged due to being shy. They declared feeling as having low status (Thomas, Jinks and Jack, 2015), acknowledging a lack of empathy on the part of some staff towards them as learners or toward patients (Curtis, Horton and Smith, 2012; Maben et al, 2012b).

Hurley et al (2019) found that issues in practice may arise due to the young age of students who have only partially developed work capabilities. In contradiction to this the majority of participants in my study were mature and had previous care work experience. This was in keeping with the demographic of nursing students in the UK (White et al, 2018). Indeed others have found maturity and work experience can be protective traits against these stressors (Chamberlain et al, 2016; Mathad, Pradhan and Rajesh, (2017). However, I also found that the only school leaver to directly enter nurse education equally had well developed resilience strategies. Thus confirming the results of previous studies within and outside

nursing that resilience is developed in a very individual or personal manner (Stephens, 2013; Richardson, 2002).

To work through these tests those experiencing difficulties took ownership of their learning. They expressed that by the second year they knew how to navigate the clinical settings in order to deal with challenges as has been seen before (Thomas, Jinks and Jack, 2015). The previous exposures to adversity gave them confidence that they would survive and indeed progress (Southwick and Charney, 2013). Some researchers argue that the more adversity one faces early in nurse education the more resilient students' become, within reason of course (Hurley et al, 2019). This concurs with mine and others' findings where students were able to take actions congruent with achieving their goals by *'staying the course'* (Reyes' et al, 2015, p 2627).

Participants in my study also were clear that they were not compromising their care values and opted to practice as they had been taught in University, once they had overcome this challenge, similar to Thomas, Jinks and Jack, (2015) results. Additionally, Grant and Kinman (2013a) purport that the ability to challenge poor practice indicates a strong sense of professional identity and is indicative of effective stress management. I also observed a cultural assessment by participants who used their time to assess an area against their values, which impacted on whether they applied for jobs in that area (Curtis, Horton and Smith, 2012). Staff and leaders who took an interest in them and inspired them, were key to upholding their resilience (Crombie et al, 2013). Practice learning was not the only area which caused issues for learners though. Indeed I found that the HEI was also noted as a stressful environment (HEE, 2018).

5.2.3 Academic requirements-failure

The worry and anxiety attributed to negative assignment feedback and occasional academic failure appears disproportionate in comparison to the other tests of resilience

experienced as part of the nursing course. However at the time this created real adversity, self-doubt and upset, thereby impacting other areas of their lives. Stephens (2013) warns that nursing students experience many stressors simultaneously. Indeed the academic year is longer for this discipline alongside the academic intensity of the course (White et al, 2018), making their resilience work different from that of others. Galbraith, Brown and Clifton (2014), also advise that cumulative stressors should be understood differently for this population, noting that seemingly minor hassles can be perceived as stressful. This overload of stress in multiple areas of life could explain the disruption to mental/cognitive processes which often inhibited the acceptance of feedback on academic work (Hurley et al, 2019).

Time management and learning to manage workloads in several competing domains of student life is noted as challenging for all regardless of the course (Clarke, Mikulenaite, and de Pury, 2019). Yet this is heightened for nursing students whose course has more requirements in terms of hours of study and practice than others (HEE, 2018; Foster, 2016).

Financial difficulties which required participants to work, is noted as a growing problem in this sector (HEE, 2018; RCN, 2018, White et al, 2018). Indeed several in my study found this an issue for self and others. For some of their peers, this negatively affected their ability to complete the course ultimately leading to attrition. Additionally, it is clear from the perspective of the participants in my study that some of the students who left the course could possibly have been *"saved"* if better signposted to formal support.

5.2.4 Attrition-The Lost

Most studies on attrition from pre-registration nursing programmes cite the reasons for leaving as complex, multifactorial and unique to each individual (Crombie et al, 2013; Girard et al, 2017; HEE, 2018). However, the following areas are recorded in the international literature; personal life crisis, institutional or professional issues (Girard et al, 2017). This maps to the statements made during the interviews with me when, initially, those in my study

cited issues in practice as the driver. Upon consideration though, they did acknowledge that the people who left had multiple issues, with financial difficulty mentioned repeatedly as a main problem resulting in attrition (RCN, 2018).

The RePAIR project (HEE, 2018), conducted research to explore the main issues for students leaving health care courses in the UK utilising several Universities as case study sites. This report found average attrition rates of 14%, with attrition defined as the number of students not completing within three years of commencing the course, compared to the number who started the course (HEE, 2018). However previous studies have noted average levels at 30% (Crombie et al, 2013). Attrition is not new then and in recent times much work has been undertaken to increase student support to prevent this.

The same report classes attrition as avoidable or unavoidable in terms of reasons for leaving the course. These results indicate that failure at assessment, wrong career choice and financial reasons, are the leading causes of attrition up to this time (HEE, 2018). However academic failure, whilst stressful to students at my own institution, is not the main reason for students not completing the course. Nor does it appear to be the reasons cited by the participants who commented on attrition in this study. Major life events exacerbated by poor practice experiences or/and academic failure were the perceptions as to why their peers resilience was affected to the point that they left the course (White et al, 2018).

What is also clear is the impact those leaving had on the morale of the group and potentially the cohort's resilience at that point in time. However, the costs associated with attrition are important, not only to the student experience but with ramifications for the local health care economy as nurse vacancies remain unfilled, and in these cohorts, a cost to the tax payer for training as HEE paid the course fees (RCN, 2018).

Group resilience is also significant for this is one of the resources that supports a community (Hart et al, 2016). Moreover it is also predictive of an individual's resilience (Southwick and Charney, 2013). The most unexpected finding for me from the participants' interviews was the collective feeling of loss in relation to attrition. This indeed impacted on individual and group resilience. Acknowledgement of group or community resilience is emerging from nurse education literature too (Sigelit et al, 2016). It is of importance to nurse education for several reasons. Personal and group/cohort resilience have a symbiotic relationship; they impact upon each other. Given the significance of peer support as a protector against stress then the wider group is a potential resource to prevent attrition. The participants in my study really seemed to care about other students. This appears in keeping with the requisite professional values and demonstrates resilience (Kristjansson et al, 2017; NMC 2018a, c).

In my study the reasons for attrition appeared preventable in some instances, involving lack of knowledge regarding more distal or organisational level resources (McLinden, 2017), with a lack of signposting to support services and myths or stigma noted pertaining to some resources. Whilst peer support was conducted in smaller, discrete groups, once maximised there was collective confusion as to how to access more formal support. A fact also highlighted in several reports regarding the wider student population and their wellbeing (Clarke, Mikulenaite, and de Pury, 2019; UK Universities, 2015; HEE, 2019; Stallman, 2011). It has been noted that service provision in the area of mental health support in some Universities has been lacking with waiting lists for counsellors and mental health advisors (HEE, 2018). Alternatively stigma still appears to exist with regard to seeking such support. Shame may be blocking some from accessing services particularly with regard to financial and mental health issues (Southwick and Charney, 2013; HEE, 2019). Concerns regarding confidentiality and the long-term impact of declaring mental health or personal issues on

course or career progression has also been cited as a barrier to seeking help (HEE, 2019). Indeed this appeared the case with some of my participants.

The duty of disclosure on patient safety grounds appeared to prevent some in my study from accessing support. This fear for students of their confidentiality being breached is seen as a reported barrier to accessing either informal support from peers or formal support. As has also been highlighted in other studies (Clohessy, McKellar and Fleet, 2019; Galbraith, Brown and Clifton, 2014; Pezaro, Clyne and Fulton, 2017). Equally finance and an associated lack of resources to bolster struggling students was noted in my study and other reports (HEE, 2019; Foster, 2016). Understanding what impedes support to deal with the tests is vital to debunking such myths (HEE, 2018). Empowering students to understand disclosure and their role within this duty is a professional requirement (NMC, 2018a).

The duality of nursing students' workload through practice learning and with academic stressors is stated as significant (Williamson, Health and Proctor-Childs, 2013). This duality is contributing to attrition and impacts the physical and mental health in this population (Liang et al, 2019). Additionally the students in my study experienced life events or issues at home which suggests a triality not just a duality of life areas to navigate. This appears a new finding to date, knowledge of which may help with understanding the challenges for students on my own course and perhaps for other nurse educators responsible for supporting diverse groups of students.

5.2.5 Life Events

Life events or *"struggles"* as noted by McAllister and Lowe (2011), were experienced by most that I interviewed. Indeed such personal adversity is cited as a well-known stressor experienced by all humans at some point in their lives (Southwick and Charney, 2013, p3). Already vulnerable, to the stressors in clinical practice and the academic rigours of the course, students are therefore at high risk of burnout and exhaustion (Lopez et al, 2018).

Some argue maturity as protective against the tests (Chamberlain et al, 2016; Mathad Pradhan and Rajesh (et al, 2017). Yet others disagree noting that mature students have more responsibilities than younger students and therefore more challenges at home (He et al, 2018). Conversely my participants, despite challenges in all three areas of their lives, kept on with their journey through nurse education thereby demonstrating resilience.

Thus the findings of my study were largely supported in this part of becoming resilient by the existing literature. However the mechanisms cited by all which enable resilience to face these causes of adversity does appear to add new insights.

5.3 The Resilience Toolbox-resources to support resilience development

In my study the resources for dealing with the tests were categorised as a resilience toolbox, aspects of which are mirrored within the current literature (HEE, 2019). The importance of individual resilience practice works in tandem with multiple sources of support and group level educational interventions (Stephens, 2013). An emphasis on the role of community support as noted earlier is duly cited in the wider literature (Hart et al, 2016; Southwick and Charney, 2013). Although, in this instance, as applied to the nurse education context providing new resilience information. This thesis may also contribute to the evidence base supporting specific educational interventions. These are immersive simulation and reflection, stated as helpful in resilience building.

The important tools identified as supportive of resilience development will now be considered in the context of the wider literature. These were debrief and role modelling in practice learning settings, with staff and peer support in the HEI. Individual practices at home were also vital. Others outside of my study have recommended a toolbox or toolkit approach for individual level interventions to enhance resilience (HEE, 2019; DoH, 2009). This maps

to the overwhelming advice from my participants on how best to support students on the course. Treat them as individuals with a choice of resources to promote resilience. By applying the Resilience Framework outlined by Hart, Blincow and Cameron (2012) to my data, later shown in Table 6, an explanation for what worked at an individual or self-led level was gained. Firstly though, the tools offered in support by others and utilised in the PLE and HEI are considered in the context of existing knowledge.

5.3.1 Debrief - Tea as empathy in the PLE

One of my findings was that a ritual of tea and debrief provided by staff to participants after traumatic episodes was more likely to help with processing the emotional labour of nursing. I unearthed that they overcame adversity through debrief with staff, peers or mindfulness exercises (Weurlander et al, 2018). Apparently this is new knowledge, as in research conducted by Loftus (1998) this ritual was only offered for some by their own peers. Whilst others in that study were sent away to have tea alone after stressful events. This resulted in feelings of exclusion from debrief which they perceived staff to be undertaking in their absence. More recently this approach is accessible for NHS employees in an online context, virtually through a social media network named 'Tea and empathy' (HEE, 2019). These are a group of psychologists and associated professionals who offer support and signpost to the appropriate services for staff experiencing post-traumatic stress.

Therefore tea appears in healthcare in the UK as symbolic for self-care often incorporating support from others, which is stated as vital to resilience (Hart, Blincow and Cameron, 2012; Andrews, Tierney and Seers, 2019). It was something, as nurses, we offer to grieving relatives and staff struggling with the emotional work of nursing (Smith, 2012; Theodosius, 2008). A national euphemism for I'm here for you and you are valued. More importantly it gives permission for the receiver and sometimes the provider to sit a moment and practice

mindfulness, debrief or peace and wise quietness (Imani et al, 2018). All useful in resilience development.

However, although debrief in itself is recognised as important, I found that staffing levels make it challenging to provide as often extra time outside of the shift is required to make this happen (Virkstis, Herleth and Langr, 2018). In a report on health and wellbeing for NHS staff, several recommendations supportive of resilience development are cited (HEE, 2019). These include post-incident support such as that performed through a paramedic model (TRIM, 2019). Additionally, there is a recognition of the need for a psychological safe space and reflective opportunity such as clinical supervision which values the role of debrief (HEE, 2019). Some participants in my study experienced these important support mechanisms, whilst others noted alternative or complimentary resources from the toolbox.

5.3.2 Role modelling

I found that for my participants, role modelling was pivotal as a protective factor in resilience work, as in most key theories (Southwick and Charney, 2013). Likewise the importance of role modelling in nursing is also highlighted (McAllister and McKinnon, 2009). Unfortunately, given the demoralised state of nursing both in the UK and globally, this could affect the resilience of such role models (RCN, 2018; HEE, 2018). Yet it is heartening that despite this reported low morale elsewhere, only the occasional negative behaviour was cited in my study as the exception.

However this is different to other studies where unprofessional behaviour was found to be more common (Weurlander et al, 2018; Wilson, 2016). Although all of the participants here could cite positive experiences in practice learning. Agreeing with a study on "*Virtuous Practice in Nursing*" in which nurses and students were very committed to delivering empathic care (Kristjansson et al, 2017), recommending that moral role modelling should be at the *"heart of nurse education"*. Whilst noting that professionalism is challenging when the

individual is disaffected by workplace adversity and *"overwhelmed with sadness and disaffection"* (Kristjansson et al, 2017, p34). This is equally true of both clinical and academic staff involved in providing support to students (Glass, 2009). As a link between stress in nurse academics and student outcome has also been observed in previous research (Glass, 2009; McDermid et al, 2016). Thereby agreeing with the existing literature that poor role models can negatively affect compassionate care delivery and resilience (Curtis et al, 2017), that could account for some of the inequities in support in my study. Ultimately though, these seemingly negative experiences can trigger adversity, with a potential for an improved level of resilience and an increased ability to challenge poor practice (White et al, 2018).

5.3.3 Staff support

Of equal importance to resilience was a variety of sources of support in both the PLE and HEI. This includes lecturers, practice educators and mentors to enable academic, practice and emotional competence to develop as noted by Grant and Kinman (2013a). The participants in my study on the whole praised the open door attitude of Faculty and the professional attitude of most nurses in practice.

Divergence though was noted in my findings in relation to the parity of support provided both in the practice and the academic environment which could be a barrier to resilience formation. This was affected by the availability, accessibility and approachability of staff (Douglas et al, 2015; Froneman, Du Plessis and Koen 2016). If all three were not present then participants felt unsupported which was exacerbated if peers were experiencing good support.

As much as staff support can enable resilience conversely where lacking it will deplete resilience (White et al, 2018). These inequities in support in both the practice and academic settings is at odds with most previous research in the UK where practice has been cited as the most challenging setting (Crombie et al, 2013). In the HEI the personal tutor system, use of

hourly paid lecturers based off site and interpersonal issues did however cause challenges for participants. Crombie et al, (2013) note that academic links need to be strong to support issues in the practice setting. Whereas other studies have acknowledged a devaluing of students if staff have not responded to emails or failed to be receptive to requests for support (Froneman, Du Plessis and Koen, 2016). If support is not strong in one triality of the participants' life worlds this clearly affects their ability to perform in the others.

In my study student-led social networking through texting for support with peers or friends was cited as an enabler. Sigalit, Sivia and Michal, (2016) noted an improvement in group resilience when social media was utilised to support students on clinical placements. This and the use of Twitter (Stephens, 2012) has been found to have a short-term increase in group and individual reports of resilience.

Several studies have recently evaluated educational interventions as useful in the development of resilience in student nurses, such as compassionate clinical supervision (Stacey et al, 2017), mindfulness (Mathad, Pradhan and Rajesh, 2017; Van der Riet et al, 2015) or a communications course (Sigalit, Sivia and Michal, 2016). The participants in my study cited simulation and reflection as those of use within the curriculum for several reasons.

5.3.4 Immersive Simulation for Building Resilience

I found that an educational strategy vital for building resilience was simulation. The participants valued simulation as useful for resilience as it involved active or experiential learning exposing students to challenging or adverse situations with actors which made it authentic. This resulted in deep learning as all of the participants could remember each scenario over the three year course whether they had been involved in the role play or as an observer. Thus there is more likelihood that these experiences could be drawn on in practice situations which challenged resilience (McKinnon and Lowe, 2011). It also closed the theory-

practice gap (Rolfe, 1998; Maben and Griffiths, 2008), in terms of bringing learning from lectures, seminars and practice settings together to make sense of the tests of resilience.

I concluded that participants appeared to value simulation as it helps assimilate theory into a practice context. Indeed practitioners, researchers and educators have identified a global common 'theory-practice' gap in many aspects of nurse education (Rolfe, 1998; Maben and Griffiths, 2008). While theoretically, ideal values may be taught in the classroom, students find that learning 'how' in the real world of practice is quite a different process. Interventions which can close this gap for students may also be more effective in terms of creating practitioners who will not compromise on their values when under pressure in the real world of practice (Maben et al, 2012b; Francis, 2017). Evident in the statements from my participants.

Simulation can be scheduled during traditional practice learning hours. The UK regulatory body for nursing reminds nurse educators that it must be utilised effectively to empower students but be proportionate to other teaching methods (NMC, 2018b). Traditionally utilised for clinical skills, engaging students to use interpersonal skills or non-technical competence through simulation is a relatively new but effective phenomenon (Bauchat, Seropian and Jeffries, 2016). Simulation is scheduled during practice learning hours currently for just a total of 13 days during the course in my own institution. This is in recognition of the important role of the real world of practice in socialisation and professionalisation (Berragon, 2011). Also in order to afford students an opportunity to experience emotional challenges to further resilience work.

The results of my study confer with the paucity of research into educational strategies supporting resilience in that it enables the students to debrief away from clinical practice (Stacey et al, 2017). In the "real world" of practice, patient needs are prioritised not the

students' learning experience (Ricketts, 2011). In simulation time, and space is created which is often missing in the lived experience of practice, as patient safety and mentor workload often mean that staff are challenged to provide a quality learning experience (Nehring, 2009).

Facilitators are either experienced academics or clinicians well versed in discussing the problematic *"reality shock"* of practice (Chamberlain et al, 2016). This is alongside an exploration of the emotional labour of nursing (International Nurses Association of Clinical Simulation and Learning, INACSL, 2016), role development, professionalisation and social learning is also encouraged through the use of simulation and professional discussion (Berragan, 2011; Ricketts, 2011; Moule, 2011; Grant and Kinman, 2013a). As I found, all of these areas have been cited in this study as testing of resilience. Therefore this mechanism offered some support and preparation for the tests.

The reality of the scenarios is key in preparing students for challenges in practice and all scenarios are written with clinical experts for accuracy (Larue, Pepin and Allard, 2015). The participants in my study all found the scenarios authentic. Talking and sharing solutions for difficult and often emotional aspects of nursing is particularly noted as supportive. Hence this is a psychologically safer space due to being outside of the challenges of real patient care (Fey et al, 2014; HEE, 2019). The emotional context of learning requires attention too, with the psychological safety of learners at the forefront of learning in this activity (DeCaporale-Ryan Dadiz and Peyre, 2016; Burbach et al, 2016).

Similar studies have found that through simulation exposure to people with mental health illness (Alexander et al, 2018) and learning disabilities (Saunder and Berridge, 2015) has proved beneficial. This has resulted in an increase in associated knowledge and skills with a decrease in unfavourable attitudes towards people often labelled as challenging patients. Scenarios involving actors emulate client groups less commonly experienced in placements,

thereby more adequately preparing the participants in my study for difficult situations outside of their immediate skillset.

Research using simulation to deal with neonatal bereavement found that, whilst student midwives were competent with resuscitation skills, the majority struggled with the emotional challenges when the baby died (Donovan and Forster, 2015). Hence simulation needs to facilitate preparation of the so-called softer skills linked to resilience characteristics (Southwick and Charney, 2013; Hart et al, 2016), albeit in a psychologically safe environment (Liebrecht and Montenery, 2016; DeCaporale-Ryan, Dadiz and Peyre, 2016). Without resilience, competence in the appropriate interpersonal skills dealing effectively with this type of emotion work would be difficult (Loftus, 1998). This is an area previously noted as a deficit in simulation before (Hurley et al, 2019).

The underpinning pedagogies are not always transparent in the nursing literature supporting simulation and there is a gap in research which evaluates the long term success of this intervention. For instance Pines et al (2014) found simulation to be of use in building resilience in their research with student nurses. However they did not fully articulate the strategies used nor the mechanisms underpinning the intervention. Yet Bauchat, Seropian and Jeffries, (2016) recommend that understanding the adult learning theories, that underpin educational techniques to teach non-technical skills, is fundamental. My study may add to the body of knowledge in this area.

Simulation has been described as an interactive learning experience which emulates the "real world" of clinical practice (Bland, Topping and Wood, 2011). In this learning activity it involves the use of role play for students, using actors as patients or staff working through carefully constructed scenarios with clear learning outcomes (Illeris, 2014; Berragan, 2011). The facilitator role as coach, mentor and lead for feedback is also an important feature

(Roberts, 2012). However the student perspective and learning experience both in theory and practice is a main driver here which differs from other more tutor-led forms of teaching (Roberts, 2012). Putting the student at the heart of the learning experience and valuing their thoughts, feelings and decisions is more likely to encourage a deeper learning and positive experience (Bland, Topping and Wood, 2011).

It is thought that by allowing students time and space to deconstruct the learning from practice, a deeper understanding of what they have witnessed may be achieved (Brown, Collins and Duguid, 1989). This allows for interpretive story telling essential for the transmission of knowledge (Lave and Wenger, 2011). It provides a concrete experience upon which students can then reflect (Kolb, 1984; Gibbs, 1988). Students are reminded of previously taught theory via a poster, video clips and discussion throughout the day. Abstract conceptualisation occurs at this stage and later when debriefing takes place (Pearson and McLafferty, 2011). This may also help realignment with previous taught knowledge and assist with a transformation in learning (Illeris, 2014).

The difficulties noted by participants with this strategy or tool were related to the skills of the facilitator and their willingness to engage in the scenarios through role modelling good practice. Training and skill of the facilitator, particularly related to debrief, is crucial to effective learning in simulation (INACSL, 2016). Debriefing is a reflective discussion which allows sense-making of an event (Fey et al, 2014). Yet unless a standardised approach is used this could be less effective (DeCaporale-Ryan, Dadiz and Peyre, 2016). HEE (2019) also note that only those predisposed to techniques such as mindfulness, used in secondary resilience interventions, will find that they work. This is a reminder of the need for a varied, or toolbox approach, to utilising resilience resources.

5.3.5 Teaching the Art of Reflection for Resilience

I found that participants in my study were frustrated with current strategies to teach reflection. Although they understood the professional requirement to undertake reflection and saw some potential use for resilience building. This is in keeping with other studies in which reflection has been described as repetitive, an academic exercise and increasing of student workload (Clohessy, McKellar and Fleet, 2019). As this is a requirement of all registered nurses, including this researcher, it is worth considering other ways of capturing reflection and reflexivity (RCN, 2019). Other studies have similarly shown that students wish for a variety of models, frameworks and examples of how to reflect to be taught (Clarke, 2014; Parrish and Crookes, 2014). Reflective diaries or journals, blogs and vlogs could be of use and more accessible, providing a more timely method to offload (Atkins and Schutz, 2013). Utilising alumni and role models to demonstrate other vehicles for reflection could be more beneficial (Duke, 2013). All recommendations in alignment with my findings.

The value of reflection in managing emotional challenges and dealing with the affective domain of learning lends itself well to resilience building (Rees, 2013). Indeed emotions are the trigger for most episodes of reflection upon and in practice (Duke, 2013; Rees, 2013; Bagheri et al, 2019 and Bulman and Schutz, 2013). Enabling students to value emotions, which are identified as adversity or stressors, as the starting point of resilience work, could be of benefit. I found that participants cited that managing confidentiality within this activity was a key barrier to resilience development, particularly associated with reflection. Therefore addressing this is key within this intervention.

I also found though that reflection was of use to some in dealing with the tests, facilitating coping and separating the trialities of their worlds. My participants demonstrated that these skills are all fundamental in resilience building alongside critical thinking and problem-solving (Southwick and Charney, 2013). However within the international literature the

challenges to learning reflective practices from the students perspective, particularly written techniques, is also noted in seminal nursing texts (Maddison et al, 2013; Parrish and Crookes, 2014; Duke, 2013). Albeit that creating curricula which overtly and effectively introduces students to this skill remains essential (Clarke, 2014; Parrish and Crookes, 2014; Rees, 2013). The same nurse educators indeed argue for caution though, in protecting novice nurses from revealing too many heart felt secrets and leaving themselves open to criticism or professional sanction if they are too honest. It appears that promoting a balance of candour and self-protection, regarding what is appropriate for the professional arena, is also a priority when resilience building. A finding similar to that of Leary (2003), related to emotion management for self-presentation, or behaviours deemed as fit for public display.

Additionally Kelsey and Hayes (2015) have a problematized interpretation of reflection. They view this professional requirement as being in use by the state to control the thoughts and practices of nurses in a subversive way, by prioritising reflective accounts and promoting rigid adherence to guidelines and evidence-based practice. Unfortunately this is an inflexible approach and could prevent creative problem solving. More of a worry in relation to resilience, accounts could also be used against individuals if students were deemed not to be coping (Howe, Smajdor and Stokel, 2014). Thereby denoting the responsibility for resilience as individual (Hart et al, 2016; HEE, 2019). Clearly discussing the appropriate sphere of revelation from personal to professional realms is required in using this strategy (Bulman and Schutz, 2013).

Whilst both simulation and reflective practice are of value and in use in the curriculum there are challenges and improvements following the participants' evaluation. Both appear to work through *"bridging the gap"* (Arendt, 1981, p32) between the reality shocks in the outer world with the inner work of the mind. Reflecting on and transforming the experience into

one to be learned from (Vasterling, 2007). However techniques to facilitate this transformational learning experience are important and require attention.

5.3.6 The Resilience Framework

I used the work of Hart, Blincow and Cameron, (2012) to make sense of the self-led tools that participants utilised away from practice and the HEI, at home. This allowed me to situate these findings within a resilience theory which furthered my understanding of this part of the process. The Resilience Framework has been used to work with people to build resilience by focussing on a positive or asset based approach (Hart, Blincow and Thomas, 2008). Based on the work of Masten's (2002) ordinary magic, it plays to people's strengths and encourages a focus on areas for development. The components key to the framework such as belonging, learning, coping and knowledge of self are considered crucial in resilience building (Southwick and Charney, 2013; Richardson, 2002 and Robertson, 2016). It was clear from discussing resilience resources, that participants were already considering their resilience characteristics and sources of strength (Richardson, 2002).

The "basics" component though is often missing in the resilience literature, yet is fundamental for moving forward in problem-solving in other areas of resilience support (Hart, Blincow and Cameron, 2012). Indeed I did not spot the importance of these elements within my data until I used this theoretical lens (Finlay, 2011). I believe that I have extended key principles from the Resilience Framework (Hart, Blincow and Cameron, 2012) to further an understanding of the tools for resilience work. Thereby adding to resilience knowledge in a new context or population, within that of nurse education and student nurses.

Table 6 demonstrates that relatively easily all of the participants had in fact identified their own assets and areas to focus on for resilience building. Several had experienced issues with sleep on the course due to academic workload. The requirement to work shift patterns and financial difficulty meant that they were working outside of the course and fatigued. Altered

sleep patterns is noted as a symptom of occupational stress (Por et al, 2011). Yet being short on sleep appears a common problem within the nursing profession (Hudacek, 2017). Exercise and healthy eating was equally challenging due to time constraints but essential to resilience practice. Once the basics were in place, the participants alluded too many of the other components reiterated in the framework which underpinned my findings, such as making friends. Additionally, many of these facets related to developing resilience appeared in my findings as cited earlier in this chapter. Therefore this table serves as a summary for explaining how resilience tools or practices are effective for this group and illuminates shared personal characteristics.

Table 6 Recognition of enablers for developing resilience mapped to the Resilience Framework (Hart, Blincow and Cameron, 2012)

Name of student	Basics	Belonging	Learning	Coping	Core self
Sarah	Sleep Exercise	Find somewhere to belong Make friends		Being brave	Hope
Martha	Exercise	Find somewhere to belong- placement/nursing Keep relationships going (kids)		Putting on rose tinted glasses- is positive Calming and self-soothing Have a laugh	Help the person to know her/himself
Cathy	Sleep Healthy diet Leisure and work	Make friends Healthy relationships Someone to count on	Map out career or life plan	Being brave Have a laugh	Help the person to know him or herself

Natasha	Sleep Enough money to live	Make friends/peers	Engaging with mentors	Being brave Calming and self-soothing (in the face of the dying)	
Julie	Leisure Being safe	Make friends and mix	Highlight achievements Develop life skills	Identifying and solving problems	Self-advocacy
Jayne	Healthy diet Sleep	Make friends and mix Focus on the good times	Highlight achievements	Being brave	Help the person to know him or herself Foster talents
Lorna	Sleep Healthy diet Exercise & fresh air	Focus on the good times Make friends	Map out career or life plan	Being brave Rose-tinted glasses Have a laugh	Promote understanding of others

5.3.7 Peer support

Belonging was associated with friends, family and the importance of peer support on the course. Although some cited belonging to the nursing profession as key to their resilience. Belonging and identifying with a group, here the nursing profession, is also significant in resilience work (Hart, Blincow and Cameron, 2012; Williamson, Health and Proctor-Childs, 2013). Several participants highlighted reflecting on achievements as part of resilience building and having a career plan. The importance of 'career resilience' and having a long-term career plan has been shown to be supportive of resilience in previous studies (Waddell et al, 2015). Nearly all mentioned the phrase 'being brave' and declared that this was a

requirement for nursing. Others combined bravery with other attributes such as being calm or self-soothing and focusing on the good times as a strategy for dealing with lack of sleep.

The importance of social connections was central to acknowledging issues and taking action to complete their goals (Reyes et al, 2015). Indeed the essential mechanism of staying connected with others is cited in all of the resilience theories based on previous research. This is then a protective factor against stress or burnout (Southwick and Charney, 2013; Robertson, 2016; Richardson, 2002). Porteous and Machin, (2018) noted similar findings in their study of first year student nurses in relation to peer support and a sense of community, as enhancing their resilience. Participants in that study also valued sharing the same challenges and goals which enabled support and the development of resilience during the course.

The participants in my study gave added insight into the operationalisation of peer support including the random nature of how these relationships developed. Specificity regarding how the process of reaching out to each other was described. Whether this was via the phone, text or social media at all hours of the day or night. This does not appear to feature in any previous study with student nurses and appears to diverge from recommendations which try to formalise support in *"buddying"* arrangements (HEE, 2018). Where students did feel more formal arrangements were required was in relation to accessing more senior students as well as in harnessing alumni as role models. These agents were viewed as pivotal in driving the participants and peers closer to their end goal of becoming a nurse for they were living proof that this was attainable. The importance of goal setting is recognised within the resilience theories and empirical studies (HEE, 2019; McAllister and McKinnon, 2009; Hart, Blincow and Cameron, 2012).

5.3.8 Self-led Personal practices

Most of the students cited extensive personal practice as enablers of resilience including yoga, other forms of exercise, writing, texting, reading, driving and watching motivational speakers. *"Me time"* for movies and music were all described as helpful in dealing with stressors. It is important that such self-care techniques were noted in all of the students as this is vital to resilience development (Andrews, Tierney and Seers, 2019; Southwick and Charney, 2013; Robertson, 2016). It appears from the participants as cited earlier, that mental activity and cognitive work creating space for internal thought processes (Arendt, 1981), is crucial to enacting resilience in public spheres of life.

Interestingly this level of personal practice has not previously been identified in other studies. Although admittedly the students liable to volunteer for this type of research could well have an enhanced understanding or interest in resilience. However this is new knowledge which may add to some understanding of resilience in nurse education.

A feature of other resilience research outside of nursing has acknowledged the importance of spirituality or faith (Southwick and Charney, 2013; Robertson, 2016). This has also been found in some nursing and nurse education studies (Gillespie et al, 2007; Mathad, Pradhan and Rajesh, 2017). Yet in my study this was not mentioned at all by the participants, however an ability to positively reframe stressors (Onan, Karaca and Barsal, 2018; Hart, Blincow and Cameron, 2012) and inherent optimism (Southwick and Charney, 2013) was evident from their responses.

5.4 Reflexivity for Resilience –or how resilience works…

I found that explicitly breaking down participants' understanding of resilience revealed some insights into the more internal processes important to resilience work. This section builds on the tests and the tools to explore the literature supporting the final part of becoming resilient. Reflection and reflexivity essential to this work were demonstrated by the

participants throughout the interview in their dialogue, description of resilience practices and in the maintenance of resilience. Within this thesis, I differentiate between reflection and reflexivity drawing on Finlay's (2002, p532-533) definitions, where reflection refers to "*thinking about"* and reflexivity relates to *"critical self-awareness".* Therefore in this context I consider the aspects of reflexive processes that participants were using to become resilient.

This is interesting when one of the main findings in this thesis is that strategies for teaching these skills within the course are not always effective. Moreover it is stated that reflexivity is a term poorly applied to nursing or described as elusive (Dowling, 2006). Although aspects have been described previously in resilience research involving cognitive processes such as reflexivity, thinking, disassociating or separating work from home life (Stacey et al, 2017; Clohessy, McKellar and Fleet, 2019; Southwick and Charney, 2013). Others have described the unconscious work that aids emotion management and ultimately resilience (Theodosius, 2006).

In my study resilience work transcended several worlds and role identities as explained by the participants, to which separating the work self from a private self, was crucial (Gray and Smith, 2009). This seems to describe a dispositional mindfulness that some argue is key to resilience work (Chamberlain et al, 2016). Again this supports findings from previous studies which note the requirement for setting boundaries between identities/worlds or the ability to *"switch off"* as essential to resilience. This is essential for students to transition and function within their separate areas of practice learning environment, university and in my study, home (Stacey et al, 2017; Clohessy, McKellar and Fleet, 2019, Larkin, Eatough and Osborne, 2011).

The variety of language and array of terms used by the participants to define resilience reiterates the seemingly universal observation that the concept is multifaceted, complex and

dynamic (Stephens, 2013; Sanderson and Brewer, 2017). Varying descriptions of resilience have been found in other studies suggestive of an individualised understanding (Clohessy, McKellar and Fleet, 2019, HEE, 2019).

I was slightly disconcerted that in my study most participants did not explore the *"bouncing back"* or buoyancy elements typically described as part of resilience (Smith, 2015, p718; Stacey et al, 2017). This is in contrast to a recent small study with student midwives in Australia exploring understandings of resilience (Clohessy, McKellar and Fleet, 2019), which could suggest a lack of resiliency awareness. Yet the terms used by all in my study were common in the resilience literature (Gillespie et al, 2007; Earvoline-Ramirez, 2007; Hart, Blincow and Cameron, 2012). Therefore participants demonstrated an individual understanding of this phenomenon with some shared aspects in common. Consequently this finding contributes to course level resilience knowledge, suggestive of some effective educational approaches within the current curriculum.

5.4.1 Understanding Resilience work

I identified that the participants' understanding and recognition of resilience appears to share some synergy with what is known about resilience to date. Although there are few studies globally that attempt to outline a process or theory for resilience development within nurse education. The process of working through emotions and being in control of them expressed in my study has synergy with Reye et al's (2015, p 2625) grounded theory study of resilience in student nurses.

This theory describes *'pushing through'* challenges experienced on the course, reiterating language used by one of my participants. Robertson (2016, p8) describes the process of resilience work as *'pulling back in order to go forward.*" I also found that most participants appreciated the temporal nature of resilience. As did Richardson (2002) who states that this process can last seconds or years depending on the severity of the stressor. That chimes with

previous acknowledgement in nursing studies that it evolves over time (Stephens, 2013). Again this was recognised as a finding in my study.

According to the participants in this study and McKinnon and Lowe (2011), resilience also involves context specific skills and resources. This means that it can be fluid and variable, thus explaining why in some situations participants' felt in control and in others they felt tested. Having a sense of control, empowerment and self-belief appears essential to the development of resilience (Southwick and Charney, 2013; Hart, Blincow and Cameron, 2012). Hence my study has reiterated some nursing and wider research findings that may resonate with others' experiences and is of use in planning a curricula supportive of resilience.

Some working knowledge of the phenomenon is to be expected given that this is a professional requirement (NMC, 2010; 2018a). Nonetheless it is useful to clarify how this is understood as without a common language confusion could arise within research or teaching (Gerrish and Lathlean, 2015; HEE; 2019). What is useful from the findings is the inference that there is merit in including wider resilience literature in discussions and work with students in the UK. Certain attributes for developing resilience tend to be shared with similar populations and suggests that resilience can be learnt (McKinnon and Lowe, 2011; Southwick and Charney, 2013).

5.4.2 The locus of control-empowerment

The participants in my study further reflected on the importance of the locus of control for resilience. As depicted by Robertson, (2016), this needs to lie with people for them to believe that they can change their behaviour or the situation. This is particularly true in order to move forward in dealing with stressors (Clohessy, McKellar and Fleet, 2019). As neophyte nurses in challenging health care and academic environments, student nurses are potentially vulnerable and therefore in need of strategies to help navigate resources (Hurley et al, 2019).

Accordingly the majority in my study believed that whilst resilience work was their responsibility, they still needed help and support in doing so. The resilience research undertaken by Hart et al (2016) concur with the fact that resilience works on many levels. Advocating that in order to navigate resources those most vulnerable in society require empowerment and support to challenge perceived or real inequities. That said those in my study had managed to navigate resources effectively, if not always efficiently. However, resilience support needs to consider these and wider resilience literature findings (Stephens, 2013; Carroll, 2011; Stacey and Cook, 2019).

Most studies and indeed professional standards (NMC, 2018a) in nursing, previously present an individualistic understanding of resilience formation which negates the impact of external factors (Stacey and Cook, 2019). Whilst HEE (2019; 2018) and the ICN (2016) advocate the need for systems wide or organisational level of support for resilience development. Few studies have previously shown though that students understand that resilience is an organisational, professional group or community responsibility.

5.4.3 Recognising the importance of resilience

The participants recognised the importance of resilience for nursing, as outlined in previous studies. However they added to the complexity of descriptions that exist in nurse education, particularly regarding individual perceptions of resilience. Their lived experiences affirm the view that there is adversity in undertaking nursing work which can be coped with (Stephens, 2013). Indeed Hart et al, (2016) acknowledge that adversity is part of human life and that more work is required which understands to what extent individuals can and do cope.

This also appears a key finding of my work. By asking the participants to score themselves out of 10, in terms of how resilient they felt at the end of the course, this allowed for some understanding of resilience. Most studies measuring resilience do so through quantitative designs with different resilience scales hoping to identify correlates or predictors

of resilience (Windle, Bennett and Noyes, 2011). This alternative approach used in my study, whilst crude, resulted in rich, in-depth data which could add some new insights into how much adversity is required to trigger resilience and how much can be coped with. Especially given the simultaneous stressors that each participant experienced (Galbraith, Brown and Clifton, 2014; Williamson, Health and Proctor-Childs, 2013; Stacey and Cook, 2019).

The resilience scores of the group initially concerned me with regard to the median being just six out of ten. However Li et al (2015) note that either extreme of resilience scores can be indicative of vulnerability in student nurses. Too high a level of resilience and one may not feel adversity nor learn from it. Too low a level and one may have poor empathy and interpersonal skills (Li et al, 2015). It would seem then, based on the resilience literature (Robertson, 2016; Southwick and Charney; McKinnon and Lowe, 2011), and my findings that a score of six is fine, as it signifies an ability to cope. Indeed it indicates a level sufficient to function, in order that nursing can be performed, with enough resilience to protect against the tests of resilience. It also appears that a painful journey is to be expected in nurse training and resilience development. The nature of the tests of resilience and how this is interpreted by the participant will dictate the level of resilience work required to overcome adversity (Richardson, 2002).

A vital factor to facing adversity is to disengage from the stressor in order to refocus, process and review strategies needed to take positive action (Reyes et al, 2015). Southwick and Charney (2013) state that *"bouncing back"* is easier for some more than others though, either due to resources, vulnerability, or lack of exposure previously to adversity. Robertson (2016, p203) describes adversity as the *"tipping point of the self"* and acknowledges that this part of resilience development is *"not a pretty or an easy business."* Richardson (2002) goes further, arguing that disruption to the effects of the stressor is crucial to resilience building and growth.

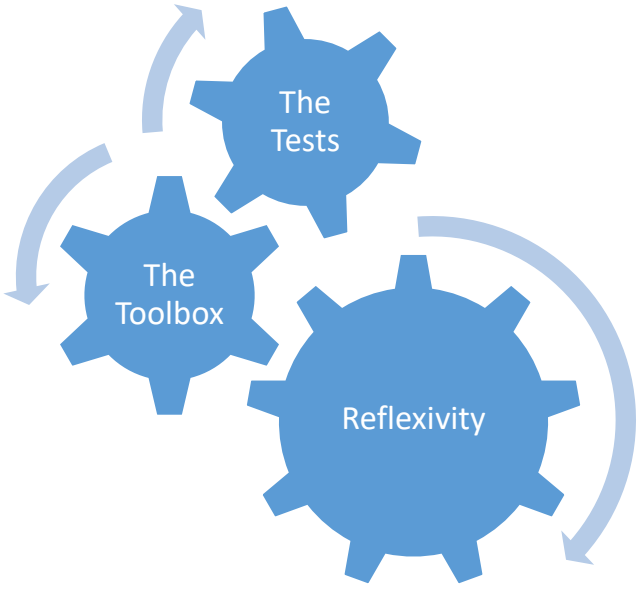
This perhaps explains Lorna's hissy fits and Sarah's comments that "*It's a painful journey, it's been fine!"* McKinnon and Lowe (2011, p xiv) are clear that opting to study nursing means *"You will encounter sadness, pain, worry, impatience, frustration and conflict."* Once faced, this can be overcome and better preparation for this emotional labour could aid resilience work (Delgado et al, 2017; Smith, 2012), thereby agreeing with the '*Boingboing approach'* to resilience (Hart et al, 2016). Facets of this appear in my research findings such as accepting and dealing with the adversity inherent in life (Southwick and Charney, 2013). However, navigating support systems is crucial to this work though.

Reyes et al (2015, p 2626) describe this process of experiencing new stressors in nurse education as *'stepping into'* new situations and experiences. For the participants in my research the most frequently cited difficult new situations were evident across the triality of their life revolving around challenges at home, in practice settings, and academic challenges in the HEI.

Above all I found the process, as per Figure 5.1, useful for summarising becoming resilient. This emphasises the overlap of the components involved similar to the hermeneutic circle, essential for the reflexivity associated with qualitative research methods such as IPA (Finlay, 2011). Each part of the process contributes to the development of resilience yet is neither completely boundaried nor linear (Richardson, 2002). It is a circular, interrelated, iterative process similar in that way to Reyes et al model (2015). The tests stimulate the requirement to delve into the toolbox whilst for resilience maintenance, reflexivity is crucial. Where resilience homeostasis is disrupted, the processes for regaining stability and growing positively from adversity are as below (Richardson, 2002). Without access to these vital components of the process then rebalance and growth may be disrupted (Robertson, 2015). Work is ongoing to maintain resilience (Hart, Blincow and Cameron, 2012). Aspects of this thesis have been previously found, however not in a UK setting. As most other studies in

nurse education are primarily testing interventions without first checking individual understandings of resilience (HEE, 2019; Traynor, 2018).

Figure 5.1 The process for becoming resilient in this study



5.5 Summary

The factors I found, which contributed to the development of resilience within the participant group are supported by the wider resilience and nurse education literature. This study though highlights the process of becoming resilient for this group of individuals within one curriculum at a specific point in time. It is the first to do so at this time in the UK nurse education context and therefore adds new insights to resilience knowledge. Therefore it may be of interest to other educators (Porteous and Machin, 2018). The potential implications of these findings for further research, policy and practice will be considered in the final chapter of this thesis.

The tests of resilience appear in keeping with that reported by nursing students worldwide. This means that strategies recommended by global research may have a place in nurse education in the UK (Sanderson and Brewer, 2017). Of note though, and new knowledge, is the impact of attrition on individual and group resilience. For this group, growing from

adversity required complex work on several levels involving self and others (Hart et al, 2016) affecting their life domains, namely the practice learning setting, HEI and home. Thereby recognising a triality of competing areas for resilience work which in nurse education appears a new concept.

The resilience toolbox bears synergy with advice to date on the need for multiple resources to support resilience work (HEE, 2019; Stephens, 2013). Much of the resilience work occurs in private, being internally focused in the realm of the 'life of the mind', which then leads to externally facing required behaviours (Arendt, 1981; Theodosius, 2006). Explanations of this individual process up to now have been omitted from the literature in both nursing and nurse education in the UK (Traynor, 2018).

However, the external context and resources, within which this work occurs, appears to be of equal importance in validating and encouraging further reflection on resilience. The findings of this study offer some insights as to how this occurs and why it is important work. Above all the participants demonstrated professional values throughout their interviews. They made insightful comments on resilience which adds to an overall understanding within the context of nurse education. This may be of use to others designing curricula on the new NMC Standards (2018b).

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this final chapter the implications of key findings for resilience theory, practice and policy in nurse education will be discussed and linked back to the original research questions. Recommendations, including further research in this area, are also outlined. These are on the whole, directed at the current and new pre-registration nursing curricula within the context of a local HEI. However, as there is a paucity of research in this area, they may be of interest to other nurse educators both globally and within the UK. The latter section of the chapter reflects on the experience of undertaking an IPA study in a nurse education context. It demonstrates reflexivity on the position of the researcher in relation to what I now know regarding resilience knowledge and nurse education since conducting the research.

6.2 Overall impact of the research for theory, practice and policy

This research has impact for theory, practice and policy in nurse education in the following ways. It adds to theoretical understandings of resilience within a nurse education context. Specifically in terms of how adversity may be overcome via mental and cognitive processes such as reflexivity, critical thinking and reflection. Tools such as yoga, mindfulness, distancing and separating home from work life were crucial parts of the final stage of the resilience process. My thesis shows that existing resilience theory from other disciplines can be applied to the nurse education setting in order to explain resilience practice on an individual level, namely the Resilience Framework (Hart, Blincow and Cameron, 2012). Moreover there is also a contribution to educational theory by outlining a process for how strategies such as simulation and reflection help resilience formation. This draws on Kolb's reflective cycle (1984, 2011), adapted to explain the mechanisms underpinning this type of simulation. Figure 6.1 outlines the process later in this chapter.

This work has already impacted at a practical level by influencing curricula development and pastoral support for nursing students. Signposting to other support mechanisms and recognition of the trigger points for the tests of resilience is now embedded throughout the course. Increasing awareness of resilience, resilience practice and a plan to utilise resilience theory from outside of the discipline are all outcomes of this study. It is of note for nurse educators and others involved in health care professional education, particularly with regard to the utility of IPA for research in these disciplines. I firmly believe that the findings would not have been so rich and revealing had another methodology been used due to the level of analysis applied to the data.

Local and national policy may be influenced by sharing best practice via networking. Findings of this research feed into national projects tackling key drivers in nurse education; recruitment, retention, attrition and wellbeing (HEE, 2018; 2019). By providing examples of how new professional body standards can be enacted, other HEI's may implement similar recommendations from this study at a policy and curricula level.

6.3 Main Findings in Respect of the Research Questions

The aim of this research was to explore how student nurses develop resilience within a values based curriculum in a University setting. This is because increasingly, resilience is thought by policy makers and practitioners to be essential for the protection and retention of student nurses (HEE, 2018; NMC, 2018a). My research questions identified the tests of resilience, aids to resilience development and useful educational interventions. When the participants reflected on the whole course and explained what resilience meant, I found that an overall process for becoming resilient emerged. It appears to be a process made up of three parts which are interrelated and traverse a triality of participants' life areas; namely the PLE, HEI and home. This model works on an individual and group level as resilience appears a community asset, as well as a professional attribute.

Part one of the process located the tests of resilience which are essential for triggering resilience work (Davies, 2019). A resilience toolbox was then outlined containing resources supportive of resilience development involving self and others. Finally the internal processes badged as reflexivity for resilience were discussed as part of understanding the phenomenon from the participants' perspective. The original questions were pivotal in isolating the principle themes and will therefore frame the main findings explained further in the following section. The recommendations will be summarised in Table 7 for clarity at the end of this section per research question and is focused on both curricula developments and nurse education research.

1. When and how is resilience tested during nursing education?

Participants in this study explained that the tests of resilience affected all three areas of their life. Within the practice learning environment these were the emotional labour of nursing and the experience of learning in practice; the diminished self. At the HEI academic failure and attrition created adversity. At home, dealing with traumatic life events required resilience work. In my study the emotional labour of nursing can be mitigated by debrief, discussion, linking theory to practice, staff and peer support. Exposure to complex clinical skills and simulation at the HEI prior to placements, especially for cardiac arrest and sudden death, helped with these tests. Although participants stated that an increased preparation for such challenges is required at key points of the curriculum, particularly in the first year and around practice modules.

Academic support and signposting students facing challenges to help, were thought by participants to prevent attrition. Life events happen to all students to a greater and lesser degree for which peer, friends, family and staff support were vital. An overload of stress simultaneously in any area of the three areas could result in resilience being tested.

Recommendation one a) - Increased resilience support within the curriculum and preparation for the likely tests of resilience.

b) Research into attrition and retention to identify the tests on a larger scale and evaluate impact on course progression.

There are various mechanisms through which existing support and preparation for the identified tests can be enhanced. For instance the course should encompass preparation for the graphic nature of nursing as recommended by participants (Morrell-Scott, 2018). Whether by use of technology, simulation or professional discussion. Increased preparation for the emotional tests and academic requirements of the course would also benefit students (Porteous and Machin, 2018). Indeed key parts of the programme have been identified to facilitate this activity as outlined in Table 7 later. Promoting an understanding of the tests from the students' perspective would also be advantageous (Stephens, 2013). Therefore findings from this study have been shared with practice partners and the nature of adversity will continue to be monitored in terms of student evaluations of practice learning areas and theoretical modules (NMC, 2018d). In particular, monitoring feedback for more distal influences negatively impacting the student experience, appears worthy of consideration (McLindon, 2017). For the participants in my study these were primarily more immediate or proximal. However others may benefit from enhanced study skills for academic failure, disability or wellbeing support (Hewett et al, 2018).

Addressing concerns, regarding practice learning and assessment, may be encouraged through implementation of the new NMC (2018 d) Standards for Student Supervision and Assessment in practice learning environments. The new process for assessment may well open up a wider support network with a team approach to student learning. Conducting this research has led me to conclude that this new approach could negate the potential for

incivility and promote a fairer assessment (Thomas, Jinks and Jack, 2015). This replaces the previous system, in which predominately one mentor was responsible for undertaking the assessment, which could lead to personality clashes and subjective assessment (Jack et al, 2018). A practice assessor now collates objective wider evidence, from several practice supervisors, and makes an overall assessment on the student's competence, knowledge and attitude (NMC, 2018 d). The new role of the Academic Assessor, based within the HEI, but linking with practice supervisors/assessors may also help, through increased partnership working between these student worlds. Thereby providing another layer of support for practice learning environments.

Improved signposting to existing support mechanisms such as mental health advisers, counsellors, disability and welfare teams (HEE, 2019) in the current and future curricula, could mitigate some of these stressors. For staff and students, policies, which provide clarity on how individuals and the professional community can navigate their way to psychological, social, cultural and physical resources that can sustain resilience, are essential (Ungar, 2008). This includes the process for raising concerns regarding self or a peer. Destigmatisation of mental health services in particular may require work as some students appear not to view this support as being for them (Cameron et al, 2018). Since I conducted this research nursing students have also seen their NHS bursaries removed adding to existing financial hardship (HEE, 2018). Hence the likelihood that more students will require financial advice as well as wider support. It is these very distal, exosystem and macrosystem influences which are often outside of the immediate control of students, academic and practice staff which can be harder to control and yet impact students - especially those with greater disability and other needs (McLindon, 2017).

Empowering students to raise issues with nurse educators and practice supervisors or assessors in practice is key to resilience building. Findings from my participants suggest that

ongoing pastoral support from within the nurse educator team and in practice settings is vital to allow those who experience complex issues and need extra help to receive it. (HEE, 2019; White et al, 2018). Yet new professional educational standards (NMC, 2018 d), appear to advocate separating objective academic progression from a previous combined academic personal tutor role which most Universities offered (White et al, 2018). I have instigated a new dedicated pre-registration nursing pastoral care team approach at my own HEI as a solution to this issue. I have done this utilising the experience of trained nurse tutors who are familiar with the potential stressors of the course. This type of support may lead to recognition of the risk factors to wellbeing and signs of vicarious trauma and/or PTSD (HEE, 2019, Rees et al, 2015; 2016).

The findings also feed into selection and recruitment processes as adversity is a fact of life particularly associated with a career in nursing (Kristjansson et al, 2017). Therefore these tests cannot be completely eradicated (Hart et al, 2016; McAllister and Lowe, 2011). It is better that course teams be honest when recruiting and selecting candidates to facilitate correct career choices (HEE, 2018). Also important is to advise that resilience strategies must be in development prior to commencing nurse education as this can be learnt and optimised (Stacey et al, 2017; Jackson, Firtko and Edenborough, 2007). However, I would not favour resilience testing as part of recruitment strategies as suggested by some (Howe, Smajdor and Storkl, 2012), given that resilience fluctuates and is dynamic (Richardson, 2002). Instead, an increased awareness of its importance for all entering this profession is desired (Howe, Smajdor and Storkl, 2012; Barratt, 2018).

Focus groups exploring attrition and retention on a wider level would be conducted in the spirit of the RePair Project (HEE, 2018), in partnership with key stakeholders, to incorporate more detailed feedback on this important component of the course. Given the recent changes in student assessment and support in practice learning this is important work on an ongoing

basis. This would be in alignment with second wave research (Richardson, 2002; Hart et al, 2016).

Detail of application within the curriculum-Recommendations include increasing complex clinical skills for acutely or critically ill patients. Clarity on signposting to support, including the new pastoral care team. The introduction of a study skills module in first semester year one to enhance academic and wellbeing skills such as self-care and resilience. Plus the roll out of the new practice learning standards for support and assessment (NMC, 2018, d). Monitoring attrition to illuminate themes negatively impacting the student experience and share with key policy writers locally and nationally (HEE, 2018; RCN, 2018; NMC, 2018c).

2. What aids the development of resilience in student nurses?

I found that resilience development required many resources analogous to a toolbox approach combining self-led activities and those involving others. Peer support, staff support, debrief, identifying key role models, participating in compassionate care, personal resilience practices and tea were all part of effective enablers of resilience. The extent of the personal practices contributes new knowledge to nurse education in the UK. Participants also stated that learning with interprofessional colleagues had enriched their practice experiences. The participants in my study were very active in their resilience work which demonstrated alignment with components of the Resilience Framework (Hart, Blincow and Cameron et al, 2012), as discussed previously. The findings from my study adds insights into how some students' achieve their end goal of completing the course.

Recommendation two- a) Creating and sharing the toolbox approach to resilience development in current and new curricula.

b) Evaluating the effect of resilience practice on a wider scale

By sharing some of these as part of a toolbox, student centred approach advocated in this study, the individual nature of resilience development is recognised and hopefully enhanced (Clohessy, McKellar and Fleet, 2019; HEE, 2019; NMC, 2018a). Feeding these results regionally and nationally, through earlier declared networks, can potentially generate discussion and sharing of best practice (HEE, 2018). Some argue that such discussion is essential too for the development of 'critical resilience' which accounts for the organisational responsibility for resilience (Traynor, 2018). Thus protecting against an overly individualistic approach to resilience responsibility.

What struck me most from the participants' perspective was the acceptance that this work was necessary and lifelong in order to transition into practice and develop *"career resilience"* (Waddell et al, 2015). Thus there is a need to ensure that this requirement is captured within current and future curricula. There is also the potential to share this work with interprofessional colleagues at my institution as a part of interprofessional education modules (Howe, Smajdor and Storkl, 2014). Therefore it is applauded that the NMC (2018b) has recognised the valuable role that non-nurses can play in practice assessment in new professional standards. This should add to the resources available to future students in the practice setting and validates the multidisciplinary context of 21st Century care delivery (Curtis et al, 2017). Hopefully this evidence base, including my small study, could also promote an appraisal of different approaches to resilience development (Peterson and Brommelsiek, 2017), as each profession is recognising the value of collegiate resilience practice (my phrase) or knowledge building in this area (Richardson, 2002).

The Resilience Framework (Hart, Blincow and Cameron, 2012), will be considered within a module at the beginning of the course to raise resilience awareness and encourage students to recognise their strengths and areas for development. As adversity will always be present in nursing and wider society, Hart et al (2016) suggest that resilience can be reframed. This is in

order to consider, to what extent, a certain amount of adversity can be tolerated. On the basis that some individuals can and do cope. The next focus should then be on how much adversity should be endured before targeted group and system level interventions should be arranged. The Resilience Framework could thus act as a trigger for students to seek support at key points of stress in the course. More research in this area could also be of benefit and will be considered shortly.

I have already shared the results of my research in a presentation to academic staff and with cross-field groups of nursing students in the final year of the course at my own Institution. These claimed much interest in this area and that the findings resonated with their experience to date. International colleagues also felt that the findings resonated with their challenges in supporting students. Increased use of alumni as credible role models is also already taking place in response to the findings of this project (HEE, 2018; Porteous and Machin, 2018).

I believe that my research has viewed the course from the perspective of the students in alignment with professional standards (NMC, 2018 a-d). This was done with an aim of empowering them to become more active partners in their learning journey and advocate against inequities in support. The shift in focus of the Quality Standards Framework (HEE, 2017) which prioritises the quality of PLE experience for students on the course, is also welcomed. The resilience literature, related to this study, suggests that there is still work to do though. In terms of creating a culture in both practice learning and the HEI environments, that recognises and values learners as future members of the workforce (HEE, 2018).

Detail of application within the curriculum -Discussion of self-led practices in the new curriculum in a study skills module on resilience theory, practice, policy and self-care. Students to create five year career plan which includes resilience strategies as part of final year module; highlighting peer support, role models and staff support for activities involving

others. Focus groups to take place to evaluate resilience support within and without the curriculum (Second wave research).

3. Which, if any, educational strategies, currently within the curriculum, aid resilience formation?

This study has the potential to add to the evidence base underpinning simulation and reflection which were found to be of use for aiding resilience formation. Simulation was effective as it was authentic and featured many of the tests of resilience for this group. Many of the mechanisms which aid resilience development are features of simulation such as staff and peer support, debrief, supporting ethical decision making and role modelling. It was recognised that the preparation for some of the tests occurred in this forum. All of the participants suggested an increase in immersive simulation and that reflection should be taught with a more practical application in mind and less academic focus.

I found new information regarding the learning process for resilience through simulation which can be further explained by adopting Kolb's reflective cycle (1984), as shown in the Figure 6.1 below. It could well be analogous to the resilience building process itself whereby a lived experience triggers adversity and emotions which then stimulates reflection on feelings or emotions and resilience processes, resulting in the required professional behaviour, here resilience (Hart et al, 2016).

Figure 6.1 Kolb (1984; 2011) as applied to simulation enhancing resilience work in nurse education

Recommendation three- a) Optimise formal planned strategies for resilience building including discussion of theoretical underpinnings for how these may work.

b) Research to evaluate new reflection strategies within the curricula

Interestingly the NMC (2018a) concur with this approach increasing the amount of practice learning hours which can be used as simulation. Again, this is timely. These could be used to cover awareness of how to better challenge system level issues which test resilience. This is believed to be in the spirit of the new nursing education framework. Thus incorporating recent reports as part of simulation, which acknowledges the importance of nurses in recognising patient acuity and uses quality improvement methodology. In order to challenge issues with data, for instance regarding the "safer staffing jigsaw" which is considered fundamental (Ball

et al, 2019, p84). As curricula which do not feature organisational and systems level responsibility for resilience nor promote skills for navigation of these, will render all educational resilience interventions *"incomplete"* (Taylor, 2019).

Although reflection was equally important as an educational strategy for resilience there were issues with the way it is taught which requires a review (Clohessy, McKellar and Fleet, 2018). Varied less restrictive approaches incorporating blogs and other social media whilst reminding students to be mindful of confidentiality is desired. Yet supporting creativity in sharing the learning from practice or academic challenges is required (White et al, 2018). A review of current and future teaching of reflection is needed in light of the findings which encompasses a broader range of reflective techniques. This would result in a career wide approach or career resilience as per Waddell et al (2015), promoting strategies for staying resilient.

Nurse education that also features ethical decision making as part of virtue/character education is also a prerequisite (Francis, 2017; Kristjansson et al, 2017, JCCV, 2017), and features in all of the aforementioned policy. The thinking being that improved ethical decision making is another tool to strengthen character especially for resilience growth. The curricula at my institution has an ethics thread throughout, which involves simulation scenarios. One module is also devoted to ethical decision making in the context of nursing. Additionally, practice assessment recognises the importance of the ethical component of nurse's work.

Detail of application within the curriculum - Maintain current curricula resilience activity as this appears to be protective for some students. Increase in the immersive simulation hours and content within the curriculum to aid promotion of the new proficiencies. Review of strategies to teach reflection incorporating a broader more student-centred approach. A summary of the new curricula level resilience support capturing key recommendations is

outlined in the table below. An online questionnaire to capture feedback on how effective reflective teaching methods are in the new curriculum (Third wave research).

Table 7 Planned Resilience support within the new curriculum

Resilience Support	**Place in New Curriculum**
Academic Assessor- supports academic and practice progression per year	Allocated a different tutor per year as per professional standards
Nursing Pastoral Care Team	Available from commencing the course
HEI wellbeing support- University mental health advisors, counsellors, disability team, student support	Available from commencing the course
Study Skills module- includes academic writing support, database searching, numeracy, reflection, self-care and resilience sessions	Year 1, semester 1
Core Capabilities- professional values/behaviours captured within practice assessments and portfolio	Commenced in semester 1 within the study skills module Portfolio assessed at end of each year as a component of successful completion of the Part/Year of the course
Mental Health First Aid	Year 1, semester 2
Interpersonal Simulation- 15 days (1 day, scenario on resilience) Group facilitators	Every practice module
Ethics module	Beginning of year two
Clinical skills simulation/CPR scenario simulation (1 day)	Beginning of each year
First Aid with actors	Beginning of each year
Practice support- Practice Supervisors, Practice Assessors, Academic Assessors Practice Education Facilitators/Educators- (practice based, support mentors and students) Practice Education Team Lecturers (based at HEI but practice and student facing)	Every practice module

Practice module leaders	
Theory based modules- seminar leaders, module leaders	Every theory module
Literature review- Supervisor	Throughout 3rd year
Transition to the Autonomous Practitioner - module with 5 year career plan (includes resilience lecture and practice)	Final theory module year 3

4. How do student nurses understand the term 'resilience' in nursing? Do they see it as important?

This study appears to contribute to knowledge construction (Tomkins and Eatough, 2010) related to both an understanding of resilience from the individual participants' perspective and the formation of resilience for this group. The language used to describe resilience was coping, dealing with emotion and/or feelings, overcoming challenges and stress, which is in keeping with previous research inside and outside of nurse education (Hart et al, 2016; Stacey and Cook, 2019). All of the participants acknowledged the importance of resilience as vital in functioning as a nurse, protective of them against the challenges of nursing, essential for personal transformations and stated that this is a work in progress. Yet it equally enables bouncing back from life events as in my study some participants had dropped to a score of 3-4 out of 10 when considering their own resilience but still had capacity for resilience growth. An understanding of resilience work as private internal mental activity involving several cognitive processes such as reflexivity, thinking, disassociating or separating work from home life was demonstrated. Some aspects of 'The Life of the Mind' by Hannah Arendt (1981) and a 'Boingboing Resilience' approach (Hart et al, 2016) were utilised in a nurse education setting as theoretical lenses through which to view and make sense of these seemingly new findings (Finlay, 2011).

Recommendation four- a) Add to resilience theory construction in nurse education

b) Collaborate in multi-site HEI/PLE research exploring resilience in the UK (Fourth wave research)

Understanding resilience from the students' perspective can lead to better design of curricula supportive of resilience development (HEE, 2019). Many of the elements of the Resilience Framework (Hart, Blincow and Cameron, 2012), were alluded to by participants when reflecting on resilience in nursing. Hence this may be a potential tool for use in resilience teaching worthy of future exploration through further research. This is thought to support a 'critical resilience' and more person-centred approach (Traynor, 2018). Incorporating wider resilience theory in teaching should be beneficial according to my findings. (Reyes et al, 2015; Richardson, 2002; Earvolina-Ramirez, 2007). Using terms other than resilience may resonate with other students' experience and open up dialogue regarding the challenges of coping with changing health care environments and landscape (HEE, 2019; Scammell, 2018).

Definitions of resilience, which provide a wider environmental context within which adversity is situated, are needed to appreciate the power imbalances and social inequalities that exist (Hart et al, 2016) here, for students within professional settings (HEE, 2018). In recognition of this, based on the findings of my research and others' work (Stacey and Cook, 2019), a new course learning outcome has been developed which recognises a wider approach to resilience. Thus meeting the new educational standards (NMC, 2018) but less individualistic.

"Produce emotionally intelligent and resilient nurses, who are able to manage their own personal health and wellbeing, and know when and how to access support in order to provide person-centred nursing care, whilst challenging systems that affect resilience and wellbeing for staff and patients." (HEI Course Specification, 2019)

A focus on the actual process of becoming resilient in a nurse education setting does not appear to have been articulated previously in the UK. However my study does have synergy

with findings from research investigating resilience with six student midwives which utilised qualitative methods in Australia (Clohessy, McKellar and Fleet, 2019). In my study the participants presented as resilient, engaged in practices supportive of resilience and had successfully navigated resources both inside and outside of the course as part of *'staying the course'* (Reyes et al, 2015; Hart et al, 2016). This suggests that current resilience training is effective for some students and should remain as a platform from which to build resilience literacy and practice. Reinforcing that the wider resilience evidence base to date may be of use in nursing and nurse education settings on an individual and group level within the context of my study (McKinnon and Lowe, 2011).

Thereby developing a curriculum foci that inculcates both the professional values and practice of resilience for a career approach. With the potential of a decrease in attrition and ultimately a local stable and sustainable workforce (Waddell et al, 2015). Both HEE (2018; 2019) and the NMC (2018a) have tasked nurse educators in the UK, through professional standards and policy formation, with providing strategies and support for nursing students in this area. Therefore my findings could be of interest to other nurse educators seeking to explore resilience knowledge and strategies. Dissemination of the findings of this research will be undertaken locally and possibly nationally, through nurse educator networks and the RCN Educator Forum. Particularly as I am now the lead for pre-registration nursing courses in my HEI, which includes curriculum development, delivery, evaluation and research to underpin the educational framework.

Detail of application - Share the findings of this research for critical discussion with students, staff (HEI and PLE) and the wider nurse education community. In order to enhance understanding of how the process of becoming resilient may work at an individual and group level. Further research is required to explore the process of 'becoming resilient' on a wider

scale across the fields of nursing and in collaboration with nurse educators and practice partners throughout the UK (fourth wave research).

6.4 Further research

This section considers the limitations of my research design and acknowledges the need for further research utilising a mixed-methods design building on the findings. My research has limitations in that this was a single case study approach with one University and a small group of participants. Therefore there is a need for more research from the learner's perspective to evaluate the value of these novel strategies (Berragon, 2011; Cordeau, 2010). A study to implement the Resilience Framework as part of resilience training within the study skills module, first semester, will be discussed with senior school managers and colleagues in order to enhance both student, staff and school resilience. As one advantage of the framework is that it allows for the resilience practitioner, or nurse educator in this instance, to work on their own resilience at the same time as working with students (Hart, Blincow and Thomas, 2008). Given the links between nurse academic wellbeing and student outcomes (Glass, 2009) and the importance of role modelling to resilience building, I would advocate this approach. I plan to continue nurse education research into the effectiveness of both practice learning and resilience building strategies due to the symbiotic nature of the two as modelled in this thesis.

I favour a longitudinal cohort study utilising mixed methods, quantitative surveys enabling statistical analysis of key responses and qualitative approaches capturing focus group data (Creswell and Porth, 2018). This would be useful to further the knowledge in this vital area, capturing baseline resilience levels, as students commence the course, and post intervention to measure the effectiveness of engagement with the Resilience Framework (Hart, Blincow and Cameron, 2012) and obtain qualitative feedback on the experience of using this tool. There is a dearth of research showing a long-term effective approach to resilience and self-

care within nursing (Andrews, Tierney and Seers, 2019) and nurse education. Given the work force crisis and professional requirement to maintain resilience over a career, this detail is missing from the current resilience knowledge base (Wadell et al, 2015). A co-production research design which considered the input of students, alumni, service users, HEI and practice learning staff as a steering group and researchers in the 'Boingboing resilience' research approach is also advocated (Hart et al, 2016).

This small study was conducted at a specific point in time with the previous professional body educational standards (NMC, 2010), a different curriculum and more mature students. Research with a wider demographic pool of participants is needed to investigate which resilience strategies work for younger, less experienced students. Particularly in light of guidance from HEE which cites that newer generations have different mental health needs (HEE, 2019). Participants in my research were on the whole mature students whose previous exposure to life events and work experience may have facilitated some growth in resilience. Due to the changing demographic to that of younger direct school entrants with the implementation of tuition fees, nurse education is may now be too costly for mature students. More research is required therefore, to enable all students to *"thrive, develop empathy and build resilience"* (HEE, 2019, p4).

Future research, such as Rees et al (2016) using the International Collaboration for Workforce Resilience model, which internationally explores the impact of stress on both students and nurses, is desirable to share findings and suggestions for resilience building. Nurse educators should unite to critically discuss findings (WHO, 2016), including the multiple interventions aimed at character education and resilience building. Alongside clinical partners the nursing voice could be rallied using an informed evidence base to influence policy makers (ICN, 2016). Indeed, whilst at the RCN Educators Forum

Conference (2019), I made contact with a small group of researchers who may work together in pursuit of developing an evidence base in this area for nurse education in the UK.

Nurse educators and practice partners must view challenges to nurse education in a optimistic light by role modelling resilience, as per Hart, Blincow and Thomas's (2008) ethos, for successful resilience practise. This is preferable to concentrating on the failings of a less than ideal system.

6.5 Researcher reflexivity and resilience

I undertook the Doctorate in Education to further my own practice and hopefully offer insights to others. Therefore it is now timely to reflect on the experience and the chosen methodology. A criticism of qualitative research, and particularly IPA, is that the project morphs into the researcher's own thoughts and opinions on a subject in place of the participants (Dowling, 2006; Paley, 2017). Nonetheless, accounting for my role in this project as a practitioner researcher is an attempt to be transparent about how I used my insider knowledge to enhance the resilience conversation with participants. However, whilst safeguarding against substituting the data for my resilience journey through nurse education (Finlay, 2002). Yet completing this study has developed both my resilience knowledge, resilience and understanding of the student journey through nurse education. I have also gained new skills in the realm of qualitative research by applying IPA for the first time.

I commenced this thesis with a conceptual analysis of resilience based on others work (Stephens, 2013; Rogers, 1989). However I quickly became aware that there was more merit in suspending beliefs in order to truly listen to participants (Tweedlie, 2013; Finlay, 2008). I did this by prioritising what they had to say on the subject of adversity in nurse education and how this can be overcome. Conducting the interviews was a highlight of this process and the

one which I enjoyed the most due to the discursive nature and interpretative insights the participants gave regarding the phenomenon (Tomkins and Eatough, 2010).

Finding out more about the individual participant's journey was a pivotal part in furthering my nurse educator practice. Thus my personal and functional reflexivity has grown due to this endeavour (Tomkins and Eatough, 2010). This has given me insights into the student nurse journey which is necessary, as my own was 30 years ago. I have always hoped to balance empathy with applying the required professional standards as part of my educator practise. Feedback from the participants and their honesty during the interviews has given me new knowledge as to both resilience and the nurse educator role in supporting students. The findings of this work, which incorporates some wider literature within and outside of the field, has informed a recent curriculum review with new professional body standards. Embedding a more 'critical' version of resilience for future nurses in curricula (Traynor, 2018).

Reflexivity is not easy when one is conducting insider research yet it is doable (Smith, Flowers and Larkin, 2009; Finlay, 2002; 2011). This has not been an easy methodology to undertake due to the anxiety of misrepresenting points and knowing which quotes or themes to preference in the wealth of data generated for each participant (Wagstaff et al, 20I4). I have tried to protect against implanting my beliefs regarding nurse education, nursing and my memories of the cohorts into the data through reflexivity (Dowling, 2006; Clancy, 2013). Specifically from auditing, via a reflective journal, decisions made as part of my research journey (Finlay, 2002). Yet I hope that my respect for the participants and disciplined practice of re-checking the data tirelessly, to evidence the origins of any themes or subthemes, has mitigated against this issue (Finlay, 2011). Indeed I do feel that most of the findings were co-constructed with the participants' from their experience. Yet the meaning

attributed, to their statements, has been developed by my analysis through the application of IPA (Tomkins and Eatough, 2010).

I would use IPA again as, whilst time consuming in the data transcription and analysis phase, it felt appropriate to investigate the topic of resilience from the participants' perspective. As both originate in the positive psychology movement (Smith, Flowers and Larkin, 2009). The associated research process, particularly the double hermeneutic, appears key to developing resilience and applying the IPA framework to data. Reflection, analysis, self-awareness, detachment, conscious and unconscious cogitation are all crucial components of the two. However, they both require external validation and the support of others combined with a flexible approach. This was achieved by supervisor and peer feedback. IPA is also growing in popularity within nursing and nurse educator research (Tweedlie, 2013). Therefore support in the application of this methodology, to nursing research, is available and quality studies exist as exemplars (Jack and Wibberley, 2014; Clohessy, McKellar and Fleet 2019).

Throughout this thesis I have commended the professional values demonstrated by the participants in their recounting of resilience. This leads me to conclude that elements of the values based recruitment process and curriculum are a success. Although ongoing support systems are needed to sustain values as well as resilience. Indeed since undertaking this project my personal and professional resilience awareness and practice has grown. I have learnt much from the participants and the resilience literature. A strengths based ethical approach, such as Hart et al (2016), that does not problematize the individual and ignore systems or organisational issues, is in line with my beliefs regarding resilience.

6.6 Conclusion

This thesis presents seven stories or resilience journeys, captured through interviews, following completion by participants of a BSc in Adult Nursing at the same Institution. It is therefore an individualistic snapshot of experience and may not resonate with others. A literature review and wider resilience reading however has added to an understanding of resilience within a nurse education context. IPA was the chosen qualitative methodology applied to the data in order to answer the research questions and is of increasing use in nursing and nurse education. A process for becoming resilient was revealed, formed across a triality of life areas for the participants. The tests, toolbox approach to developing resilience and reflexivity for resilience are thought to add new findings and support others' work in this area. This could be of interest to nurse educators globally and within the UK. Further mixed methods research could build on this work.

National and international nursing policy, which impacts upon resilience and nursing practice, does not always recognise the emotional labour of nursing. This could act as a stressor impacting upon resilience building with regard specifically to the control of the emotions. There is often an individualistic approach to resilience building, that when presented does not always legitimise the role of the environment and organisations within this dynamic. Student nurses, as novices to the profession, are particularly vulnerable to narrow conceptualisations of resilience by practice and academic assessors which could impact on their course progression. However, mechanisms situated within new quality standards frameworks and regulatory body policy could improve this situation, if supported well by a curriculum wide approach to resilience building. This could enable the protection of students whilst learning in order to build their shields. By understanding the resilience journey and process of becoming resilient I hope now to enhance the curriculum, disseminate findings that may be of use to others and consider my own ongoing nurse educator practice.

Appendices

Appendix One- HEI Collaborative Capability Framework

The Collaborative Capability Framework is a tool designed to develop the knowledge skills and attitudes that you will need to demonstrate to work effectively with colleagues from your own and other health care professions for the purpose of high quality safe and effective person-centred care delivery. It is recognised that collaboration is a complex skill which is developed in stages over time. The stages in the development are firstly communication, followed by co-operation and finally collaboration.

The capabilities are a framework which comprises nine capabilities divided between three domains

Domains	Capabilities	Mapping of Teaching on the Course	Mapping of Assessment on the Course
Personal and Professional	Communication Assertiveness Emotional resilience Conflict resolution	1st year Communication module Simulation	Relevant theory assignments Annually via portfolio Every placement via practice books, assignments
Organisational	Team working Role Clarification	2nd year Evidence-based Theory module 2nd year Field specific nursing modules Simulation	Relevant theory assignments Annually via portfolio Every placement via practice books, assignments
Ethical	Ethical Values Decision making Leadership	2nd year Ethics and law module Field specific nursing modules Simulation	Relevant theory assignments Annually via portfolio Every placement via practice books, assignments

		Service Improvement Module Transition to the Accountable Practitioner Module	

As part of the ongoing development of this portfolio, you will be expected to demonstrate evidence;

Year One Personal transformation

Year Two Professional transformation

Year Three Service transformation

Values Based Recruitment as per HEE (2016) recommendations

Values are measured via assessment of UCAS personal statement, at interview via group communication exercise using questions based on situational judgement testing and in individual written work.

Teams of academics, service users and practice partners assess the work for congruity with the Code (NMC, 2018), NHS Constitution (DoH, 2015) and the 6 C's (Cummings and Bennett, 2012).

Appendix Two- The Resilience Framework (Adult) (Hart, Blincow and Cameron, 2012)

Resilience Framework (Adults) – Copyright Hart, Blincow & Cameron (adapted from original) www.boingboing.org.uk					
	BASICS	**BELONGING**	**LEARNING**	**COPING**	**CORE SELF**
SPECIFIC APPROACHES	Good enough housing	Find somewhere to belong	Make work & learning as successful as possible	Understanding boundaries and keeping within them	Instil a sense of hope
	Enough money to live	Help understand place in the world, & that others may face similar situations		Being brave	
	Being safe	Tap into good influences (eg peer support)	Engage mentors	Identifying & solving problems (reduce self blame and guilt)	Promote understanding of others
	Access & transport	Keep relationships going (eg educator /support partners/carers/family)	Map out career or life plan	Putting on rose-tinted glasses (reframing/reappraising)	Help the person to know her/himself
	Healthy diet	The more healthy relationships the better		Fostering their interests	
	Exercise and fresh air	Take what you can from relationships where there is some hope	Help self-organisation	Calming down & self-soothing (support reflection, not feeling overwhelmed by illness)	Help the person take responsibility for her/himself (self-advocacy)
	Enough sleep	Get together people the person can count on	Highlight achievements	Remember tomorrow is another day	Foster talents
	Leisure & work occupations	Responsibilities & obligations		Lean on others when necessary	
		Focus on good times and places	Develop life skills	Have a laugh	There are tried and tested treatments for specific problems, use them
		Make sense of where the person has come from			
		Predict a good experience of someone or something new			
		Make friends and mix			
NOBLE TRUTHS					
ACCEPTING Interpersonal skills, empathy		**CONSERVING** Interpersonal skills, trust	**COMMITMENT** Ongoing support issues	**ENLISTING** Self (eg not passive), family, friends, mental health professionals, GP	

Appendix Three- Joanna Briggs Institute Tools for Appraising Research

JBI Critical Appraisal Checklist for Qualitative Research

1. Is there congruity between the stated philosophical perspective and the research methodology?

2. Is there congruity between the research methodology and the research question or objectives

3. Is there congruity between the research methodology and the methods used to collect data?

4. Is there congruity between the research methodology and the representation and analysis of data?

5. Is there congruity between the research methodology and the interpretation of results?

6. Is there a statement locating the researcher culturally or theoretically?

7. Is the influence of the researcher on the research, and vice- versa, addressed?

8. Are participants, and their voices, adequately represented?

9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?

10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

JBI Critical Appraisal Checklist for Analytical Cross Sectional Studies

1. Were the criteria for inclusion in the sample clearly defined?

2. Were the study subjects and the setting described in detail?

3. Was the exposure measured in a valid and reliable way?

4. Were objective, standard criteria used for measurement of the condition?

5. Were confounding factors identified?

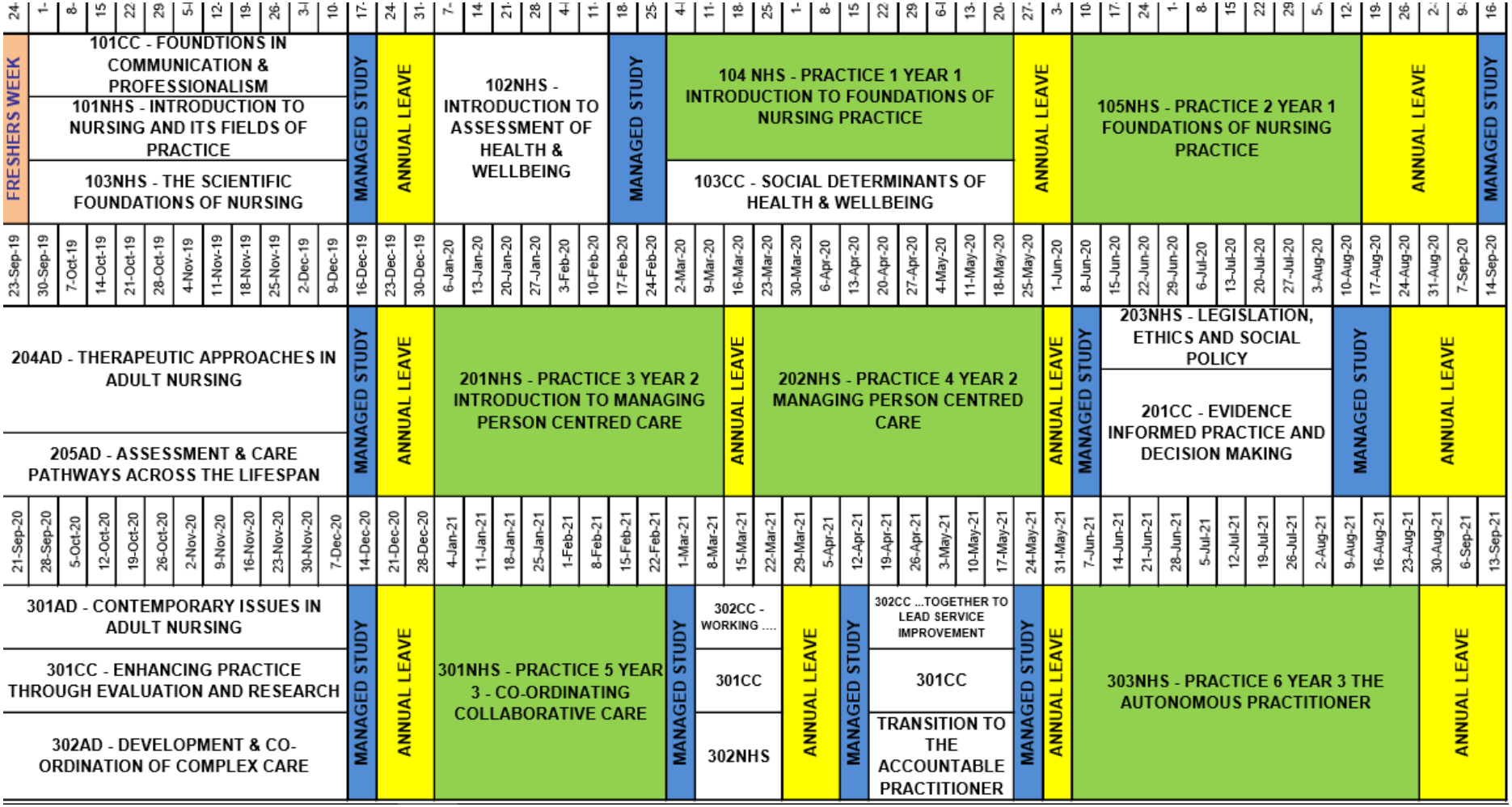
6. Were strategies to deal with confounding factors stated?

7. Were the outcomes measured in a valid and reliable way?

8. Was appropriate statistical analysis used?

Appendix Four- Adult Nursing Course Plan

White blocks = theory, green blocks = practice modules.



Appendix Five- Timeline for Research

Stage of Research	**Timeline**
Research proposal as part of EdD	September 2016- January 2017
Steering group with students to review research design, methods.	February 2017
Ethical approval process	April-July 2017
Data Collection	July 2017-February 2018
Data Transcription by myself and initial data analysis	July 2017-February 2018
Data analysis workshop	December 2017
Data analysis process (as per Six Step, Smith, Flowers and Larkin, 2009).	December 2017-January 2019

Appendix Six- Ethics Approval

Dear Nick Peim

Re: "Creating Compassionate Practitioners: How do student nurses view the concept of emotional resilience and current educational strategies aimed at supporting this within a values based adult nursing course?"

Application for Ethical Review ERN_17-0554

Thank you for your application for ethical review for the above project, which was reviewed by the Humanities and Social Sciences Ethical Review Committee.

On behalf of the Committee, I confirm that this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly bought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages(available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit athealthandsafety@contacts.bham.ac.uk.

Kind regards

UoB Research Support Officer

Certificate of Ethical Approval

Applicant:

Laura Strumidlo

Project Title:

Creating Compassionate Practitioners: How do student nurses view the concept of emotional resilience and current educational strategies aimed at supporting this within a values based adult nursing course?

This is to certify that the above named applicant has completed the University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

09 July 2017

Project Reference Number:

P60510

Appendix Seven–Data Collection phase tools

Recruitment Poster 1.

Volunteers Requested for Resilience Research Project Steering group with Adult Student Nurses

Do you want to have input into developing research tools?

Have you an hour to spare in March and wish to learn more about research from the participant /researcher perspective and possibly develop your resilience awareness?

Certificate for your portfolio from attending the 1 hour steering group available

For more information contact Laura Strumidlo on ….

Recruitment Poster 2.

Volunteers Requested for Resilience Research with Adult Student Nurses

Do you want to participate a research project?

Have you an hour to spare and wish to learn more about research from the participant /researcher perspective and possibly develop your resilience awareness?

For more information contact Laura Strumidlo on ….

Participant Information Sheet

Why I am being asked to take part in this study?

Dear student, you are invited to participate in this study entitled "***Creating Compassionate Practitioners: how do student nurses view the concept of emotional resilience and current educational strategies aimed at supporting resilience in the nursing course?"*** This is because you are a 3rd year nursing student who is undertaking the Adult Nursing BSc course at this University where the values based curriculum is taught which utilises several educational interventions aimed at supporting emotional resilience in nursing. There are very few studies exploring this topic from the perspective of the student nurse and it is believed important that you should have a voice to aid understanding of this concept and the development of future support in this area.

Whilst there are no direct benefits involved in taking part in this study you may gain knowledge of the research process which could help you in your future career and studies. You may also develop a deeper understanding of what support mechanisms work to promote your emotional resilience which is required for a career in nursing.

What do I have to do?

What is required of you is your time and participation in a 45 minute to 1 hour individual interview asking your views on the above topic. This will be conducted on campus but away from the main nursing teaching rooms at a time to suit you. Adult nursing students at this University have helped develop these questions to ensure that they are fit for purpose. You will be asked to sign a consent form prior to your participation and the researcher will check if you have any questions regarding the study. The interview will be audio-recorded during the discussion with your permission and later transcribed into a document by the researcher for analysis. The transcript will be kept confidential and a pseudonym chosen by the researcher to protect your identity. Data will be stored in keeping with both University of Birmingham and this University governance processes to ensure confidentiality. On a computer which is password protected and only used by the researcher. Paper copies and audio recordings will be kept in a locked drawer for which the researcher only has keys in a secure room. Only the researcher and supervisor will have access to the transcript which at this stage will have had all identifiable information removed.

Who is the researcher?

The researcher is an experienced nurse and Nurse Teacher who is currently studying for the Doctorate in Education at the University of Birmingham. This study has been ethically approved both at that Institution (University of Birmingham) and here at Other University. This study will form part of the thesis submitted as part of this academic award. Although the researcher is a member of the course team **taking part in this study or more importantly not taking part will in no way affect your progression on the adult nursing course.** It is anticipated that journal articles or presentations at conferences would disseminate the results of findings from this research which could include quotes from the transcripts however your identity would be protected through the use of the pseudonym. A summary report of the main findings of the research would be emailed to you post submission of the thesis on request.

Are there any risks in taking part?

Talking about emotions may of course stimulate an emotional response to memories or recollections from nursing practice or personal challenges that you may have faced. The researcher is experienced in supporting people in distress and will signpost you to this University well-being and health support services should you require this.

https://share thisuniversity.ac.uk/students/healthandwellbeing/Pages/Home.aspx

You may stop the interview at any time and ask to withdraw from the study with no explanation. Withdrawal is possible by emailing the researcher directly however, once your data has been analysed it will not be possible to withdraw. Analysis will begin one month after interview.

Some participants though in similar studies have reported that such research opportunities can be cathartic and may benefit well-being.

Both yourself and the researcher are governed by the Nursing Midwifery Council Code for Professional Standards (2018). Therefore, it is important that you do not raise issues regarding patient care that have not already been dealt with. Any breaches of the professional standards revealed in the interview would have to be disclosed to the Course team at this University.

Your time is precious and the researcher will aim to keep to the allotted interview slot.

For any further questions please ask the researcher.

Laura Strumidlo –

For any complaints regarding the research process please contact the student supervisor

Nick Peim at University of Birmingham – [redacted] and

Associate P.V.C. Research at C.U. Professor ….

Informed Consent Form Template

You have indicated a wish to be involved in the following study: Creating Compassionate Practitioners: how do student nurses view the concept of emotional resilience and current educational strategies aimed at supporting resilience within the nursing course? In order to take part please read and sign each element of this form. Any questions, do ask the researcher, Laura Strumidlo

This information is being collected as part of a research project concerned with emotional resilience by the Department of Education in the University of Birmingham in collaboration with this University. The information which you supply and that which may be collected as part of the research project will be entered into a filing system or database and will only be accessed by authorised personnel involved in the project. The information will be retained by the University of Birmingham and will only be used for the purpose of research, and statistical and audit purposes. By supplying this information you are consenting to the University storing your information for the purposes stated above. The information will be processed by the University of Birmingham in accordance with the provisions of the Data Protection Act 1998. No identifiable personal data will be published.

	Please sign
1. I confirm that I have read and understood the participant information sheet for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time up to one month from the interview.	☐
3. I understand that all the information I provide will be kept confidential and treated in line with the current data protection laws and relevant governance policies.	☐
4. I understand that the conduct of both myself and the researcher is governed by the NMC Code (2015).	☐
5. I agree to be audio recorded as part of the research project.	☐
6. I agree to the use of non-identifiable quotes in publications.	☐
7. I agree to take part in the research project	☐

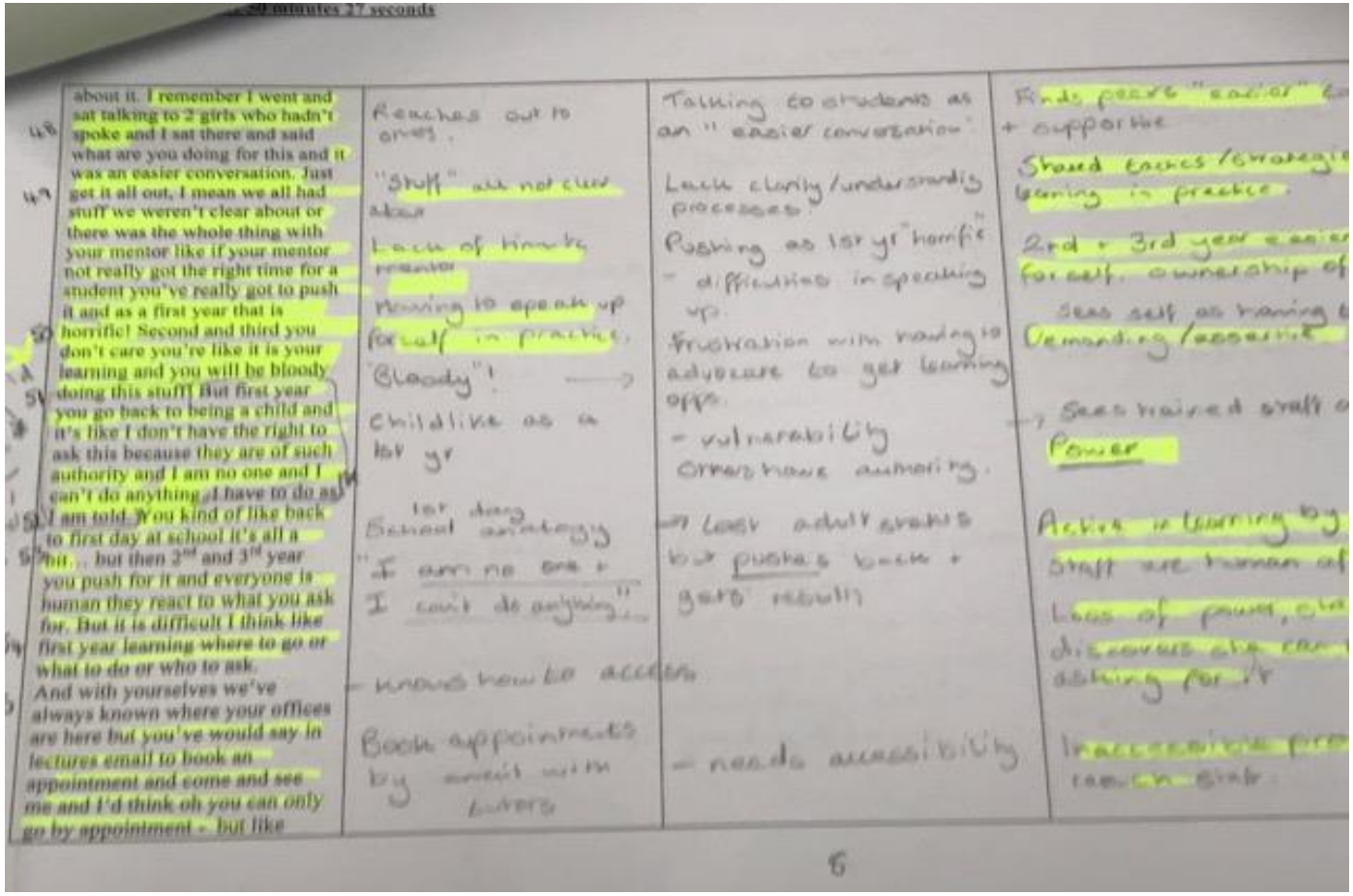
Name of participant: .....

Signature of participant: ..... Date:

Name of Researcher: .....

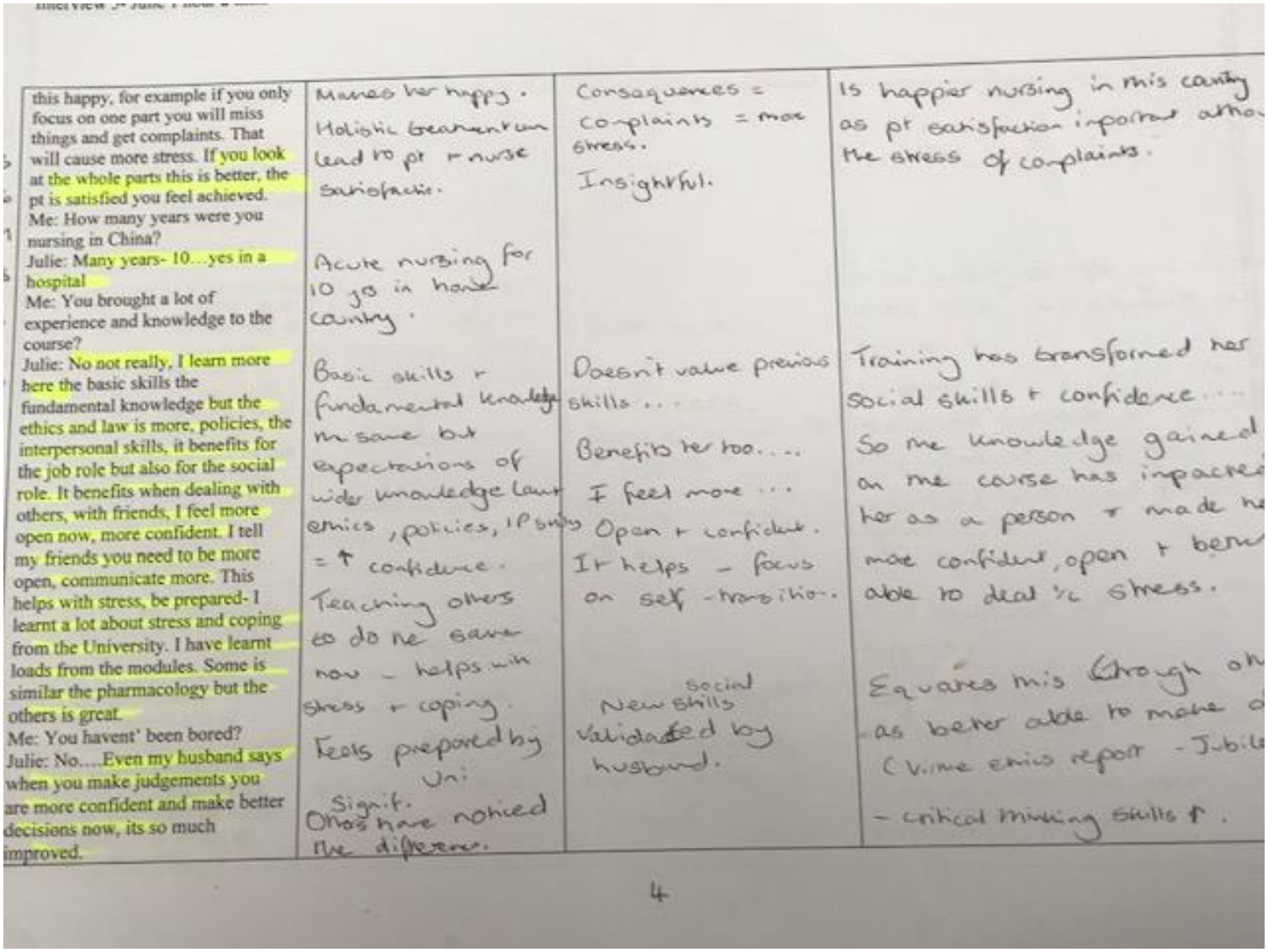
Signature of researcher: ..... Date:

Appendix Eight- Participant Transcripts



Description Language Analysis

Cathy- photo of transcript during idiographic analysis



this happy, for example if you only focus on one part you will miss things and get complaints. That will cause more stress. If you look at the whole parts this is better, the pt is satisfied you feel achieved.
Me: How many years were you nursing in China?
Julie: Many years- 10…yes in a hospital
Me: You brought a lot of experience and knowledge to the course?
Julie: No not really, I learn more here the basic skills the fundamental knowledge but the ethics and law is more, policies, the interpersonal skills, it benefits for the job role but also for the social role. It benefits when dealing with others, with friends, I feel more open now, more confident. I tell my friends you need to be more open, communicate more. This helps with stress, be prepared- I learnt a lot about stress and coping from the University. I have learnt loads from the modules. Some is similar the pharmacology but the others is great.
Me: You havent' been bored?
Julie: No….Even my husband says when you make judgements you are more confident and make better decisions now, its so much improved.

Makes her happy.
Holistic framework
lead to pt + nurse satisfactn.

Acute nursing for 10 yrs in home country.

Basic skills + fundamental knowledge in same but expectations of wider knowledge (law, ethics, policies, IP) = ↑ confidence.
Teaching others to do ne same now - helps with stress + coping.
Feels prepared by Uni
Signif. Ones have noticed the difference.

Consequences = complaints = more stress.
Insightful.

Doesn't value previous skills…

Benefits her too….
I feel more …
Open + confident.
It helps - focus on self - transition.

New social skills validated by husband.

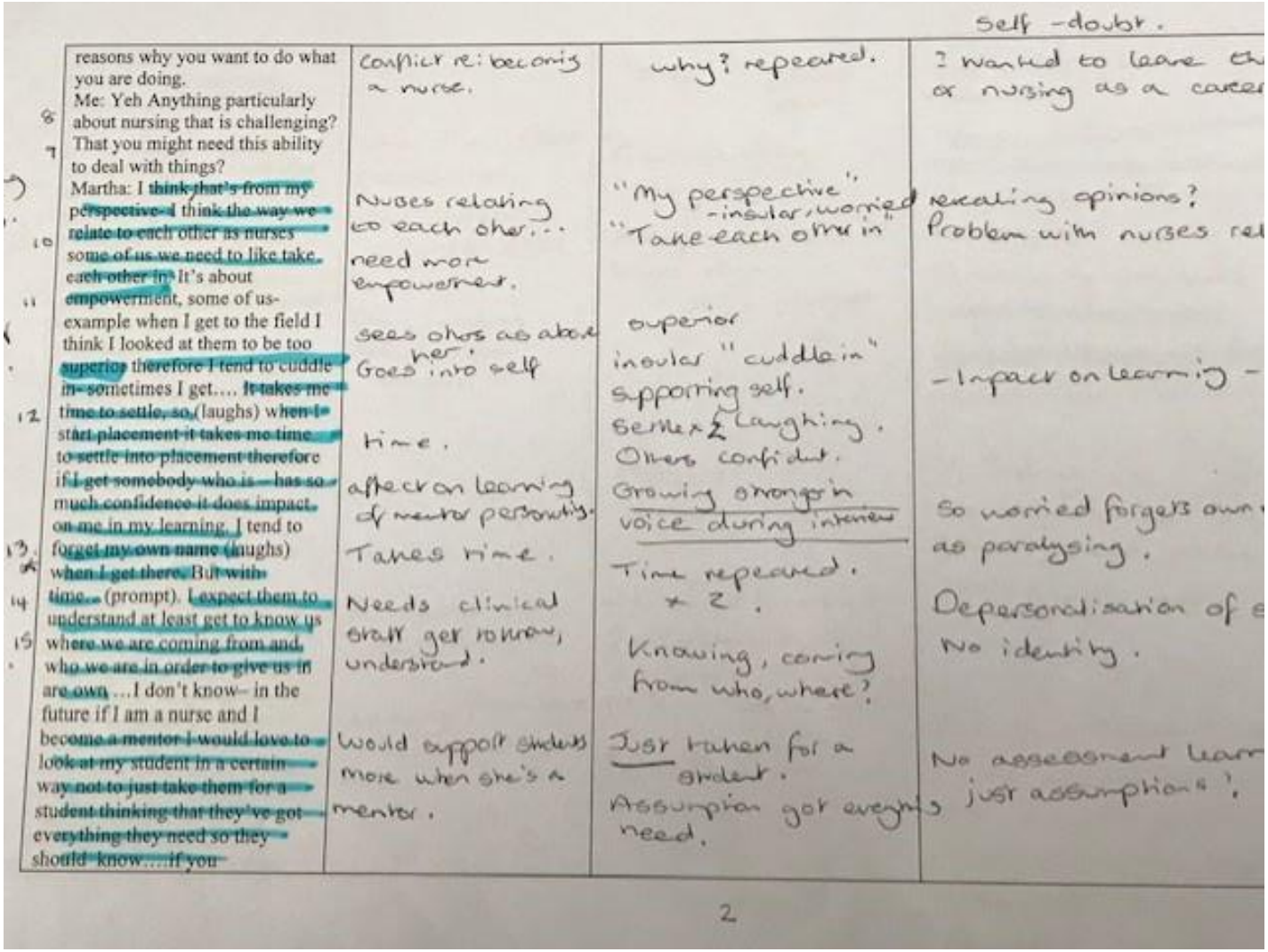
Is happier nursing in this country as pt satisfaction important alth… the stress of complaints.

Training has transformed her social skills + confidence….
So the knowledge gained on the course has impacted her as a person + made her more confident, open + better able to deal w/ stress.

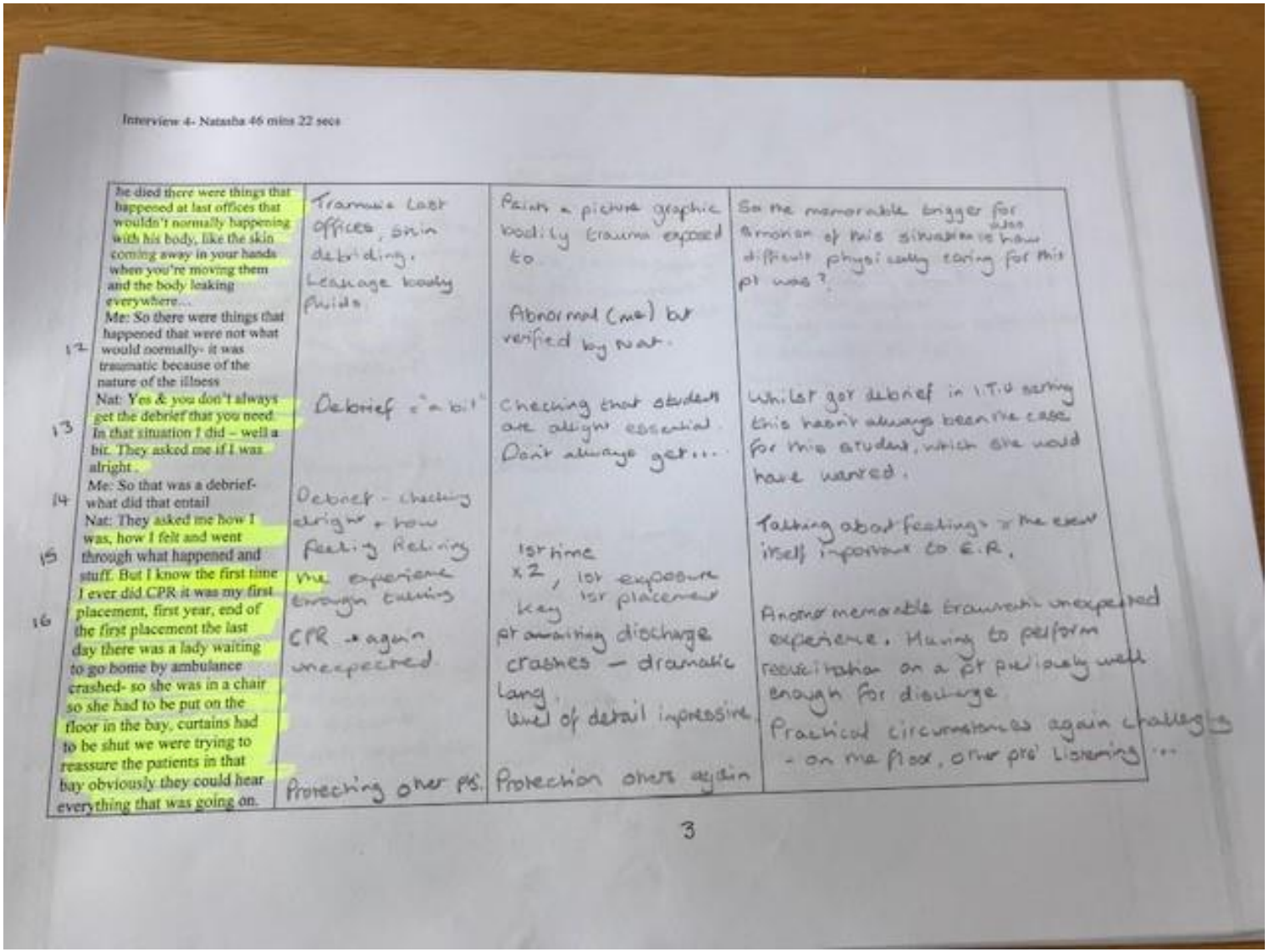
Equates this through ch… as better able to make d…
(Crime ethics report - Jubil…
- critical thinking skills ↑.

4

Julie -photo of transcript during idiographic analysis



Martha- photo of transcript during idiographic analysis

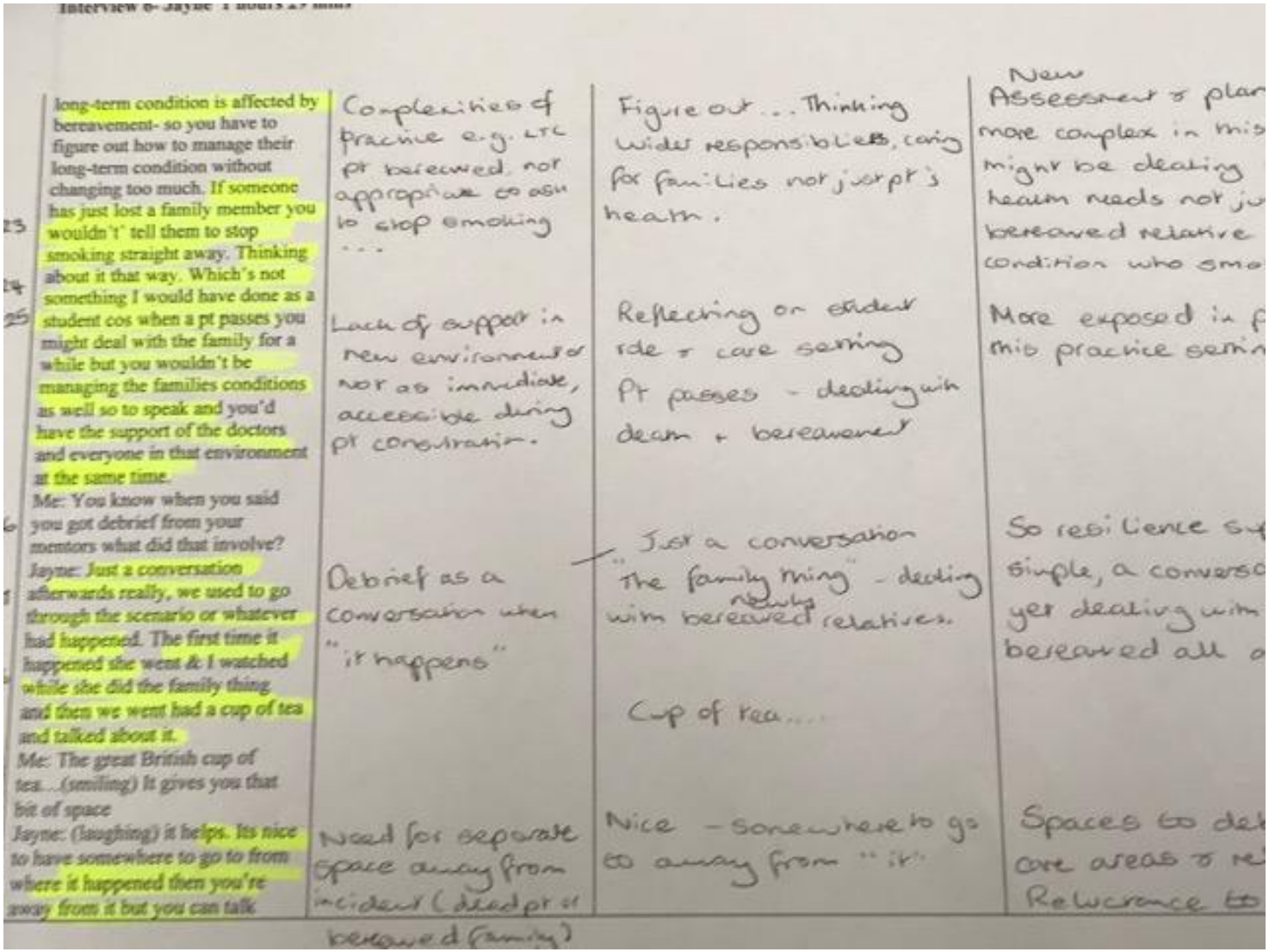


Interview 4- Natasha 46 mins 22 secs

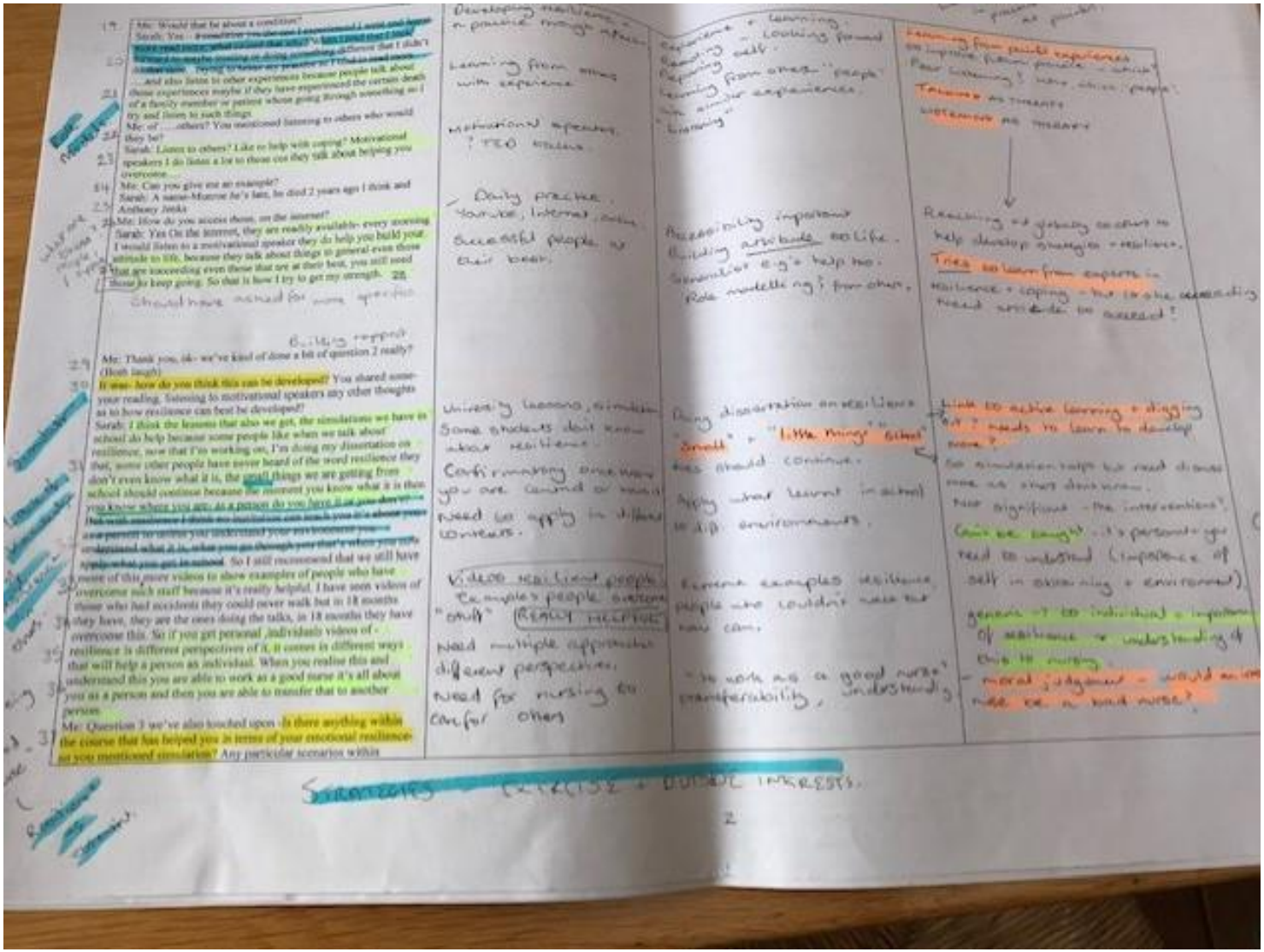
	he died there were things that happened at last offices that wouldn't normally happening with his body, like the skin coming away in your hands when you're moving them and the body leaking everywhere...	Trauma Last offices, skin debriding. Leakage bodily fluids	Paints a picture graphic bodily trauma exposed to	Some memorable trigger for memories of this situation is how difficult physically caring for this pt was?
12	Me: So there were things that happened that were not what would normally- it was traumatic because of the nature of the illness		Abnormal (me) but verified by Nat.	
13	Nat: Yes & you don't always get the debrief that you need. In that situation I did – well a bit. They asked me if I was alright.	Debrief "a bit"	Checking that students are alright essential. Don't always get...	Whilst got debrief in I.T.U saying this hasn't always been the case for this student, which she would have wanted.
14	Me: So that was a debrief- what did that entail	Debrief - checking alright + how feeling Relving		Talking about feelings + the event itself important to E.R.
15	Nat: They asked me how I was, how I felt and went through what happened and stuff. But I know the first time I ever did CPR it was my first	me experience enough training	1st time x2, 1st exposure key 1st placement	
16	placement, first year, end of the first placement the last day there was a lady waiting to go home by ambulance crashed- so she was in a chair so she had to be put on the floor in the bay, curtains had to be shut we were trying to reassure the patients in that bay obviously they could hear everything that was going on.	CPR - again unexpected	pt awaiting discharge crashes – dramatic lang, level of detail impressive	Another memorable trauma/unexpected experience. Having to perform resuscitation on a pt previously well enough for discharge. Practical circumstances again challenging - on the floor, other pts listening...
		Protecting other pts.	Protection others again	

3

Natasha - photo of transcript during idiographic analysis



Jayne- photo of transcript during idiographic analysis



Sarah- photo of transcript during idiographic analysis

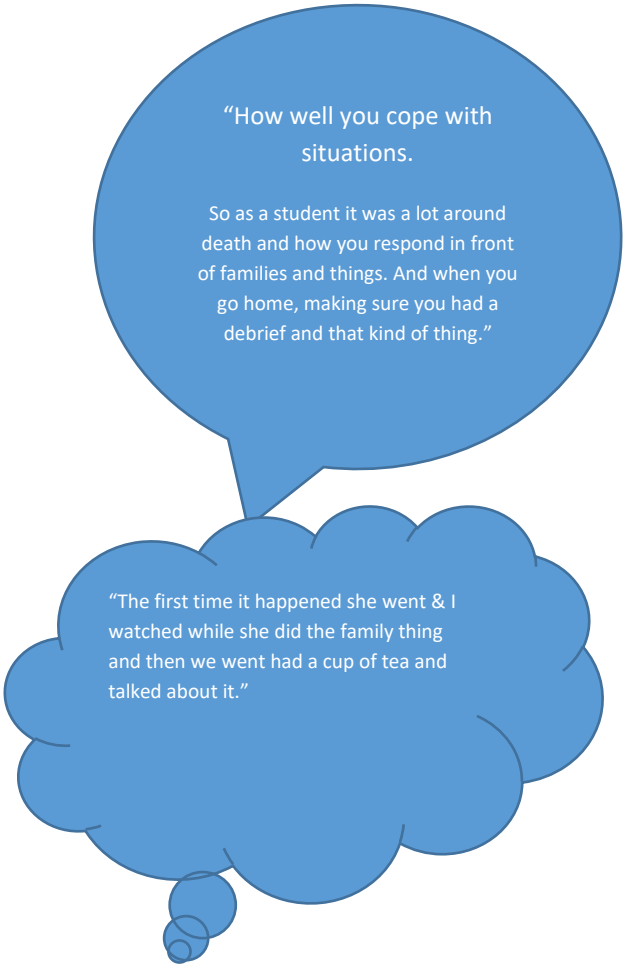
Appendix Nine- Example of Idiographic word docs for data analysis

Jayne- Developing emergent themes with my interpretation. Diagram for step 3 of IPA

Q1. What is resilience in nursing?

Table 1.0 Stressors for resilience

Mentors on the ward quite good at dealing with this type of thing (debrief- "just a conversation really")
Spaces to debrief are essential- if not there, this is stressful
clinical environments less support due to staffing levels- isolation…
Worry of passing placement added to the stress of the experience
Different emotions experienced in different settings e.g. aggression
Now qualified is dealing with physically complex and psychological needs of patients' in a different environment on her own – lack of immediate support
Transition to the qualified nurse- learning how to cope on her own in a small team is stressful
Need to be able to unburden emotions experienced in new situations and gain others perspectives- lack of access to this = stress
Need to "switch off personal emotions"- mask!
More stressful on the course- especially 3rd year with workload, placement 40 hours a week then studying on top.
Money worries- financial hardship affected several colleagues
Juggling childcare stressful for others, particularly around shift work



Dealing with the poor values displayed by some clinical staff…toxic cultures of care- everyone would be a bit on edge and miserable…

Younger mentors had empathy- older mentors were more "suck it up and carry on…"

"I think it's almost harder too the amount of empathy type things you have in Uni then when you're working with people like that but you've been taught one way they are doing like that you almost think am I doing it wrong, which is the right way? Should I change the way I work to match theirs…but you don't feel like yourself and it makes you feel all funny again."

Q2. How do you think resilience can be developed?

"Yeh but it's different now as you're in a room on your own and if they are angry & they start shouting at you, you're …I'm on my own now."

? Different stations to try out different techniques for dealing with emotional worry

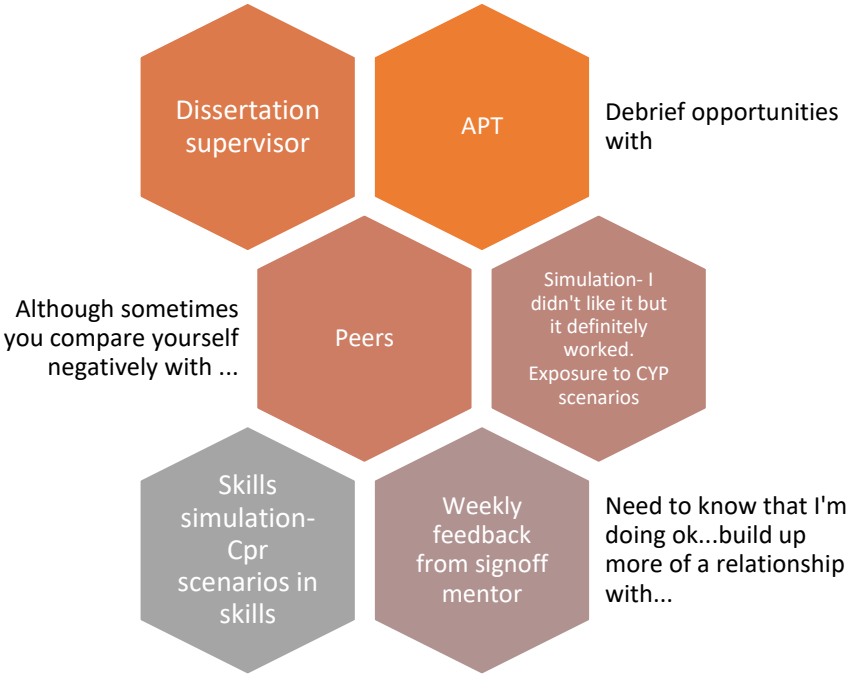
"Need to be supported to figure out what helps you as a person"

"Breaking things down into targets, drawing, writing, texting, online thingys, breathing things…"

Better signposting to support for financial issues- need for immediate support, counselling…"put in placement launches"

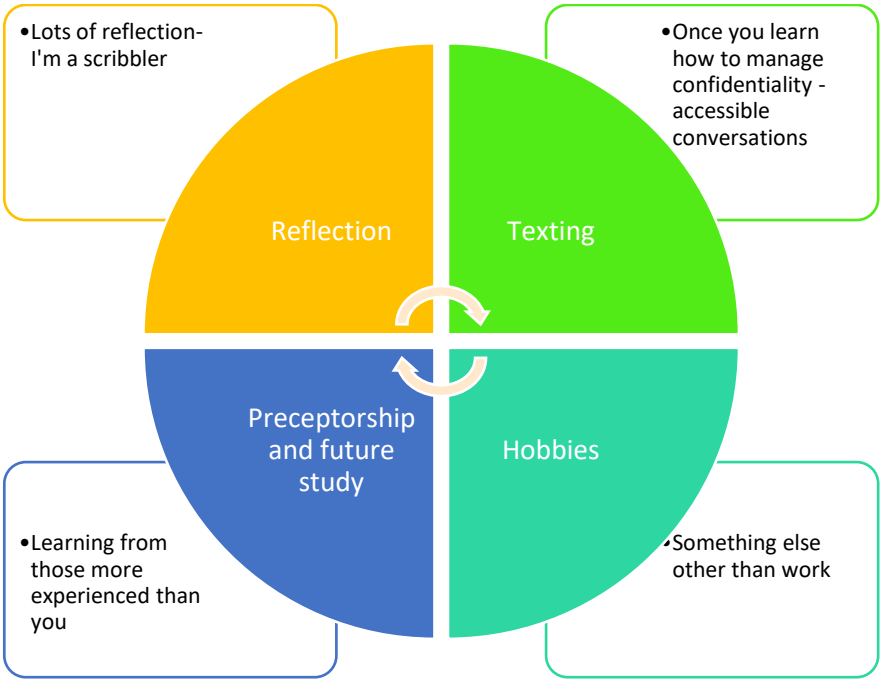
Encourage "talking" but some don't feel they can share with Uni or placement! "Too big for peer support"

Q3. Anything within the course that helped develop resilience?



Q4. Anything outside of the course that has helped you and other students?

Q5. What will you use to stay resilient?



Q6. What other support could be provided on the course?

Teach practically how to use Reflection- this is how you reflect within minutes	2 mins of scribbling in a note book
More Simulation- but bigger scenarios working in teams	Observing others was just as helpful
More practice debrief and link to simulation learning – some of this is complex, you need reminding	Increase clinical simulation- use Metiman more Make CPR scenarios more authentic
1:1 support with APT's increase	
Have more senior students helping out in teaching/OSCE's- role modelling	Newly qualified staff in Fresher's week was great- we need more of that

Q7. Emotional Resilience score out of 10 for current state? 

But at different times on the course was a 2-3!!

Appendix Ten- Photographs of collated findings and development of superordinate themes as part of data analysis process

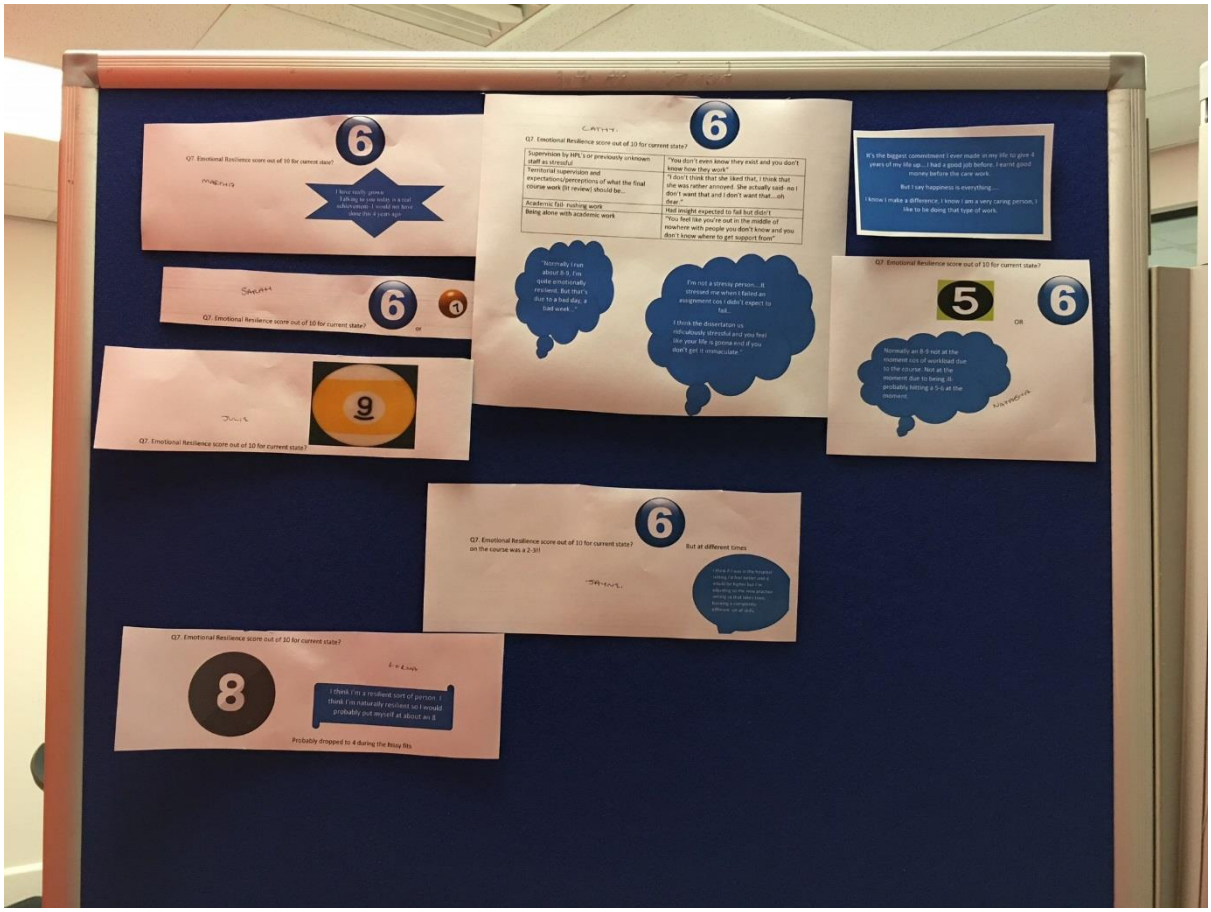


Photo 1- Resilience scores for the group

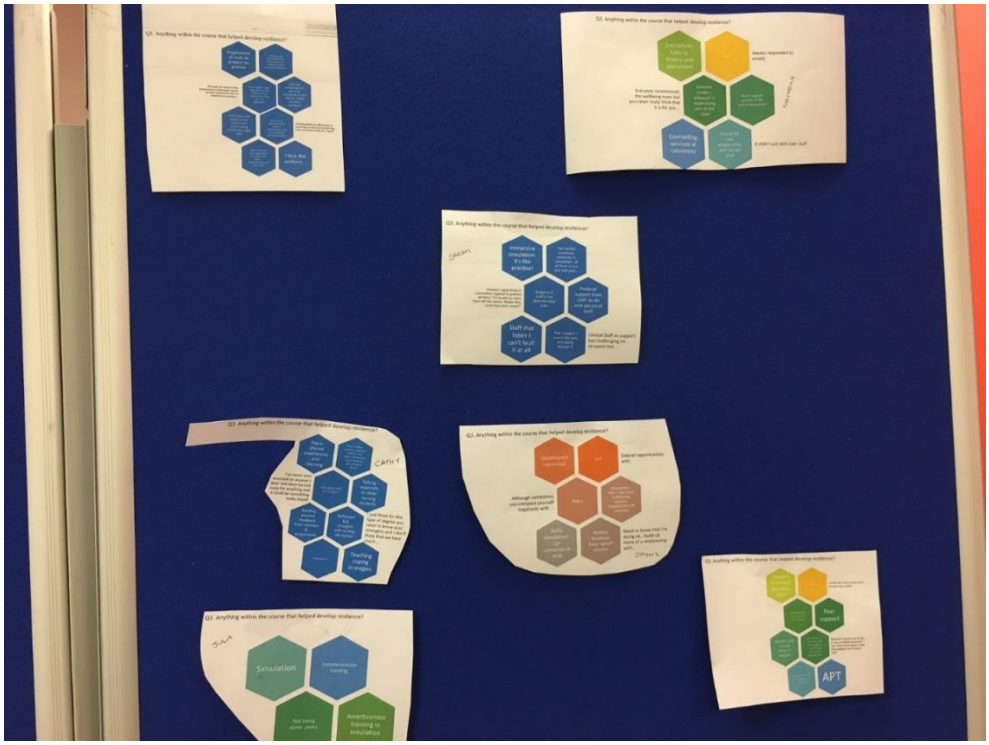


Photo 2 – Collated Findings for which educational strategies aid resilience within the course

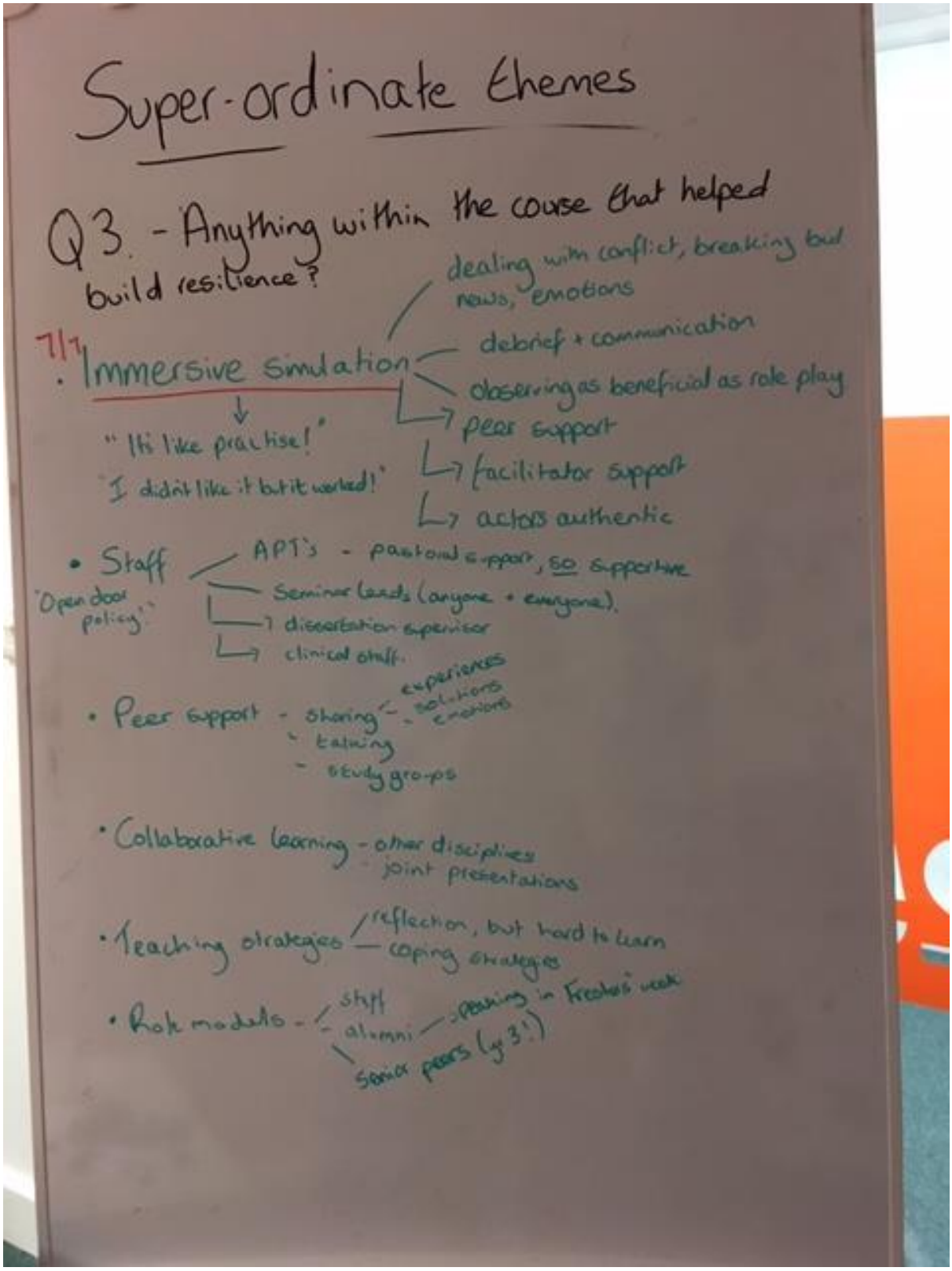


Photo 3- Developing Superordinate themes for resilience support within the course

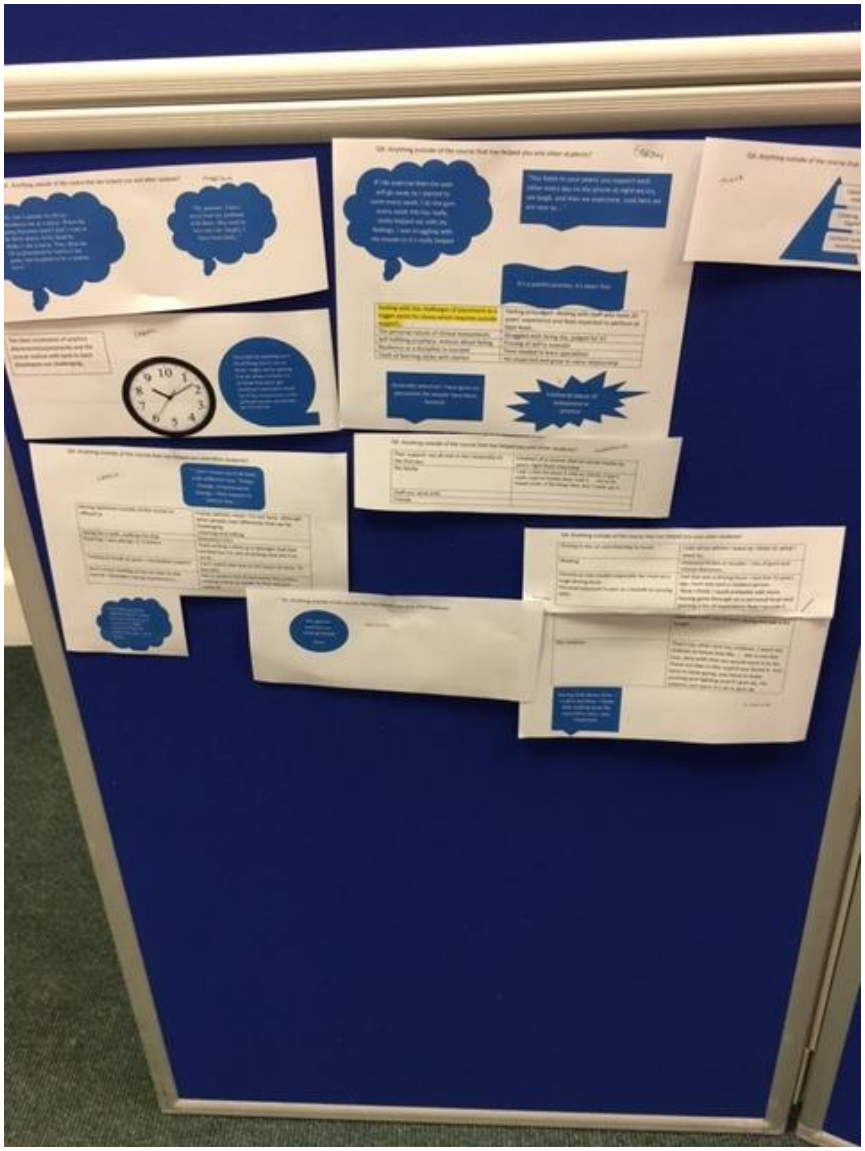


Photo 4- Collated findings for resilience support outside of the course

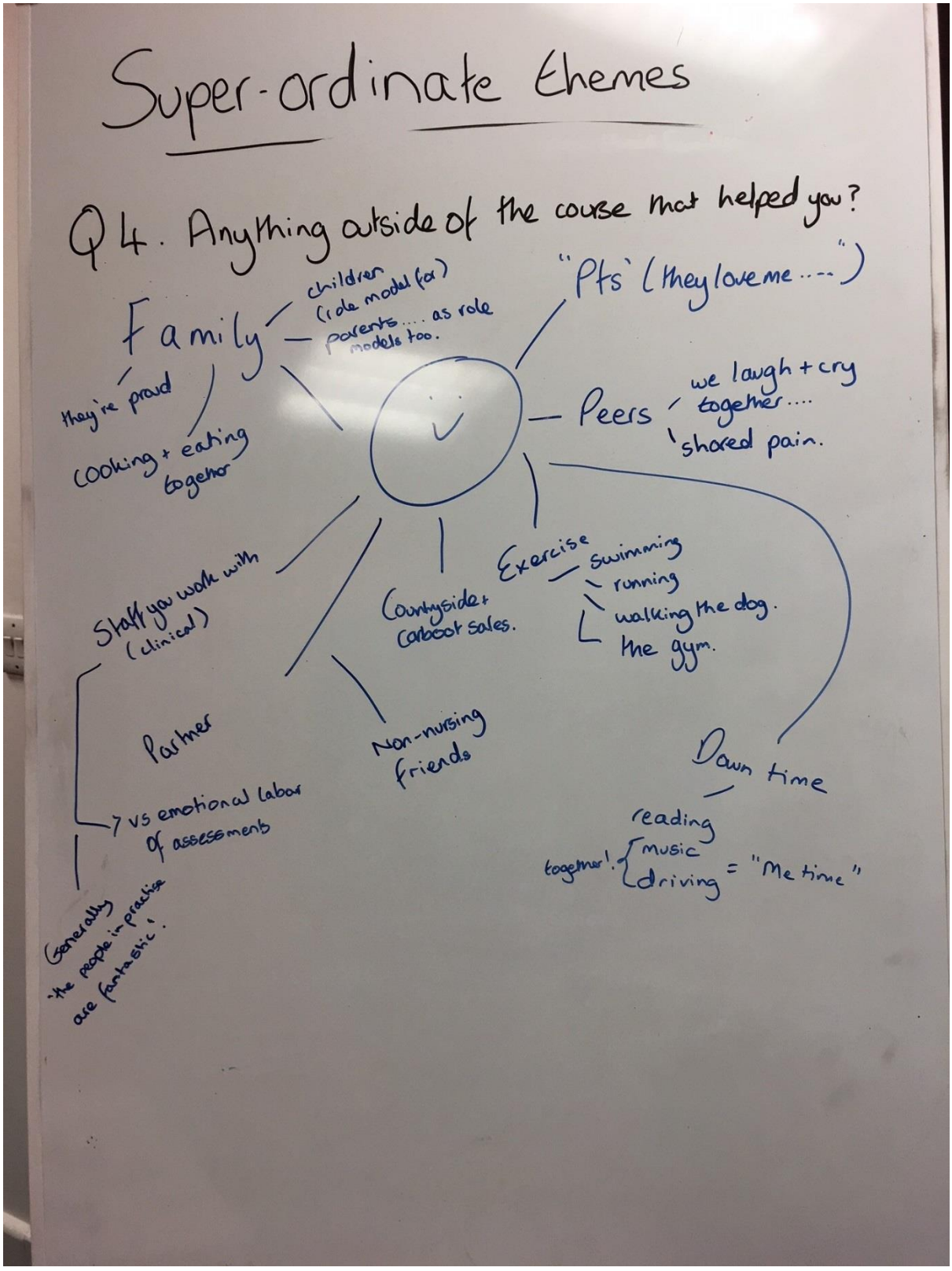


Photo 5- Developing superordinate themes for resilience aids outside of the course.

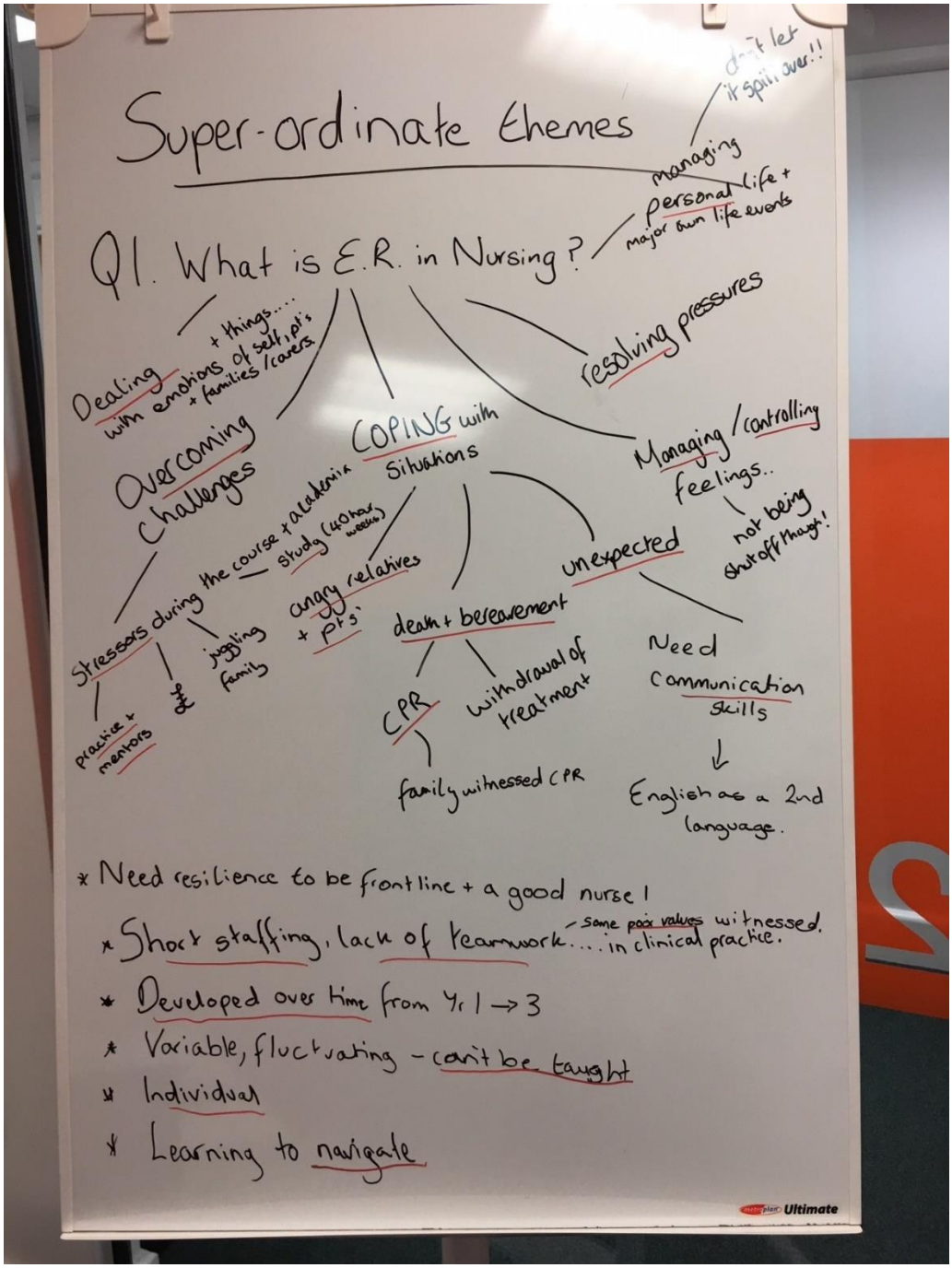


Photo 6– Superordinate themes for defining and understanding resilience

Participant	Death and bereavement	Emotional labour of nursing	Clinical placements	Academic requirements of the course	Communication/ interpersonal skills development	Life events
Sarah	x (p1, s5) multiple loss	x (p4,77) We cry, we laugh, we overcome)	x (p4-5,s81-102) fear of failing	X (p2, s31) Did literature review on ER	Shyness affecting communication- (p4, s81)	x (p4, s69) low mood
Martha	X (p10, s100) You can't save them all	X (p10, s81-87)Thrives on the positive emotional work of nursing	x (p1, s6-7) Feeling judged	Group work, self-doubt (p6, s59)	x (p2, s12) Cuddles in	
Cathy	X (p4, s26-27) End of life care	x (p1,s5)Anger from relatives and patients	x (p8,s51) low status	x (p13, s89; p21-23, s174-183) failed assessment		x (p25, 217-218) loss of relationship
Natasha	x (p1, s2; p1-2, s5)Related to CPR and withdrawal of treatment in ITU	x (p2,s6-11;p3-5,s15-28)Sadness and crying	x (p16,s128) non-nursing roles	x (p16, s124) overwhelming		x (p9,s63;p15, s122) serious illness
Julie	X (p4, s 38) Had 10 years previous nursing experience outside the UK	x (p3,s32; p9,s109,113)	x (p2,s13-16) culture of areas	x (p2, s8-11) time management	x (p1-2, s7; p14,s114-175)) If I got the communication wrong it broke	x (p1,s3-6) learning to nurse in a new country
Jayne	x (p1,s6) unexpected death, CPR	x (p4,s36-39) CPR and debrief	x (p2,s19; p11,s122; p13,s140-143; p14, s147-154) lack of empathy	x (p6, s64-70; p21,s238-241) attrition	x (p24-26, s263-288) poor skills of others	x (p31,s345-346) leaving home

Lorna	x (p3, s11) CPR	x (p6, s7) Breaking bad news, witnessed suffering	X (p45, s 285) Excellent experiences	x (p30,s 151-166) failed assessment		X (p33, s 180-182) (p40, s 228) (p41, s232) personal bereavement

Appendix Eleven- Table to evidence quotations for Chapter Four (section 4.2) The Tests of Resilience

Yellow highlighted themes are the exceptions and contradict the group findings- for example Lorna had no issues on placement.

Julie did not cite death and dying as traumatic but had 10 years nursing experience in another country this appears to be a protective factor.

Martha accepted death and dying as part of nursing work, she also found strength in the emotional labour of nursing.

Sarah utilised academic requirements of the course as opportunities to learn about resilience theory.

Appendix Twelve- Table to evidence quotations for Figure 4.6 Defining Resilience

Participant	Coping	Overcoming challenges	Managing/controlling feelings	Resolving stress	Dealing with emotions
Sarah	x (p1, s13) supporting others	x (p1, s2) overcoming and keep on working through	x (p1, s2) keeping calm		X (p1, s2) not breaking down
Martha		x (p1, s3) It's about empowerment	x (p1, s6) taking, receiving, picking things		x (p1, s2) dealing with them
Cathy	X_(p1, s2) coping mentally	x (p1, s2) how do you go home and unwind	x (p1, s2) leaving at the door		
Natasha			x (p1, s2) being able to control them		x (p1, s2) controlling our own emotions
Julie				x (p1,s2) how you deal with pressure	
Jayne	x (p1,s2) how you cope with situations				x (p4,s36-39) How you respond in front of families
Lorna	x (p1,s3) Strategies for protection				x (p6, s7,s30) dealing with situations that strike a more personal chord

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