Investigating Resilience in Midwifery

Final Report

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Background

Midwifery is acknowledged as emotionally demanding work. Working with women and their families during emotionally intensive times may entail dealing with anxiety, pain, fear and loss as well as joy and excitement. The emotion work skills that this requires are largely unrecognised and undervalued.

In addition to these everyday challenges, midwives in the United Kingdom are also facing increasing pressures due in part to the rising birth rate, growing numbers of women entering pregnancy with complex social and physical needs and a national shortage of midwives to care for them. These pressures, together with the recognised emotional demands of the job, increase midwives' experience of stress and workplace adversity and contribute to increased sickness rates and poor staff retention. The resulting staff shortages further exacerbate the pressure on frontline staff.

Despite these concerns there are midwives who, in the face of adversity, are able to flourish and thrive in the workplace and have long fulfilling careers. These midwives demonstrate professional resilience and may provide a valuable insight into the ways in which individuals are able to positively adapt to an adverse working environment. Although there have been some studies investigating resilience in nursing and other caring professions, little is understood about resilience in the midwifery profession.

Study aims and objectives

The aims of the study were i) to explore clinical midwives' understanding and experience of resilience using a professional online discussion group, and ii) to model the concept in collaboration with a panel of experts in the field.

Specific objectives were to identify the personal, professional and contextual factors considered to contribute to or act as barriers to resilience; and to explore how the resilience of student and newly qualified midwives might be enhanced.

This research was funded by the Royal College of Midwives (RCM).

Methods

Following ethical approval, midwives who self identified as resilient with > 15 years experience of hands-on clinical practice were recruited to the study through an advert placed in the RCM's *Midwives* magazine. Eligible participants joined a closed on-line discussion group hosted by the Royal College of Midwives Communities discussion forum. A total of eleven midwives actively participated in the online discussion facilitated

by the research team which took place over one month between October and November 2012. Data were thematically analysed using NVivo software.

In the Stage 2 of the study, the findings were discussed with a group of experts in midwifery workforce research and resilience studies. The aim was to refine the modelling of the concept, including identifying its specific characteristics and influencing factors.

Findings

Following independent cross-checking of analysis between the two researchers, four overarching themes were identified that related to contextual, professional and personal factors involved in resilience. The major themes identified were: Challenges to resilience, Managing and coping, Self awareness and Building resiliency. Each major theme had several sub-themes.

Challenges to resilience:
This theme related to stressors indentified by midwives that created workplace adversity and required the development of resilient mechanisms in themselves or their colleagues. Challenges were categorised into personal and professional constraints, work conditions and concerns regarding quality of care. Participants identified 'critical moments' when midwives were especially susceptible to workplace adversity such as following a difficult case or when newly qualified. Results from the data suggested that workplace adversity was a common experience for all participants.

Managing and coping:
This theme comprised the resilient strategies that participants employed to cope with the challenges faced. It was evident that these strategies had developed during the course of their career, therefore suggesting that resilience in midwifery was a learned process. The theme was subdivided into five separate themes, which related to various aspects of the strategies that midwives adopted in order to cope with adversity: gaining perspective, work-life balance, mood changers, social support and self efficacy.

Self awareness:
This theme encompassed various elements of the self, with midwives highlighting the importance of drawing on personal resources and their core sense of self. Central to this theme was personal and professional identity. There was evidence of the importance of a highly developed sense of professional identity, having a love of midwifery practice, and a strong sense of public service. Other subthemes under this category included: autonomy, attributes and obligation to oneself or self care.

Building resilience:
This final theme was concerned with the building and development of resilience and involved the longer term strategies for enhancing resilience in the self and colleagues. Key to this was protective self-management, which included recognising triggers or warning signs and taking pre-emptive action to avoid/reduce stress or adversity.

Learning and investment, supporting colleagues and facilitating empowerment were also incorporated with this theme.

Implications

This study has a number of implications for midwifery education, practice and research. It was evident that the concept of resilience resonated with participants and could be proactively fostered in the initial and continuing education of midwives. This preliminary exploratory study suggests that further research is warranted. Comparative studies exploring resilience in midwives at different career stages and in different clinical roles and settings may provide a deeper insight into resilient practices and could lead to the development of an intervention to support resilience promotion in midwifery.

1 Introduction

Midwives in the UK are in an increasingly challenging situation. Problems arising from a national shortage of midwives, rising birth rate and growing numbers of women with complex social and physical care needs, present demands for the profession which have been well documented in the midwifery and national press (Warwick, 2011). These concerns are not unique to the UK, with similar issues being discussed in Australia (Australian Health Workforce Advisory Committee, 2002) and some European countries (Hunter et al., 2008). It is hardly surprising that low morale and stress are reported within the midwifery workforce.

There is another side of the picture however: some midwives *do* stay in the profession, not just from economic necessity but because they want to (Kirkham et al., 2006). Understanding more about why and how some midwives are able to withstand workplace adversity and remain positive and motivated, could benefit the profession as a whole.

Studies of employee wellbeing indicate that a key issue is resilience (Jackson et al., 2007). This idea has been taken up enthusiastically by the business community, with the publication of an 'Emotional Resilience Toolkit'. Supported by the Department of Health, this is aimed at promoting the resilience of individuals and teams, with long term goals of maximising employee health and wellbeing and helping organisations 'bounce back in tough times' (Business in the Community, 2009). A number of other recent initiatives have been established, focusing on resilience research and practice in a broad range of arenas. For example, the ESRC funded Boing Boing project and Resilience Forum (http://www. boingboing.org.uk) focus on applying the concept of resilience to support disadvantaged children and their families (Hart et al., 2007).

1.1 What is resilience?

The term resilience describes relative resistance to adversity (Rutter, 1999). Its conceptual roots are found primarily within child development, psychology and physiological stress literature (Hodges et al., 2008). Opinion is divided on the origins and characteristics of resilience, with debate centring on whether resilience is a stable personality trait, a set of constructive coping mechanisms or a process of emotional adaptation. Most definitions however refer to successful or positive adaptation to adversity (Luthar et al., 2000), without residual significant psychological or physiological disruption (Seery et al., 2010). 'Resilient' responses to adversity are considered to be *habitual* patterns of cognition, behaviour and emotion that *consistently* draw on effective resources to reduce risk to self (Luthar et al., 2000), rather than isolated or occasional episodes of effective coping. In other words, *resilience is the ability of an individual to respond positively and consistently to adversity, using effective coping strategies.*

1.2 Rationale for the study

This study was prompted by concerns regarding the challenges currently facing the midwifery profession. These have potential to impact on both the emotional wellbeing of individual midwives and also on the morale of the profession as a whole. The national shortage of midwives has been the subject of media attention and national campaigns (Campbell, 2012, Warwick, 2012). However, whilst there is a Government commitment to increase the number of qualified midwives (Department of Health, 2012) and applications for midwifery undergraduate programmes are reported to be high (Department of Health, 2011) it appears to be staff retention that is a problem for the profession; with a significant number of midwives leaving the post within the first 5 years (Royal College of Midwives, 2010)[†].

These concerns are not new. A decade ago, reports by Mavis Kirkham and colleagues (Kirkham et al., 2006, Ball et al., 2002, Curtis et al., 2003) highlighted the reasons why midwives leave the profession and why they stay. The key reason given for leaving was dissatisfaction with midwifery, in particular the way that it was practised within the UK NHS, lack of workplace autonomy and support (Ball et al., 2002). The current situation is only likely to exacerbate these concerns; in many areas of the UK, midwives face staff shortages and an increased workload resulting from a rapidly rising birth rate and the need to care for women with increasingly complex health and social needs.

It is unlikely that these problems will go away in the foreseeable future, thus it is timely to consider how best to support midwives so that they are better prepared when they encounter these challenges, and more resilient in the face of adverse workplace conditions.

It is also the case that, even when workplace conditions are more positive, midwifery remains emotionally demanding work(Hunter, 2010). As acknowledged in other studies, supporting women and their families during the emotionally intense times of pregnancy, childbirth and transition to parenthood requires midwives to develop skills in emotion work(Hunter, 2004, Hunter, 2006). It also means that midwives need to attend to their own support needs in order to remain positive and motivated(Kenworthy and Kirkham, 2011, Leinweber and Rowe, 2010). Thus workplace resilience is a concept that may have relevance across midwifery practice settings.

By investigating the experiences of midwives who have remained in practice for many years and who describe themselves as being able to 'bounce back' after a difficult day at work, it was anticipated that important insights could be gained into resilience in midwifery. This new knowledge could in turn have broader benefits for the profession, for example by informing the development of undergraduate curricula or by prompting changes in the support available for qualified midwives. To date, there has been no other study directly concerned with investigating resiliency in UK midwives.

[†] Data on staff retention contained in the Midwifery 2020 report are related to Scottish statistics.

2   A review of the resilience literature

This chapter explores the literature regarding resilience in the health professions to provide an insight into the evidence regarding resilience in midwifery. Essentially it seeks to acknowledge and consolidate the key areas and provide empirical evidence within the context of an informed, current debate. Relevant literature was identified through searches of databases including ASSIA, BioMed Central, Cinahl, OVID, PubMED, and Wiley, using key terms which included: resilience, hardiness, coping, midwifery, and health professional. This review includes a combination of published research articles, literature reviews and discussion papers. It was noted that there were a number of self-help books aimed at building resilience in health professionals (Skovholt and Trotter-Mathison, 2011, Neenan, 2009), however these have a limited research underpinning thus we have not included them in the review.

2.1 Background

Resilience can be defined as the ability of an individual to cope with and adapt positively to adverse circumstances. The literature investigating resilience has its roots in developmental psychology and has tended to focus on child and family resilience (Hill et al., 2007, Hart et al., 2007) or personal resilience of individuals faced with particularly extreme adversity, for instance those exposed to tragedy (Kent et al., 2011), violence (Dutton and Greene, 2010) or terrorism (Soffer-Dudek et al., 2011). Resilience has been viewed as a collection of traits or characteristics (such as optimism, self-efficacy, hardiness etc) which assist an individual to adapt to adversity. However it is now widely accepted that resilience stems from a combination of internal and external factors and can be seen as a dynamic process which is developed over time (Tugade and Fredrickson, 2004, Ungar, 2012). It has been argued that resilience is a learned process that uses adaptable cognitive, behavioural and emotional responses to adversities and therefore, as a learned process, resilience is a resource that is available to all (Neenan, 2009).

Resilience in midwifery is concerned with the ability of midwives to adapt to the adversities they face through the course of their work; put simply, their professional resilience. From the outset it is worth clarifying the difference between the personal and professional resilience of midwives. In the face of adversity an individual may decide to leave the profession and it should be acknowledged that in doing so they do not lack resilience; rather for that person, leaving the profession may be considered to be a personally resilient move. They are making a positive step to remove themselves from a negative or harmful experience and as such could be seen to demonstrate personal resilience. However, this 'personal resilience' is different from the 'professional resilience' where a midwife continues to practice and to positively adapt in the face of workplace adversity.

2.2 Workplace adversity

Exposure to prolonged periods of adversity is common in midwifery due to a number of both professional and organisational factors. The nature of childbearing means that midwives care for women and their families during an emotionally intensive time. Although for the most part this experience will be joyful, often they will be exposed to women's anxiety and pain and also may experience vicarious secondary trauma due to caring for women during adverse situations arising from pregnancy complications and fetal loss (Leinweber and Rowe, 2010). Midwifery work can therefore be seen as being intrinsically emotionally demanding, and it has been argued that the extensive 'emotion work' that this creates for midwives is largely unrecognised and undervalued (Hunter, 2010). Conflicting ideologies have also been recognised to contribute towards the stress experienced by staff. Midwives have reported a mismatch between the professional ideal of being 'with woman' and providing woman-centred care, and the reality of working in a busy workplace environment where the needs of the institution are perceived to take precedence. This conflict of ideologies creates dissonance and can contribute to the emotional difficulty experienced by midwives(Hunter, 2004).

Workplace adversity is also affected by organisational factors such as shift working, heavy workload, bullying, poor quality support and staff shortages (Mollart et al., 2011, Ball et al., 2002, Kirkham et al., 2006). An extensive study of why UK midwives leave or stay in practice, conducted on behalf of the RCM between 2000 - 2006, showed that high amounts of stress or workplace adversity in midwifery was widespread and associated with both physical and mental ill-health, increased rates of sickness and poor staff retention, (Ball et al., 2002) which further exacerbated the negative working conditions of midwives in practice. Stress and burnout in the profession has been widely researched and documented,(Mollart et al., 2011, Sandall, 1998, Mackin and Sinclair, 1998) however the ability of some midwives to withstand adversity and demonstrate professional resilience has received much less attention.

Relatively high levels of attrition(Royal College of Midwives, 2010, Hansard, 2009) and poor morale in nursing and midwifery suggest that current approaches to the education and support of staff do not always effectively prepare them to meet personal and professional demands. Research into healthcare related stress has provided invaluable information on the multi-faceted demands on the professions but has not revealed why some individuals cope well with such demands whilst others experience significant psychological and physical ill-effects. The Government's new strategy for mental health (Department of Health., 2011) recognises the importance of building resilience for the health and well-being of individuals and advocates that employers recognise and promote these qualities. This requires that we have a clear understanding of what resilience is and how it can be fostered.

In recent years there have been a small number of studies which have explored resiliency within the health professions in a bid to identify the means by which resilience

can be fostered and in turn promote career longevity. Predominantly this has focussed on resilience in nursing although there have also been studies involving social workers (Kinman and Grant, 2011, Adamson et al., 2012) and general practitioners (Jensen et al., 2008, Cooke et al., 2013) or a combination of different health professionals (McDonald et al., 2011, McAllister and Mckinnon, 2009, McCann et al., 2013, Bringsen et al., 2012). Research exploring resilience in midwives is scarce. Indeed only one multi-professional study was identified which investigated the resilience of midwives, however, as discussed later in the chapter, the study sample contained both midwives and nurses and it was not possible to differentiate between the responses of the two practitioner groups. (McDonald et al., 2011).

2.3 Resilience in nursing

Several studies have been conducted exploring resilience within various fields of nursing, using both quantitative and qualitative methods. It is notable that most studies have been conducted in USA and Australasia. Two American studies have looked at the effect of job satisfaction on resilience. Larrabee et al. (Larrabee et al., 2010) investigated the influence of job satisfaction on intent to stay in practice. Using survey methods, these researchers gathered data from 464 registered nurses from a number of specialities (medical- surgical, critical and perioperative, and paediatrics). Unsurprisingly they found that high workplace stress negatively affected job satisfaction scores which in turn, was predictive of nurses' intent to stay in practice. Another quantitative study (Matos et al., 2010) which again used survey methods containing a number of subscales relating resilience and job satisfaction had similar findings. This much smaller study recruited 32 psychiatric nurses from a single centre and found a correlation between resilience and job satisfaction with the majority of respondents having both high levels of resilience and high levels of job satisfaction. The subscale of satisfaction with professional status had a high mean score whilst there was a low score for the satisfaction with physician-nurse interaction suggesting a need to improve interprofessional working and communication in this area.

Gillespie and colleagues (Gillespie et al., 2007) developed a model of resilience based upon a review of the literature and an ethnographic study of operating theatres. They tested their model through a national survey of 1430 nurses who worked in theatres in Australia; the survey contained a number of psychometric tests. Using regression analysis they subsequently modified their model and identified a total of five variables that they found to explain resilience at statistically significant levels and which they argue accounted for 60% of variation in resilience of the sample. The final variables they identified were: hope, self-efficacy, coping, control and competence. Interestingly variables such as age, education, experience and length of time in employment were not found to contribute to workplace resilience.

Coping has been a prominent feature in the research exploring stress and burnout. Similar to the concept of resilience, it stems from a more positive psychological approach

that focuses on the ability to adapt to adverse conditions. A British study was conducted which explored stress and coping strategies of community mental health nurses in Wales (Burnard et al., 2000). Participants (*n*= 301) were asked to complete a questionnaire which included validated tools to measure stress, burnout and coping. The results showed that perception of workload; excessive paperwork and administration were identified as key stressors. A number of common coping strategies were cited by respondents including peer support and supervision, although informal rather than formal support networks were preferred. Other coping strategies identified were: personal strategies (such as relaxation), and belief in self. This 'belief in self' appears to have parallels to the key variable of 'self-efficacy' identified in Gillespie's study (Gillespie et al., 2007).

'Belief in self' has also been identified in other qualitative studies. A qualitative study by Edward and colleagues investigated resilience in crisis care mental health clinicians in Australia (Edward, 2005). A total of six participants (4 nurses, 1 allied health professional and 1 doctor) took part in semi-structured interviews. Analysis of data identified four key themes: sense of self, faith and hope, having insight, looking after self.

A qualitative study (Hodges et al., 2008) investigating professional resilience of newly qualified nurses was conducted in America where attrition rates of new graduate nurses are high: approximately 60% leave within one year of qualifying. This study used a combination of observation, focus group and semi structured interviews in order to gain an insight into the nature of professional resilience. Similar to the findings of midwifery research (Hughes and Fraser, 2011, Van der Putten, 2008, Fenwick et al., 2012, Hunter, 2004)the authors reported that following qualification there was a degree of adversity felt by the new nurses. It was reported that participants struggled to reconcile the differences between their personal view of how to care for patients (which had been supported by their training), and the care they were actually able to provide as qualified nurses in an unpredictable practice setting. However with time, participants were able to reconcile these discrepancies, and this reconciliation proved to be key in the development of participants' resilience. It enabled them to consolidate their learning and practice, assisting them to develop their sense of competence and confirm their professional identity. This process was believed to be facilitated by positive work environments that were accepting and supportive of new nurses and where experienced staff members provided supportive direction and guidance to novices.

Links between developing professional competence and developing resilience has been found by other researchers. A qualitative study using semi-structured interviews to explore and reflect upon resilience in geriatric nursing recruited nine nurses working in residential aged care facilities in Australia (Cameron and Brownie, 2010). Findings from this study appear to support the notion that resilience is developed through clinical experience and increasing professional competence which could lead to enhanced professional identity.   A positive attitude and achieving work-life balance were also recognised as valuable. Interestingly the authors also found that possessing a strong sense of purpose and the participants' sense that they were 'making a difference' to the

lives of service users also fostered resilience. Although other studies had made reference to the role of clients/patients, these tended to relate to the 'stressors' or 'adversity' felt by clinicians and so this was the only study where participants specifically related the positive contribution of service users to the building of professional resilience within nurses.

Several literature reviews have usefully summarised the current state of knowledge related to resilience in the nursing professions and identified the implications for practice. The review conducted by Jackson et al. (Jackson et al., 2007) found that nurses can be active agents to positively adjust to workplace adversity, and therefore they propose 'self development' strategies to facilitate resilience. The strategies suggested include the building of positive nurturing professional relationships; maintaining positivity; developing emotional insight; achieving life balance and spirituality, and also becoming more reflective. They propose that resilience building should be incorporated into the education of nurses and that professional support mechanisms such as mentoring be adopted. It would appear that 'self development' of nurses is not just the responsibility of individuals but also educators and health care institutions. This is supported by another review of the literature by Grafton and colleagues (Grafton et al., 2010) focusing on resilience and its implications for oncology nursing.   The authors advocate that resilience should be seen as an innate resource and as such should be available to everyone providing they are able to adequately access and develop it. They suggest that individual nurses have a responsibility to ensure they develop 'self-care' practices and processes as these are recognised to promote resilience. However they also recognise that healthcare institutions have an important role to play through the provision of appropriate support strategies that assist in the development of self-care through services such as education and counselling, as well as work based facilities such as quiet rooms that enable staff to relax and reflect on practice.

A paper by McAllister and McKinnon (McAllister and Mckinnon, 2009) discusses the resilience research and its implications for nursing education for trainees as well as registered nurses. They suggest that the predictors of resilience (adaptability, positive identity, social support etc) can be strengthened through education and training. Specifically, it is proposed that education programmes should focus on enabling individuals to explore and develop their professional identity, as well as building their capacity for coping, and teaching leadership for change in order to prepare individuals to better adapt to change. Further, policies and practices need to be implemented into the workplace that promotes reflective learning within teams. They also suggest that 'cultural generativity' should be encouraged whereby the experiences of resilient clinicians are utilised through sharing of lessons and insights, thus acting as role models and building resilience capacity within the nursing profession.

It is evident that nursing is increasingly embracing the concept of resilience as an approach to ameliorate the effects of stress on the workforce. Several common themes within the literature are apparent. The need to invest and develop in the 'self' was

identified by several papers (Gillespie et al., 2007, Burnard et al., 2000, Edward, 2005, Hodges et al., 2008, Jackson et al., 2007, Grafton et al., 2010). Developing positive professional relationships or supportive peer networks was also frequently recognised as promoting resilience (Burnard et al., 2000, Hodges et al., 2008, Jackson et al., 2007, McAllister and Mckinnon, 2009), and both professional competence (Gillespie et al., 2007, Hodges et al., 2008, Cameron and Brownie, 2010) and professional identity (Larrabee et al., 2010, Hodges et al., 2008, McAllister and Mckinnon, 2009) were highlighted too. Reflective practice was mentioned as an approach that facilitates professional resilience (McAllister and Mckinnon, 2009, Grafton et al., 2010, Jackson et al., 2011).

2.4 Resilience in other public service workers and health professions

Similar to midwifery and nursing, social work is another profession which is exposed to workplace adversity. The emotional demands and high stress associated with working with an often involuntary client group that are in need of support, are known to contribute to the adversity experienced by practitioners (Lloyd et al., 2002). In New Zealand, Adamson et al. (Adamson et al., 2012) conducted a qualitative study of social workers with at least three years post qualification experience, and who self identified as being resilient. A total of 21 participants took part in one-to-one semi structured interviews. The data analysis led to the development of a conceptual framework with three main foci: sense of self; practice context and mediating factors between self and context. Mediating factors included work-life balance, developmental learning, coping behaviours and relational skills, supervision and peer support, professional identity, and lastly knowledge, education and theory. These mediating factors appear to have close affiliation with those factors in the nursing literature known to affect resilience.

 A British quantitative study explored resilience in trainee social workers (Kinman and Grant, 2011). This study examined the role of several emotional and social competencies as predictors of resilience in the profession. The sample of 240 trainee social workers were asked to complete a range of questionnaires assessing emotional and social competencies which included validated scales of emotional intelligence, reflective ability, empathy and social competence as well psychological distress. The results of this study showed that trainee social workers with highly developed emotional and social competencies were more resilient to stress. Specifically, emotional intelligence, reflective ability and empathy were identified as key protective factors. The authors suggest that emotional and social competence can be increased during training by interventions aimed at increasing insight into own feelings and better understanding the emotions and intention of others. In turn this would serve to promote resilience in the workforce. The importance of teaching reflective practice to enhance resilience was also stressed and is supported by others (McAllister and Mckinnon, 2009). Building reflexivity into training

programmes has long been supported by the nursing and midwifery professions (Rolfe et al., 2001).

A Canadian study explored resilience in general practitioners (GPs) through using one-to-one interviews with 17 GPs (Jensen et al., 2008). The sample included GPs relatively new to the profession although the majority were those with considerable experience (> 20 years). Participants were asked what elements they felt were pertinent to developing resilience in the profession. Following thematic analysis of data, four resilience themes were identified by the researchers: 1) attitudes and awareness (which included valuing the role and self awareness), 2) balance and prioritisation (i.e. work-life balance), 3) practice management style (business management, office personnel and practice arrangements), and lastly, 4) supportive relations (personal and professional). Their findings provide support for the concept of resilience as an evolving, dynamic learned process.

Another Canadian study investigated physician wellbeing using mixed methods (Wallace and Lemaire, 2007). Following in-depth interviews with 54 doctors, the researchers identified key factors relating to well being and further explored these factors through survey methods. Questionnaires were sent out to 275 physicians working in medicine and a total of 182 participants responded (response rate of 66%). As was found with the previous study (Jensen et al., 2008), supportive relationships with colleagues and family or friends were important in promoting wellbeing of doctors. Work overload and emotional demands of work were negatively related to wellbeing. Of note was the finding that the negative effects of work demands appeared to be buffered through meaningful interactions with patients. The authors suggest that patient interactions could not only be a source of stress but were also a source of satisfaction in the working lives of doctors.

A recent study investigating resilience of doctors training to become GPs in Australia investigated relationships between burnout, uncertainty and resilience (Cooke et al., 2013). This study used survey methods and comprised several validated scales to measure resilience, burnout, quality of professional life, personal meaning in patient care and intolerance of uncertainty scale. A total of 128 participants were recruited. Results suggested that 14% of their sample were at risk of burnout, with secondary traumatic stress and intolerance of uncertainty particularly associated with higher risk of burnout. However, age, sex, practice location, and training duration, were not found to be associated with burnout. Strikingly only 8% of participants were found to have high resilience scores with 82% having low- moderate scores. As may be expected high resilience scores were associated with low burnout scores.

There are several common themes within the studies investigating resilience in social workers and general practitioners, many of which appear to be closely related to those identified within the nursing literature. These themes include contextual (Jensen et al., 2008, Adamson et al., 2012) interpersonal (Adamson et al., 2012, Kinman and Grant, 2011, Jensen et al., 2008, Wallace and Lemaire, 2007) as well as individual factors (Jensen et al., 2008, Cooke et al., 2013). Comparative studies of resilience between health professionals are limited, although one literature review was identified. This

review paper by McCann *et al.* (McCann et al., 2013) explored the literature from five health professions (nursing, social work, psychology, counselling and medicine) to detect both the individual and contextual qualities associated with resilience for each profession and identify commonalities between them. They reported on a number of individual and contextual factors of resilience, which can be seen in Table 1 (page 16). Their paper suggest that although a number of the individual and contextual factors were linked to more than one profession, only two factors: gender and maintaining work-life balance were found to consistently relate to resilience across each of the professions. However it should be noted that as this was a review of the literature involving many studies with differing methodologies, results obtained by drawing comparisons between the findings of such diverse studies may be limited. However, it does provide some insight into the various factors which may contribute to resilience in health professionals although midwives were not included in this.

Table 1: Individual and contextual factors associated with resilience in health professions

	Nursing	Social work	Psychology	Counselling	Medicine
Individual Factors:					
Work/life balance	X	X	X	X	X
Recreational activities		X	X		
Hope & optimism	X	X			
Professional identity	X	X			
Demographic factors	X	X	X	X	X
Sense of purpose			X		
Self care		X	X	X	X
Control	X			X	X
Contextual Factors:					
Client/patient interaction		X	X		X
Partner/family Support	X			X	
Peer support/ mentoring	X	X	X		
Promote reflection	X				X
Supervision	X	X		X	
Professional development					
Manageable workload		X		X	

Adapted from McCann et al. 2013 (McCann et al., 2013)

2.5 Resilience in midwifery

Only one study was identified that explored the resilience of midwives. McDonald tested a work-based intervention developed to support resilience in Australian nurses and midwives (McDonald et al., 2011). Fourteen clinicians (nurses and midwives) received the intervention, although it is not known how many of these were practising midwives. A case study approach was used, with participants recruited from a women and children's

health service; a setting which McDonald *et al*. report as being characterised by various issues indicating high workplace adversity (e.g. staff shortages, organisation restructuring, highly publicised adverse patient outcome and a history of workplace bullying).

The primary function of the intervention was to facilitate positive responses to workplace adversity. The authors report that the intervention was based on Social Learning Theory and was an educational programme that comprised six workshops plus one to one mentoring from a senior/retired nurse or midwife. The workshops were informed by the strategies identified by Jackson and colleagues (Jackson et al., 2007) that were reported to enhance resilience in nurses. Each workshop lasted a full day, with the workshops and mentoring programme spread over a period of six months. The programme comprised workshops in the following areas: mentoring relationships, building hardiness, intellectual flexibility, achieving life balance, reflective and critical thinking, and moving forward, planning for the future. This paper does not indicate who delivered the workshops.

The intervention programme was evaluated through interviews with participants following delivery of the programme as well as via workshop evaluations. The authors report that the intervention was positively received by participants who felt it benefitted them both personally and professionally. Professional gains cited included: closer group dynamic, more supportive communication, as well as increased assertiveness and confidence in clinical setting. The findings indicated increased knowledge of resilience, a readiness to monitor and maintain resilience strategies both individually and with their peers. The intervention was found to be successful in improving supportive professional relationships amongst the participants and in facilitating resilience through self-reflection, self care and improved communication skills. However, it is difficult to determine the validity of the findings as key facts are lacking. Firstly the researchers did not publish data regarding the actual number of midwives included, and do not distinguish between nurses and midwives in the findings. As the intervention was informed by nursing research, it may have been helpful to compare the findings from the two professional groups in order to consider its 'fit' for midwives. Secondly it is not evident who delivered the intervention (although a 'facilitator' is mentioned and their crucial role is acknowledged) or who collected the evaluation data. If the intervention and evaluation are conducted by the same individuals, it may be that a degree of social desirability bias influenced the findings. It is also not possible to disaggregate the effects of the various elements of the programme; for example, whether the perceived benefits stemmed from the mentoring, the workshop content, reflective diary keeping or from even less tangible elements such as peer support. One of the acknowledged problems with interpreting findings from complex interventions is identifying what the 'active ingredients' might be (Campbell et al., 2007). Nevertheless, several of the adversities encountered by the participants have similarities to those faced by midwives, for example staff shortages and workplace bullying (Mollart et al., 2011, Ball et al., 2002, Kirkham et al., 2006) and so this study is useful in providing an insight into how resilience may be improved within midwifery.

2.6 Conclusion

The evidence from health professions research has identified certain factors that appear to mediate resiliency: positive perceptual and attributional styles, self-actualisation, self-awareness, reflexivity, self-efficacy and active coping techniques (Larrabee et al., 2010, Garrosa et al., 2010). It is argued that resiliency can be learned or developed (Grafton et al., 2010), with implications for the education and support of practitioners. Recommendations for education include pedagogical techniques to help students identify effective coping strategies and connect them to the concept of resilience (Grafton et al., 2010), the development of emotional insight and self-awareness through reflexivity (Jackson et al., 2007), group and individual clinical supervision (Arvidsson et al., 2008, Howard, 2008). However, whereas traditional clinical supervision has focused on clinical competency, these recommendations also encompass interventions aimed at enhancing personal confidence and self-efficacy, and addressing stress management techniques (Gillespie et al., 2007, Arvidsson et al., 2008).

To date, there has been limited research that has tested the hypothesis that these interventions lead to enhanced resiliency in midwives or nurses and no report of the use of resilience theory in midwifery or nursing education. There is thus ample scope for developing a research programme in this area, particularly within midwifery where there has been no study explicitly investigating resilience.

This study is the first step in developing such a programme. It provides a preliminary exploration of resilience in a self-selected group of UK midwives in order to investigate whether the concept has salience and relevance for the profession.

3 Methodology

A two stage exploratory qualitative study was undertaken over six months between September 2012 and March 2013, using a closed online discussion group hosted by the Royal College of Midwives Online Communities.

3.1 Research aims and questions

The *aims of the study* were i) to explore clinical midwives' understanding and experience of resilience using professional online discussion groups, and ii) to model the concept in collaboration with a panel of experts in the field.

Research questions:

1. How do clinical midwives across the four UK countries, who have been in practice for more than 15 years and who categorise themselves as 'resilient', describe their experience of resilience?

2. What personal factors do they identify as contributing to their resilience?

3. What professional factors do they identify as contributing to their resilience?

4. What contextual factors do they identify as contributing to their resilience?

5. What factors do they identify as acting as barriers to being resilient?

6. In the opinion of these midwives, how could the resilience of student and newly qualified midwives be enhanced?

3.2 Study design

In Stage 1, a critical review of the literature was undertaken prior to setting up, recruiting for and conducting an online discussion group with clinical midwives from the four UK countries. Data were analysed thematically using NVIVO.

In Stage 2, the findings were discussed with a group of experts with backgrounds in midwifery workforce research and resilience studies. The aim was to support the research team in refining the modelling of the concept, including identifying its specific characteristics and influencing factors.

3.3 Project management

The core research team consisted of Professor Billie Hunter (BH) and Research Associate Lucie Warren (LW), in collaboration with Dr Jeannette Hewitt (JH).

The original study was conceived by BH and JH. As Lead Investigator, BH was responsible for leading the study, overseeing its management and ensuring the overall quality. Under the supervision of BH, LW co-ordinated the day-to-day running of the project. She organised participant recruitment and liaison, designed the data collection tools and set up the online discussions. LW liaised with the PAG and Expert Panel and she was also responsible for literature searching and reviewing.

BH and LW both participated in the online discussions, conducted the data analysis and contributed equally to the Final Report writing. JH contributed to the literature review and acted as independent cross checker for the data analysis.

A Project Advisory Group (PAG) was appointed, with members representing RCM, Cardiff School of Nursing and Midwifery Studies and a practising clinical midwife. The PAG met three times during the life of the project, to provide advice to the core team and monitor the study progress.

3.4 Ethical review

Ethical review was sought from the Research Ethics Committee, Cardiff School of Nursing and Midwifery Studies, Cardiff University. Following some minor amendments, a favourable review was received (see Appendix 1). The study design has sought to address the common ethical concerns around research conducted over the internet(Herron et al., 2011); As this study accessed anonymised data, and participants opted into the study of their own accord, no particular ethical concerns were identified and it was not considered necessary to apply for NHS Research Ethics Review.

3.5 Access

With the assistance of the Administrator of the RCM Communities, the study was publicised in the RCM Midwives Journal and in the RCM E-news several weeks prior to the project start. The publicity included a brief statement about the project, why it was being conducted and who would be eligible to participate as follows:

> *Are you a midwife in hands-on clinical practice in one of the four UK countries? Have you been in practice for 15 years or more? Would you describe yourself as someone who is able to bounce back after a stressful or difficult day at work? If you can say yes to all these questions, then we invite you to take part in our RCM supported study investigating resilience in midwifery. For more information email Billie Hunter: HunterB1@cardiff.ac.uk*

We did not explicitly define the term 'resilience' in any of the participant information or publicity. However, as we were purposively sampling midwives who self-identified as resilient, it was important to explain who we were looking for – hence the use of the colloquialism 'bouncing back'. As highlighted, staff retention is a concern for the profession, as such participants' length of time in practice in excess of 15 years was chosen in order to capture those who demonstrated resilience through career longevity.

 Interested midwives were asked to contact the research team directly. Once eligibility was confirmed, the potential participant was sent an information sheet and informed about the timing of the online discussion and that they would be notified by email when the discussion group was open. Potential participants could request additional information from the Lead Investigator about the study via the co-ordinator of the RCM communities.

The information sheet (see Appendix 2) included an explanation of the study and why it was being carried out, what would be entailed for participants and how the data would be used. It was emphasised that the data would be anonymous and the level of engagement would be entirely at the participant's discretion, with the right to opt in and opt out as desired. The possibility that participation might trigger personal concerns about the emotional challenges of practice was noted. If such a situation occurred, participants were advised that they could seek professional advice and support from their Supervisor of Midwives, and that counselling support could be available via their employer (e.g. NHS Staff Counselling Service) or GP.

The online nature of the discussions required particular consideration. A closed online group was set up so that only those midwives who had given consent and who had been formally admitted to the group could take part. All participants were requested to keep their personal identity and the identity of their workplace anonymous, and they were informed that any identifiers would be removed from the data collected. As this was a closed group, it was not possible for other RCM members accessing other discussion groups to see who the members were or to view the discussions.

All data were stored securely. Electronic data were stored on a password-protected computer, and hard copies of research material were kept in a locked filing cabinet. Only fully anonymised data were shared with the PAG and Expert Panel.

Following the set-up of the 'Resilience discussion group', participants were notified by email and asked to register with the RCM online community and request membership to the Resilience Group in order to be able to contribute to the discussion. They were also sent a copy of the discussion group ground rules (see

Appendix 3). Participants were confirmed as members of the Resilience group by the Administrator of the RCM Online Communities had been provided with a list of consenting, eligible midwives.

3.6 Sample

A convenience, self-selected sample of midwives was recruited. As the level of interest in the study was unknown, the sample size not pre-determined. The inclusion criteria were:

- Practising midwife in hands-on clinical practice in the UK

- Member of RCM (necessary to access RCM discussion groups)

- Practising as a midwife for 15+ years

- Self-categorising as 'resilient'

Nineteen midwives contacted the team to express an interest in participating, 12 registered as members of the discussion group and 11 midwives actively participated in the discussions.

3.7 Data Collection

Stage 1:

The online discussion group ran from October 22nd 2012 to November 26th 2012.

BH and LW took it in terms to access the discussions on a daily basis, to ensure that there were no problems and that the discussions were running smoothly. A 'light touch' approach to facilitating the discussions was taken, so that the natural flow of the discussion was not interrupted. Questions were occasionally posed if there had been no posts for a while, and brief feedback was given to thank participants and encourage further contributions.

In addition, a vignette was created with the intention of providing a prompt to start the discussions (see Appendix 4). The vignette, portraying a fictional midwife who described herself as someone who could 'bounce back', was piloted with two midwives in clinical practice and minor changes were made following their feedback. Prompts were also devised which could be posted in the event of halts in the discussion (see Appendix 4). The intention had been to post the vignette at the beginning of data collection, however, this was pre-empted by the first participant's comment, which was posted on the day prior to the official 'opening' and entitled 'How I cope'. She began by writing: 'So, how to bounce back after a bad day at work?' before describing the coping strategies that she used herself and those that she had heard her colleagues mention. As the group discussions flowed naturally from that point, prompts were not required and the vignette was not introduced until half way through data collection. There were two distinct discussion threads: 'How I cope' and 'What do you think'. The latter thread contained the

vignette asking participants to reflect on reasons why and how the fictional midwife was thought to be resilient.

It was decided that after the discussions had finished, the group would close. Originally, it had been planned that the comments would remain visible to the group members for several weeks. However, discussions with the Communities Administrator indicated that this could only be achieved by keeping the group 'live' and thus additional comments could be posted. It was thought that this would create ethical problems, as these discussions could not be used as data for analysis. The participants were therefore informed that the group would be closed, but that if they wished to continue with the discussion they could start their own discussion thread outside of the resilience group.

When the group closed, all participants were sent an email thanking them for their contributions, and informed that they would be sent a copy of the Final Project Report.

Conducting online data collection was a new experience for the research team. It presented many new experiences, which will be the subject of a future publication.

Stage 2:

A group of experts with backgrounds in midwifery workforce research and resilience studies were contacted, and invited to review the preliminary data analysis and emerging themes. The purpose of the Expert Group was to support the research team in refining the modelling of the concept, including identifying its specific characteristics and influencing factors. Details of members of this group can be found in the acknowledgements section on page 1.

3.8 Data analysis

The data from the Discussion Forum were copy and pasted into a Word document and entered into NVivo. All identifiers were removed at this point. The discussion was read through several times to enable deep familiarisation with the content, recognised as important to aid the analysis and coding of data (Gibbs, 2007). Following familiarisation data were subsequently thematically analysed.

The basic framework for analysis was a three stage approach as documented by King and Horrocks (King and Horrocks, 2010). Firstly descriptive codes were classified, this stage aimed to identify and describe the view points and perceptions of participants in order to code them, these initial descriptive codes were labelled. Next was stage two; interpretive coding. The descriptive codes were looked at to see if they had any commonality and similar meaning that meant they could be grouped together under a new interpretive code. Finally stage three involved the defining of the overarching themes using the interpretive coding to identify the key concepts within the analysis. At all stages the full discussion data were referred back to, which ensured that the codes were developed within the context of the original conversation.

BH and LW conducted the thematic analysis. Coding was undertaken 'blind' with both researchers coding transcripts independently, followed by a meeting to cross check the themes and critically appraise the coding. Following discussion and some refinement of themes, there was mutual agreement regarding the defined codes.

JH acted as a further external independent cross-checker of the coding to enhance the analytic rigour. JH has a background in mental health nursing and was thus able to provide a different perspective to data analysis and interpretation (BH and LW have backgrounds in midwifery). There was a high level of consensus between all data coders.

Following the first stage of data analysis, an overview of the thematic analysis and illustrative data extracts were forwarded to the Expert Group and members of the Project Advisory Group for their comments. For example, we invited feedback on what was noteworthy in the findings, whether there was congruence between data and interpretation, how the findings might relate to other literature, and where the study could lead to in terms of future research. The Expert Panel feedback was very useful for enhancing the analysis. Their comments generally confirmed the data interpretation, and the findings were thought to corroborate those of other studies of workplace resilience and add to the empirical evidence. In addition, issues of particular interest and importance were noted, and areas for further research were identified. These will be discussed further in Chapter Five.

4 Findings

The online discussions generated a wealth of rich qualitative data. Thematic analysis identified four overarching themes:

- **Challenges to resilience**

- **Managing and coping**

- **Self-awareness**

- **Building resiliency**

Each major theme contained many subthemes, as can be seen within the Figures 1-5 (pages 59 - 63). Themes and sub-themes are discussed in turn, using extracts from the data to illustrate. It should be noted that, where participants respond in the third person, they are referring to an imaginary resilient midwife described in the vignette that was posted for discussion (see Appendix 4). The convention of square brackets is used to provide additional explanations as necessary, apart from this all quotes are verbatim. To faithfully capture the contributors' responses as they were written, we have decided not to correct any typographical errors in the data.

Online Group Statistics

Statistics from the discussion group site showed twelve midwives registered as members of the discussion group and eleven midwives eventually participated in the discussions. By the end of data collection the first thread: 'How I cope' had 233 views and a total of 33 replies. The second thread: 'What do you think?', which commenced half way through data collection, had 118 views and 26 replies. The number of posts per person varied from one to ten with the majority contributing posts at least three times (*n=8*).These statistics, and the detailed nature of the posts, seem to demonstrate the participants' keen interest, as they often returned to the site to contribute to the discussions and to read the other posts.

4.1 Challenges to resilience

Participants described a range of stressors or challenges that created adversity, and which they thought had led to the development of their own resilience or the resilience of others. These stressors were categorised into personal and professional challenges, work conditions and concerns regarding quality of care. The discussions gave the impression that workplace adversity was a common experience for all participants.

4.1.1 Personal Challenges

Personal challenges were infrequently mentioned, although this may be because the discussions were clearly focused on resilience at work. A few midwives recognised that the adversity they faced during work life could impact on personal life, and vice versa although, as one noted, work could be viewed positively as providing some distance if there were problems at home. Generally participants kept work and home life separate, as will be seen in Major Theme 2: Managing and coping.

> *I sometimes find my work emotionally exhausting which has made home life suffer. Sometimes you walk through the door and have nothing left to give. (No 9)*

> *Leave home troubles at the door of the unit, that way work can be therapeutic! (No 4)*

4.1.2 Professional Challenges

In contrast, professional challenges were widely discussed and participants often referred to professional situations that were stressful and increased a sense of adversity. These included situations that constrained professional practice at both micro and macro levels.

At a micro level, hospital policies and protocols could restrict individuals' clinical decision-making and how midwives practised. When policies and protocols were perceived as privileging a risk-centred approach to practice, participants felt their individual autonomy as midwives was compromised:

> *…the complexity of care now means we are far more aware of risk, problems and clinical governance and of course the huge increase in paperwork and technology (No 6)*

> *Sometimes I feel as though I am involved in some sort of duel, so appropriate care is given (i.e. normalising pain in labour etc) (No 3)*   [Referring to the balancing of needs between woman and institution]

Professional challenges were also experienced at a more macro level: hospital 'politics' were referred to, characterised by inflexible and bureaucratic management styles which controlled practice, hindered flexible working and undermined occupational autonomy.

> *I have also had a rotational role within an obstetric unit and interestingly found this very frustrating as I felt very much under the control of management - every time I moved I felt I was starting again. (No 9)*

> [Referring to the vignette] *She works hard at being the best she can be - often in difficult circumstances - due to shortage of staff, increasing complex cases, more medicalisation and 'hospital politics'….she will hate hospital politics and things that get in the way of doing a good job. (No 1)*

A perceived 'bullying culture' was also referred to by some.

> *There was a period when as a younger midwife I nearly gave it up after some harsh treatment from a manager. (No 8)*

...a perceived 'bullying' culture does not make for a good working environment and is counter-productive, and how can we possibly give the women our best in these circumstances?!! (No 4)Participants identified critical moments in a midwife's career that could leave him or her especially susceptible to stress. At these times, professional challenges were most keenly felt and could have most effect. These critical moments were identified as: when midwives were newly qualified, after an adverse incident or case with a poor outcome, and when midwives were 'under investigation' by their employer and/or the NMC.

> *Have recently been investigated and cleared of - what I would call every MW* [midwives'] *nightmare, it took 10 months. I was taken out of clinical practice but never went off sick once, I was cleared and am now back clinical - how? I don't know. It nearly broke me but I would not let it. (No 1)*

> *I was talking to 2 very newly qualified midwives after a very busy shift last night and they both spoke about the high confidence levels they had being senior 3rd year students, only to lose it when qualified. (No 8)*

> *I worry that new midwives these days are really thrown in at the deep end! They are supported through their training always having a mentor to work with, but when they qualify, despite preceptorship (which sadly is often a paper exercise rather than a real practical help) they go from feeling confident on qualifying to being terrified when they practice! (No 4)*

4.1.3 Work conditions

Work conditions were linked to these professional challenges, and provided specific examples of stressful situations that challenged resilience. These were all situations over which midwives felt they had little or no control and included: excessive workload, excessive paperwork, staff shortages, not being able to take breaks, and working with stressed colleagues. When these negative working conditions disrupted home life, this was a particularly challenging experience.

Several midwives mentioned that high workload and low staffing levels meant that they often went without breaks, and finished late. For a few there was an expectation that some administration (such as online training programmes and supervision work) would be done in their own time, although it was apparent that where possible, this was resisted.

> *I agree about the working from home, I have not signed up to the IT options either. We often don't get meal breaks and stay late, so more unpaid work at home is a no no! (No 8)*

> *Closing the unit one shift, nearly closing the next, having to go into work on days off to do supervision stuff and then another shift that nearly runs away from you (No 1)*

> [Referring to the vignette]*She doesn't like seeing her peers stressed, expecting them to go without breaks and leave late to give the care they want to (No 2)*

> [Referring to the vignette]*She will find short staffing difficult and the endless paperwork frustrating. (No 9)*

4.1.4 Quality of care

As well as these more pragmatic stressors, participants described how compromised quality of care presented an ideological challenge. It was evident from the discussions that midwives felt torn between the care that they would ideally like to provide for women, and the care that they were actually able to give.

For example, this could occur when participants thought that there was too little 'time to care', when resources were lacking or when a managerial emphasis on administration and documentation took midwives away from providing woman-centred care. Midwives reported that quality of care was also affected by the increasing medicalisation of childbirth. Sometimes these situations could be interlinked.

Underpinning these concerns regarding quality of care was a mismatch between professional ideals and the realities of everyday practice.

> *.. midwives come into the profession with high hopes and ideals but sadly sometimes find themselves 'firefighting' rather than giving the care they aspire to. (No 4)*

> [Referring to the vignette*] She gets upset about not being able to give one-to-one care enough, unnecessary interventions and medicalisation/protocolisation of labour, negative attitudes and behaviours of ?less resilient staff (counting the days to retirement etc), bureaucracy/ forms/ computers/tick boxes. (No 10)*

> [Referring to the vignette*] I am sure that the aspects that she east enjoys are the paperwork/computerwork which sometimes midwives feel takes over and takes them away from giving the care that they want to give to women (No 11)*

Resilient responses

The other three major themes comprise the resilient responses to these challenges as described by the participants. It should be remembered that the participants are all midwives who self-identified as resilient. They also commented on colleagues who were more or less able to 'bounce back', and on times in their lives where they had found it more difficult to be resilient.

4.2 Managing and coping

This theme included resilient strategies (or coping mechanisms) employed by the participants to cope day to day with the workplace challenges described in the previous theme. Participants described how these pragmatic and proactive strategies had been developed or learnt over time and as a result of workplace experiences. Five sub themes for managing and coping were identified: gaining perspective, mood changers, social support, work- life balance and self-efficacy.

4.2.1 Gaining perspective

Participants described how they attempted to gain a sense of perspective on adverse situations by the use of reflection, both solitary and with colleagues. Following a difficult shift or case, some would discuss with colleagues or their supervisor of midwives, whilst others used the journey home or walking the dog as a time to reflect on their own and make sense of the situation.

> *When there are particularly difficult issues I have a very supportive and wise Supervisor of Midwives who helps me put things in perspective. (No 4)*

> *What helps me is getting on the bus and the train after the shift and watching other people in their lives with their conversations and just emptying my brain or slowly pondering an event at work… One thing childbirth taught me personally is that no matter how horrible or hard it feels, it will end! I remember this during difficult days and it gives a bit of perspective by allowing me to step back for a few seconds and refocus (No 3)*

> *I am the hot bath and reflective type of person - I often sit and reflect as I drive home - multitasking is easy as I only have a 10 min drive (No 6)*

> *Reflecting and thinking over issues on the way home (I am always on my own here) or on the hills with the dog (again, mostly on my own) allows me to 'park' or 'compartmentalise' or 'process' what has been going on so that when I get in I can put it behind me until I get back to work. (No 9)*

Balance between work and home life was achieved by conserving energy and by compartmentalising. It was notable that many participants described being able to 'switch off', leaving work problems at work and home concerns at home.

4.2.2 Mood changers

'Switching off' appeared to be facilitated by outside interests and the use of mood changers, which were extensively described: from calming activities such as alcohol, music and warm baths, to the positive stimulation of exercise. We were struck by the frequent mention of pets, in particular the benefits of dog walking!

> *I find that whilst alcohol can help me unwind after a difficult day, drinking more than 2 or 3 units just makes me maudling!* [sic – means maudlin ie over-emotional] *(No 9)*

> *I have had a dog (well two) since 1985, when I had been qualified 2.5 years and I am now beginning to think that dog-walking is key, having read various other comments. There's not much a good dog-walk doesn't solve. (No 10)*

> *I see others mention things I did and do to keep on going, music is a brilliant it can be such a mood changer and I have never been so fit I cycled and went to the gym (and still do) and feel this helps keep be sane. (No 1)*

A good sense of humour was also identified as being important and, although it was not specified, perhaps it was valued for its ability to 'lighten the mood'.

I think also that having a sense of humour helps build resilience, does anyone else agree? You know that black sense of humour you develop that acts as a defence mechanism and helps you cope with the difficult stuff? (No 9)

A sense of humour is vital, especially the black sort. (No 8)

4.2.3 Social support

The value of social support was frequently mentioned. This could be provided at home from partners, family and friends and/or from work colleagues. Some participants found social support from home gave a sense of perspective on work problems, although for others sharing work difficulties with partners was avoided.

Trusted work colleagues were frequently mentioned as sources of support and personal affirmation. However, participants appeared to be careful to seek out those colleagues they had identified as being like-minded, empathetic or 'safe'. Such relationships were often described as mutually supportive and reciprocal.

I have a supervisor who I can really talk to without fear. I also have a supervisor friend who has the wisdom of Solomon and she always helps to keep things in perspective. (No 8)

I agree it is good to talk over a particular issue with one or two trusted colleagues - to establish one's position and next step or response and then stop. (No 10)

I stayed away from those who I knew would make me feel undermined or negative. (No 9)

You need space from that to let your head rest. But what does help is work colleagues talking to people who really understand where you are coming from. (No 1)

Only one participant reported discussing work issues with her partner, whilst others had made a conscious decision to avoid this.

[I] need to de-brief for 2-3 minutes with my husband. Sometimes that happens as soon as I get home and sometimes after I've slept off night shift. He nods and quietly lets me blow off steam. (No 5)

I don't tend to take work problems home, as my partner tends to see things in black and white and we know things are not like that. (No 8)

4.2.4 Work-life balance

Frequently the midwives talked about the need to have a work-life balance. Often this would mean keeping work and home life separate, with some participants almost compartmentalising the two elements. The need to have outside interests was also raised by a number of participants.

I agree with the comment about having other interests-I am always busy out of work and this does help to detach yourself in your time off. I also have a long journey home and have always reflected on my shifts so that by the time I arrive home I can hopefully switch off….Being able to leave work at work [ie leaving the stressors of the job in the workplace]is something that comes with experience-initially I brought my

work home with me and over time learnt that you had to be able to separate work and home life or something would suffer. (No 11)

I find that being able to 'switch off' when I leave the unit, and leave the problems there is a help. I also think that having a busy life with other interests and commitments helps me to do this. (No 4)

4.2.5 Self-efficacy

The sub-theme of self-efficacy was unexpected. Although it was noted by participants that there were aspects of the working conditions which they had little control over (see Work conditions page 27), some participants did describe how they would attempt to control what they were able to, based on reasonable expectations of themselves and others and what could be realistically achieved.

It was evident that the participants had a sense of belief in their capabilities as midwives, feeling confident in their working lives and in their ability to affect change. Participants described how they thought they had become resilient by 'finding a niche' where they felt a strong sense of personal and professional 'fit'; alternatively some 'embraced change', sometimes seeking out new midwifery roles and employment in an attempt to control the challenges of the workplace.

All these roles have developed my skills, confidence and knowledge and, in addition, for many of these roles I have had some degree of control and influence over my workload. (No 9)

A change is often better than a rest. Also I am not bored. It also builds resilience more directly as it is a challenge settling into a new place, learning the job, getting to know people, taking nothing for granted, finding the way around and how things are done. (No 10)

[Referring to the vignette] She believes that she is a valued member of the team and has some influence in any change. (No 9)

No matter how busy or stressful it can be it is important to acknowledge that we are dealing with a 24/7 situation and others will pick up where I have left off ….Part of the price for aiming high and 'giving your all' while on duty is that occasionally you can't do the impossible, we must tell ourselves that it is the system that is failing, not us! (No 4)

4.3 Self-awareness

The third overarching theme was that of self-awareness and this theme encompassed various elements of the self. There was frequent reference to 'knowing yourself' and the importance of drawing on personal resources and the core self. Self-awareness was described partly as being developed over time, but also as being underpinned by existing personal attributes and innate tendencies.

4.3.1 Identity

Within the discussions were many examples of a strong sense of personal and professional Identity. The highly developed professional identity of the participants was

very noticeable. There were many descriptions of participants' love of midwifery practice and sense of belonging to a professional 'family'. A sense of vocation was referred to, with midwifery commonly described as something someone *is* rather than what they *do* – that is, professional identity was integrated with personal identity. Many viewed their profession as being a core part of themselves.

> *I feel midwifery has been my vocation and is part of a bigger say "karmic" picture and that I am sustained in my midwifery by a spiritual impulse of some sort (can't really put it into words but I know it is there). (No 10)*

> *A midwife is what I am. It's written through my body like a stick of rock. (No 9)*

Underpinning this love of midwifery practice and enjoyment of their work was a commitment to 'making a difference', at both an individual and wider societal level. The importance of public service and the experience of contributing to the greater good were common themes in the discussions. It seemed that work had a moral dimension for these midwives, and for some it contributed to an existential search for 'greater meaning'. In turn, this appeared to give them a great sense of purpose and fulfilment.

> *I love this job and feel genuinely sad that with looming retirement it is going to end soon (No 8)*

> *A positive outlook is surely a must, we do a great job despite the limitations, and we really can make a difference if we let ourselves! (No 4)*

As described in Chapter Three, for one of the discussion threads, the midwives were given a brief scenario involving a fictional midwife called Liz who worked on a busy labour ward (see Appendix 4). Participants were asked what it was that kept Liz going. Their responses clearly demonstrated the strong sense of contributing to a 'greater good'.

> *She thinks she has a fantastic job - interesting, varied, worthwhile, reasonably well-paid, secure, stimulating, and often fun. It accords with her sense of purpose and her sense of the importance of public service. (No 10)*

> *Liz is passionate about midwifery and believes that she can make a difference (No 9)*

> *Liz is very experienced and obviously loves her job or would not have stayed in the profession as long-she has a lot to offer to women and to her colleagues and is probably a good role model to all…... Liz stays in the job because she always wanted to be a midwife and she knows that when she goes home at the end of the day she has given good care to her women. (No 11)*

> *She goes back for more because she truly believes that she "makes a difference" (No 2)*

4.3.2 Autonomy

Exercising autonomy, in both personal and professional life, was also a frequent area of discussion. Having a strong sense of autonomy was viewed as important and the experience of being an autonomous individual appeared central to participants' perception of themselves as resilient midwives. Integral to this sense of autonomy was the ability to control as much as possible and exercise choice, in order to manage the

challenges of practice (See also 'Professional Challenges' page 26). When autonomy was compromised, this was experienced as an important challenge.

> *I must say also that I love my work and do feel in control of what I do, there are very few shifts where I have felt as though I was not in control … I do think that if midwives feel that they have some control (perhaps control is not the best word to use!) over their situation then they will feel better able to manage the stresses that inevitably occur (No 4)*

> *All these roles have developed my skills, confidence and knowledge and, in addition, for many of these roles I have had some degree of control and influence over my workload. (No 9)*

4.3.3 Attributes

Participants also described a range of personal attributes that they felt contributed to being able to 'bounce back' in times of adversity. These included confidence, self-esteem and self-regard, a balanced approach to life underpinned by acceptance of 'what is,' and a pragmatic, adaptable response to difficult situations. Some participants described themselves as natural optimists, whilst others thought they were naturally more anxious but had found ways to manage their anxiety.

> *I have always believed myself to be very resilient with high levels of stamina and energy which have been with me throughout life….I am interested in the comments about optimism as I am naturally optimistic (my husband sometimes thinks I am too optimistic!) and find change a challenge to be welcomed and embraced. (No 9)*

> *I am not a big worrier and I know I am quite an optimistic person and all these things are closely linked - optimism, anxiety, ability to let go. (No 10)*

> *I am fortunate to believe in myself, and have enough confidence in my integrity (No 1)*

4.3.4 Obligation to oneself

Throughout the data, there was evidence that participants felt a sense of 'obligation to oneself': that it was important to be self-protective by being aware of one's own capabilities and limitations, and not have unreasonable self-expectations. Related to this was the need to be aware of the expectations of others, and to evaluate the reasonableness of these expectations and how they could influence personal behaviour and experiences.

> *I can remember some good advice given to me by my first ward sister. She said so long as you've done your best, kept everyone fed, watered and pain free and no-one has fallen out of bed, you've managed very well. I've taken that advice literally and that's how I cope. (No 5)*

'Obligation to oneself' is closely affiliated to the subtheme 'Protective self-management' in the next major theme.

4.4 Building resilience

The fourth and final major theme was concerned with the building of resilience, and included longer-term strategies for enhancing resilience in both self and others. Sub themes included: protective self-management, learning and investment, role modelling, supporting colleagues and facilitating empowerment.

Although linked to the pragmatic day-to-day strategies outlined in the Managing and Coping theme, the data in this theme referred to a deeper investment in creating sustainable ways of being and interacting. The data suggested that those who feel themselves to be resilient may also be able to contribute to developing resilience in colleagues, with implications for building team resilience as well as wider institutional and NHS resilience.

These longer-term approaches to building resilience drew on learning about oneself and investing in that learning. Linked to the previous theme, participants described the value of knowing oneself, and working with this self-knowledge to make constructive use of anxiety and recognise personal limitations.

4.4.1 Protective self-management

Many of the participants described using what we have categorised as 'Protective self-management'. Underpinned by emotional awareness, this self-protective approach included anticipating stress and recognising warning signs, in oneself and others, and taking steps to avoid challenging situations or hindering relationships.

> *I stayed away from those who I knew would make me feel undermined or negative.*
> *(No 9)*

> *What I find works for me is my ability to rationalise. (No 5)*

> *Usually I have to sort work problems before I leave or make a plan (or in my head on*
> *the way home) otherwise it may fester until I go back. (No 9)*

4.4.2 Learning/Investment

It was evident that resilience was in some cases a learnt process whereby individuals found their strength through adversity. Experience of previous challenges (for example, personal experience of being 'under investigation') in which participants had coped and 'come through' was described as a key ingredient in building resilience.

> *I never thought I would have coped but I did and bounce back I have, learnt resilience,*
> *how - I don't know if it was that or I just found an inner strength I never knew I*
> *had. (No 1)*

One participant talked about recognising herself as an anxious person but, instead of this being problematic, she had learned to use her anxiety constructively.

I think I am naturally a bit of a worrier, always have been, but less so since getting older. I try to use that to help me work more safely by checking what I and others are doing. (No 7)

Others identified that role modelling was as an important mechanism for learning resilient approaches, and it is probable that the participants also acted as role models for their colleagues.

[Referring to the vignette] *Liz is very experienced and obviously loves her job or would not have stayed in the profession as long-she has a lot to offer to women and to her colleagues and is probably a good role model to all. (No 11)*

4.4.3 Supporting colleagues

Participants discussed the importance of providing support for colleagues and there appeared to be a general consensus that accessing a collegial support system was beneficial. In particular, student and newly qualified midwives were identified as needing focused support and nurturing by experienced midwives. Supervisors of Midwives sometimes provided professional support, though the need for this to be 'non-threatening' was emphasised.

Related to the 'Managing and Coping' theme, the provision of support by trusted, empathic colleagues offered opportunities for reflection and gaining a sense of perspective on adversity. A buddy system was suggested as one way of providing social support in the workplace.

Interestingly, it was not just *receiving* support that was thought to be beneficial for building resilience. *Providing* emotional support to others was described as a satisfying and affirming experience for individuals, suggesting that there are particular benefits to be gained from mutuality and reciprocity.

I wonder if being an 'oldie' and feeling that we have to look after the newer midwives takes away some of the personal stress? (No 4)

I love being a midwife and learned very early in my career to seek out like minded individuals and also other individuals who I knew would be supportive in certain situations. I also know that others use me for support and that mutuality helps build resilience. (No 9)

I agree with nurturing new midwives and I do think we could do more, perhaps a buddy system not just during shift time, but an intermediary before supervisors are needed. (No 8)

4.4.4 Facilitating Empowerment

'Empowerment' was mentioned frequently as a way to build resiliency in others and also to promote and protect optimism - most notably in the less experienced members of staff.

We must support and empower younger colleagues so that they will stay with us and not be frustrated by the realities of working in the NHS. ..... I think the simplest things can empower them and make them feel good about themselves, this will surely help

them to become more resilient.....how many times do we make a point of telling them that they have done well.....specific and sincere, you will see them growing!! (No 4)

I do not particularly see optimism among experienced colleagues. I think this is more likely among new midwives, and I see it as my responsibility to avoid reducing their optimism, and to encourage them in their development. (No 7)

4.5 Conclusion

Thematic analysis of the rich qualitative data identified four major themes. In the theme 'Challenges to resilience', midwives described the adverse situations which had led them to develop resiliency. These situations predominantly focused on workplace challenges, a common experience of all.

Resilient responses to adversity were categorised into three further major themes: 'Managing and coping'; 'Self-awareness'; and 'Building resiliency'. Analysis indicated that the participants drew not only on a range of practical coping strategies, but also on a strong core sense of self and self-awareness, developed over time. The importance of a sense of self-efficacy and a strong midwifery identity ran throughout the accounts, as did the significance of social support. These resilient responses were built over time, sometimes learnt through role modelling and certainly through self-reflection. The discussions indicated a deep investment in developing positive ways of working, and of supporting colleagues to adopt similar resilient moves.

In the final chapter, we discuss these findings in the light of the wider literature and consider the implications for midwifery education and practice.

5 Discussion and implications for midwifery practice and education

This small exploratory study aimed to explore clinical midwives' understanding and experience of resilience using a professional online discussion group, and to model the concept in collaboration with a panel of experts in the field. In particular, it sought to: investigate how clinical midwives, who had been in practice for more than 15 years and who categorised themselves as 'resilient', described their experience of resilience; identify the personal, professional and contextual factors considered to contribute to or act as barriers to resilience; explore how the resilience of student and newly qualified midwives might be enhanced.

These study aims have been achieved. The online group of clinical midwives generated extensive and sustained discussions, strongly suggesting that the concept of resilience had salience for this professional group, and that it is worthy of further study. Data analysis identified a number of themes related to the specific research questions. These may have theoretical transferability to other midwives and certainly warrant enquiry. Consultation with Expert Group members confirmed the credibility and relevance (and sometimes the originality) of the findings, and enabled us to further develop our understanding of the concept.

In the final chapter we discuss the findings with reference to the wider resilience literature, incorporating feedback from members of the Expert Group. We consider the implications for midwifery practice and education and identify areas for future research.

5.1 Limitations and strengths

The study has both strengths and limitations. The online discussions had advantages over a conventional focus group. Firstly, the virtual nature of the discussions appeared to facilitate 'natural' group interaction, and, in comparison with face-to-face focus groups, minimised the need for researcher input. This in turn should have diminished the influence of the researchers on the data. Group members commented on each other's posts and offered feedback and support to each other. There was evidence that the group members felt some degree of 'ownership', as indicated by the first post which was initiated prior to the research team officially triggering the discussions. Secondly, the discussions took place over the period of one month, enabling participants to contribute at several instances over a period of time and affording a longitudinal element to data collection. Thirdly, midwives could participate at a time (and in a place) to suit their own needs. It was noteworthy that many participated in the evening or after a shift had ended. This is likely to have enhanced participation. Lastly, participants were able to compose replies in their own time, and the detailed and often lengthy posts indicated

that their responses had been carefully considered. Thus we consider that the method of data collection has a number of strengths.

Study rigour was enhanced by the approach taken to data analysis described in Chapter Three, with independent coding and cross checking of analysis enhancing trustworthiness. Also the additional consideration of the data provided by the external Expert Group members provided peer review, as well as an external perspective on data interpretation. As Expert Group members had backgrounds both in and external to midwifery, this afforded a well-rounded evaluation of the findings.

However, the findings should be interpreted with some degree of caution. They represent a snapshot of the experiences of a small, self-selected sample of UK midwives, who had been in practice for fifteen years or more. Because of the inclusion criteria, all were RCM members and all self-defined as resilient. Very different data might have been generated from a sample of more recently qualified midwives, or from those who had moved away from hands on practice or those less confident with using social media. In addition, demographic data were not obtained from participants and hence there is no information available about participants' age, gender, geographic location, or type of workplace setting. Given that the literature indicates the significance of context on experiences of resilience, and that the participants commented on the importance of finding a workplace 'niche', these would be important factors to consider in any future studies.

5.2 Discussion of Findings

The study has generated some findings that are reflected in the broader resilience literature, as well as elements that have been less widely identified and discussed. The midwives' understanding of resilience broadly supported theoretical definitions of resilience (Seery et al., 2010, Neenan, 2009) which focus on positive adaptation to adversity without significant residual disruption; that is, '*the ability of an individual to respond positively and consistently to adversity, using effective coping strategies'*. The analytic themes from this study are reminiscent of the resilience framework used by Angie Hart and colleagues(Hart et al., 2007) in their therapeutic work with children and families. Within this framework, four 'noble truths' of resilience are proposed: *accepting* what is and who people are; *conserving* anything good that has gone before; *commitment* and *enlisting* the help of others. Hart et al suggest that these processes are underpinned by conceptual areas relating to belonging (attachment), learning, coping and the core self, similar to our findings relating to building resiliency, managing and coping and self-awareness.

Unexpected findings included the potential contribution that a strong sense of professional identity can make to the development of professional resilience. It was also evident that professional resilience may not always be synonymous with personal resilience; for example, as a self-protective action, a midwife may decide to move workplace, thus creating degree of workplace instability, or even leave the profession.

It was also noticeable and unexpected that there was little mention of the services users/women in the discussions. This could be because interactions with women were not experienced as contributing to resilience (although this would contrast with the evidence from other studies which indicates that meaningful and reciprocal relationships with women are important for midwives' job satisfaction) (Sandall, 1998, Hunter, 2006, Kirkham et al., 2006). Alternatively it may be a taken for granted element of work, which participants did not feel the need to make explicit in their discussions. Interestingly, the literature review only identified one study (with GPs) in which interactions with clients were identified as stress buffers and sources of job satisfaction. The role played by relationships with clients in the development of resilience is worth exploring further.

Interestingly, it was positive and reciprocal relationships with colleagues that the participants in this study described as important. Positive collegial relationships could be a source of job satisfaction and provided opportunities for developing resilience in self and others. This focus on colleagues may be linked to the context in which the participants worked. Hunter(Hunter, 2004) observed that colleagues were the 'primary reference group' for hospital-based midwives, whereas community-based midwives had fewer interactions with colleagues and described relationships with clients as most important for their sense of 'a job well done'. Again, it would have been illuminating to have known more about the work context of the study participants.

5.2.1 Challenges to resilience

Many of the adverse situations described by the participants are well documented in current midwifery literature, including research studies, reports and opinion pieces. They are also evident in studies of other health practitioners and public service workers (McCann et al., 2013, Adamson et al., 2012, Ball et al., 2002, Jackson et al., 2007). Although alarming in their prevalence and persistence, these workplace challenges were not unexpected. They reflect the explanations of workplace stress provided by Marmot (Marmot, 2004) : that stress is not just the result of having too much work, rather it is experienced when individuals experience an imbalance between workplace demands and personal control, and when there is an imbalance between effort expended and rewards received.   What made the findings particularly interesting however was that the participants were able to make links between these adversities and the development of personal and professional resilience. This meant that the focus of their discussions did not remain with the negative aspects of work, rather they moved on from this to describe their strategies for creating as positive a response as possible. In other words, how they managed to 'bounce back'. Using Marmot's model, it could be that resilient individuals are proactive in their attempts to redress the imbalances that lead to stress.

Adverse work conditions resulting from staff shortages and high workload were widely noted, consistent with widely publicised concerns regarding a national shortfall of midwives (Campbell, 2012, Warwick, 2012). The accounts gave vivid examples of the impact of such stresses when they occur day in, day out. There was also frequent mention of inflexible management, and of workplace cultures which were perceived by

some participants as 'bullying'. These factors are frequently cited in studies of midwives' stress and dissatisfaction with their work (Kirkham et al., 2006, Curtis et al., 2003, Ball et al., 2002, Mollart et al., 2011, Sandall, 1998, Mackin and Sinclair, 1998).

Ideological conflicts were also noted as a source of challenge. The compromised quality of care which resulted from adverse work conditions was demoralising, and as was the emotional dissonance created by a mismatch between professional ideals and workplace realities. This dissonance, and the frustrations it presents, are well documented in other research studies (for example (Ball et al., 2002, Mollart et al., 2011, Hunter, 2004)). Tensions also arose from the uncomfortable juxtaposition of professional autonomy with institutional policies and protocols. Midwives described how their expectations for autonomous practice were challenged and often confounded by the imposition of standardised procedures, which left little room for exercising professional judgement. In contrast, having a strong sense of autonomy was central to many participants' accounts of personal and professional resilience.

It was also commonly identified that there are critical moments in a midwife's working life when these adversities may be most keenly felt and have most impact. The challenges experienced by newly qualified midwives were frequently discussed, with an emphasis on their vulnerability and need for peer support. This is reflected in the statistics for midwifery staff retention (Royal College of Midwives, 2010), which indicate that it is midwives within the first five years of qualification who are most at risk of leaving the profession, and is further supported by studies of the experiences of newly qualified midwives (Van der Putten, 2008, Fenwick et al., 2012, Hughes and Fraser, 2011). The emotional impact on midwives of experiencing adverse incidents or of being the subject of an investigation or complaint has been less well researched. An Australian study of how an external maternity services review created a culture of fear for midwives provides important but rare insights (Hood et al., 2010). The findings of this study, in particular the frank disclosures of two participants, suggest that this is an important area which requires attention in both practice and education. It would also benefit from further research investigation.

5.2.2 Managing and coping

Participants frequently referred to resilient responses when under pressure, which applied to the immediate responses required for acute events, rather than the longer term investment to build resilience. It appeared that what was pivotal to coping with acute workplace adversity was the participants' ability to gain a sense of perspective and this was achieved through reflecting informally with colleagues, or accessing their supervisor of midwives. Reflection has been identified as important by other researchers investigating resilience in caring professions (Jackson et al., 2007, Grafton et al., 2010, Kinman and Grant, 2011). Some have suggested that team reflection is important in building resilience (McAllister and Mckinnon, 2009) however, participants also reported that they found reflecting on their own, away from their place of work was extremely useful in gaining perspective. This solitary reflection was facilitated through day to day

activities, such as travelling home after a shift or walking the dog. Solitary reflection did not take place within the home; rather it would appear that the activities that facilitated reflection enabled the midwives to keep work and home separate. In a similar vein, the ability to 'switch-off' was cited as important to help manage difficulties at work and provides the opportunity to gain distance from adversity and this has been identified elsewhere as an effective coping mechanism (Burnard et al., 2000).

Using mood changers as a means to 'switch-off' such as exercise, listening to music, soaking in a bath or having other external activities such as hobbies are known coping mechanisms (Burnard et al., 2000). In this study it was apparent that these were positive mood changers which were actively utilised to improve how participants felt. When alcohol was mentioned it was noted that its benefit was found in small doses and excess was more likely to exacerbate the adversity. Walking the dog, as well as providing midwives with time and space to reflect on work, appeared to have an added benefit; to lift and alter mood. It has been suggested that pet ownership is associated with improved physical and mental health (McConnell et al., 2011), although no literature was identified that linked owning a pet to improved resilience in the caring professions.

As may be expected, social support was key when it came to coping with adversity and the support gained from colleagues was linked with reflection and gaining perspective. Peer support is widely recognised as valuable in maintaining resilience (Hodges et al., 2008, Adamson et al., 2012, Jensen et al., 2008). What was interesting about the findings of this study is that the participants referred to identifying 'safe' or 'trusted' colleagues to talk with or confide in. This may provide evidence that the widespread perception of bullying in the workplace noted in previous studies (Curtis et al., 2003, Gillen et al., 2008, Gillen et al., 2009) continues today. Rarely were partners mentioned as a form of social support and this may be due to the need to keep work and home life separate. Creating a work life balance has been identified by many as important for resilience (Cameron and Brownie, 2010, Jackson et al., 2007, Adamson et al., 2012, McCann et al., 2013, McDonald et al., 2011), and indeed this was also highlighted in this study.

An unexpected finding was the subtheme of self efficacy which, although identified as a variable by Gillespie and colleagues (Gillespie et al., 2009), is not frequently reported. Self efficacy is closely affiliated to control and autonomy and the participants described trying to control what they were able to whilst having realistic expectations of what could be achieved.

5.2.3 Self-awareness

The importance of self-awareness for building resilience ran through many of the discussions. A well developed understanding of personal emotions and those of others was seen as an essential resource which midwives could draw on at times of adversity; these were also seen as emotional awareness skills that could be developed over time and with experience.

This emotional self-awareness has much in common with emotional intelligence, described as: knowing one's emotions, handling feelings, motivating oneself, recognising emotions in others, handling relationships (Goleman, 1996). Emotional awareness and emotional intelligence have been identified in several studies (Hunter, 2010, Nicholls and Webb, 2006, El-Nemer et al., 2006) as essential for high quality care and as core attributes of exemplary midwives (Hunter, 2010, Nicholls and Webb, 2006, Byrom and Downe, 2010). It is therefore not surprising to find them emphasised in the accounts of midwifery resiliency. However, we identified an interesting sub-theme of self protection and self-obligation, which may be elements of self-awareness that are critical for resiliency but seldom discussed. That is, an important element of resilient self-awareness was to have a balanced evaluation of one's potential, not over-expect of oneself, and to be alert for the unrealistic expectations of others. Such an approach entails acceptance, which Neenan (Neenan, 2009) characterises as 'change what it is possible to change, if you are unable to change it, then change how you feel about it'. Self protection and duty to the self also links to the notion of 'self-care' identified in the studies by Adamson *et al.*(Adamson et al., 2012) and Grafton *et al.*(Grafton et al., 2010).

The relationship between emotional intelligence and resilience has received some research attention (Kinman and Grant, 2011, Garg and Rastogi, 2009) and certainly warrants further study, particularly in relation to its application to health care workers.

As noted in the literature review, initial understandings of resilience suggested that it was an innate character trait or collection of traits; personal qualities which one either had or hadn't. However, a wealth of research studies across a range of disciplines has extended this understanding. Current thinking suggests that resilience develops over time and is a combination of internal and external factors (Tugade and Fredrickson, 2004). This debate was reflected in the discussions. Some participants did refer to the influence of innate personal attributes such as confidence, self-esteem and optimism, which they had learnt in childhood and brought with them to their work. Others however described 'working' on developing these qualities. It was generally agreed that resilience was something that could be enhanced, and that peers played a key role in building the resilience of their colleagues.

An unexpected and important finding was the importance of professional identity as a midwife for the development of resilience. Professional identity was also linked to the existence of occupational autonomy – or at least the potential for this. A strong sense of collective identity and public service ran though the discussions, and there was consensus that a feeling of professional 'belonging' and 'love of the job' contributed to resilience. Adamson *et al.*(Adamson et al., 2012) made a similar observation in their study of resilient social workers. It was interesting to note, however, that the discussions of a 'love of midwifery' did not include any discussions of the importance of developing positive and reciprocal relationships with mothers, as might have been expected. In other studies of midwives' roles and occupational identities, (Kirkham et al., 2006, Sandall, 1998, Hunter, 2006, El-Nemer et al., 2006, Hunter, 2004) these two themes are often interlinked.

The potential importance of professional identity for resilience needs further exploration. Professional identity has not been identified as a key characteristic in studies of nurses' resilience and this possible difference between midwives and nurses was also commented on by members of the Expert Group, especially those who had a background in nursing. It would certainly be interesting to investigate further.

5.2.4 Building resiliency

The idea that it is possible to build and develop resilience in oneself is widely acknowledged (Luthar et al., 2000, Neenan, 2009, Grafton et al., 2010) and was a common theme within the discussions. Building resilience, although affiliated to the theme of 'coping and managing', was more about long-term investment and protection rather than the immediate protective response to acute adverse events.

A key element of building resiliency was 'protective self management', which referred to the protective approaches used by participants. These approaches included recognising triggers or warning signs and taking active steps to minimise their impact such as avoiding hindering relationships, or addressing problems as they arise. This idea of recognising potential stressors and addressing them links in with the resilience literature on autonomy, control and self care (Adamson et al., 2012, Grafton et al., 2010, Gillespie et al., 2009).

Participants shared descriptions of what they had learnt, what worked for them and also what they found unhelpful (such as too much alcohol). There was some evidence that participants were able to master extreme adversity in the workplace, and those few participants who discussed this, talked in terms of overcoming or triumphing over such hardships. It would seem that successfully navigating their way through adversity served to build on and provide confirmation of their resilience. Psychologists refer to this process as 'stress inoculation' where stress is not just seen in terms of its negative effects on mental health and well being but is seen as playing an important role in positive adaptive mechanisms (Lyons et al., 2009). It should be noted that as this study recruited midwives who identified themselves as being resilient, only those midwives who had positively adapted to this 'stress inoculation' would have been included in the discussion as those who had not managed to adapt are unlikely to have participated. As such this study provides only one side of this argument.

It is also the case that we do not know how the participants' perceived resilience may have been experienced by their colleagues, particularly the more junior ones. Could it be that midwives who exercise 'protective self management' may at times do so by using coping strategies which include withdrawal and passing on emotionally challenging situations to their colleagues? Studies that have explored midwives' experiences of unkindness and bullying in the workplace often contain accounts of midwives feeling abandoned and unsupported by colleagues(Ball et al., 2002, Gillen et al., 2008, Gillen et

al., 2009, Kenworthy and Kirkham, 2011). This suggests that further research into all aspects of the phenomenon is needed.

Peer support has been identified by many as a means to promote resilience in the caring professions (Hodges et al., 2008, Adamson et al., 2012, Jensen et al., 2008). Participants recognised that this was important and, similar to the work conducted by Hodges et al. (Hodges et al., 2008), they identified that providing nurturing professional relationships focused on students and newly qualified midwives was especially valuable to enhance the resilience of vulnerable colleagues. Reciprocal benefits of peer support were noted, where some midwives revealed that providing emotional support to their fellow midwives was not only beneficial to those who received it but actually served to build the resilience of those that provided support. It was not clear why this occurred, but it may be to do with the sense of wellbeing they received when supporting others, or that it provided them with a strong sense of being a 'team player'. Building self resilience through supporting others appears to be a novel finding and would be worthy of further research.

If resilience is a learnt process then it would follow that it should be possible to teach or promote resilience in others and several studies have suggested this (McDonald et al., 2011, Hart et al., 2007, Skovholt and Trotter-Mathison, 2011). The intervention developed by McDonald *et al.*(McDonald et al., 2011) was based on the premise that resilience could be transmitted to others and utilised midwives and nurses who demonstrated career longevity to act as mentors to their less senior colleagues. Mentoring and use of role models was highlighted by participants in this study as influencing resilience. Midwives discussed the importance of facilitating empowerment in others, and promoting/protecting optimism, as a means to enhance resilience in others. Jackson and colleagues (Jackson et al., 2007) also note the importance of maintaining a positive outlook in mediating the effects of workplace adversity, although facilitating empowerment in colleagues was not identified within the literature. The midwives in this study not only identified themselves as being resilient, but were keen to build resiliency in their colleagues, which suggests that midwives themselves could be resource for building resilience

5.3 Implications for midwifery education and practice

This study has a number of potential implications for midwifery education and practice. Most importantly, the findings strongly suggest that the concept of resilience is meaningful to midwives and could be built into initial and continuing midwifery education, as well as informing approaches to midwifery supervision. From the perspectives of the study participants, developing emotional awareness and self-care is paramount for resilient practice, and education and supervision both need to acknowledge the challenges of practice rather than gloss over them. However, whilst advocating the inclusion of resilience into education and professional development, we caution against the introduction of resilience programmes that focus on individual change and ignore the significance of context. In the challenging environment of the

current NHS, there is a danger that these could be a convenient salve for managers. Sending vulnerable staff on resilience courses as part of their continuing professional development runs the risk of individualising common concerns rather than addressing the structural and contextual sources of stress that are known to contribute to workplace adversity.

We recommend that:

1. Pre-registration midwifery education includes participative sessions aimed at discussing the challenges of practice and enhancing emotional awareness of self and others.

2. Reflective sessions in pre-registration midwifery education should include consideration of personal emotions, resilient approaches to adversity and how to care for the self, as well as the more usual focus on clinical practice.

3. Midwifery supervision should include discussions of resilient approaches to adversity, positive mood changers and how to care for the self. This suggests the need to adopt a clinical supervision approach, which focuses on self-development. This could be achieved through reflective group supervision as well as one to one supervision.

4. More attention be paid to 'critical moments' in a midwife's career, when additional support and mentoring could be provided. These should include the first year of practice, and when a midwife has experienced a traumatic clinical event or is the subject of a complaint or investigation.

6 Further research

This preliminary exploratory study suggests a number of areas for further research, as follows:

1. A large scale study with a representative sample of midwives would extend the insights provided by the current study. The sample should include midwives at different career stages, in a range of clinical roles and working in different geographical and clinical locations. This should be a mixed methods study, which could include validated measures of resiliency as well as further qualitative investigation into how resilience is experienced, as well as how the coping strategies of resilient midwives are experienced by others (colleagues and clients).

2. It would be particularly interesting to explore the significance of context on resilience, in order to further unpack how adversity, and resilient responses to adversity, are experienced in different practice settings, for example, via a comparative study of hospital and community based practice. Other studies of midwives' work suggest that work context is an important determinant of experience.

3. The concept of resilience may have particular relevance for midwives working in challenging situations internationally. A study of international midwifery, with midwives working in their countries of origin within the developing world as well as those undertaking overseas development work, could extend our understanding of midwifery resilience and how it may be nurtured, thus further adding to the body of midwifery knowledge.

4. A longitudinal study of student and newly qualified midwives to investigate how resilience develops (or not) over time.

5. A comparative study of resilience across the NHS in different health care (or health and social care) practitioners. Given that the current evidence base focuses mainly on nurses' resilience, it would be interesting to compare midwives' experiences with those of nurses working in differing specialisms.

6. Develop an intervention to support resilience promotion in the NHS. This intervention would be developed following theory building via further exploratory research, as suggested above and should   consider issues of structure and context rather than focusing solely on individual change.

6.1 Final thoughts

We hope that this study will provide some initial insights into the concept of resilience and how it may be experienced within UK midwifery, and that this will lead to further study in this area. By understanding more about resilience, it may be possible to better nurture novice midwives and those experiencing workplace stress. In other words, it may

provide new knowledge to enable the profession to 'care for the carers'; as a result, we would argue that midwives will be better able to provide supportive care for women and families.

Resilience is not about becoming tough or hardened, rather it is characterised by adaptability, self-knowledge and emotional awareness. Whilst resilience may involve resistance to adversity(Rutter, 1999) , it may also require the ability to yield and 'go with the flow'. Resilient health care practitioners will also need to be compassionate and empathic, towards both their clients and their colleagues. This study indicates that resilience is a complex phenomenon, which warrants serious consideration from clinical midwives, managers, educators and researchers.

References

ADAMSON, C., BEDDOE, E. & DAVYS, A. 2012. Building resilient practitioners: Definitions and practitioner understandings. *British Journal of Social Work,* doi: 10.1093/bjsw/bcs142.

ARVIDSSON, B., SKARSATER, I., OIJERVALL, J. & FRIDLUND, B. 2008. Process-orientated group supervision implemented during nursing education: nurses' conceptions 1 year after their nursing degree. *Journal of Nursing Management,* 16**,** 868-875.

AUSTRALIAN HEALTH WORKFORCE ADVISORY COMMITTEE 2002. The midwifery workforce in Australia 2001-2012. Sydney: AHWAC.

BALL, L., CURTIS, P. & KIRKHAM, M. 2002. *Why do midwives leave? ,* London, Royal College of Midwives.

BRINGSEN, A., ANDERSSON, H. I., EJLERTSSON, G. & TROEIN, M. 2012. Exploring workplace related health resources from a salutgenic perspective: results from a focus group study among healthcare workers in Sweden. *Work,* 42**,** 403-414.

BURNARD, P., EDWARDS, D., FOTHERGILL, A., HANNIGAN, B. & COYKE, D. 2000. Community mental health nurses in Wales: self reported stressors and coping strategies. *Journal of Psychiatric and Mental Health Nursing,* 7**,** 523-528.

BUSINESS IN THE COMMUNITY 2009. Emotional Resilience Toolkit. *http://www.bitc.org.uk/resources/publications/emotional_resilience.html.*

BYROM, S. & DOWNE, S. 2010. 'She sort of shines': midwives' accounts of 'good' midwifery and 'good' leadership. *Midwifery,* 26**,** 126-137.

CAMERON, F. & BROWNIE, S. 2010. Enhancing resilience in registered aged care nurses. *Australasian Journal of Ageing,* 29**,** 66-71.

CAMPBELL, D. 2012. NHS watchdog warns of midwife shortage. *The Guardian 28/06/2012,* 28/06/2012.

CAMPBELL, N. C., MURRAY, E., DARBYSHIRE, J., EMERY, J., FARMER, A., GRIFFITHS, F., GUTHRIE, B., LESTER, H., WILSON, P. & KINMOUTH, A. L. 2007. Designing and evaluating complex interventions to improve health. *British Medical Journal,* 334**,** 455-459.

COOKE, G. P. E., DOUST, J. A. & STEELE, M. C. 2013. A survey of resilience, burnout and tolerance of uncertainty in Australian general practice registrars. *BMC Medical Education,* 12**,** doi:10.1186/1472-6920-13-2.

CURTIS, P., BALL, L. & KIRKHAM, M. 2003. *Why do midwives leave? Talking to managers,* London, Royal College of Midwives.

DEPARTMENT OF HEALTH 2011. Press Release: Record number of midwives training places in the NHS. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_124956.

DEPARTMENT OF HEALTH 2012. Press Release: NHS pledges more support for women with postnatal depression. https://www.gov.uk/government/news/nhs-pledges-more-support-for-women-with-postnatal-depression.

DEPARTMENT OF HEALTH. 2011. No health without mental health. London: DOH.

DUTTON, M. A. & GREENE, R. 2010. Resilience and crime victimization. *Journal of Traumatic Stress,* 23**,** 215-222.

EDWARD, K. 2005. The phenonmenom of resilience in crisis care mental health clinicians. *International Journal of Mental Health Nursing,* 14**,** 142-148.

EL-NEMER, A., DOWNE, S. & SMALL, N. 2006. 'She would help me from the heart': an ethnography of Egyptian women in labour. *Social Science and Medicine,* 62**,** 81-92.

FENWICK, J., HAMMOND, A., RAYMOND, J., SMITH, R., GRAY, J., FOUREUR, M., HOMER, C. & SYMON, A. 2012. 'Surviving, not thriving: a qualitative study of newly qualified midwives. *Journal of Clinical Nursing,* 21**,** 2054-2063.

GARG, P. & RASTOGI, R. 2009. Emotional intelligence and stress resiliency: A relationship study. *International Journal of Educational Administration,* 1**,** 1-16.

GARROSA, E., RAINBO, C., MORENO-JIMENEZ, B. & MONTERIO, M. J. 2010. The relationship between job stressors, hardy personality, coping resources and burnout in a sample of nurses: a correlational study at two timepoints. *International Journal of Nursing Studies,* 47**,** 205-215.

GIBBS, G. 2007. *Analyzing qualitative data,* London, Sage.

GILLEN, P., SINCLAIR, M. & KERNOHAN, G. 2008. *The nature and manifestations of bullying in midwifery,* Ulster, University of Ulster.

GILLEN, P., SINCLAIR, M. & KERNOHAN, G. 2009. Student midwives' experience of bullying. *Evidence Based Midwifery,* 7**,** 46-53.

GILLESPIE, B. M., CHABOYER, W. & WALLIS, M. 2009. The influence of personal charateristics on the reslience of operating room nurses. A predictor study. *International Journal of Nursing Studies,* 46**,** 968-976.

GILLESPIE, B. M., CHABOYER, W., WALLIS, M. & GRIMBEEK, P. 2007. Resilience in the operating room: Developing and testing of a resilience model. *Journal of Advanced Nursing,* 59**,** 427-438.

GOLEMAN, D. 1996. *Emotional intelligence: Why it can matter more than IQ,* London, Bloomsbury.

GRAFTON, E., GILLESPIE, B. M. & HENDERSON, S. 2010. Resilience: The power within. *Oncology Nursing Forum,* 37**,** 698-705.

HANSARD. 2009 Available at: http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm091015/text/91015w0022.htm.

HART, A., BLINCOW, D. & THOMAS, H. 2007. *Resilient Therapy: working with children and families,* Hove, Routledge.

HERRON, M., SINCLAIR, M., KERNOHAN, W. G. & STOCKDALE, J. 2011. Ethical issues in undertaking internet research of user-generated content: a review of the literature. *Evidence Based Midwifery,* 9**,** 9-15.

HILL, M., STAFFORD, A., SEAMAN, P., ROSS, N. & DANIEL, B. 2007. *Parenting and resilience,* York, Joseph Rowntree Foundation.

HODGES, H. F., KEELEY, A. C. & TROYAN, P. J. 2008. Professional Resilience in Baccalaureate-Prepared Acute Care Nurses. *Nursing Education Research,* 29**,** 80-89.

HOOD, L., FENWICK, J. & BUTT, J. 2010. A story of scrutiny and fear: Australian midwives' experience of an external review of obstetric services, being involved with litigation and the impact on clinical practice. *Midwifery,* 26**,** 268-285.

HOWARD, F. 2008. Managing stress or enhancing wellbeing? Positive psychology's contribution to clinical supervision. *Australian Psychologist,* 43**,** 105-111.

HUGHES, A. J. & FRASER, D. M. 2011. 'SINK or SWIM': the experience of newly qualified midwives in England. *Midwifery,* 27**,** 382-386.

HUNTER, B. 2004. Conflicting ideologies as a source of emotion work in midwifery. *Midwifery,* 20**,** 261-272.

HUNTER, B. 2006. The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery,* 22**,** 308-322.

HUNTER, B. 2010. Mapping the emotional terrain of midwifery: what can we see and what lies ahead? *International Journal of Work Organisation and Emotion,* 3**,** 253-269.

HUNTER, B., BERG, M., LUNDGREN, I., OLAFSDOTTIR, O. & KIRKHAM, M. 2008. Relationships: the hidden threads in the tapestry of maternity care. Guest commentary. *Midwifery,* 24**,** 132-137.

JACKSON, D., FIRTKO, A. & EDENBOROUGH, M. 2007. Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing,* 60**,** 1-9.

JACKSON, D., HUTCHINSON, M., EVERETT, B., MANNIX, J., WEAVER, R. & SALAMONSON, Y. 2011. Struggling for legitimacy: nursing students' stories of organisational aggression, resilience and resistance. *Nursing Inquiry,* 18**,** 102-110.

JENSEN, P. M., TROLLOPE-KUMAR, K., WATERS, H. & EVERSON, J. 2008. Building physician resilience. *Canadian Family Physician,* 54**,** 722-729.

KENT, M., DAVIS, M. C., STARK, S. L. & STEWART, L. A. 2011. A resilience-oriented treatment for posttraumatic stress disorder: result of a preliminary randomized clinical trial. *Journal of Traumatic Stress,* 24**,** 591-595.

KENWORTHY, D. & KIRKHAM, M. 2011. *Midwives coping with loss and grief: Stillbirth, professional and personal losses,* London, Radcliffe Publishing Ltd.

KING, N. & HORROCKS, C. 2010. *Interviews in qualitative research,* London, Sage.

KINMAN, G. & GRANT, L. 2011. Exploring stress resilience in trainee social workers: the role of emotional and social competencies. *British Journal of Social Work,* 41**,** 261-275.

KIRKHAM, M., MORGAN, R. & DAVIES, C. 2006. *Why do midwives stay? ,* London, Royal College of Midwives.

LARRABEE, J. H., WU, Y., PERSILY, C. A., SIMONI, P. A., JOHNSTON, P. A., MARCISCHAK, T. L., MOTT, C. L. & GLADDEN, S. D. 2010. Influence of stress resliency on RN job satisfaction and intent to stay. *Western Journal of Nursing Research,* 32**,** 81-102.

LEINWEBER, J. & ROWE, H. J. 2010. The costs of 'being with woman': secondary traumatic stress in midwifery. *Midwifery,* 26**,** 76-87.

LLOYD, C., KING, R. & CHENOWETH, L. 2002. Social work, stress and burnout: a review. *Journal of Mental Health,* 11**,** 255-265.

LUTHAR, S. S., CICCHETTI, D. & BECKER, B. 2000. The construct of resilience: a critical evaluation for future work. *Child Development,* 71**,** 543-562.

LYONS, D. M., PARKER, K. J., KATZ, M. & SCHATZBERG, A. F. 2009. Developmental cascades linking stress inoculation, arousal regulation and resilience. *Frontiers in Behavioral Neuroscience,* 3**,** 32.

MACKIN, P. & SINCLAIR, M. 1998. Labour ward midwives' perceptions of stress. *Journal of Advanced Nursing,* 27**,** 986-991.

MARMOT, M. 2004. *Status Syndrome,* London, Bloomsbury.

MATOS, P. S., NEUSHOTZ, L. A., GRIFFIN, M. T. & FITZPATRICK, J. J. 2010. An exploratory study of resilience and job satisfaction amoung psychiatric nurses working in inpatient units. *International Journal of Mental Health Nursing,* 19**,** 307-312.

MCALLISTER, M. & MCKINNON, J. 2009. The importance of teaching and learning resilience in the health disciplines: A critial review of the literature. *Nurse Education Today,* 29**,** 371-379.

MCCANN, C. M., BEDDOE, E., MCCORMICK, K., HUGGARD, P., KEDGE, S., ADAMSON, C. & HUGGARD, J. 2013. Resilience in the health professions: A review of recent literature. *International Journal of Wellbeing,* 3**,** 60-81.

MCCONNELL, A. R., BROWN, C. M., SHODA, T. M., STAYTON, L. E. & MARTIN, C. E. 2011. Friends with benefits: on the positive consequences of pet ownership. *Journal of Personality and Social Psychology,* 101**,** 1239-1252.

MCDONALD, G., JACKSON, D., WILKES, L. & VICKERS, M. H. 2011. A workbased educational intervention to support the development of personal resilience in nurses and midwives. *Nurse Education Today,* 32**,** 378-384.

MOLLART, L., SKINNER, V. M., NEWING, C. & FOUREUR, M. 2011. Factors that influence midwives work-related stress and burnout. *Women and Birth*.

NEENAN, M. 2009. *Developing resilience: a cognitive approach,* London, Routledge.

NICHOLLS, L. & WEBB, C. 2006. What makes a good midwife? An integrative review of methodologically-diverse research. *Journal of Advanced Nursing,* 56**,** 414-449.

ROLFE, G., FRESHWATER, D. & JASPER, M. 2001. *Critical reflection for nursing and the helping professions: a user's guide.,* Basingstoke, Palgrave.

ROYAL COLLEGE OF MIDWIVES 2010. Workforce and workload stream: Final report. *Midwifery 2020 programme.* London: RCM.

RUTTER, M. 1999. Resilience concepts and findings: implications for family therapy. *Journal of Family Therapy,* 21**,** 119-144.

SANDALL, J. 1998. Occupational burnout in midwives: new ways of working and the relationship between organisational factors and psychological health and wellbeing. *Risk, Decision and Policy,* 3**,** 213-232.

SEERY, M. D., HOLMAN, E. A. & SILVER, R. C. 2010. Whatever does not kill is: Cummulative lifetime adversity, vulnerability and resilience. *Journal of Personality and Social Psychology,* 99**,** 1025-1041.

SKOVHOLT, T. M. & TROTTER-MATHISON, M. 2011. *The resilient practitioner burnout prevention and self-care strategies for counsellors, therapists, teachers and health professionals. 2nd Edition,* London, Routledge.

SOFFER-DUDEK, N., WERTHEIM, R. & SHAHAR, G. 2011. Lucid dreaming and resilience in the face of expopsure to terrorism. *Journal of Traumatic Stress,* 24**,** 125-128.

TUGADE, M. M. & FREDRICKSON, B. L. 2004. Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology,* 86**,** 320-333.

UNGAR, M. 2012. Social ecologies and their contribution to resilience *In:* UNGAR, M. (ed.) *The social ecology of resilience: A handbook of theory and practice.* New York: Springer.

VAN DER PUTTEN, D. 2008. The lived experience of newly qualified midwives: a qualitative study. *British Journal of Midwifery,* 16**,** 348-358.

WALLACE, J. E. & LEMAIRE, J. 2007. On physician well being - You'll get by with a little help from your friends. *Social Science and Medicine,* 64**,** 2565-2577.

WARWICK, C. 2011. Our maternity care in on the brink - on the edge of our ability to cope. Commentary. *The Observer 02/01/2011*.

WARWICK, C. 2012. "Campaigning vital to ensure promises are kept" says Cathy Warwick. *RCM Protect Maternity Services* [Online]. Available: http://protect.rcm.org.uk/news/entry/campaigning-vital-to-ensure-promises-are-kept-says-cathy-warwick.

Appendices

Appendix 1: Research Ethics Committee confirmation of approval

Cardiff School of Nursing and Midwifery Studies
Head of School and Dean Professor Sheila C Hunt

Ysgol Astudiaethau Nyrsio a Bydwreigiaeth Caerdydd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila C Hunt

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01 October 2012

Professor Billie Hunter
SONMS
4th Floor Eastgate House
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Cardiff
CF24 0AB

Dear Billie

Application for School Research Ethics Committee approval
Reference: 2012/04/01

The Committee notes the modification to the Participant Information sheet for the Resilience in Midwifery Project and is able to approve the revised document. This approval is based on Version 2 of the Participation Information sheet dated 27th September 2012.

All ongoing projects will be monitored every 12 months and it is a condition of continued approval that you complete the monitoring form. Please inform the SONMS REC when the project has ended.

Please use the SONMS REC project reference number above in any future correspondence.

Yours sincerely,

Rosemary Williams
EO: Research Administration

Appendix 2: Participant Information Sheet

Investigating Resilience in Midwifery Ref 2012/04.01

Online Information for potential applicants

Are you a midwife in hands-on clinical practice in one of the 4 UK countries? Have you been in practice for 15 years or more? Would you describe yourself as someone who is able to bounce back after a stressful or difficult day at work?

If you can say yes to all these questions, then we invite you to take part in our RCM supported study investigating resilience in midwifery.

What does the study aim to do and why is it being undertaken?

Resilience is the ability of an individual to respond positively and consistently to adversity. In other words, it is the ability to 'bounce back' when times are tough.

Studies of workforce morale suggest that emotional resilience is important for employee wellbeing. However, there have been no studies specifically focusing on resilience in midwifery, and we know little about how midwives are able to 'bounce back' and what might support or hinder this.

This study aims to explore midwives' understanding and experience of resilience, in order to develop the knowledge base for practice and education. Firstly, data will be collected via an online discussion group hosted by RCM. Then the anonymised data will be analysed with the help of a panel of experts in midwifery, in order to model the concept of resilience in midwifery.

The study is being supported by the RCM, as part of their role in supporting the wellbeing of the midwifery workforce.

Who can take part?

- Any midwife in hands-on clinical practice, who has been in practice for 15 years or more

- Who is a member of RCM

- Who works in one of the 4 UK countries

- Who would describe themself as being able to bounce back after a difficult day at work

What will participation mean for me?

The discussion group will be hosted on the RCM Communities website and will run for one month. An advert will be placed on the RCM website, alerting midwives to the start and finish dates for the discussions.

The Lead Investigator will start the discussion with questions to prompt conversation, and will moderate the discussions with the support of the study Research Assistant and the co-ordinator of RCM Communities. Possible topics for discussion might include: what factors contribute to being resilient, and what factors act as barriers to resilience?

Opting into the study and the level of involvement is entirely at your discretion. You can opt in and out, and contribute as much or as little as you wish. Through opting in you are giving consent for your contribution to the discussion to be used for the purpose of this research. You can withdraw from the discussion at any point, however any prior contributions posted to the group may still be used. You will be asked to keep your personal identity and the identity of your workplace anonymous. Any identifying information will be removed following data collection, and in the reporting of findings.

It is possible that participation might trigger personal concerns about the emotional challenges of practice. If such a situation occurs, you can seek professional advice and support from your Supervisor of Midwives, and counselling support may be available via your employer (e.g. NHS Staff Counselling Service) or GP.

Has the study undergone ethical review? The proposal has been reviewed and approved by the Cardiff School of Nursing and Midwifery Studies Research Ethics Committee, who believe that the study has a low likelihood of harm to participants.

How will the data be used?

The study is of considerable interest to the RCM, and it is anticipated that the findings will have relevance for practice, policy and education. The findings will be disseminated to the midwifery profession via a Study Report (accessible via the RCM website), journal articles and conference presentations.

We also hope that the findings will lead to future large scale studies in this area.

If you have any questions about the study, or would like more information, please contact the Lead Investigator via the co-ordinator of the RCM communities.

Lead investigator: Dr Billie Hunter, RCM Professor of Midwifery, Cardiff School of Nursing and Midwifery Studies, Cardiff University HunterB1@cardiff.ac.uk

Version 2 27ᵗʰ September 2012

Appendix 3 Discussion group ground rules

Resilience discussion group: Ground rules

Thank you for agreeing to participate in this study.

This discussion group is a <u>closed</u> group. This means that only those midwives who have consented to participate in this study will be able to read the discussion thread and the comments posted.

Participation is voluntary and based on informed consent.

In order for the discussions to be the open and honest views of members of the group, participants are asked to respect each other's privacy and not repeat the discussions with people outside of this group.

Please act in a respectful way to other members of the group.

Please avoid using personally identifiable information when discussing clients, colleagues and your employers.

Finally please abide by the RCM Communities Guidelines when posting comments.

Thank you.

Appendix 4 Discussion group vignette and prompt guide

Vignette:

Liz is a midwife working full-time on a busy labour ward. She has been in practice for 15 years and describes herself as someone who is able to bounce back after a difficult day.

- How do you think Liz feels about her working life?
    - o What aspects about her work life do you think she may enjoy?
    - o What aspects about her work life do you think she may not like?
- What is it about Liz that makes her stay in practice?
- When Liz has a difficult case, how does she manage to bounce back?
- What sources of support might she use?
- How do you think Liz manages to balance her work and home life?
- Do you think Liz's resilience would be affected by changing her hours to part-time or by moving to another area such as out in the community?
- What prevents Liz from leaving the profession? / What keeps her going?

Prompts:

- What individual qualities do you think may make a midwife stay in the profession?
- Is midwifery a profession you would recommend to others? (If yes/no then why?)
- What keeps you going when you have a bad day?
- What aspects of your work life do you enjoy?
- Are there any aspects of your working life that you would like to change?
- Why do you think some midwives feel unable to stay in the profession?

Figure 1 Resilience themes

Figure 2 Challenges to resilience sub themes
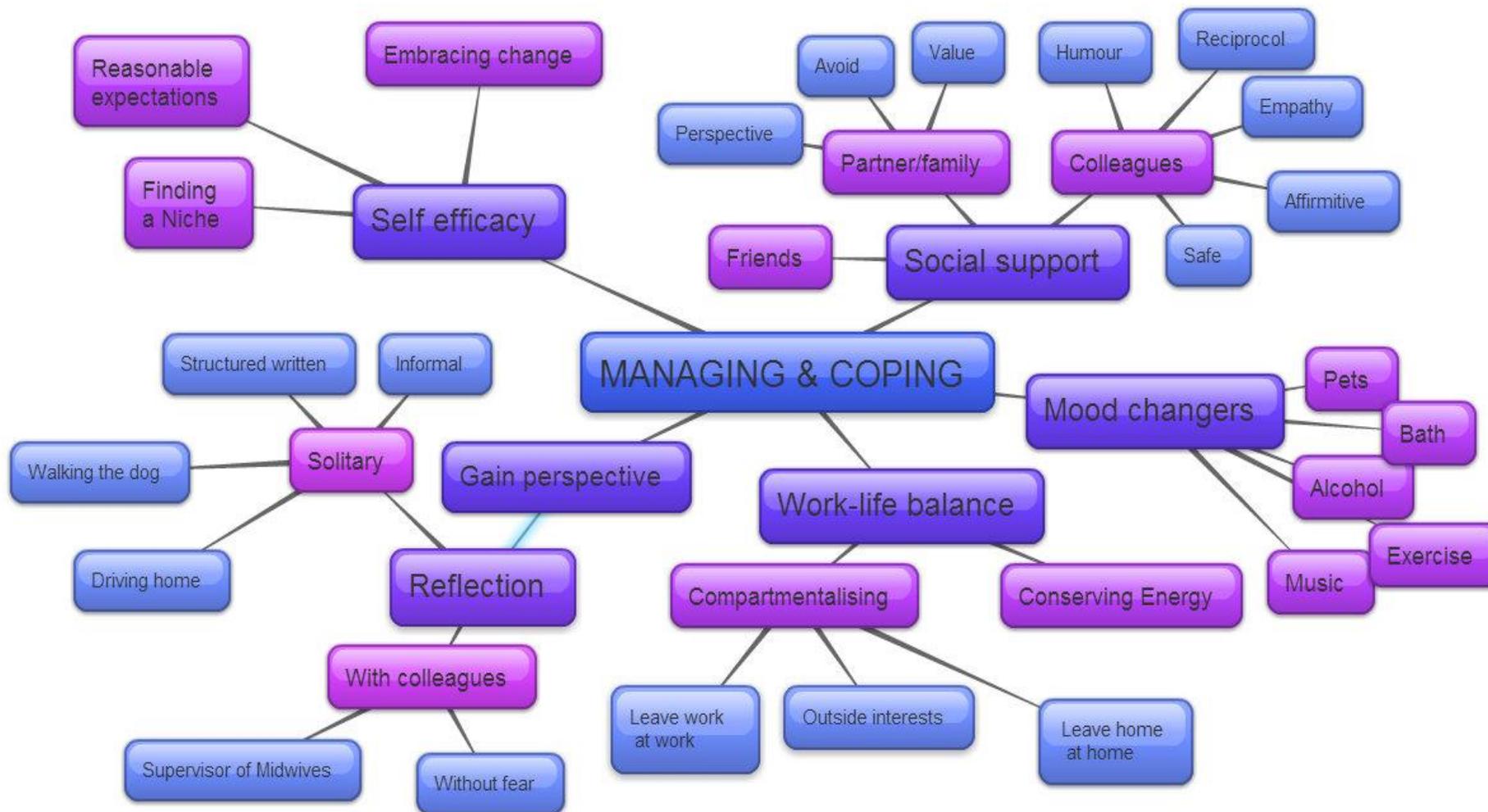
Figure 3 Managing and Coping sub themes

Figure 4 Self awareness sub themes

Figure 5 Building resilience sub themes