Hyper acute stroke: the specialist nursing impact. Exploring feelings of secondary traumatic stress. A qualitative enquiry.

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Contents

List of figures

List of tables

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Abstract

Secondary Traumatic Stress (STS) has been defined as the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995). STS significantly impacts on nursing practice and performance, patient satisfaction and has organizational negative implications. Stroke specialist nurses are at risk of developing STS due to patients presenting with acute and often unpredictable illness. However, the emotional impact on their practice has not been investigated. This study aimed to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations.

Design

Narrative Methodology.

Methods

Following university study ethical approval, stroke specialist nurses from across the UK were asked to participate and were asked to provide stories of their traumatic or stressful experiences related to hyper acute stroke. Data was collected electronically

where participants contributed their narratives by email (n=10) and by audiotaped semi structured interviews (n=14).

Results

Narrative analysis resulted in the emergence of four core themes: trigger situations, stress reactions, factors which exacerbate STS reactions and coping strategies.

Conclusions

The data suggests that stroke specialist nurses are exposed to traumatic events occasioned during the hyper acute care episode. This subjection led to them describing feelings commensurate with STS. The physical and psychosocial effects have implications for nurses, patients and acute stroke services.

Glossary of terms

Alteplase: Brand name for drug used in thrombolysis.

ASU: Acute stroke unit.

BO: Burnout.

CF: Compassion Fatigue.

CVA: Cerebro Vascular Accident.

Decompressive Hemicraniectomy: removal of part of the skull to dissipate a build-up of pressure within the cranial cavity (mass effect). This surgery is a lifesaving undertaking; however, it does not prevent disability. An emergency undertaking, it is only offered by specialist neurosurgical centres. The intervention requires intensive care unit monitoring post procedure.

ED: Emergency department.

HASU: Hyper acute stroke unit.

HDU: High dependency unit.

ITU: Intensive therapy unit.

MCA: Middle Cerebral Artery.

MCA Syndrome: complete occlusion of the middle cerebral artery leading to cytotoxic oedema and mass effect. It is associated with the poorest outcomes- profound disability or death (with or without decompressive surgery).

Mechanical Clot Retrieval/ Thrombectomy: removal of an insitu thrombus (blood clot) by means of a catheter inserted distally. A highly specialised technique, it is only offered by specialist neurosurgical centres. The patient requires monitoring in an intensive care unit post procedure.

PTSD: Post-Traumatic Stress Disorder.

SSN: Stroke Specialist Nurse.

STS: Secondary Traumatic Stress.

Thrombolysis: breakdown of a blood clot to its constituent parts (‘clot busting’). Restores a blood supply to an otherwise blocked artery. Drug is given peripherally (intravenous), although in certain clinical cases can be given intra arterially.

tPA: Activated Tissue Plasminogen. Drug used in thrombolysis. Degrades plasminogen to plasmin.

VT: Vicarious Traumatisation.

Chapter 1: Introduction

This chapter will serve as an introduction to the topic area and will offer a rationale for its subsequent investigation. I will discuss this study's background in terms of how it has been shaped by prior work alongside personal interest and experience. This section will discuss the concept of secondary traumatic stress (STS) and position this within current healthcare practice. A particular reference shall be made to the potential for STS in specialist stroke nursing populations. This in turn shall lead to the identification of this research's aims before outlining the overall thesis structure.

1.1: Topic Background and Study Context.

This section will now aim to introduce the reader to the topic of human stress reactions and in particular the concept of secondary traumatic stress (STS). A brief overview of the history of the concept development will be offered before going forwards to define STS, describing its manifestations and who is susceptible to it. There exist a number of closely related and similar concepts within the field of traumatology. These concepts and their relationship to and with STS will also be described before considering how this could potentially impact on practice.

1.2: Historical Overview.

The response to catastrophic events has been under consideration since the 17th and 18th centuries, however what has been recognized as trauma syndromes has been given greater attention in the literature from the American Civil War (1861-1865) onwards (Trimble, 1981). Around this time, the pathologization of trauma was emerging. Trauma had previously been referred to describe a wound (Broderick and Travenso, 2010). The then pioneers of neurology and psychiatry, Janet, Charcot and Freud, began the conceptualization of trauma by referring to the notion that psychological shock and horrifying experiences alone and the memory of them could produce hysteria- a mental disorder characterized by emotional outbursts, susceptibility to suggestion and muscular contractions and paralysis that could not be explained anatomically (van der Kolk, 2015. Rose, 1999. Levy and Sznaider, 2010). With the 20th century, war has led to the development of theories regarding people's responses to trauma and has increased furthermore in proportion with the catastrophic events of the last 100 years. The two world wars have contributed a lexicon of phrases related to people's psychological responses to mechanised warfare- battle neurosis, shell shock, battle fatigue and combat exhaustion (Snigg, 2015). These conflicts led to a further recognition that stress could induce neurosis in large groups of people, be it military or civilian (Rose, 1999). Since 1945 other wars (Korea, Vietnam, Afghanistan, Yugoslavia, Gulf War, Iraq, Kosovo) have served to force a greater appreciation of the effect on individuals' psyche (Jones and Wessely, 2007. French and Nikolic-Novakovic, 2012).

Arguably, the public and professional interest in traumatology was focused by the experience of troops in and after the Korean (1950-53) and Vietnam (1955-75) wars (Blake et al, 1990. Boscarino, 1995). Veterans were reported as suffering nightmares, dissociated states, withdrawal, depression, depersonalization and anxiety. Furthermore, it was recognized that these symptoms were not limited to the short-term neurotic reactions of proximity to action but were the long term and delayed sequel of exposure to trauma- in essence, post-traumatic stress (Figley, 1978). Ultimately, this led to the American Psychiatric Association (1980) recognition of Post-Traumatic Stress Disorder (PTSD) as, ‘the development of characteristic symptoms following a psychologically traumatic experience outside the range of human experience’ (pp. 232-3).

The last 35 years has seen two domains emerge to explain the psychological response to armed conflict: trauma focused verses psychosocial approaches (Boothby et al, 2006). In trauma focused approaches, the critical factor is direct exposure to violence and destruction (physical assault, destruction of one’s home, disappearance or death of a loved one). In psychosocial approaches attention is centred on the stressful and material conditions caused or exacerbated by armed conflict (poverty, malnutrition, displacement, community divisions, ostracism, destruction of social networks, war disability, sexual assault and children either made orphans or conscripted). The debate here appears to lie between exposure and its consequences or what has been the cause and what is the effect. Either way, the argument upholds that a traumatic response is potentiated. There are other 20th and early 21st century catastrophes have also promoted a greater appreciation and arguably could incorporate the theories of exposure and response in its aftermath. Much has been written with regards to traumatology and genocides/ ethnic cleansing (Karenian et al, 2011. Reider and Elbert, 2013. Weine et al, 1995. Yehuda et al, 1995), the nuclear threat (Kim et al, 2011), the present refugee crisis (Alpack et al, 2015), terrorist attacks (Garcia- Vera, 2016) and multiple man-made and natural disasters (Creamer and Liddel, 2005). On an individual level, greater awareness has been given to victim’s responses to abuse, exploitation, abduction and sexual assault (McCann and Pearlman, 1989, 1991). The psychological response to what is unimaginable adversity has cultivated a greater interest in the true dimensions of human suffering; an attention aided by the advent of technology and global communication systems (van der Kolk and McFarlane, 1999). However, such mass media exposure, with prolonged coverage of insensitive or negative effects may adversely result in decline in public interest, response or charity (Fry, 2005). A term referred to in 1983 by Charles Sternberg, the then director of the International Rescue Committee, as ‘Compassion Fatigue’.

1.3: Traumatology- Conceptual Developments and Classification.

Primary victims are however not the only sufferers of traumatic stress. Remer and Ferguson (1995) have referred to victimization as having a ‘ripple effect’, whereby ‘damage’ spreads out in waves from victims to wash over all those with whom they have intimate contact. Figley (1995) has defined secondary traumatic stress disorder (STSD) as ‘the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized or suffering person’.

STSD as a concept has been described as the development of Post- Traumatic Stress Disorder (PTSD) symptoms in individuals who play a significant role in the life of ‘survivors’, be it friends, family, caregivers or therapists (Figley, 1995). This statement builds upon Figley’s (1978, 1983) earlier thoughts of how caring for traumatized individuals leaves a mark on their carers- ‘the cost of caring’ and is considered as a natural consequence of caring. The symptoms of STS mirror those of Post- Traumatic Stress Disorder with the exception being that in STS, the precipitating or responsible trauma is not witnessed by the affected individual. The stressor is the exposure to the knowledge about the traumatic event experienced by another (Bride et al, 2004; Figley, 1995; Figley, 2002). What appears to be key is the exposure to another's traumatic experience by someone who invests in them empathy (Pearlman and Saakvitne, 1995; Stamm, 1999). More recently, the concept has also recognized STS has an element that is driven by fear that arises from a threat to one's personal safety (Huggard, Stamm and Pearlman, 2013). STS has been hypothesized to be of rapid and unexpected onset as a reaction to exposure to another's trauma experience, even though the exposure itself may be of a relatively short duration itself (Figley, 1995). It may occur regardless of race, gender, age or level of education/ training (Rudolph and Stamm, 1999).

STS has been explained with reference to the trauma transmission model (Figley, 1995, 2002). The trauma transmission model emphasises secondary traumatic stress development as the natural product of working with trauma victims within the foundations of empathy and exposure, the empathetic exposure being towards the victim. The combination of empathy and exposure consequently results in the individual experiencing the same symptoms as the traumatised subject- i.e., post-traumatic stress disorder. The defining characteristics are that of re-experiencing, constant vigilance, memory avoidance and numbing of emotions and actions. Cognitive shifts and relational disturbances have also been proposed as common symptoms of secondary trauma (Figley, 1995). Overall, the constellations of symptoms fall within four categories- cognitive, emotional, physical and behavioural (Figley, 1995; Dutton and Rubenstein, 1995; Morrisette, 2004; *Figure 1, below*).

Cognitive- difficulty concentrating, pessimism, confusion, obsessiveness, distrust, negative self-appraisal, forgetfulness, poor problem solving/ decision making.

Emotional- anxiety, anger, embarrassment, sadness, hopelessness/ despair, fearfulness, frustration, loss of control, worry, over excitability, numbing, agitation.

Physical- nausea, headaches, palpitations, sleep disturbance, chest tightness, vomiting, dizziness, fatigue, weakness.

Behavioural- exaggerated startle response, irritability, agitation, overwhelmed, avoidance, withdrawal, employment changes.

Figure 1: Cognitive, emotional, physical, and behavioural symptoms of STS

The study of traumatology has spawned a number of similarly related concepts, most notably- compassion fatigue (CF), burnout (BO), vicarious traumatization (VT) and post-traumatic stress disorder (PTSD). The symptoms of STS are identical to that of PTSD. The difference between the two concepts is the mechanism of trauma- the person who experiences the trauma may develop PTSD, whereas the one hearing about the trauma may develop STS (Figley and Kleber, 1995). CF has drawn many parallels with STS. CF reflects deep feelings of sorrow, sympathy or suffering associated with the deep desire to alleviate the pain or suffering of another person (Tabor, 2011). This can be to the point of exhaustion and in view of this energy depletion, the concept has recently incorporated the aspect of BO. It has been suggested that CF represents two parts- STS and BO; however, it has been contested as to whether the concept is unitary or two distinct content domains

(Figley, 1995; Figley and Stamm, 1996). VT is most pertinent to those that work with victims of violence (Pearlman and Saakvitne, 1995). VT has been described as ‘the transformation of the inner experience of the therapist that comes about as a result of empathetic engagement with the client’s trauma material’ (McCann and Pearlman, 1995, p.151). This means that individuals who work with the victims of traumatic events, themselves fall victim to STS reactions brought on by helping or wanting to help, a traumatized person (Collins and Long, 2003). In VT, the person undergoes characteristic negative cognitive changes as a result of cumulative exposure over time with symptoms of a consistency with PTSD (Pearlman and Saakvitne, 1995). BO, although often grouped into the psychological consequences of working with trauma victims, appears as a ‘looser’ concept. Maslach (1982) referred to burnout in terms of a state of emotional exhaustion/ disconnectedness and subsequent decreased lack of work fulfilment. Maslach and Leitner (1997) have however stated that BO is multifactorial and can be influenced by workload, working relationships and work-related stress. Interestingly, BO is not the sole preserve of those that work with the victims of trauma or the helping professions.

The terms used are not merely a question of semantics. Despite the similarities between these concepts underlying these terms, there are distinct differences that require accurate diagnosis for the most appropriate intervention (Middleton, 2015). CF has been adopted euphemistically for STS as it is considered less derogatory due to the perception that STS indicates a pathological process (Figley, 1995). The Diagnostic and Statistical Manual (DSM) IV and DSM V (American Psychiatric Association, 1994, 2013) may have added to this perception in describing the symptoms and criteria for diagnosing PTSD, the concept from which STS originated.

The approach to mental ill health is pathologically focused with The Diagnostic and Statistical Manual of Mental Health Disorders being used to diagnose individuals based on their pattern of pathological or negative symptoms (Hyatt and Burkhart, 2013). STS is often described erroneously in terms of symptoms when what is being experienced is a normal reaction to an abnormal situation (Phipps and Byrne, 2003). The physical reactions and changes in cognitions are the product of the natural process of overcoming stressful events (Van Minnen et al, 2000). Essentially, the experienced reactions are neither of an underlying personal deficiency or a pathological condition (Morisette, 2004. Zimbardo et al, 2012).

The use of the term's symptoms, classification and diagnosis are however indicative of a pathological process. Historically the use of such terms has led to dilemmas in stress reactions recognition, classification and management. An example of this has been identified by Van der Kolk (2015) as the approach taken in the light of the British army's early experience of 'shell shock' from 1914. A diagnosis of shell shock- an anxiety neurosis in response to the psychological trauma of mechanised warfare- meant that combat veterans were entitled to treatment and a disability pension. By contrast if the alternative diagnosis of neurasthenia- an anxiety response viewed as a functional (non- organic) disorder- was made, neither a treatment nor pension was given. As the war progressed, shellshock was initially renamed as 'NYDN' (Not Yet Diagnosed, Nervous). The ambiguity was completed in 1917 whereby shellshock was reclassified as neurasthenia. However, the diagnosis in these cases was at the discretion of the treating physician as to which the soldier received.

It is possible to contend this as still resonating with current practice regarding the label of diagnosis, who ascribes it and what treatment is thereafter prescribed. Rose (1996, 1997) has referred to the techniques employed by the psycho-sciences-assessment, classification and discipline to generate reformatory interventions upon individuals and groups. It could be offered that although the psy disciplines (psychiatry, psychology, psychoanalysis, psychotherapy) applying these techniques are observed as attempting to provide an appropriate therapeutic activity, it is subject to the knowledge, beliefs, experience and authority of the professional ascribing the diagnosis.

Classification can be seen as the process by which the complexity of phenomena is reduced by arranging them into categories according to some established criteria for one or more purposes (Dalal and Sivakumar, 2009). This can be broken down to classical taxonomy where the candidate meets exactly the set criteria that meet the definition, or numerical taxonomy where the candidate meets a certain number of criteria to qualify for a diagnosis. The fidelity of classification could be disputed where there exist separate classifications providing considerably different descriptions of the same disorder such as the ICD-11 model and the DSM-5 (Hansen et al, 2015).

Bracken et al (1995) have offered that it is possible to contend that such experiences of fear and suffering are not easily described by classifications, with the further suggestion being made that biomedical reasoning does not take account of psycho-social and economic influences. Furthermore, Rosen et al (2007) have discussed the medicalization of responses to stressful events as one of the shortcomings of traumatology. What is problematic is that expected and understandable reactions after extreme events are referred to as symptoms (Summerfield, 2004). What is required is an appreciation of the full context if a labelling situation is to be avoided.

The argument can be further expanded when considering the appropriateness of applying Western diagnoses and treatments to people who inhabit non-Western cultures (Miller and Rasmussen, 2010). The accurate assessment of psychiatric disorders is difficult to ensure in non- Western subjects for whom the validity of psychiatric measures developed in (and by) might be restricted (Fazel et al, 2005). These examples could further argue against the validity of classifications in that they represent a challenge to a collective description where there is uniformity.

Thought also needs to be given to the implications of diagnostic labelling. Whereby an accurate and appropriate diagnosis can prove beneficial in terms of access to services, there are considerable negative aspects to its application. Diagnostic labelling has been related to individuals being discriminated against and stigmatized across varying levels of society (Angermayer and Dietrich, 2006). Anticipated and actual discrimination along with internalised stigma has also been reported as affecting the individual in terms of decreased life satisfaction and self- esteem (Read et al, 2006). Furthermore, diagnostic labelling can lead to judgemental, discriminatory and negative attributions that have potentially damaging consequences for maintenance of sustainable, open and successful therapeutic relationships between the individual and their healthcare worker (Ross and Goldner, 2009).

Despite the effort made to provide an understanding of the positive and negative aspects of caring relationships (Nimmo and Huggard, 2013), ambiguity remains an issue when considering the concepts of STS, CF, PTSD and VT**,** and their definition (Baired and Kracken, 2006). Numerous studies have sought to identify the correlates of STS, CF, PTSD and VT. However, a lack of true conceptual clarity exists between these constructs, their definitions and their characteristics (Adams et al, 2004. Coetzee and Klopper, 2010. Fernando and Consedine, 2014. Ledoux, 2015. Ludick and Figley, 2017. Sinclair et al, 2017. Coetzee and Laschinger, 2018). This has led to difficulty in attempting to use this body of literature to inform practice and propose training initiatives. In addition, these conceptualizations have considerable overlap in their descriptions of traumatized individual's symptoms. To complicate the issue further, these terms are often used interchangeably (Collins and Long, 2003; Elwood et al, 2011), with Figley (1995) and other authors using compassion fatigue as being parallel with STS. The implication is that the available evidence is difficult to understand and interpret (Najjar et al, 2009).

1.4: Traumatization and caring relationships.

STS can affect anyone within the context of a caring relationship. However, Figley (1995, 1998), proposes that carers who encounter traumatized individuals daily, such as therapists, mental health workers and nurses, may be considered at greater risk. The term compassion fatigue was first used in a nursing publication by Joinson in 1992. In her article, 'Coping with compassion fatigue', she described the theory of nurses being worn down by dealing with hospital emergencies on a daily basis. The article is interesting in that it refers to nurses experiencing many of the symptoms of STS (anxiety, fear, lack of control, exhaustion, stomach complaints, and headaches). Gates and Gillespie (2008) have commented that not all nurses will develop STS, nonetheless, they categorize nurses risk of developing STS as dependent on the nurse/ nursing (emergency department, intensive care, mental health, educational level, career longevity, patient contact), patients (severe trauma, death, reminder of a family member, victims of violence/ combat, sexual assault, injured children) and work place (heavy workload, increased year worked in nursing, long work hours, increased patient contact). Protective factors have been identified as peer support, education, preparedness training and debriefing (O’Connor and Jeavons, 2003; Lavoie et al, 2011).

Secondary traumatic stress has significant organisational issues for healthcare providers. It has repercussions for staff wellbeing and retention, may compromise the care provided and the quality of service overall, and has a negative impact on patient safety and satisfaction (Breen et al, 2014). The identification and reduction of secondary traumatic stress represents a worthwhile investigation for healthcare organisations due to the implications of an increase in staff productivity, reduced absenteeism, increased patient safety and satisfaction (Cohen-Katz et al 2004). However, what needs to be appreciated is why STS or to give it its other moniker, compassion fatigue (the term proposed by Figley (1995) as being considered as less pathological and more in keeping with that of a reaction), has gained such interest internationally over the last 25 years.

Draper (2014) has situated contemporary nursing at a significant point in its history discussing how it has become subject to greater focus on standards of care, emphasis on outcome measures, changes in the workforce skill mix and the consolidation of a graduate profession. It could be argued that these elements constitute the greatest challenges to nursing in the immediate future. Furthermore, this viewpoint can be contested as having great importance in why compassionate care and subsequently the emotional impact of caring has become a focus of great debate within healthcare and nursing in particular.

The improvement in diagnosis and treatments when coupled to the use of new technologies has led to increased life expectancy and subsequently an increased demand in healthcare provision. However, this has created gaps in quality accompanied by workforce shortages that threaten service supply (Naylor and Kurtzman, 2010). In nursing, this has led to expanding roles ranging from the elementary, specialist and advanced (Daly and Carnwell, 2003) and encompassed powers of non- medical prescription (Lockwood and Fealy, 2008). These roles could be seen to have expanded professional practice, provided an alternative means of shoring up gaps in medical service provision and been cost effective. However, this has also led to professional tensions between nurses and physicians over autonomy, leadership (Iglehart, 2013) and role differentiation (Begley et al, 2012). As nurses' diversity of roles has accumulated in response to socio-political and demographic trends, along with medico-technological advances, the discipline has striven to forge a professional identity (Keeling and Templeman, 2013).

Where compassion has been described as a moral virtue- the authentic heart and soul of nursing, professionalism has been seen as a force that potentially undermines compassionate practice (Bradshaw, 2009). The drive for professionalism has presented a tension within nursing between a profession defined by standards or as a fundamentally moral activity for which professional status is viewed as a secondary consideration (Bradshaw, 2009. Curtis et al, 2012). There exists a further tension between nurses' professional ideals and the reality of clinical practice (Traynor, 2019).

The last decade has seen NHS standards around staffing, leadership and compassionate practice being called into question (Francis, 2013. Randall and McKeown, 2014, Hays et al, 2016). Traynor (2014) has cited examples of such failings as the neglect of vulnerable patients, substandard treatment and increased mortality which has been situated in cultures of mediocrity, intimidation and financial pressure. Stenhouse et al (2016) have identified that these concerns are not the preserve of the UK alone and have cited similar issues as being raised in Australia, Brazil, Canada, Sweden, Turkey and the United States. The focus in these debates has centred on care and compassion, with the emphasis placed on a perceived lack of compassion or ‘compassion deficit’.

In terms of the UK, Rydon-Grange (2018) argues that the typical NHS organizational set up and those of modern healthcare settings undermine compassionate care. These features include ward understaffing, excessive working patterns and practices and the dogged focus on achieving service efficiency. Furthermore, the focus on financial savings has resulted in a dramatic reduction in frontline staff and an inability to deliver care to a safe and sufficient standard (Goodwin, 2019). This place demands on the subjective, personal and moral values of nurses who have been working, often for years, in under resourced and over stretched environments which can lead to BO and STS (Sinclair et al, 2017. Dashtipour et al, 2020).

The culture and leadership within the NHS have been identified as being characterized by dysfunction and riddled by negative behavioural traits. Pope (2017) has referred to the persistent problem of negative and intimidating behaviours within the NHS. Dysfunctional organizational behaviours can have a devastating impact on patients and staff. Goodwin (2019) has cited the culture of interrogation, blame and accusation without acknowledgement of the underlying problem as being inherent within the NHS. Central to this is an inexperienced, intolerant and intimidating leadership culture leading to a system where disbelief, fear and lack of care for the workforce are endemic. Furthermore, this leadership has allowed a system of organized silence and institutional deafness to gestate (Pope, 2019). The culture of fear, lack of or suppression of voice, collective denial and justification for serious failings have resulted in these behaviours becoming enmeshed in the fabric of NHS organizations resulting in a ‘narrative of silence’ (Hendy and Tucker, 2021).

Healthcare systems appear to be governed more by market forces and managerial values (McCaffrey and McConnell, 2015). Alongside this the climate of evidence-based practice, outcome measures such as indices of mortality, morbidity, length of stay and clinical or economic outcomes have attained a greater significance. It could be stated that the provision of compassionate care has been obscured or even lost amid the changes that have taken place within healthcare provision (Mercer and Flynn, 2012).

The recognition of these failings along with the shortcomings in the NHS organization and culture and their resolution have become the enforced and overarching principle designed to govern all levels of UK healthcare, with the wider research and policy agenda looking to compassion as the key to improving the quality of relationships, services and organizations (Pedersen and Obling, 2019). The development of a system reflective of being positive, values steered, and safety dominated demands that compassionate care is not only an individual requirement but is a requirement of the organizations in which they work (Tierney et al, 2019. Mohindra, 2021). Nursing finds itself in pursuit of professional status whilst being situated at the heart of systems where extreme efficiency is championed. What is more healthcare workers are subjected to multiple complex demands. The health needs of service users and their carers, the provision of information, clinical audit, multidisciplinary/ multiagency liaison, administration and organisational beaurocracy are often some of the competing demands placed on the time, focus and energy of healthcare workers (McGonagle et al, 2014). These elements alongside the press for increased efficiency and productivity can be seen at odds with an ideology of individualized ethical care.

Kline (2019) has stated the essential and decisive role leadership plays in influencing safe, quality patient care and service provision. Compassionate leadership is a prerequisite of embedding compassionate care in clinical practice and has been cited as involving inclusion, respect, consideration and empathy (Saab et al, 2019). O'Driscoll et al (2018) opines that compassionate care for patients is sustainable where there is compassion for staff and calls for the NHS and individual organizations to support its nurses to deliver compassionate care in what are at times challenging circumstances. Kline (2019) has cited the NHS long term plan as acknowledging the crucial importance of caring for staff to improve patient care. It is suggested however that nurses find themselves struggling to maintain values and deliver compassionate care when placed against healthcare organizations attempts to maintain costs, productivity and performance targets (Traynor, 2019). The call is for both individuals and organizations to act as change agents to promote care that is built on the foundations of being person centred, values, ethics, moral frameworks and having compassion for staff along with patients (Mohindra, 2021).

This background can be linked in with secondary traumatic stress. Whitehead and Myers (2016) and Twigg et al (2021) have reported that patient average acuities are rising, nursing workloads are higher and how outcomes are impacted by nursing ratios. Furthermore, it has been argued by Needleman (2013) that it is nurses who appear to be bearing the brunt of health system changes. Nursing care has had to evolve to meet the demands of a rapidly changing healthcare landscape predominated by innovation, digital transformation and accelerated knowledge creation (Kavanagh and Sharpnack, 2021). Furthermore, Young et al (2018) have debated the concerns placed on the use of technology and acquisition of knowledge and skills and nurses' ability to focus on delivering fundamental patient care. It is argued by this researcher that the combination of unsupportive organizations that lack effective and understanding leaderships and the emphasis on productivity at the detriment of compassion are fertile grounds for STS to gestate in.

This overview has offered a brief definition of what STS is and described its place within the study of human responses to trauma. The definition proposed by Figley (1995) is the one that shall be referred to throughout this thesis. The evolution of STS as a concept has been recounted with reference to the impact of recent world events, individual experiences and the importance of mass media. STS has been explained as the 'cost of caring for others in emotional pain' (Figley, 1995) and can affect anyone working with traumatized individuals, including nurses (Ledoux, 2015). There exists an overlap and ambiguity between other conceptualized aspects of human suffering and stress (PTSD, CF, VT, BO). Despite the differences (and similarities), these conceptualizations are often used interchangeably (Elwood et al, 2011). This lack of clarity has implications for assessment, supportive interventions and understanding the current evidence (Watts and Robertson, 2015).

1.5: STS and Stroke Nursing.

One area in which feelings of secondary traumatic stress could evolve is that of hyper acute stroke specialist nursing. Hyper acute stroke care relates to the clinical experience in the first 72 hours. It is characterised by acute neurological illness, emergency admission and intervention, unpredictable or uncertain outcomes and increased mortality. The last 25 years has witnessed technological and scientific advances in the treatment of stroke such as thrombolysis (Bhulmki et al, 2007), mechanical thrombectomy (Evans et al, 2017) and the use of telemedicine (Bowman, 2017). The stroke specialist nurse role has evolved in tandem with these advances but also in response to the service demands that have been highlighted at national levels (Royal College of Physicians, 2015. British Association of Stroke Physicians, 2019). However, there are no national standards with regards to the role definition and competencies. As with other areas of clinical nursing, there are wide variations in the titles, roles and responsibilities ascribed to specialist stroke nursing. These range in terms of titles from lead nurse, clinical nurse specialist, stroke nurse clinician, stroke specialist nurse, stroke nurse practitioner, stroke advanced nurse practitioner and stroke nurse consultant (Cooper et al, 2019). There is a broad variation in the interpretation of these roles and their responsibilities. These vary from the ward-based level nurse to community services, service development and planning, performance improvement and policy implementation to assessment, investigation, diagnosis, prescribing and treatment of acute stroke and are either with or without the collaboration of senior physicians (Burton et al, 2009. Sanders and

Ashman, 2018. Cooper et al, 2019. Bailey et al, 2021). These roles (and the number of nurses occupying them), responsibilities and titles are also variable given the differences in service provision across the UK. In the hyper acute setting, stroke specialist nurses (SSNs) are at the forefront of the service provision and are pivotal to the care episode as they are often involved in stroke assessment, investigation, diagnosis, the delivery of interventions and admission to the acute stroke unit (Fitzpatrick and Birns, 2004. Middleton et al, 2019). It has been suggested that in the UK SSNs appear to be more actively involved in the selection and decision-making process for interventions such as thrombolysis (Hamilton et al, 2017).

Stroke specialist nurses working in hyper acute care may develop secondary traumatic stress (STS) through repeated exposure to caring for unpredictable acutely ill stroke patients and through being the focal point of time dependent, emergency interventions that are often target/ results driven. While much research has concentrated on secondary traumatisation in oncology (Algamadi, 2021. Xie et al, 2021), psychiatric (Mangoulia et al, 2015) and emergency personnel/ nursing (Oginska-Bulik et al, 2020. Duffy et al, 2015), there has been no study of nurses involved in acute stroke care, who are subject to similarly intense stresses and repeated exposure to patient's traumas and losses.

The paucity of evidence concerning STS and stroke nursing means that it is not possible to comment on its prevalence within these subjects. Appendix 1 refers to the small and unpublished prevalence study undertaken within this researcher's area of practice. This did reveal that staff working within an acute stroke unit were at risk of developing both burnout and STS, albeit the numbers were small. Larger, multicentre studies are warranted to illuminate the prevalence of STS of those working in stroke services.

It is argued that the services with greatest similarity to that of hyper acute stroke are those of the emergency department (ED) and intensive care (ICU) given their acuity and highly dependent patients. Several studies examining prevalence of STS in nurses working in these areas have been conducted. (Duffy et al, 2015) reported greater prevalence rates of STS in ED nurses compared to those working outside of this speciality. Prevalence of STS in nursing populations in the area of emergency nursing has been estimated depending on country, regions and target groups as ranging between 7 and 67% (Von Reuden et al, 2010. Duffy et al, 2015. Gunusen et al, 2018). A recent study of emergency nurses by Ratrout and Hamden-Mansour (2020) reported almost half of their sample as having high to severe levels of STS. Furthermore, the prevalence of STS was found to be 51% in nurses during the COVID outbreak, with the mean STS being higher in ICU-CCU nurses than in other wards/ areas (Ariapooran et al, 2021). It has been suggested that the prevalence of STS will most likely continue to grow given the increasing acuity and demands on services (Hunsaker et al, 2015) with between 40 and 85% of helping professionals estimated to develop it (Dreher et al, 2019). This has clear implications for nurses' emotional wellbeing. It also has ramifications for patient safety, the quality-of-service provision and has a negative association with nurse retention (Sasso et al, 2019. Chen et al, 2021). It has been observed that the prevalence of STS in terms of stroke nursing populations is unknown and requires further investigation. However, what also requires appraisal is the effect that STS has on these nurses as professionals and as people.

1.6: Personal Location: Mark’s story.

This thesis has been developed from the standpoint of a previous study that I was involved in, the development of an interest related to it and my own personal experience of the topic. I was involved as a co-contributor in a point prevalence study of compassion fatigue and burnout amongst all grades of stroke unit nursing staff (Fitzsimmons, Lopez and Wilkinson, 2014. Unpublished. Appendix 1). The results indicated that staff was at moderate risk of burnout, with a smaller proportion being at risk of secondary traumatic stress. Whilst this pilot study infers that nurses working in acute stroke units are at risk of secondary traumatisation, it did not describe their experience of it. This small-scale study prompted a further interest in the area of secondary trauma. However, a number of personal observations and experiences led me to consider this area as being worthy of deeper investigation.

I have worked with stroke patients and their families now for over twenty-five years. This period has seen many changes to the delivery of stroke care at local, national and international levels. At the start of my journey in stroke care, there were no dedicated stroke services. Patients with stroke were looked after under the auspices of either general medicine or elderly care. There were no dedicated acute stroke or rehabilitation units, no dedicated stroke physicians and no stroke nurses. Interventions with thrombolysis, thrombectomy and the use of telemedicine were innovations that lay in an uncharted and distant clinical future. Initially when services began to specialise, SSNs became a feature of this provision. However, the SSN role at this point was more concerned with advice and education (patients/ relatives/ staff) and audit. The development of the SSN role to encompass acute care was in response to greater service need, the development of acute interventions, the demands of national standards and audit and competition between regional stroke service providers. The acute SSN role developed to include acute stroke assessment, investigation, diagnosis, access to acute stroke unit beds and being involved in the identification and delivery of acute interventions such as thrombolysis.

My own personal nursing trajectory with regards to stroke care has seen my evolution through from being a staff nurse, to charge nurse to ward manager and then on to being a stroke advanced nurse practitioner. At the start of this thesis, I had worked as an advanced nurse practitioner for 10 years in stroke services (another 3 was spent in this role before becoming a stroke nurse consultant). A large portion of this was spent working in the hyper acute area where my main duties were patient assessment, investigation booking and interpretation, diagnosis and involvement in the delivery of acute interventions. In addition to this, 10 of these years found me in the role of nurse manager for a seven strong team of stroke specialist nurses whose clinical responsibilities were situated in the area of acute care. In this time, I have listened to the stories offered up by members of this team who have described such tragic stroke related scenarios that left them perturbed. Furthermore, I have been able to recall similar circumstances that I have personally been involved in. The following story refers to one of many clinical scenarios that recall my own personal experience of STS: The following account occurred within the setting of an acute stroke unit in a general hospital in the Northwest of England. Mrs. S was brought in by ambulance to the emergency department following a sudden onset of left sided weakness and a visual problem. All her family had been present with her at home at the time of her becoming unwell and had made their own way into the hospital. She was rapidly evaluated by the stroke team and found to have left facial droop, dense left arm and leg weakness and visual/ sensory inattention. Her CT brain scan demonstrated no haemorrhage, and she was taken to the acute stroke unit where she was given IV thrombolysis. The initial period following the intervention involves close monitoring for the first two hours. I undertook these duties. Her family remained present throughout. Over the course of the next two hours the patient made an excellent response to the intervention. Discussion continued through this time frame with the patient and her family. Her improvement had been so dramatic that at two hours her neurological deficits had completely resolved. Naturally all parties present were delighted by her rapid recovery; however, I did inform her family that monitoring needed to be continued and that we needed to observe her closely as she 'was still not out of the woods'. I then 'handed over' her case to the nurse who would continue to look after her that afternoon. After 10 minutes I returned to the patient to inform her and her family that my colleague would now continue her monitoring. It was at this point that I noted she again had a facial droop. It quickly became apparent that her left arm and leg were now flaccid and that she had a visual and sensory inattention. Her observations were stable but, in this setting, an acute haemorrhagic transformation following thrombolysis needed to be excluded. A CT brain scan was completed but demonstrated no changes. The patient and family were informed that a likely re occlusion of a cerebral blood vessel had occurred resulting in her deterioration and that we needed to continue to monitor her for any improvement or indeed further relapse. She remained in the acute unit for seven days during which time there was no neurological improvement.

I experienced several feelings both at the time and because of these events. I have worked with stroke patients for roughly 20 years- the last 10 of which have been in the acute area. I have also been involved in numerous cases where I have known patients who have had further events and with whom I had previously developed a good rapport. I have looked after many people who I have met outside of work who have had strokes and even a proportion of people with whom I have worked suffer strokes. Down the years, I have also been involved in many cases where thrombolysis has featured with outcomes varying from full recovery to death. The case in question affected me like no other. I initially found the familiar feeling of being nervous yet excited at being involved in this emergency and being part of the many ‘hands at the pump’ to work rapidly to deliver the intervention. This continued through the first two hours of her care. Along with this was the developing rapport with the patient and relatives but also recognition that I was providing them with support at a critical and often intense time. I think that there was also a sense of elation from the patient and her family that she had made such excellent progress. I also admit that it is or was difficult not to be swept along in these moments, especially when being hugged/ slapped on the back by family members who are claiming to have just witnessed ‘a miracle’. However, I have seen patients in similar circumstances deteriorate and such wariness prevents a wholesale celebration along with the patient/ relatives. I appreciate that stroke is often characterised complication and unpredictability- which in this case was rapid and could not be legislated for (the usual outcomes post thrombolysis being full recovery, partial resolution, fluctuating neurology, no response at all, haemorrhagic transformation, death). The clinical spectrum was run in the course of 3 hours- profound neurological deficits to full recovery and back again to severe and what turned out to be permanent disability.

The full array of emotions was also run through anxiety to hope to elation to despair then devastation, all of which were felt by everyone present- patient/ family/ me.

The following days I found that my thoughts were overwhelmed by what had occurred. I was becoming preoccupied by the case and felt unable to concentrate. My sleep was disturbed, and I would often ring up colleagues asking how the lady was and if her family were all right. I dreaded the thought of attending to patients in the AED who may require thrombolysis as it just served as a reminder. I did feel more irritable and reproached myself for feeling like this. I discussed these feelings with a number of my close work colleagues- but not the senior medical staff or management. I felt weak but did not want others to see me as so. I did not seek support from my GP or counselling. I felt that I knew what was wrong with me but also that no one would know what this was like. At no point did I however feel disconnected or insensitive to patients or lose the essence of my beliefs.

The lady in question underwent rehabilitation under the same service but in another part of the hospital that I rarely go to. Unfortunately, she made no recovery. My feelings regarding the events gradually improved, except for feeling anxious about acute admissions. The lady did return to clinic at 3 and 6 months where I reviewed her. I did not experience any distress on these occasions and my rapport with her and her husband remained good. She remained under the review of my early supported discharge colleagues who made me aware of how much her and her family valued what I had done for her. What was a cause for upset was when she returned at 9 months. I knew that this was the point at which it was likely the conversation would centre on reaching a plateau and discharge. I could of and should have seen her on this attendance. My courage failed me, and she was subsequently seen and discharged by her consultant.

My overall feeling is that I have not reacted like this before or since to clinical events such as this. There have been similar events but with certain differences. Perhaps that this scenario was played out in full view of an expectant family may have had some influence. Perhaps the accumulation of 20 years of stroke care has a bearing. Possibly the feelings were a reaction to an altogether distressing case where all felt helpless (and on reflection in my own case- helpless to help). If I am honest- then I should also feel shame. If I am honest-I have an appreciation of self-preservation'.

Although the thoughts and feelings referred to here were my own, the story has similarity to those that have been expressed by my colleagues. Their stories, like mine, have all been located within the hyper acute arena. Many have been related to being involved in the process of delivering potentially life changing interventions. Some referred to those who were ineligible for treatment or where the treatment was met with no response or complications. Often these stories referred to poor outcomes. The stories of these experiences are characterized by nurses being witness to events that they have found upsetting or traumatic. The impact, as seen in my personal account, often extended beyond the initial presentation and was woven into the fabric of these nurses' lives. What has been experienced by me and others, have led to my conviction that the descriptions are commensurate with feelings of STS. I believe this aspect of SSNs working lives needs greater exploration and appreciation. It can therefore be seen as a justification for undertaking this inquiry.

1.7: The Study Aims

This study aimed to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations. This aim will include:

- To explore if stroke specialist nurses experience feelings of STS through their care of acutely ill patients presenting with cerebrovascular events.
- To examine in what circumstances these feelings might occur.
- To reveal what factors exist which could exacerbate or relieve STS feelings.
- To explore what could be the potential implications for nursing care and stroke service provision.
- To highlight the possible impact on stroke specialist nurses' professional and private lives.

1.8: Thesis Structure.

This first chapter has served as an introduction to the thesis, giving a background to the area and a rational for its conduct. Chapter 2 provides a systematised literature review discussing the evidence related to STS in nursing populations. Chapter 3 outlines the methodology underpinning this research. This is a qualitative study using a narrative approach based on the work of Polkinghorne (1995). This chapter discusses the ontological and epistemological positioning in relation to this work. The chapter further discusses the methods including recruitment, sampling, ethical considerations and the methods used for both data collection and analysis. The following chapters (4, 5, 6 and 7) present the study findings and their discussion. This includes extensive excerpts of the sample's responses. Chapter 8 presents a synopsis and overall discussion the thesis findings. The thesis concludes by stating what are the study’s strengths and weaknesses and what are its implications for clinical practice, education, management and research.

1.9: Summary.

This chapter has described the background to the topic under investigation and has offered the rationale for undertaking it. The concept of STS and its place within healthcare practice and in particular its relevance to specialist stroke nursing has been highlighted. Reference has been made to this researcher’s involvement in prior work in this area, along with their own personal interest and experience of STS and hyper acute stroke nursing, adding further justification for this exploration. The research aims have been identified and an overview given of the thesis structure. The following chapter will discuss the literature concerning STS in nursing populations.

Chapter 2: The Literature Review.

2.1: Introduction

The aim of this literature review is to introduce the current knowledge base related to the topic of secondary traumatic stress and its relevance to the sphere of nursing. The preceding chapter referred to the literature describing the background landscape of STS in general terms. This literature review presents a portrait of nurses' specific experience of STS, the composition describing its evolution and impacts on nursing populations. It furthermore aims to ground the proposed study within a larger framework of information and ideas which explain how the available evidence informs unresolved questions or gaps in the literature (Ravitch and Riggan, 2012). The emerging themes central to the construct of secondary traumatic stress will be described along with their respective categories. The subsequent analysis of the identified appropriate evidence will be discussed in terms of how it has influenced the proposed study and in laying the foundations that will enable the research question to be answered.

The approach adopted for this review is in keeping with one which is systematized rather than systematic. Systematized reviews can be likened to that of systematic reviews demonstrating an awareness of the latter's' processes but lacks one or more of its necessary components- most notably that it does not claim to present all of the evidence (Grant and Booth, 2009). It has been suggested that systematized literature reviews do not involve a broad scope exploration of all the literature related to the topic in question. Instead, reviewers selectively choose the pieces of literature that support the particular perspective which is being offered for consideration

(Rocco and Plakhotnik, 2009). This meets agreement with the views offered by Maxwell (2006) that literature reviews should be concerned with works that are of most relevance to the study's research questions. Furthermore, relevance is championed in opposition to thoroughness as this has important implications for the design, conduct, or interpretation of the study. The works given consideration in this review will be reflective of these views. It is envisaged that by their inclusion, patterns within the literature will emerge, offering a premise for the study's intentions.

2.2: Review questions

This evaluative report of the current literature aims to answer five elementary questions:

- Do nurses suffer from STS as a result of their work?
- In what circumstances do nurses develop STS?
- How does STS evince in nursing populations?
- What factors serve to exacerbate or mitigate STS in nursing populations?
- Is STS referred to in terms of stroke nursing?

These questions were derived from the researcher's awareness of the conceptual/ theoretical models that explain the construct of STS. A particular appreciation was afforded to the work of Dutton and Rubenstein's (1995) who's model emphasises the role of exposure to the traumatic events, the trauma reactions and what exacerbated it, coping strategies as a response and the personal and environmental mediators during secondary traumatic stress evolution. Despite there being a number of alternative theoretical STS developmental models (the stress process model, Aneshensel, 1995. Compassion/Stress Fatigue Model, Figley, 2002. Professional Quality of Life Model, Stamm, 2009. Wounded Healer Theory, Conti-O'Hare, 2002), Dutton and Rubenstein's framework captures the inherent concerns of the STS phenomenon and was felt most apposite to the research questions development.

2.3: The Search Methodology

2.3.1: Search Terms

For the purposes of this review, STS has been described as the development of PTSD symptoms in individuals who play a significant role in the life of 'survivors', be it friends, family, caregivers or therapists (Figley, 1995). This statement builds upon Figley's (1978, 1983) earlier thoughts of how caring for traumatized individuals leaves a mark on their carers- 'the cost of caring' and that this is a natural consequence of caring. The symptoms of STS mirror those of PTSD with the exception being that in STS, the precipitating or responsible trauma is not witnessed by the affected individual. The stressor is the exposure to the knowledge about the traumatic event experienced by another (Bride et al, 2004; Figley, 1995; Figley, 2002). What appears to be key is the exposure to another's trauma material by someone who invests in them empathy (Pearlman and Saakvitne, 1995; Stamm, 1999). However, given the interchangeability of names employed to describe the phenomena (STS, compassion fatigue) and the subsequent related symptoms, the search was undertaken using the terms- secondary traumatic stress, compassion fatigue and nursing *(*Figure 2, *below*).

1. Secondary Traumatic Stress.
2. Compassion Fatigue.
3. 1 OR 2.
4. Nurse.
5. 3 AND 4.
6. Qualitative.
7. 5 AND 6

Figure 2: Search terms

2.3.2: Search Strategy

The literature search was performed electronically, with the MEDLINE, CINAHL, EMBASE, PsycINFO, EMCARE and HMIC databases accessed. In conjunction, a brief hand search also was pursued, reviewing titles taken from the references of studies that had already been identified. The inclusion and exclusion criterion (Figures 3 and 4, *below*) were established in order to form the most appropriate cluster of studies for analysis (Barroso and Sandelowski, 2004). The search was conducted within the dates from 1992 to the present date. The year 1992 was selected as a starting point given that this was when the term compassion fatigue first appeared in the nursing literature (Joinson, 1992). Only primary research articles from peer reviewed journals which were in the English language were selected for review. Papers relating to (registered) adult nursing were selected for review, thus excluding any studies where the primary focus lay primarily within paediatric or midwifery specialisms. This core aim of this review was to gain an appreciation of nurses' lived experience of STS. Studies that referred to quantitative findings were excluded from the review as papers describing nurses' experiences of STS were more relevant to this study's research questions. However, papers using mixed methods were considered if there was a clear qualitative arm from which useful data could be extracted.

- Non primary research articles.

- Primary research articles from peer reviewed journals dating from 1992 to the present date.
- Studies in the English language.
- Studies involving exclusively qualified nurses.
- Studies involving adult nursing populations.
- Studies with a clear qualitative methodology and results.
- Mixed methods studies that clearly identified a qualitative arm and results.

Figure 3: Inclusion criteria

Article titles and abstracts were read, with nursing related, primary research articles being chosen for where reference was made to secondary STS and compassion fatigue. The articles chosen for further review were then read in full and selected for inclusion based on relevancy. Figure 5 *(below)* illustrates the search strategy and selection process for the papers included in this review. In total, 46 qualitative papers were identified from their titles, abstracts and content.

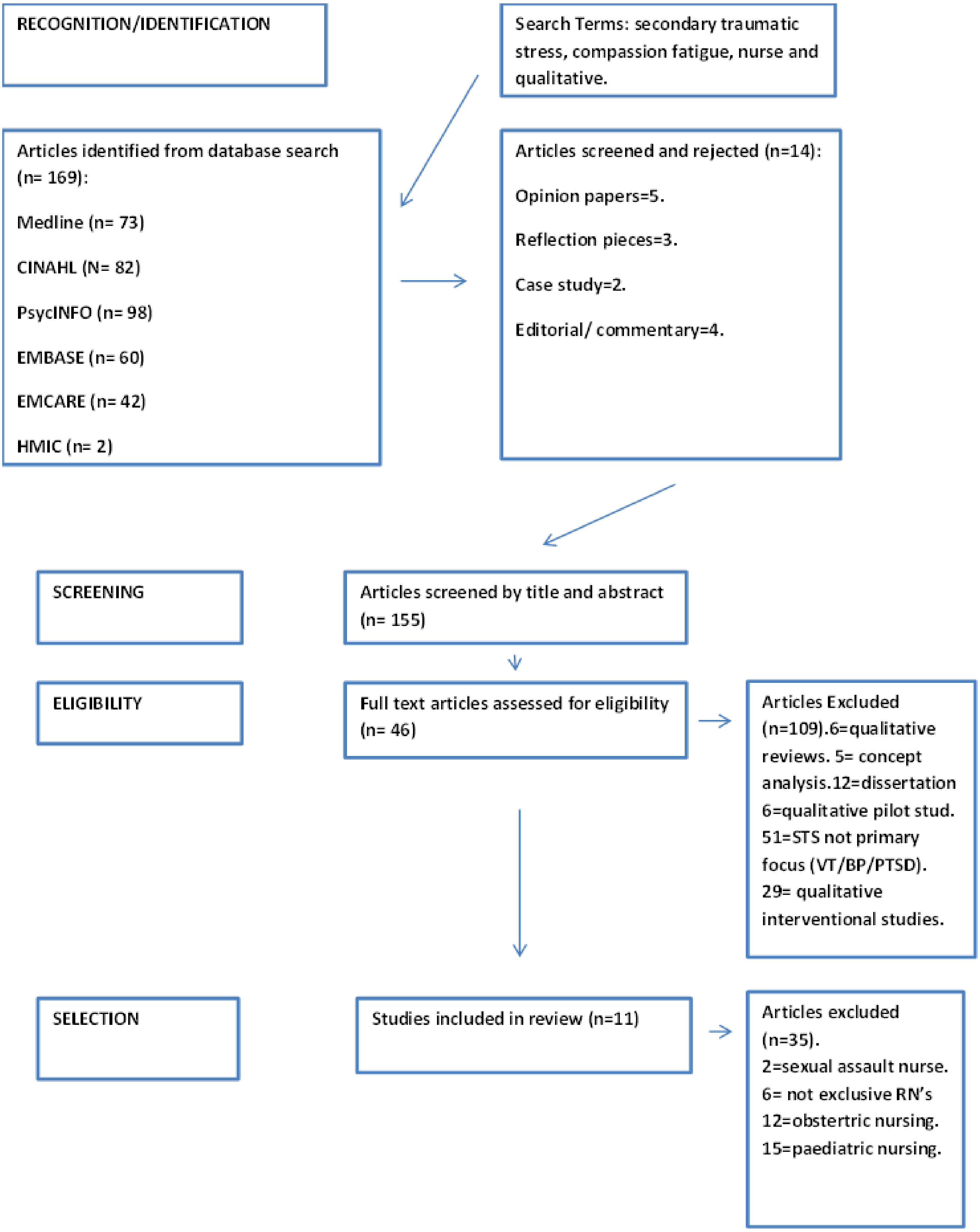

Figure 5: Search strategy and selection process

Following further appraisal, eleven papers were subsequently selected for inclusion in this review. 6 papers were excluded because of their participants not being exclusively nurses. One of these papers (Morrrison and Joy, 2016), which was incidentally the only one from the UK, did report what was considered valuable qualitative data. However, the study participants were comprised of registered and non- qualified nurses. The responses gleaned from the texts could not be attributed individually to the qualified nurses. As this review concerns itself with the experience of qualified nurses, this study was excluded. Several papers were read that referred to nursing in terms of obstetrics (n=12). These studies did not make for easy reading not only from the perspective of a researcher, but also a father and husband. The description of trauma encountered by women, neonates and nurses in some of these studies was shocking in its description (Beck 2013, Beck et al, 2015, Hutti et al, 2016, Faucher, 2013). While the experience of trauma was palpable, these stories were not included in this literature review. It is offered that the devastating experiences relayed in these papers is a clinical situation unique to this speciality and is unlike those encountered in other spheres of the caring professions. Another area that is arguably unique to the experience of STS in nursing is that concerning sexual assault services. Two papers that referred to the experience of STS in the context of sexual assault were also excluded (Townsend and Campbell, 2009. van der Wath et al, 2013). It is argued that bearing witness to children's suffering, regardless of the situation, has the potential to be traumatising (Lavoie et al, 2011). 15 papers referring to STS in paediatric nursing were excluded on these grounds from this review. The paper by Gunusen et al (2018) did yield qualitative data that was given respect to being included in this review. The data reported in this research did however refer to experiences at a Turkish oncology service that catered mainly for adults but also on occasion children. The nurses involved in this study therefore had experience of nursing both these populations. The paper made reference to events involving both age groups) only one reference was made in the data to an event specifically related to a child). However, only the experiences related to STS when caring for adults was included in this review.

2.3.3: Study Characteristics

No papers were found that reported on STS or compassion fatigue and stroke nursing. The main characteristics are detailed in Table 1. All studies included were in the English language; however, the abstract on one study (Walsh and Buchanan, 2011) was presented in English with a further version in French owing to its Canadian origins. One study was from Japan, one from Turkey and four were from the United States, with the remaining five being from Canada. With the exception of Yoder (2008), all the authors report affiliations to higher education establishments. Eight of the authors have published previous work related to the subject (Perry et al, 2008, Sabo 2016, Shepard, 2015, Gunusen et al, 2018 and Fukomori et al, 2018).

Qualitative research aims to explore and understand the complex interplay between humans and their environment (Finlayson and Dixon, 2008). All papers reported a clear methodological approach to collect qualitative data. With the exceptions of Yoder (2008) and Giarelli et al (2016) both of which was of mixed design (only the data relating to the qualitative arm was referred to in this review); all the studies were situated in the naturalistic paradigm (phenomenology- descriptive/ interpretive), thereby allowing the researchers to capture the human subjective experience- with the emphasis being placed on individuals encounters (Nott, 2001).

The aim of each individual study was clearly identified and appropriate to the study design. The participants' involvement was appropriate to the study's aims. Ethical approval was referred to in each paper. Eight studies described samples as working in oncology/ palliative care (Fukumori et al, 2018. Gunusen et al 2018. Phillips and Volker, 2019. Finley and Sheppard, 2016. Giarelli et al, 2016. Melvin, 2012. Perry et al, 2011. Sabo, 2011). The remaining Three studies referred to various backgrounds (acute care- Walsh and Buchanan, 2011., community-based hospital including ED, home care, medical/ surgical ITU- Yoder, 2008., and general and psychiatric care, Austin et al, 2009).

Table 1: Study characteristics

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
Yoder (2008): USA	Explore prevalence and factors that lead to compassion fatigue and methods of coping.	Mixed methods: quantative analysis using ProQoL scale and qualitative content analysis of written transcripts.	RNs employed in a 123 bed community hospital: 106 responders, with 71 completing narrative accounts.	Age: 20-60 or >. Experience yrs. as RN: < 5- 30 or > Area: ER n=23, home care n=9, ICU n=16, med/surg n=31, oncology n=13, PCU n=10. Education ranged from basic diploma n=14 to MNs n=2.	Study was limited to 1 community hospital. No demographic data comparing nurses in the study with the total hospital RN population. No accepted definition re CF. Researcher was well known to the sample.

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
Austin et al (2009): Canada.	An exploration of Canadian nurses' experience of compassion fatigue.	Descriptive phenomenology. Audiotaped interviews. Place of interviews reported as in the participants home, work or university. Not individually specified.	5 registered nurses who self-identified as having or having had compassion fatigue.	Participants described as being from various service areas. Four other nurses declared an interest to take part but withdrew when 'too ill' or 'too overwhelmed with work' became. No other data available.	None reported.

Author/location	Aim	Method	Sample size	Participant Characteristics	Reported Limitations
Perry et al (2011): Canada.	Investigate the experience of compassion fatigue in Canadian oncology nurses.	Descriptive phenomenology of narratives which were submitted online.	Purposive: 19 oncology nurses recruited following a national advertisement in the *Canadian Oncology Nursing Journal.*	All female. Age 20-60 Experience as a nurse ranged from 2-33 yrs. Experience as an oncology nurse 2-23 yrs. Inclusion criteria to have experienced compassion fatigue.	Sample size reported as a small % (n=19) of total oncology nurses in Canada.
Sabo (2011): Canada.	To enhance knowledge and understanding of the	Interpretative Phenomenology.	Purposive: 12 HSCT nurses from 3 Canadian tertiary	Age range 24- 50 yrs. Years of experience on	Purposive sample reduced diversity. No

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
	effects of nursing work on the psychosocial health and wellbeing of haematological oncology nurses (HSCT).	2 separate audiotaped interviews using open ended questions and a focus group. Interviews and focus group location unspecified.	healthcare facilities.	HSCT unit ranged from 1- 19.5 yrs. No data re sex of participants available.	males involved in the study. Homogenous nature of the sample reduced overall number of participants. Author's prior work as a HSCT nurse had potential to influence the process of interpretation.

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
Walsh and Buchanan (2011): Canada.	Acute care nurses' experiences related to witnessing patient's trauma and suffering.	Descriptive phenomenology. Open ended, unstructured, audiotaped interviews. Saturation achieved the 5th participant. Interviews conducted in the participant's home.	Purposive: 5 acute care nurses.	All self-reported either current or past stress by witnessing patient's trauma or suffering. All employed in acute care. All had < 10yrs experience, majority <5 yrs. All female. Median age 30.2 yrs.	Small sample (n=5). Sample seen as homogenous- all female, similar cultural and socioeconomic backgrounds. All samples were relatively new to their position.

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
Melvin (2012): USA	Explore the prevalence, nature, effects and coping strategies of professional compassion fatigue in hospice and palliative care nurses.	Descriptive phenomenology. Semi structured audiotaped interviews. Participants interviewed in a closed conference room at the home health agency.	Purposive: 6 hospice and palliative care nurses.	All female. Participants experience ranged from 11-33 yrs. (minimum inclusion 10 yrs.). None selected as exhibiting signs of compassion fatigue.	Reported sample size as small (n=6) limiting generalizability. Purposive sampling may have resulted in limiting the information that the sample were willing to share.

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
Finley and Sheppard (2016): USA	To augment and illuminate early career oncology nurses experience of CF.	Qualitative phenomenology using open ended interviews.	Purposive: 5 oncology nurses.	All female. Ages: 25-44.Years in oncology: 0-7. BSc= 4, MSc= 1. RN= 3, ANP (oncology) = 1, unit educator and charge RN= 1.	Sample size of five oncology nurses from 1 single level trauma facility limits generalizability. All female population. All had seven or fewer years' experience in oncological nursing specialty.

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
Giarelli et al (2016): USA	To examine the factors that influence risk of nurses CF.	Descriptive: mixed methods. Audio recorded in depth interviews either by telephone or in person.	20 oncology nurses.	All female. RN= 6, BScN= 14. Age range: 22- 51. Yrs. Nursing= 0.75- 29. Yrs. In oncology= 0.75- 29.	Relatively homogenous sample that included no male participants. Sample included a manager who was a member of the research team which may have positively or negatively influenced participation in the study. Work schedule (shifts) were set therefore impact of alternative shifts was

Author/location	Aim	Method	Sample size	Participant Characteristics	Reported Limitations
					unknown. Homogenous sample with respect to race and ethnicity- more sociodemographic diverse sample might have offered an understanding of racial/ cultural variants that might impact CF.

Author/location	Aim	Method	Sample size	Participant Characteristics	Reported Limitations
Gunusen et al (2018): Turkey	To explore secondary traumatic stress experiences of nurses caring for cancer patients.	Qualitative descriptive approach using semi-structured in-depth interviews, evaluated using content analysis.	13 oncology nurses	All female participants. Average age was 31 years. All were educated to Bachelor's degree level. One had a	Authors reported that after the recordings stopped, the nurses mentioned several things that they had not shared

Author/location	Aim	Method	Sample size	Participant Characteristics	Reported Limitations
				master's degree. Mean length of work experience was 9 years, with the mean years of oncology experience being 4.	during the data collection.
Phillips and Volker (2019): USA	To explore the emotional evolution of being an oncology nurse	Qualitative descriptive design. Semi structured interviews.	Purposive and snowball: 7 oncology nurses with at least 3 years' experience from community	6 female, 1 male. Mean age 41.3 yrs. Average 13.9 yrs. In nursing. 10.6 yrs. in oncology speciality.	Sample size referred to as small. Purposive selection included self-selected patients and possibly more likely to want to tell their story.

Author/location	Aim	Method	Sample size	Participant Characteristics	Reported Limitations
			(outpatient) and academic (inpatient) cancer centres.	All oncology certified nurses or nurse practitioners.	Sample was reported as relatively homogenous therefore decreasing transferability.
Fukumori et al (2020): Japan	Describe the components and frequencies of traumatic events experienced by patients with cancer which give rise to nurses' compassion fatigue	Qualitative design. Semi structured interviews	Purposive: selected from 6 designated cancer hospitals in Japan. 30 Japanese nurses with at least 2 years' experience in cancer care and	30 nurses. 29 female. Ages ranged between 23-57 years. Mean age of nursing experience 28 yrs. Mean cancer experience 18 yrs. All referred to patients >18yo	Authors queried if data was fully saturated. Did not include nurses who provided home visit or hospice located nursing care. Suggested results were pertinent to patients in the acute phase of cancer. Focus was on patient's

Author/location	**Aim**	**Method**	**Sample size**	**Participant Characteristics**	**Reported Limitations**
			had a history of CF.		traumatic events triggering CF and not organizational factors.

2.4: Results: Emerging Themes and Categories

All the studies included offered illustrations of participants’ comments from their interview or narrative transcripts. On account of the large volume of qualitative data reviewed, a thematic analysis was undertaken. Themes were developed based on an analysis and synthesis of the content from all the selected studies. This approach can be described as a method for identifying, analysing and reporting ideas or patterns emerging within data (Braun and Clarke, 2014). It involves the search for and identification of common threads that extends across the qualitative findings (Nowell et al, 2017). The analysis borrowed from that of Savin- Baden and Major (2013). Figure 6 demonstrates the process undertaken to illuminate these study’s key themes and their related sub-categories.

Following the identification of the papers, the individual studies were subjected to multiple readings from which the key themes were identified and named. Each of the papers where a theme was identified was tagged (with a handwritten note) before being put with the other papers noted relevant papers. The papers were then compared against each other for related themes. The process of re-reading was then repeated to search for sub-categories inherent within these themes. Following this, sub-categories were then identified and named. The papers were once more compared against each other to look for consistency across the associated sub-categories. The analysis revealed 4 recurring primary themes pervading the papers with multiple sub-categories also being identified (Figure 7).

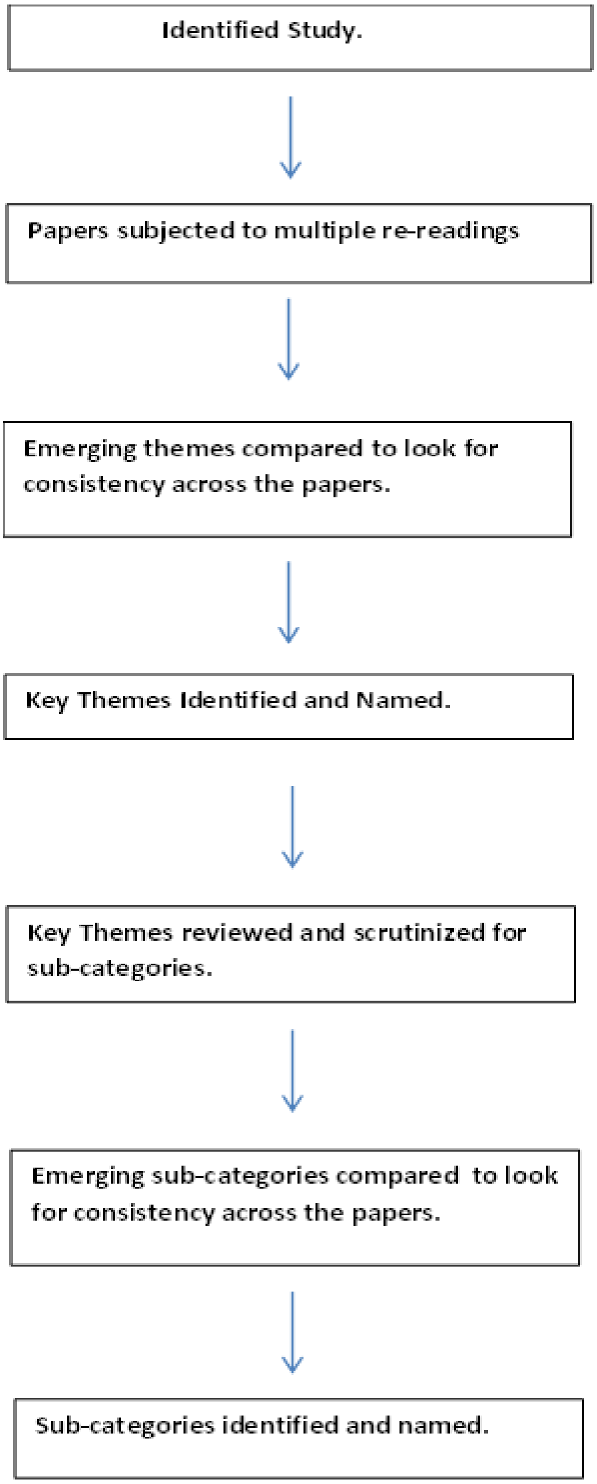

Figure 6: Process of identifying themes and Sub-categories

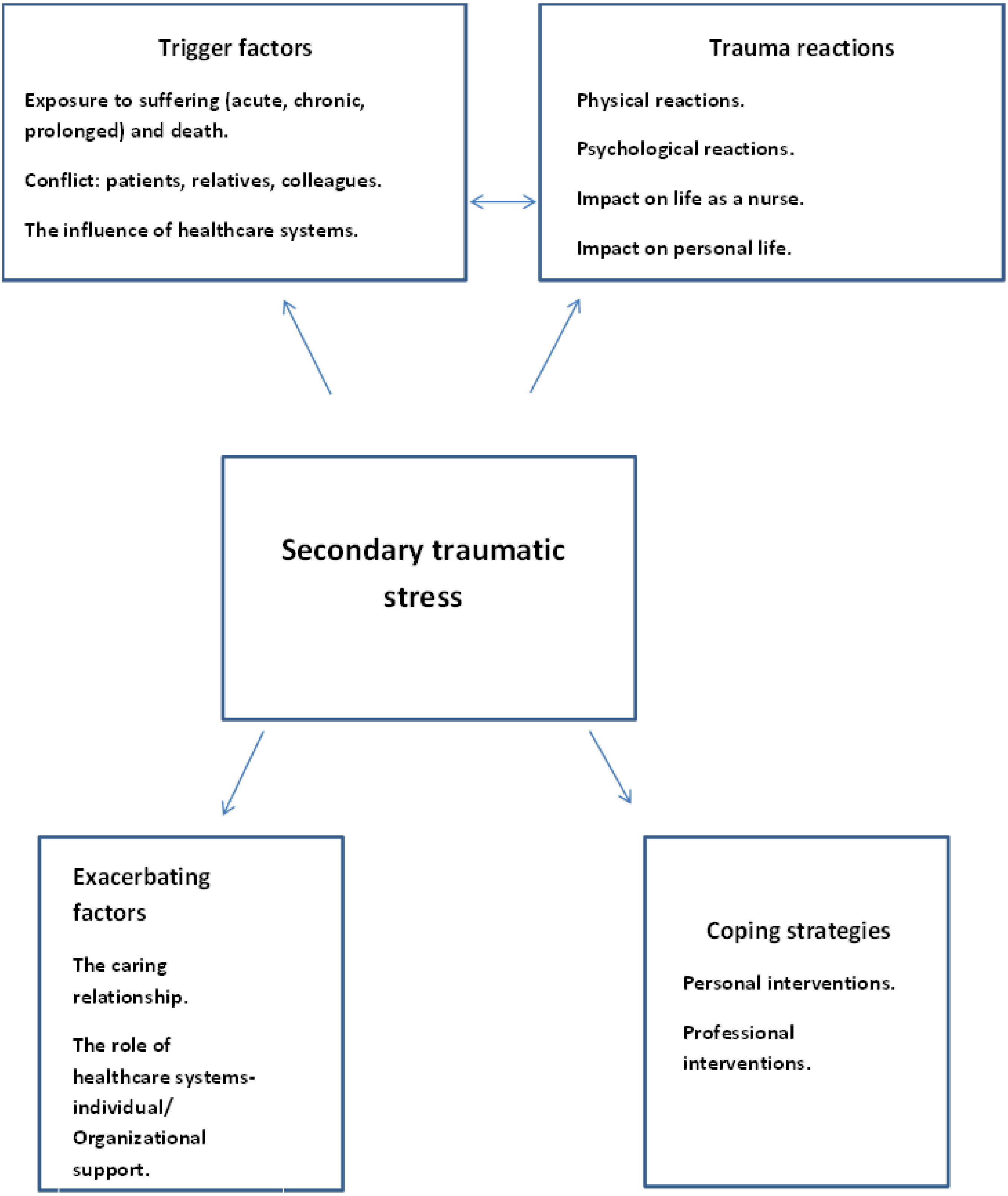

Figure 7: Themes and Sub-categories

2.4.1: Trigger Situations

The common theme present in all these papers is that stress reactions are induced by being exposed to other people's suffering. Lavoie et al (2011) have suggested three separate means of bearing witness to suffering- exposure as a witness, exposure as a victim and contextual exposure, that is, the circumstances in which the stressful/ traumatic event was encountered. The studies describe settings of both acute and longer-term natures. It has been theorized that people involved in direct trauma such as RTAs, burns and intentional wounding do not suffer the same trauma as encountered by oncology patients (Quinal et al, 2009). It is therefore reasonable to suggest that the type of trauma occasioned by patients may result in different stress reactions in those who care for them. The literature makes particular reference to patients with episodes of prolonged suffering. This suggests patients with longer term conditions as opposed to those presenting with acute illness. However, while being witness to prolonged suffering was noted as being particularly traumatic (Finley and Sheppard, 2016. Yoder, 2008. Walsh and Buchanan, 2011), the predominant cause of traumatic reactions appears as repetitive exposure to serious illness and death. Melvin's (2012) work referenced the erosive nature of bearing witness to multiple deaths, with participants recalling that multiple losses had 'eaten away' at them as nurses and people. It is possible to argue here that repetitive exposure to suffering and death could be from either acute or chronic presentations. What appears to be of importance is how traumatic incidents in the form of patient distress and mortality are amassed.

Another source of distress centred on nurse's involvement in what was perceived as futile care. The participants in Sabo's (2011) paper referred to how they believed that patients should be kept comfortable and allowed them to have their remaining time with their families rather than be subjected to interventions that had no benefit. This paper suggests that in caring relationships, nurses become privy to and share in the suffering of another with the intention of acting as an advocate to lessen their suffering. However, the attempt to alleviate someone's suffering without taking it on as our own is argued as the cause of further strain (Sabo, 2011).

Yoder (2008) has also reported on stressful situations encountered by futile care. However, a further consequence raised by this scenario has been the potential for conflict with relatives. Yoder (2008) refers to such a case without hope made stressful by the family's insistence that 'everything be done'. The reference to potential conflict links in with STS and exposure as a victim. Several papers described the potential for conflict with colleagues, physicians and/ or patients and relatives (Giarelli et al, 2016. Fukumori et al, 2018. Phillips and Volker, 2019). Challenging behaviours of patients and relatives, including exacting and angry individuals may appear at the other end of the care spectrum to the needs of seriously ill and dying patients. However, the perceived disrespect that accompanies this conduct can detrimentally alter the nurse's approach to caring with Walsh and Buchanan (2010) respondent's describing how they have been forced to confront these situations with toughness in order not to be overwhelmed. Fukumori et al (2020) have also spoke of the family in terms of STS. However, by contrast the traumatic stress was generated by being witness to families being in conflict with each other, mainly with regards to communication, treatment and patient's wishes. Furthermore, Finley and Sheppard (2016) have discussed the demands of distressed families who need emotional support. The dependence and over relation subsequently resulted in traumatic stress.

A further precipitating factor which was referred to in a number of the studies was conflict involving physicians (Yoder, 2008. Sabo, 2011. Giarelli et al, 2016, Phillips and Volker, 2019). Physicians are referred to in the context of futile care, potentially aggravating the situation by not being honest regarding patients' prognosis (Yoder, 2008. Giarelli et al, 2016). Phillips and Volker (2019) referred to medics not engaging with patients to the point of denying them the opportunity to have a dignified death. What are reported to underlie this discord are poor communication, poor support systems and hostile working environments. Sabo (2011) refers to nurses' proximity to care, doctors' blunt means of communicating and feeling that they had to 'pick up the pieces' when doctors had left. It is possible to suggest that the conflict encountered here is not only the product of frustration, but also uncertainty evolving from incomplete communication (Sabo, 2011). Alternatively, Yoder's (2008) sample referred to physician's decisions or demands as contributing to stress. An additional source of nurses' distress was the feeling that nurses acted as advocates for their seriously ill or dying patients but felt that they were not listened to (Finley and Sheppard, 2016).

Many of the papers included in this review allude to trigger situations evolving in response to problematic healthcare systems (Yoder, 2008. Austin, 2009. Walsh and Buchanan, 2010. Melvin, 2012. Giarelli et al, 2016). In this contextual exposure, several elements were consistent such as heavy work burden, constant prioritising, high acuity, lack of time, overtime/ having to work extra days and general lack of resources. Austin et al, (2009) have specifically referred to the impact of nurses working long shifts without the appropriate recovery time between shifts. Furthermore, two of Austin et al (2009) participants described how they felt discouraged by management inactivity. Several of the reviewed papers revealed the difference between what they saw as their role of patient care and its reality-

‘computers, education, control issues, mandatory meetings and other things’ (Yoder, 2008, p.194). Moreover, is the apparent impact whereby nurses are seemingly prevented from making a real difference as due to such role demands resulting in meaningful patient contact and care being reduced to the bare minimum with the opportunity to develop therapeutic relationships with patients being negatively impacted (Giarelli et al, 2016). The overall feelings nurses expressed was that they had not fulfilled their obligation to help their patients (Walsh and Buchanan, 2010. Gunusen et al, 2018).

Ultimately, system failings are contributory as a causative factor to stress reactions whereby the process of caring is diluted from what should be meaningful to the prosaic. What is clear is that these contributing factors are multidimensional. These triggering factors may precipitate stress reactions through different mechanisms and debatably do not occur in isolation to each other. It may require further investigation to ascertain to what degree the interplay of these factors have in the development of traumatic stress reactions.

2.4.2: Trauma Reactions

The experience of trauma provokes a number of physical afflictions. Somatic complaints of aches, pains, lack of energy and extreme tiredness have been highlighted among participant’s responses including exhaustion (Perry et al, 2011. Phillips and Volker, 2019), stomach pains (Gunusen et al, 2018) palpitations and not be able to breathe (Walsh and Buchanan, 2011). What was often reported along with physical complaints was the seeming inability to recover from the feeling of fatigue. Several participants responded how they had previously been able to ‘refuel’ or bounce back, but in the advent of the traumatic experience found this more elusive (Austin et al, 2008. Melvin, 2012).

It is, however, the psychological problems that have become synonymous with traumatic experiences (Bush, 2009) which were most reflected in the literature reviewed. These included the classic features of stimulus avoidance, event revival, and intrusive thoughts including nightmares, hyper arousal and dissociation. In addition to this insomnia, general distress, anorexia, anxiety, panic attacks, pessimistic outlook and depression have all been emphasized (Harris and Quinn Griffin, 2015). Interestingly, only one study (Gunusen et al, 2019) saw one respondent state that their mood as so low that they required antidepressants. This data clearly indicated a nurse in distress and went on to further reveal that the individual also suffered insomnia, waking from sleep in tears. The literature references several similar elements that caused the participant’s distress. What is apparent from the data is that intrusive thoughts, nightmares and preoccupation with events, the ‘symptoms’ most readily associated with STS, often caught these nurses unaware and without recourse to avoid them (Walsh and Buchanan, 2011). Furthermore, the experience of trauma appears to have a transformative and harmful impact on these nurse’s psyche. The data speaks of nurses becoming changed in their outlook from being hopeful and confident to pessimistic (Phillips and Volker, 2019). There is also a sorrow at not only feeling like this and not being able to do anything about it, but also a lament for the nurses (and people) they used to be (Phillips and Volker, 2019. Findlay and Sheppard, 2016).

The papers by Phillips and Volker (2019) and Findlay and Sheppard (2016) speak of nurses’ feelings in terms of the way they used to be and where they now found themselves located. This aptly ties to the effect trauma reactions have on the sufferer’s life as a nurse. The literature speaks about a shift in their perceptions about their own individual ability to function as a nurse and their subsequent feelings of impotence or inadequacy and of being defeated by work (Yoder, 2008). One nurse reported how they had initially felt a sense of invincibility. However, the reaction to traumatic events led to the feeling of being unable to give anymore (Perry et al, 2011) and live up to their own expectations (Giarelli et al, 2016). Furthermore, the nurses in Gunusen et al (2018) indicated that the things that they had previously viewed as important had lost its significance signalling a dissonance with their core values of being a nurse. This in turn provokes questions about the ability to enact a moral responsibility. Walsh and Buchanan (2010) identified this in their respondents who reported a loss of empathy and becoming ‘hardened’, whereas Findley and Sheppard (2016) quote one respondent who stated that some days they did not feel as compassionate. There is a palpable sense of anguish in one of these nurses who saw their loss of empathy as rendering them the same as ‘other nurses’. The dissonance between formerly holding dear the core values of nursing and the subsequent impact of reacting to trauma posed its own source of personal distress. Not only did this produce changes in an individual’s sense of self, but also their feelings about nursing. This is felt most poignantly in Austin et al (2009) where nurses reported their sense of inadequacy (‘my job is to build hope and I am the most hopeless person in the room,’ p. 206) and loss (‘they said that they had loved nursing. The love of nursing, however, was expressed in the past tense,’ p. 208).

The emotional costs encountered in professional life stretch to encompass family, personal relationships and social life (Perry et al, 2011). The responses offered refer to disruption of family relationships often precipitated by tiredness and lack of time. This in turn can lead to conflict with the very people who are most likely to be these nurses’ best means of support (Melvin, 2012). Furthermore, personal interests are diminished, alongside withdrawal from community involvements resulting in the potential for isolation (Austin et al, 2009). It would appear that the problems encountered through caring and the effect in and on personal life compound each other synergistically to a situation without respite.

Trauma reactions have been described as physical and psychological; however, the effects extend beyond that. Undoubtedly, the manifestations have the potential to be debilitating (Figley, 1999). Nonetheless, there is a considerable impact on both the ability to provide optimal care and to maintain a life outside of the work environment (Baired and Kracen, 2006. Dominguez- Gomez and Routledge, 2009). While presentations are rightly viewed as important, what needs equal appreciation is what contributes to making symptoms worse and ultimately, what improves the situation.

2.4.3: Exacerbating factors

It is possible to debate that bearing witness to multiple traumatic events can either be the cause of STS or a mechanism for exacerbating it. This could be appreciated in those nurses with many years of service or those by comparison who have had relatively short nursing careers (Findlay and Sheppard, 2016). However, what also needs to be considered alongside multiple exposures to traumatic events is the nature of the episode(s), the location in which it occurred (clinical area/ specialty) and its duration (acute verses prolonged suffering). Furthermore, it is suggested that many of the reactions to traumatic events could also be seen as exacerbating factors. All the elements discussed that impinge on the ability to foster caring relationships could also be regarded as making matters worse. Nevertheless, the choice between detachment and attachment induces the potential for exacerbation either way. Finley and Sheppard's (2016) research realized the perils of failing to maintain boundaries and the pitfalls of emotional investment. The dilemma between attachment and avoidance has been appropriately detailed in Phillips and Volker (2016) whereby nurses felt the need to 'titrate their emotions'. This was further elaborated as 'peaks and valleys' of attachment to patients or pulling back from them. Ultimately, where there is an emotional commitment, there is also the potential for greater distress. Walsh and

Buchanan (2010) participants reasoned that detachment or withdrawal from patients would protect them from bearing witness to another potentially traumatic event. This could however be perceived as being at odds with nursing's core values. It might be argued that with the same level of insight, the dissonance with nursing values could equally prove distressing. Alternatively, becoming too attached could aggravate the problem, prompting to recall the inability to leave things behind. The Perry et al (2011) study revealed how one nurse picked up on patient's emotions and then found that they were unable to let go of them. The overall impression they admitted to was one of being too attached (to patients) for their own good.

The trauma of bearing witness to patients' acute or prolonged suffering was made worse by fluctuations in patients' conditions such as deterioration and recurrence. Fukumori et al (2018) made specific reference to these elements. However, the paper also highlighted the impact of stopping ineffective treatments. This was compounded by patients not adapting to poor or unexpected outcomes. STS was further aggravated where patients fell into the category of being young. Their suffering was viewed as something that was not only unexpected but also unfair, particularly where it was prolonged in duration (Fukumori et al, 2018. Finley and Sheppard, 2016).

Another point raised within the literature was the reports of lack of formal support. This was seen to exist on both individual and organizational levels. What nurses felt most keenly was cultures devoid of understanding, characterized by feeling alone and unheard (Sabo, 2011). One of the participants in Sabo's (2011) paper reported how after starting on the ward they were crippled by anxiety for the first 6 months. This was ascribed to lack of knowledge. It does however raise questions of support and supervision. The impression created from reading the literature indicates a set of circumstances by which nurses provide care but seemingly are neither cared for nor able to care for themselves.

There also exists the similarity between the trauma reactions which impact on personal life and how personal issues can inflame the position. Perry et al (2011) have referred to the role of past personal events (sick child/ failing marriage/ sibling's illness) and co- existing physical and emotional stress intensifying trauma reactions. There also appeared an apparent resentment at not being able to focus on one's own personal traumas as opposed to that of patients. What the literature suggests is that nurses become enmeshed in their patient's trauma at the cost of ignoring or being unable to attend to not just the plight of their own loved ones, but also themselves.

There are other factors that have a detrimental bearing on the individuals' response to STS. Finley and Sheppard (2016) have recognized negative coping mechanisms among their participants- including the use of alcohol and either not eating or binge eating. Furthermore, personality traits were also cited in this study as being the focus for maladaptation. Reference was made to being stuck in the mind set of perfectionism, leading to a fixated and jaded identity with the ultimate frustration being a desire for normalcy but not knowing how to achieve it.

The findings discussed by Austin et al (2009) refer to the negative feelings that family members have towards those within their family who are employed in a nursing role. The text refers to a partner recognizing that his wife is unhappy in her work and has lost their work- personal life balance; there is resentment at the effect on family life. The nurse in question appears acutely aware of this, but also appears unwilling or unable to change, seemingly willing to let her family down rather than her patients. Furthermore, the loss of a distinction between work- personal life balances can serve to perpetuate stress.

Exacerbating factors appear to exist on a multi-level basis. There again appear both professional and personal influences that can be of further detriment. On the one hand there exists a necessity for healthcare organizations to adequately support their workers. This should include programmes directed at recognizing and reducing nurse’s vulnerability to STS. However, it is suggested that those in caring positions gain an awareness and insight into the potential for reactions to trauma. What would appear critical is to retain perspective, while maintaining an even work-life balance.

2.4.4: Activities that reduce/ relieve symptoms

The literature reported on a number of initiatives aimed towards relieving or reducing symptoms associated with traumatic stress reactions. This took the direction of either professional or personal coping strategies. Giarelli et al (2019) and Findlay and Sheppard (2016) have favourably discussed the impact of both supportive management and sharing their experiences with colleagues/ peers. Several of the papers reported suggestions regarding professional initiatives including changing working patterns (Yoder, 2008), courses and further education (Austin et al, 2008) and mentorship and supervisory programmes (Sabo, 2011). Walsh and Buchanan (2010) referred to the use of counselling and critical incident stress management. Giarelli et al (2016) study made specific reference to exploring interventions. The suggestion was made for formal support programmes such as debriefing as a defusing activity alongside the need for discussion with and listening to colleagues.

Perry et al (2011) have stated collegial support as beneficial, but where this is lacking, the risk is heightened. It could be suggested that teamwork and environments geared to supporting each other should be the focus for all teams involved in providing healthcare services. Several coping strategies could be seen to involve both professional and personal elements. The Perry et al (2011) paper remarked on participants own recognition that they were becoming overwhelmed by their experiences. However, these participants appeared to lack insight into the cause of why they felt like this. It could be considered that if these participants had an earlier insight into their behaviour, they may have adjusted it such to protect themselves. This study further reported on how maturity and experience had led to a greater sense perspective with regards to capabilities and limitations.

Phillips and Volker (2019) have asserted that nurses must come to the realization that they all have an ‘expiration date’. Essentially, this means that nurses recognize when they have given all that they can and make the choice to either take a break from a particular arm of the service or leave it all together. This offers up several implications. Nurses should not be pushed to the limits of their endurance by the stressful nature of the work they do. Furthermore, the suggestion of leaving revisits the problem of retaining valuable and experienced staff. However, it is questionable as to what potentially jaded nurses would offer by continuing. The nurses in Phillips and Volker’s (2019) study saw a break from the service as a positive coping strategy. Hernandez et al (2007) has referred to how individuals learn to cope with adversity from being in contact with traumatized people. Fundamentally, what this equates to is a form of experiential learning. This is reflected in the Phillips and Volker (2019) paper which reports how the experience of navigating traumas such as accumulated loss can be seen in a positive light in that it is something that has to be experienced in order to appreciate the process. This has also been found by

Findlay and Sheppard (2016) who have referred to nurses' changes in perspective whereby meaning can be found in and through these experiences.

Several of the studies reviewed reported on individuals own personal interventions such as focusing on life outside of work. These interventions reported the use of prayer, hobbies and social activities. The ability to maintain a healthy work- life balance and setting boundaries was an essential element in mitigating stress (Findlay and Sheppard, 2016). Furthermore, connecting with family and friends outside of work was regarded as particularly important as a coping strategy (Melvin, 2012. Perry et al, 2011).

The findings of this literature review have suggested distressing and at times overwhelming situations. Nonetheless, despite the suffering encountered by those who both experience it and bear witness to it, the presence of hope may serve to reduce suffering. Sabo (2011) has referred to hope in this context of being the chance to effect change or a positive outcome. This does not necessarily mean finding miraculous cures or preventing death. The hope is one of creating a change that can approach these elements in a more positive manner.

2.5: Discussion

The nursing literature in relation to STS is dominated by quantitative studies mainly discussing its prevalence and the associated assessment tools. The search undertaken as part of this review has highlighted that there exists a paucity of qualitative studies describing nurses' experiences of STS. However, the studies that have been selected have offered a crucial appreciation of their subjects' experiences. Furthermore, these papers form an understanding of what has been and what should be considered for further investigation. What is more, the insights garnered from the knowledge of what evidence has gone before has been elemental to informing the conduct of the research question and the approach to answering it.

This review aimed to answer a number of questions in respect of nurses' experiences of STS. The papers included in this critique have clearly identified that nursing populations are subject to developing STS through the nature and circumstances of their work. There appears to be a number of factors responsible in its development, but of greatest significance is the exposure (often repetitive) to patients suffering. The studies included in this review indicate that repeated exposure to traumatic events can produce and exacerbate stress reactions. Some of the individual responses reported in the text of these studies refer to upsetting experiences. However, it is difficult to know if these were single episodes or the result of multiple events that occasioned an acute unsettling response. It is also difficult to appreciate to what degree the particular environment, intensity and duration of the traumatic event influenced these reactions. Several the papers discussed long term effects and describe the effects in terms of year's duration. Agreement could be met suggestion that the direction of future research could embrace longitudinal studies of chronic exposure, long term effects and institutional support (Sabo, 2006).

The situations in which STS occurred were also wide ranging with its experience being cited in nurses working in acute and longer-term care, emergency and high dependency situations and oncology/ palliative care. While some nurses reported having varied somatic complaints, by far the greatest impacts of these nurse's experience of STS was of a psychological nature. Interestingly this review was unable to locate any qualitative appreciation relating to STS in psychiatric nursing populations. It is possible to suggest that the dearth in this type of literature as anomalous given that psychiatric nurses are often involved in the care of severely traumatized patients (Beck, 2011). It is possible to consider this area worthy of further investigation. Many of the studies reported how STS was initially spawned from conflict with other professionals and relatives, poor support systems (formal and informal) and problematic healthcare systems. Furthermore, these elements along with nurses' attempts to adjust to the experience of STS actually contributed to its exacerbation. A considerable proportion of the subjects in these studies moved to alleviate their feelings of STS through formal and informal means. However, social and family support was identified as key mitigating factors in these nurses' responses to STS.

The studies which have been cited in this review could arguably form the foundations of understanding nurses lived experiences of STS. It is possible to state that this basis offers a valuable insight into the topic. While the suggestion has been made that further research possibilities could focus on psychiatric nursing and longitudinal studies, it has been possible to identify several gaps within the evidence that has relevance to the researcher's area of practice and proposed study. These papers have revealed the experiences of nurses working in the settings of emergency services, 'acute care', oncology/ palliative care, intensive care and community hospital settings. However, the papers included in this review made no reference to patients who had suffered a stroke or any form of neurologically related disability in the areas studied. Furthermore, none of the papers referred to nurses in terms of being specialists in their respective roles. This represents an incomplete appreciation both in terms of how STS might occur in specialist nurses but also those specialists nursing stroke victims.

It can be argued that there exist similarities and differences between the areas and subjects studied in the papers used in this review and the area of interest- hyper acute stroke care. It can be stated that there is some comparison with hyper acute stroke care and particularly the areas of emergency/ acute care, high dependency and palliative approaches. It is offered that within these realms there are essential elements that have similarity to not only stroke specialist practice but also non- specialist nursing practice. However, there can be observed a marked contrast in terms of specialist nursing and the very nature of hyper acute stroke specialist nursing where clinical assessment and diagnosis, increased acuity, high patient turnover, time dependent critical interventions (thrombolysis/ thrombectomy) and wide-ranging high stakes outcomes are readily encountered. The experience of STS in stroke nursing in general and indeed in SSNs has not been previously appreciated. This represents a vindication for undertaking this study.

2.6: Strengths and limitations

This literature review was undertaken with guidance from my supervisory team. The process of the devised literature search and the identification of the relevant evidence was the initial focus of discussion between the researcher and their supervisory team. The identified individual papers and their attributes were debated at our academic meetings. This led to a consensus on which studies were felt to be appropriate to warrant inclusion in this review. These discussions and the decisions resulting from them formed an essential means of quality control and assurance. It fostered confidence in the review process, literature inclusion and findings. It is therefore regarded as the integral strength of this review.

Although this review had included the literature which was felt to be most appropriate to the overall projects aims, it is not without its limitations. This review is recognized as systematized in its approach. While the approach still allowed the researcher to pursue practice based qualitative studies providing rich accounts of the experience of STS, it nonetheless did not conform to the thoroughness of a systematic review. As systematized reviews do not claim to present the evidence in its entirety (Grant and Booth, 2009), it cannot be stated with absolute confidence that the approach was comprehensive. It is acknowledged that the search strategy employed may have resulted in overlooking potentially relevant, eligible and valuable evidence which may have been located in texts not published in the English language, non-peer reviewed journals or amongst possible grey literature.

A further consideration is the problem raised by the interchangeable terminology of stress reactions (Nolte et al, 2017). It is possible to offer that there might have been some studies falling under the bracket of vicarious trauma, post- traumatic stress disorder or possibly even burnout that may have included valuable data on traumatic stress reactions in nursing populations. However, the devised search strategy excluded such papers. Whatever these papers might have contributed to this review has remained latent.

Probyn et al (2016) have discussed transferability, the extent that the findings of a particular study can be applied to other situations, as a key component of qualitative research. Holloway and Wheeler (2010, p. 303) argue that transferability and generalizability, the extent to which a study’s findings apply to other populations, are not too dissimilar. The studies reviewed comprised of samples taken from the developed countries of Japan, Turkey, Canada and the United States of America. This therefore makes generalizability difficult.

2.6.1: Implications for a narrative approach

This reviews findings have informed the intentions of the research. It was noticeable that none of the studies included in this review used a narrative approach. This study is that of a qualitative design using a narrative approach. The choice of undertaking a narrative inquiry has hinged on two further considerations. All of the papers in this review have described nurses recounting traumatic episodes. There is an emotional aspect to capturing such data, not only for the participants but for the researcher who is exposed to it. There is an ethical dimension to undertaking this form of research in that those involved in its execution should care about how knowledge is produced. Narrative research values the importance of relationships and is cognizant of the potential emotional aspect of storytelling (Wang and Geale (2015). The argument is presented that adopting a narrative approach is therefore ethically appropriate. Adama et al (2016) has referred to how studying individuals storied lives gives an insight into the storytellers lived experience, their sociocultural environment and the interaction of the story within it. Clandinin et al (2018) have also emphasised how individuals' stories are embedded in their respective cultures. The argument is made that using a narrative approach is justified as the best means of exploring the culture of SSNs and its interplay in their experiences of STS. It is suggested that this will allow the most productive understanding of the topic area. The findings of this literature review have garnered an insight into what areas need to be explored to attain a deeper understanding of SSN's trauma related experiences. This review has informed my data collection methods by making consideration of how to access the SSN's stories- whether this is by directly 'asking for stories' or through interview questions, the approaches will be influenced by the literature's findings. The findings of this literature review will also inform the data analysis and its subsequent discussion. The data analysis will also aim to uncover themes and sub-categories within the SSN's storied accounts. The themes and sub-categories identified within the data analysis will be linked back to the existing literature to illustrate where there is congruence or divergence from what is known and also where new knowledge can be illuminated. It is anticipated that this will not only add to the evidence on stress reactions in specialist nurses but will also add to the canon of narrative research in the caring professions.

2.7: Summary

This chapter has discussed the literature relative to secondary traumatic stress in nursing populations and its implications for further investigation. There exists a large number of quantitative studies that describe STS prevalence and measurement of stress reactions. There is however by comparison a paucity of evidence related to the lived experience of STS in nursing populations. 11 primary research papers were identified from which qualitative data was captured. A thematic analysis of the relevant qualitative studies has realised a greater appreciation of how stress reactions consistent with STS impact across a variety of nursing specialisms. The feelings and opinions of the impact of STS in stroke specialist nursing have, as yet not been considered. The evaluated existing qualitative literature, fused with the latter sentiment in regard to stroke specialist nursing, supports the aims of the proposed narrative study. The following chapter will present the design, methodology and methods by which the study was undertaken.

Chapter 3: Methodology and methods.

3.1 Introduction

This chapter will describe the research approach relevant of this study. The study aims will be highlighted alongside the implications for the research design. Reference will be made to the philosophical assumptions that underlie this inquiry and offer an insight into the researchers' own ontological and epistemological perspectives. This section will illuminate the theoretical basis of the proposed methodological approach (narrative inquiry) and its relevance to the investigation. The procedural methods employed (including ethical considerations) will be discussed and particular attention will be given as to how the assembled data was subsequently analysed.

This study aimed to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations. The particular interest is to explore the stroke nurse specialist's experience of feelings of secondary traumatic stress. This has in part been fuelled by the earlier preparatory work. However, it has also been driven by the researcher's own emotive experiences provoked during the course of my work in the hyper acute stroke arena. Furthermore, the research aims have been stimulated by observation and descriptions of STS feelings by fellow stroke specialist nurse colleagues.

3.2 The study aims

Developing the research's specific aims is essential to the progression of the investigation. Doody and Bailey (2016) have described how this important aspect can prove difficult for novice researchers to navigate. However, with adaptation and refinement, the research question can influence all strands of the study that follow including methodological choices, methods, the sample, data collection and analysis.

The previous chapter discussed the literature describing nurses' experience of secondary traumatisation. Nurses' experience of secondary traumatic stress was described in terms of four key domains- exposure to trauma, trauma reactions, exacerbating factors and mediating influences. These studies were undertaken in the clinical areas of oncology, acute and emergency nursing. However, there has been no study of nurses involved in acute stroke care, who are arguably subject to similarly intense stresses and repeated exposure to patient's traumas and losses. Several elements were realized that have proved influential to the conception of this study's question and subsequent design. These elements include the researcher's own experience of these feelings, appreciating and observing their colleague's experiences and an attempt to quantify how many stroke nursing staff could be at risk of being traumatized. Watson (2016) has discussed the value of undertaking pilot studies to the refinement of the main investigation. A point prevalence study of burnout and compassion fatigue amongst stroke unit nursing staff (of all grades) was undertaken in which the researcher was a co contributor (Fitzsimmons, Lopez and Wilkinson, 2014. Appendix 1). The results indicated that staff was at moderate risk of burnout, with a smaller proportion being at risk of secondary traumatic stress. This brief and unreported investigation was independent of any further appraisal and therefore not a true pilot study, the findings were nonetheless influential to this researcher's thoughts. The results inferred those nurses working in acute stroke units are at risk of secondary traumatisation. However, it did not describe their experience of it.

Edwards (2014) has argued the principles of originality in research and in particular doctoral study. In one sense this study demonstrates originality in that his area has not previously been investigated. It was envisaged that this enquiry would add to the knowledge base concerning the experiences of stroke specialist nurses and the emotional demands that their role in acute care stimulates. The research questions are harmonious with those identified at the outset of this inquiry with the aim being to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations and included:

- To explore if stroke specialist nurses experience feelings of STS through their care of acutely ill patients presenting with cerebrovascular events.
- To examine in what circumstances these feelings might occur.
- To reveal what factors, exist which could exacerbate or relieve STS feelings.
- To explore what could be the potential implications for nursing care and stroke service provision.
- To highlight the possible impact on stroke specialist nurses' professional and private lives

3.3 Research Design

Research design refers to the strategy adopted that will effectively answer the research question (Achora and Matua, 2016). The research design should make clear all of the steps that lead to the production of valid and reliable evidence including the area under examination, the sample, data collection and analysis. This study used a qualitative methodology. Qualitative inquiry aims to investigate individuals' behaviours, experiences, opinions and attitudes, considering the effects of events on people and the influence of culture and social groupings, with a view to producing rich and in-depth descriptions of the phenomena under consideration (Welford et al, 2011). It can furthermore be viewed as a strategy to explain the nature of reality and its social construction, the relationship between the researcher and the area of interest and the situational constraints that shape the study (Silverman, 2010). This study aims to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations. It is therefore offered that a qualitative research design is harmonious with the research aims.

Welford et al (2013) have described the most frequently used qualitative methodologies in nursing recording a vast array of methods employed to capture and analyse data. However, when choosing a method of inquiry, researchers must reflect on their own set of values and beliefs, the connection between the self and the research, and the theoretical basis of the intended approach (Gangeness and Yurkovich, 2006). Furthermore, clarifying and making clear the assumptions underpinning a methodology, and the methodological choices made throughout the research, are core features of credible robust research (Cote and Turgeon, 2005). It can be argued that the investigators world view and philosophical assumptions may impact on the conduct of the research. It is therefore considered necessary that the researcher's reasoning in regard to this is made explicit.

3.4 Ontology

According to Guba and Lincoln (1994) ontological assumptions refer to the conceptualization of the nature of reality and human's knowledge of it. An individual's ontological stance can be therefore regarded as their view of how the world exists and the way in which they interpret it (Creswell, 2016). On consideration of the research question and its focus on trying to understand the nature of the specialist nurse behaviour, the researcher identified their ontological stance as one of a ‘subtle realism’. Hammersley (1992) proposes subtle realism as acknowledging that external reality exists independently of beliefs and understandings. It is however only knowable through the human mind and socially constructed meanings (Snape and Spencer, 2003). The concession made by subtle realism is that all research involves subjective perceptions and observations, and those different methods will produce different pictures of the participants, meaning there is no incontrovertible truth or definitive method to access it (Hammersley, 1995).

3.5 Epistemology

Epistemology refers to the generation of knowledge, gravitates towards questions of what knowledge constitutes, the identification of reality and how the researcher relates to the researched (Creswell, 2014). Snowden (2014) has stated that there is no agreed definition of knowledge, offering that it consists of a number of cognitive processes including belief, perception, association and reasoning. However, an epistemology makes claims or assumptions about the reality of knowledge (Blaikie, 1993). Epistemology is a theory of knowledge, of what can be known and what criteria are applied to justify it being knowledge (Petty et al, 2012).

The researcher’s epistemological position was directed by social constructionism. Crotty (1998) predicates that in social constructionism all knowledge, including all meaningful reality, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within a social context. Welford et al (2011) argues that constructionists are epistemologically subjective and has realized the value to nursing research where the investigator aspires to gain an understanding of how a phenomenon is interpreted in practice. It offers possibilities to appreciate multiple constructed realities, is value bound and demonstrates that the relationship between the knower and the known are interlaced.

Narrative has been reported as sharing underlying assumptions with constructivism, maintaining that that we understand ourselves and our world by the way of subjective and culturally rooted processes (Spector-Mersel, 2010). The consonance between constructivist and narrative modes offers that reality is shaped largely by the way in which it is perceived, known, interpreted and responded to through stories.

3.6 Narrative approach

Human experience is nearly always communicated in narrative form where individuals relay their experiences in storied form (Marshall and Case, 2010). People use stories to shape their understanding of the world around them and convey meaning to others (Berry, 2016). Narrative research can be referred to as a mode of qualitative inquiry that collects and then analyses participants' storied data (Emden, 1998. Hoshmand, 2005). Narrative research has no single heritage or methodology and draws on epistemological influences sourced from philosophy, anthropology, sociology, psychology, sociolinguistics, ethnomethodology and literary criticism (Priest et al, 2002). Narrative has been identified as being both the phenomenon and the method, bringing diverse elements of experience, thought and feelings into a unified whole (Clandenin and Connolly, 1994. Polkinghorne, 1995), with the fundamental aim being to establish rich descriptions of individuals experiences (Casey et al, 2015).

Narrative has recently become an attractive methodology for nurse researchers with a subsequent increase being noted over the last few decades in nursing related narrative based studies (Kelly and Howie, 2007). Nursing practice is immersed in stories, both of our own experiences and the people that we care for (Casey et al, 2015). It can therefore be suggested that narrative research sits well with understanding the effects of health and illness on both patients and those that care for them (Frank, 1995. 2001. Riessman, 2003. Overcash, 2004). McCance et al (2001) have discussed using narrative methodology in exploring nursing practice. The discussion presents a set of dilemmas as to the identification of what narratives are and what they are not. Edwards (2016) makes a clear differentiation between narrative and story. Narrative is referred to as an account of events as experienced by the narrator. Story is described as the repeated telling or reading of an account by people other than the narrator. Paley and Eva (2005) offer a further distinction between the two elements. Their opinion offers a view of narrative as a rehearsed causally connected sequence of events. In contrast, a story is referred to as a specific form of narrative which has a causal sequence of events and organizes it in such a way to create a plot which has central characters, a problem, an explanation and a reaction. It is therefore possible to contend that all stories can be regarded as narratives, but not all narratives are stories.

The distinction drawn by the researcher conforms to the views expressed by Polkinghorne (1988) whereby a story is a representation of events or experiences expressed in a way that can be understood by others and that narrative is the form or process of telling stories, while narratives refer to the unique stories of individuals, which are distinct in content and plot. Edvardsson et al (2003) postulates that most academics treat narratives as discrete units, with clear beginnings and endings. This has been expanded to describe stories as having structure being possessive of a start, middle and an end, the openings and closings offering a unity and coherence (Mishler, 1995). Polkinghorne (1988) has also noted the importance of stories having a sequence and a plot. This has importance in linking happenings temporally, demonstrating the effect that events have on each other. In the broadest sense, narrative is given as any spoken or written presentations (Polkinghorne, 1988).

The conviction is that story and narrative are two separate but nonetheless intertwined elements. However, the terms narrative and story are often used interchangeably within studies. This can have the effect of producing blurred boundaries and confusion (Carson and Fairburn, 2002). In order to mitigate against ambiguity, this study will refer to the terms of story and narrative synonymously and will aim to adhere to the maxim that is most suitable to this enquiry's aims, 'a narrative is a story that tells of a sequence of events that are significant for the narrator and his or her audience' (Denzin, 1989, p. 37).

As this study is concerned with nurses 'stories' of their experiences it is of a qualitative nature and the method applied will be that of narrative enquiry. The narrative approach considered and adopted in undertaking this study follows that of Polkinghorne (1988) and his theory of narrative meaning. Kim (2016, p. 190) has provided a succinct commentary on this work stating how Polkinghorne posits that narrative inquiry is a means to understanding human experience through stories. These stories allow us to understand the human phenomena and human existence. According to Polkinghorne, the ultimate goal of narrative inquiry is to understand meaningful human experiences. He defines narrative meaning as 'a cognitive process that organizes human experiences into temporally meaningful episodes. It concerns diverse aspects of experience that involve human actions and the events that affect human beings. Human actions are influenced by this meaningfulness which is projected in stories and narratives. In view of Polkinghorne's treatise, it was considered that the implication of finding meaning from stories to gain a better understanding of events and experiences was an appropriate approach to inform the research.

Narrative enquiry relies on narratives or stories for data. People use stories to shape their understanding of the world around them and to convey meaning to others (Berry, 2016). Narrative research concerns itself with the person's construction of knowledge from the reconstruction of experiences (Clandinin and Connelly, 2007). The method is justified in that narratives/ stories allow nurses to understand the tensions from previous practice which affect their meanings of nursing in the present and shapes understandings for practice in the future (Chan, 2005). It also provides an opportunity to understand oneself, being able to reflect on who we are what we do and engage with real life problems (Carson and Fairbairn, 2002). Further discussion is given to the elements of reflexivity and positionality later in this chapter (section 3.11).

Mattingly (2008) has examined the relationship between narrative and cultures. Communication is influenced by culture and its social context. Individuals draw from a cultural repository of stories that they develop into personal ones. Individuals therefore describe themselves in specific social contexts. Narrative research refers to the importance of cultures and the way in which individuals position themselves in relation to other's differences and similarities (Cobley, 2004). Furthermore, narrative enquiry can be used to improve the understanding of groups, communities and contexts (Marshall and Rossman, 2006). It is argued that this study not only examines individuals and their responses to trauma, but also investigates the culture which they inhabit and how the community mores are contributory.

Riessman and Speedy (2007) have deliberated over how identities are constructed through storytelling. Identities are forged through the stories that individuals tell about their lives. Essentially, people become the stories through which they tell about their lives. Stroke specialist nurses practice incorporates the traditional caring role but also sees them to take on many of the duties formerly ascribed to medicine. This has implications for identity- how they view themselves and how others also perceive them. The choice of a narrative methodology was therefore deemed as appropriate to examine this important aspect of stroke specialist nurses practice and identify its place in trauma reactions.

At present no study of STS in nursing populations has used a narrative methodology to garner and analyse data. It is envisaged that this methodological approach will be the foundation for a meaningful and valid exploration of the phenomenon of STS in stroke specialist nurses. It is appropriate to the aims of the study and is a relevant means to answer the research question.

3.7 The Participants

Recruitment of participants is one of the major elements of a research study, with failure to give sufficient attention to the process being cited as an oversight in terms of the research design (Jessiman, 2013). The requirements and challenges of quantitative and qualitative sampling differ. In quantative sampling the aim is inference to a population. In qualitative studies, the sample is chosen not to represent others, but for their likelihood of having information on the phenomenon of interest (McCrae and Purssell, 2016). In qualitative investigations the emphasis is placed on the quality of the information garnered and not the number of informants (Patton, 2002). However, it is important that the researcher makes reference to the procedures followed to obtain the sample as insufficient detail may cast doubt on the methodological approach, findings and overall quality of the study (Coyne, 1997).

Initially, the sample was to be a purposive one of stroke specialist nurses. Purposive sampling involves the conscious selection by the researcher of certain subjects or elements to include in the study that are best suited to answer the research question (Etikan, 2016). There was a similarity with theoretical sampling in that there was a purposeful selection of the sample in the initial stage (Robinson, 2014). However, the sampling strategy was not based on the data collected or the themes emerging from it. This study aimed to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations and did not seek to explore any other discipline or groups experience of STS. The approach therefore was made in relation to the participant's all being members of the same group, that being, exclusively stroke specialist nurses. In this respect, the sample could also be referred to as homogenous (Holloway and Freshwater, 2007). Although the researcher's position is not that of an SSN, their role does include responsibilities which have similarities with theirs (assessment, investigation, diagnosis and involvement in the delivery of interventions). The researcher has knowledge of their role through their position clinically and as an SSN manager. They also have experience of the area and topic under investigation (hyper acute stroke care and STS). As one stroke nursing professional in dialog with another, it allowed an insider privilege of understanding the context of the participants work and an appreciation of the situations that might provoke traumatic reactions.

Most studies require a provisional decision on sample size at the initial design stage. Without this being given consideration, the duration and required resource allocation of the project cannot be ascertained, making planning difficult. A priori sample specification need not be a fixed number, an approximate sample size range can be given with a minimum and maximum (Robinson, 2014). Qualitative theorists have not been able to reach agreement on an optimal sample size (Beitin, 2012). Furthermore, Holloway and Freshwater (2007) have stated that there is no fixed sample size in narrative research and have given example study sample sizes ranging from 4 to one involving over 40. Kvale and Brinkmann (2009) has suggested that the number of interviews in interview studies, at the time of writing, tended to be around 15 plus/minus 10. The initial aim was to recruit a minimum number of 4 participants, with an upper limit of 25.

An important consideration when discussing qualitative sampling is the concept of saturation. Data saturation is reached when the ability to obtain new information has been attained and when further coding is no longer feasible (Fusch and Ness, 2015). In narrative research, saturation occurs when new interview data do not yield any new knowledge but confirm or are redundant with what has been found in the existing data. Achieving data saturation will therefore have implications for determining sample size. The concept of saturation is divisive (Mason, 2010). Guest et al (2006) have referred to saturation as one of the key quality markers in qualitative studies and the gold standard by which purposive samples are determined. However, Kim (2016, pp. 160-1) has highlighted that in qualitative investigations there will always be new things that unfold making true data saturation difficult to achieve. If data saturation is to be pursued, the strategy for it needs to be made explicit when discussing the data selected for analysis (Fusch and Ness, 2015). The researcher’s opinion with regards to saturation finds some agreement with that of Suarez-Ortega (2013) whereby the interviewee has exhausted all relevant stories that they wanted to share. However, it was believed that of greater importance was that of securing a depth and breadth of data that allows for the research questions to be answered effectively.

In order to access a sample appropriate to meeting the study aims, a number of relevant national forums were contacted. Gatekeepers have been described as someone who gives access to potential interviewees, but who are not necessarily actually involved in the research themselves (Miller et al, 2012). Gatekeepers (the secretariat) of the Cheshire and Merseyside Stroke Specialist Nurses Forum, the National Stroke Nurse Forum, the Scottish Stroke Nursing Forum, The Northern Ireland Multidisciplinary Association of Stroke Teams (nurse leads) and The British Association of Neurological Nurses were contacted by email.

Marks et al (2017) have referred to the difficulties recruitment can afford novice researchers, stating that the process is often underestimated, so much so that the operation can leave the investigator feeling frustrated. No response was obtained from any of the nurses who were members of the Northern Ireland Multidisciplinary Association of Stroke Teams. Similarly, no expressions of interest were realised from the British Association of Neurological Nurses. Initially, most expressions of interest were reported from the National Stroke Nurse Forum (membership covers England and Wales) and regionally from the Cheshire and Merseyside stroke network nursing contingent.

Access to the Scottish stroke nursing populations proved to be stymied. The Scottish Stroke Nurses Forum has its own research committee responsible for granting approval for anyone undertaking research to access its members. All of the information relevant to the study was sent to the forum in the first instance. However, the committee secretariat wanted further clarification with regards to the sample, the environment in which the research would be conducted, further participant information documentation and confirmation of university study and ethical approval. There exist a number of differences in service provision between English and Scottish stroke services. Although there are beds allocated to thrombolysis, in Scotland not all areas where thrombolysis is undertaken are referred to as ‘hyper acute areas’. Another issue relates to stroke nursing designations. In Scotland it would appear that many individuals referred to as being a ‘stroke specialist nurse’ work in rehabilitation areas (the community). There is in this respect a similar problem in England in that many nurses who are involved in hyper acute stroke care are not privileged with the title of specialist nurse. The proliferation of roles and titles could prove problematic in relation to recruitment. It was therefore decided that the sample’s key characteristic is any qualified nurse who is involved in the specialized area of acute assessment and treatment for hyper acute stroke patients. The researcher supplied all of the information that was asked of the forum, particularly my intended participants, full study details (including information sheets and consent forms) and the university ethical approval. Having been satisfied by the relevant information, the Scottish Stroke Nurses Research committee agreed to let its members make expressions of interest. A number of these nurses were recruited, all of which were into the electronic arm of the study.

McFadyen and Rankin (2016) have documented the responsibility afforded to gatekeepers in their role of allowing or denying the researcher access to potential participants. The researcher had been frustrated by what was considered to be excessive demands by the Scottish Stroke Nurse Forums gatekeepers. However, on reflection, there was an eagerness to recruit and what was an over sensitivity to what appeared obstructive. The researcher came to appreciate that gatekeepers need to be assured how the studies given their consideration adhere to ethical principles. Furthermore, there is a responsibility to protect participants. Given the sensitive nature of this study, it was acknowledged that the forum was appropriate in its actions.

3.8 Data Collection

Healthcare research aims to understand its participant's experiences and adopts data collection methods that enhance the ability to capture the truthful essence of that experience (Dibley, 2011). Spector-Mersel (2010) and Carter and Little (2007) have described how ontology and epistemology guide methodological choices. The researcher's ontological position was that of a subtle realism. This makes reference to how different methods will produce different pictures of the individuals under investigation. Their epistemological stance was that of social constructionism. This advocates that meaningful reality is constructed out of interactions between human beings. The ontological and epistemological positions led the researcher to select the best method that will produce the best data to answer the research question. Corbally and O'Neill (2014) have stated that narrative can take place through either written or spoken media. The method of data collection was through a mixture of written texts and semi structured interviews- methods identified as appropriate to this methodology (Holloway and Freshwater, 2007) and in keeping with the ontological and epistemological standpoints. The data was collected using two distinct means- emailed texts and through face-to-face interviews.

3.8.1 Data Collected by email

An alternative means of data collection proposed in this study was to ask participants to contribute their stories by email. Walker (2013) has identified online research methods as being an efficient, economical and safe means of data collection. In addition to this, Toronto (2017) has cited electronically garnered data as being favourable in terms of being inexpensive and convenient. Furthermore, it avoids the need for data transcription, hastening the propensity for prompt data analysis. There also exists the potential to safeguard participants from having their responses unduly influenced by the researcher which could occur in face-to-face interview scenarios (however the narratives supplied by the respondents are influenced by their perception of what the researcher wants). There is the advantage that participants are able to compose their responses in their own familiar environment and at their own pace. However, respondents need also to maintain a sense of focus, direction and discipline in producing and returning their data, with Meho (2006) stating it may take them longer to complete this. Using this approach calls for considerations of data security, confidentiality and anonymity. The same level of assurances must therefore be made as the more traditional methods of data collection (Walker, 2013). Opdenakker (2006) has also identified how spontaneity, often the basis for richness collected in some qualitative interviews, will also is lost to this process. Arguably, the greatest disadvantage of using email instead of an interview is that other, valuable non-verbal data, such as facial expressions, body language, laughter, voice tones and even tears will be lost to the interpretation (Meho, 2006). Despite these reservations, emailed narratives were used as part of data collection strategy. The ability to collect data by electronic means was beneficial in that it allowed the researcher to have widespread access participants in areas which would have been geographically difficult for me to attend (Cantrell and Lupinacci, 2007). This included access to large, centralized hyper acute stroke centres and more disparate regional/ localized services. On a personal level, data collection via email has a positive impact on saving money and time away from clinical duties that would both be given up to travel. However, the overall feeling was that by utilising this data collection method (along with face-to-face interviews) it would be possible to capture the required data to build the overarching narrative of SSN’s experiences.

The data was collected by ‘asking for stories’- the story being specifically asked for by the researcher attempting to access the thoughts and feelings of the participants (Czarniawska, 2004). The specialist nurses who expressed interest in the study were emailed the participant information sheet. On agreement to be involved, the contributors were sent a list of guiding questions, the lead question being ‘please can you tell me in as much detail as possible of any events related to your specialist hyper acute practice that have made you feel traumatized or distressed’. The emphasis was placed on acquiring data with ‘as much detail’ in the anticipation of obtaining stories that had both context and content (setting the scene, the background to the event, what happened, which characters were involved, what was the outcome). The specialist nurses would be asked to contribute demographic information and their descriptions of traumatic/ stressful experiences related to hyper acute stroke care with the questions being used to guide their responses.

3.8.2 Face to Face Interviews

Kim (2016, pp. 94-7) notes that knowing how to ask good questions is paramount in generating meaningful narrative data, further offering that at interview, open ended questions encourage more thoughtful and personally meaningful answers. It was concluded that the interviews would be undertaken using semi- structured questions. Bold (2012, pp. 103-4) has referred to semi structured questions being used at interview as being able to guide the data collection rather than dictate its direction. Core questions can be used to maintain focus along with flexibility being used to clarify points raised by the interviewee. In using open ended questions, the interviewer can make decisions about the content and nature of the interview as it progresses.

Agee (2009) has commented that researchers often find the process of developing interview questions difficult. Carson and Fairburn (2002) have deliberated on the use of questions to generate narrative data. Their paper opines that narrative precludes preconceived questions with no particular theory to orientate questions around, insisting that the main focus should be on the respondents' story. However, the researcher also reflected on what had influenced my thoughts on what questions required asking. The use of an overarching STS framework (Dutton and Rubenstein, 1995) has been given consideration in the study's design. It was felt that this was of greatest influence when cogitating on the development of questions to ask the participants in relation to their experiences. The researcher reflected on the key elements of this STS framework- the role of exposure to traumatic events, the experience of trauma reactions, personal and environmental factors in the course of STS evolution and coping strategies as a response to trauma. Following this a set of interview questions was developed to put to the participants that was felt to be in keeping with the aims of the research and would allow the best access the participant's narratives.

Doody and Noonan (2013) have discussed the use of semi-structured interviews using pre-determined questions and advocate the use of an interview guide to collect comparable data from the participants. A set of guiding questions was developed by the researcher with the aim of collecting similar types of data from all participants-that is their stories related to their experiences (appendix 3). This guide was the same as that used for the electronic data collection. However, at interview the questions used were employed more as a guide for enabling individuals to recount their encounters, evolving with and to each respondent. On further reflection, it was felt that undertaking semi structured interviews using open ended questions elicited rich narrative data. Riessman (2008) has discussed the relationship between the researcher and interviewer and how dialogue between the two constructs the story. The researcher's interviewing style was one that allowed them to have influence within the data and its evolution but also one that would promote the flow of the narrative. The approach to the interview was with the intent of hearing stories and used an interview style that opened with a question which invited stories from the participants, exemplars being, 'can you tell me about that?' and 'what was the experience like for you?' (Riessman, 1993, p. 55). However, the researcher also at times restricted their intervention, particularly when the narrative was in full flow and used purposeful questioning afterward to seek clarifications or check omissions thereafter (Kelly and Howie, 2007).

As a novice qualitative researcher this investigator did not find the interview process easy. Despite the similarities between them and the specialist nurses professionally, interviewing people who were previously unknown in places that was unfamiliar with was felt daunting. However, the more interviews that were completed the less awkward, more confident and engaged they became. It eventually was a part of the research process that they came to enjoy.

All the interviews were conducted within rooms attached to the clinical areas. Other staff members within these areas were made aware that research interviews were being undertaken within these rooms and were asked not to disturb the occupants. It was later noted that all these rooms were spacious enough for the purpose undertaken, were well ventilated and were afforded natural light. Interviews were undertaken at times convenient for the participants, that is, within normal working hours therefore ensuring that the research activity did not impinge on their private time.

All the interviews were undertaken within the hospital setting. Woith et al (2014) have described the potential barriers to conducting qualitative research within a hospital setting citing a lack of administrative support, environmental distractions, scheduling and time constraints as problematic. All of the participants who had agreed to be interviewed were contacted by email and/ or telephone to confirm a date and place where the interview could be conducted. Such preplanning aimed to minimise, as much as possible, barriers to undertaking the interviews. All of the interviews were undertaken in the participants own hospitals with the exception of two participants who agreed to be interviewed at the researcher’s area of practice. Jessiman (2013) has discussed the incentives for participants in research studies. It is necessary to explain why two participants agreed to be interviewed away from their own clinical area. The respondents firstly agreed to participate in the research. A request was made from them to also gain an insight into the researcher’s service and particular aspects of it (telemedicine). The researcher agreed to their request in combining the two ventures, resulting in the participants being interviewed in their area of practice.

Prior to undertaking the actual interviews, the study was described in person to the participants clarifying the study aims and the motivation for the enterprise. Reciprocity has been identified as story sharing that can be used in qualitative data collection to strengthen co-operative researcher/ participant relationships by fostering rapport and removing power inequities (Blythe et al 2013). The researcher shared their experience of hyper acute stroke and secondary traumatic stress with the participant. It was felt that being open and generous with their own personal experiences, giving clarity to their own aims and position, helped to forge equality and trust between both the researcher as the investigator and the respondent (Rhodes and Carlsen, 2018). The researcher was mindful that this had the potential for influencing the participant in them offering up their experience of what they considered that they might want to hear. However, this was countered by the researcher's investment in an honest approach. All of the subjects were given copies of the participation information sheets and were allowed to read over the content prior to the interview. Following this, written consent was obtained from the participant and the interview commenced.

The duration of the interviews ranged between 27 minutes and 1 hour and 51 minutes. All interviews were audiotaped using an audio recorder. The interviewees were made aware that the data collection was to be through audio recording. No objections were made to this. The use of audiotaping in data collection is valuable as it grants the researcher a record of how the information was captured which in turn is critical to the analytical process (Al Yateem, 2012). The researcher was mindful that audio recording could potentially make the participants feel more self-conscious and cautious about what they may be willing to disclose. However, it was felt that audiotaping was the easiest means at their disposal to collect the interview data. The researcher tried to make the audio recorder as unobtrusive as possible. However, there was concern regarding the equipment's ability to clearly capture the respondents' words. The interviews recordings proved to be of high quality in terms of both sound and content. The greatest concern was regarding a technical failure with the recording device. Having travelled over a hundred miles to undertake one interview, the researcher found the audio recorder was not working. This could have resulted in lost data, time and ultimately credibility. The solution was to ask the clerical staff at the hospital to have the use of one of their recorders. In the event, the researcher got their own equipment to work. However, there was a valuable lesson learned for any future research requiring audiotaping- ensure the equipment is reliable and ensure there is a contingency.

3.8.3 Field Notes

Following each interview, the researcher made comprehensive field notes in their research Journal (examples are offered in appendices 4 and 5). These entries were composed on each occasion whilst travelling back from where the interview had been undertaken (notes from the interviews undertaken in the researcher's own area of practice were completed in their own office directly afterwards). Early note taking was considered beneficial given that all aspects of the interview had remained fresh in the mind. The researcher then reflected again on the notes later that evening when at home. These notes formed a collection of their memories, impressions and ideas related to the data collection. Events were described in full, including impressions of characters, their social setting and how the interview went. However, it is not just a description of what went on behind the scenes (Ellis et al, 2011). The thoughts compiled in these notes offer a level of reflection which is arguably the researcher's own personal narrative of my research journey (Watt, 2007). It was felt that these descriptions offered a context to the research and how it was undertaken. Moreover, by re-ordering the material and making connections within and outside of the interview, the process can be regarded as the beginning of the analysis (Wengraf, 2001).

3.9 Ethical Approval

Given the importance of ethics for the conduct of research, many different international professional associations, government agencies and universities have adopted specific codes, rules and policies related to research ethics (Resnik, 2012). The responsible conduct of research calls for researchers to adhere to the guidelines of the organizations to which they are affiliated (Steneck, 2006). Generating original knowledge through a PhD programme includes meeting the moral and legal obligations stipulated by the respective academic institutions (McAreavy and Muir, 2011). Prior to writing the protocol for ethical approval, the researcher's reading led them to an appreciation of other disciplines use of ethical guidelines (for example the British Psychological Society Code of Human Research Ethics, 2014). Such reading fostered a greater ethical awareness that was helpful in understanding the requisites of an application for ethical approval. However, the understanding of the ethical standards required for research was guided by discussions held with the researcher's supervisory team. This also ensured that the application for ethical approval followed the university's academic ethical framework. Ethical approval was sought and obtained from the university ethics board without any alterations being required of the original protocol (appendix 6). Further to this, no subsequent issues were raised that required a resubmission for ethical approval.

3.9.1 Consent

Informed consent based on the principles of autonomy is the foundation of ethically sound research (Byrne, 2001). The consent process was governed by three elemental considerations- the individual is capable of making their own decisions, they are acting voluntarily, and they have been provided with the requisite amount of supporting information to enable them to make an informed decision (Twycross, 2009). All individuals had the right to choose if they would like to participate in the study or not. Regardless of inclusion or non- participation, the choices made by the respondents were respected. Originally, there were two individuals expressed an interest in participation who did take part in the data collection. One withdrew, explaining to the researcher that she had left the stroke service due to stress and did not want to be reminded of her experience. The other individual failed to make further contact after three attempts were made to ask if they still wanted to be involved. All of the individuals who agreed to participate electronically were supplied with the study information leaflet and the devised consent checklist/ form (appendices 7 and 8). In addition to this, all were supplied with the researcher's contact details if they wanted to discuss any aspect of the research (this also applied to those who had agreed to interview).

All of the individuals who agreed to participate were asked for their consent which was obtained either electronically or by written means. Wester (2011) has discussed research coercion in terms of not respecting individuals' right to decide not to be involved in research. In gaining consent face to face, certain individuals may feel 'obliged' to participate. Gaining consent electronically can be seen as advantageous in that it can reduce the potential for coercion. Wang and Geale (2015) have described the need for researcher transparency at this point. A full explanation of the study at this juncture helps to foster a sense of trust in the researchers' motives and the research relationship. Elmir et al (2011) have discussed the application of self-disclosure. This involves the researcher revealing information about themselves to the participant. This can result in greater engagement by participants in the data collection process. However, it does also carry the potential for confusion with there being a blurring of boundaries between the researcher's role as a healthcare professional and an investigator (Dickson-Swift et al, 2008).

The researcher believed in the possibilities offered by this direction. The individuals who had agreed to participate electronically were sent (along with the information sheet and consent form) a copy of a reflective clinical scenario that described the investigators experience regarding STS. Alternatively, the individuals who were interviewed had the same scenario described to them prior to obtaining consent. It was felt that this assisted not only in describing and elucidating the researcher's own personal interest in the study, but was also an expression of openness, rapport and sensitivity.

Allmark et al (2009) have discussed the ethical steps required for data collection and in particular interviews. As the electronic respondents' identities were removed following receipt of their data, the respondents were thanked in advance for their co-operation. Following the interviews, the opportunity to ask questions and offer viewpoints was given. All participants were given the option to contact the researcher at a later point if they felt this was required. No further contacts were made by any of the respondents.

3.9.2 Avoiding Harm: the participant

Ethical issues are particularly germane to narrative research. Individuals may be asked to contribute their stories of experiences which may prove emotive. Revisiting potentially sensitive and long submerged events requires great responsiveness on behalf of the researcher (Larsson and Sjoblom, 2009). Although the participants' narratives do not necessarily equate to them being vulnerable, an appreciation was realised that some aspects of their data had the potential to be sensitive. However, the data must be engaged with to attain an understanding of nurses' experiences. Being cogniscent of the potential for participants to relive traumatic incidents during the data collection, familiarity with the university distress protocol for qualitative data collection (Haigh and Witham, 2014) was made and could be employed if it was deemed necessary.

What is nonetheless problematic in electronically garnered data is the difficulty in gauging respondent distress (Walker, 2013). The potential for participants encountering distress was referred to in the study information sheet. This advised that the data collection could be suspended, or study withdrawal could be enacted at any point. The complexity remains that the responsibility for recognition of discomfort and potential discontinuation rests with the participant.

3.9.3 Avoiding Harm: the researcher

In comparison, exposure to such sensitive material can be potentially unsettling. However, what is also of concern is where researchers have had experience of the topic in question; it may affect how they experience participant's emotions (Petty, 2017). The researcher's practice is rooted in the area under investigation where there has been personal experience of the issues under examination. A strategy of confidential debriefing with the investigator's research colleagues as described by Ashton (2014) was undertaken to address my own emotional responses.

3.9.4 Maintaining Confidentiality/ Anonymity

There exists a moral obligation to protect the privacy of participants and ensure anonymity regardless of if the data was collected electronically or via face-to-face interviews. Anonymity is an assurance that participants' identities will not be divulged. The overriding principle of confidentiality in research is that the generated data is only used for the purposes to which the participant has given consent (Saunders et al, 2014). It is suggested that identities, places and any other identifiable materials be disguised (Ummel and Achille, 2016). All individuals involved in this research, along with their areas of practice were allocated pseudonyms to preserve anonymity.

McDermid et al (2014) have discussed the issues related to conducting qualitative research in the context of pre-existing peer and collegial relationships. The researcher is part of several regional stroke related networks that involve face to face participation with individuals who were voluntarily recruited into the study. None of the sample was aware of the other’s responses. To reiterate, all individuals and service providers (organizations) were anonymized.

Electronically collected data and consent forms were returned to my secure university email. The returned data was immediately downloaded. In order to safeguard confidentiality and anonymity, the respondents identifying email address was deleted. At no point was any participant known to anyone but the researcher. All participants were assured that the data collected was for the sole purposes of this study. The data was securely housed and was inaccessible to any other individual other than the researcher, thus ensuring confidentiality was maintained.

3.10 Data Analysis

Researchers who are engaged in narrative studies look to find methods that help them to both define their object of investigation and study it (De Fina and Georgakopoulou, 2012). They adopt strategies that will project a particular meaning to the hitherto collected data. In short, life is not stories turned into text- it requires interpretation (Price et al, 2017). However, narrative data analysis can be problematic with multiple approaches to it having been reported (Robert and Shenhav, 2014).

As a novice researcher, undertaking wide reading on narrative data analysis, this researcher became preoccupied with selecting what they considered the right ‘fit’. Their thoughts were consumed by being able to justify my choices at a viva. They recognized what was the danger of becoming blinkered by the use of analytical frameworks and of being rigid in their belief that they could only adopt a singular approach to appraising the data. However, they became aware of Edwards (2016) suggestion that narrative research is flexible to multiple and novel approaches to data analysis. In Creswell's (2007) assertion that narrative researchers create data analysis procedures appropriate to their study, further reassurance was found.

Polkinghorne (1995) has referred to paradigmatic analysis of narratives. This moves from stories collected as data- autobiographical accounts of personal experiences, describing how and why events occurred and the actions resulting from them presented in a chronological order with the elements of beginning, middle and end- to common elements or themes that cut across the stories, characters or settings to produce general concepts. The purpose of paradigmatic analysis or to use its other term, the 'analysis of narratives', is to not only illuminate categories, but to give description to the relationship between them. This can be done deductively by applying theory to data, or inductively by allowing themes to emerge and concepts to develop from the stories (McCance et al, 2001).

An alternative approach offered by Polkinghorne (1995) is what is referred to as 'narrative analysis'. The data here can come from a number of sources that are not always that of a story- the actions, events or experiences being reported without temporal arrangement. These actions and events are subsequently integrated into a temporally organized whole and configured to that of a plot. The plot is the thematic line of the narrative, with different events contributing to the analytical development of a narrative. In this case the plot being that of a presentation of hyper acute stroke, the characters involved (patient, relatives, SSN, doctors, nurses) and the traumatic event. The resulting narrative must not only fit the data but result in a series of constructions that offer a new understanding of a particular situation (Smeyers, 2001).

There are inherent distinctions to be found in both approaches. In analysis of narratives, the narrative is the source of knowledge. The ‘narrative’ in narrative analysis is the result of the composition of the story from the data (Smeyers and Verhesschen, 2001). The strength of paradigmatic analysis is its capacity to generate knowledge, whereas narrative analysis provides insight and understanding about the people being studied (Coulter and Smith, 2009). The researcher held the initial impression of data analysis that a single approach would be used. However, the data at their disposal was varied. Some of the electronic data was that of a fully formed story. Some of the other electronically harvested data answered the interview questions reporting events, happenings and experiences. Meanwhile, most of the interviewees’ responses took the form of offering up or referring to stories. Contemplation lay with which form of analysis to follow- the paradigmatic or narrative mode. What the data was proposing was a mixture of both. Two papers that the researcher had read described data analysis techniques encapsulating both approaches (McCance et al, 2001. Howie et al, 2004). It therefore felt that this route was appropriate to this study.

The data collected yielded a substantial volume of material. Electronic data was downloaded immediately. Audio taped interviews were transcribed by me in the form of handwritten drafts. The handwritten transcripts were then typed up using a word processor. The original audio recordings were replayed whilst reviewing the electronic transcripts to check for any omissions, hesitations, background noises and interruptions. These were included in the transcript and where appropriate are referred to in the data analysis. The electronic transcripts (from both methods of data collection) have then been subjected to multiple re readings. The transcription proceeded in tandem with repeated examination of the recorded data (Nikander, 2008). It followed the practice described by Goodson (2013, p. 40) in making handwritten comments on the transcript pages before adding them to the researcher's transcription notebook/ diary. Moving back and forth between the recordings and transcripts allowed for checking and rechecking for accuracy (Easton et al, 2000). The researcher also referred back to the field notes made directly following each interview, checking their impressions against the completed transcripts for context that could have a bearing on interpretation (Davidson, 2009). Tessier (2012) has commented favourably on an approach involving field notes, transcripts and working from tape recordings. The transcription format involved all of these approaches. It was time consuming. However, despite the process being laborious, it enhanced accuracy and trustworthiness.

Initially the non- storied data was considered and subjected it to further re-reading. This led to an appreciation of what the content and context was. Emden (1998) has described methods for narrative construction that were appreciated as part of this analysis. The researcher's presence in the data collection (questions/ conversation) was retained in the text to demonstrate significance, context and impact. All non- essential words that would distract from the essence of the text were deleted. The text was then subjected to further readings and subtractions made until a sub plot remained. These were then moved together to create a whole story (core created story) describing the specialist nurses experiences related to STS (Priest et al, 2002).

The two variants of storied data were then subjected to a final stage of thematic analysis. Petty et al (2018) have discussed how after the story has been identified/ created it becomes itself the unit of analysis so that meanings can be extracted, and themes generated. The thematic analysis approach that was used in this study was based on that on Braun and Clarke (2006, *Table 2*). The data was re- read which allows for the identification of codes and identification of themes. Themes were then checked for consistency with the data. Further notes were added to the transcripts that highlighting ideas and similarities between data sets. Different sections of data were given definition/ names. The themes compared to each other, and this led to the establishment of themes and their associated categories (*Figure 7*). The analysis was to then look for patterns and connections across all of and between the themes identified. This resulted in the final report where participant’s extracts from the stories are used to illustrate the themes and are linked back to the literature in the analysis. Thematic analysis was appropriate to this study after finding agreement with Petty et al (2018) in that the focus of interest was the content of the story rather than how it was structured.

Table 2: Thematic analysis (after Braun and Clarke, 2006)

1. Familiarization with the data	Transcribe, read, re-read.
2. Generate Codes	Generate codes across the data sets.
3. Identify themes	Collate codes into themes, gather data into each theme.
4. Check themes	Reviewed to check are these themes consistent with the data.
5. Define and name themes	Refine each theme and the overall story. Generate clear definitions and names.

6. Report	Select most compelling extracts to illuminate themes. Link back to the literature. Produce oral or written evidence of the analysis.

This data analysis has also been influenced by the work of several narrative theorists, most notably that of Frank (1995) and Mattingly (1998). Both authors have commented extensively on narrative theory and its application in the biomedical arena. Cohn et al (2009) have argued that the categories discussed by Frank (and also by Mattingly) are relevant to the human condition and to the narratives that emerge from suffering, powerlessness and loss of control. The researcher offers that these elements are endemic to the experience of STS. In Jones et al (2012) study of medical students and their experience of traumatic and transformative events during their training, they opined that the stories they constructed were organized and understood by using similar conceptual categories to those used in illness narratives. This data analysis has been influenced by the researcher's belief that these conceptual categories have relevance to SSNs experience of STS. SSNs, are arguably subjected to similar traumatic and transformative experiences. Furthermore, as stroke care is framed within the biomedical arena, the researcher therefore finds that reference to illness narratives is appropriate to the analysis.

Following the analysis, the researcher opted not to return to the participants to check the findings with them. Although this is seen as a means of enhancing validity, it was believed that this strategy could be problematic for the researcher's subsequent interpretations. Morse (2015) has reasoned against the use of member checking as a strategy for determining rigor in qualitative inquiries citing how participants may disagree with the researcher's analysis. Paley and Eva (2005) have also stated that narratives can be viewed as accounts of 'how I want it to seem to you'. Furthermore, Emden (1998) has referred to stories as being in a state of flux. Participants may no longer hold the same feelings, may have forgotten or have regrets about what they have volunteered. This study has described specialist nurses' experiences which have been traumatic. The concern has been raised with regards to reliving what could prove distressing. This researcher's concern was therefore that it could potentiate this. Furthermore, Koelsch (2013) has opined that researchers cannot expect participants' subjectivity to remain static. The telling of any story is a unique event and can never be the same again (Dibley, 2011). The researcher affirms their opinion that the analysis remained true to what the participants offered. However, the researcher also appreciates their position within the generation of these data. The participants do not have a monopoly over what is considered to be the truth and its interpretation. Ultimately, this was the researcher's interpretation, and they affirm their belief in the ownership of their own perspective.

3.11 Reflexivity

Reflexivity has been defined as the continual process by which the researcher contemplates how personal experiences influence their professional work, an activity by which there is open acknowledgement and exploration of possible areas of subjectivity in their work (Carolan, 2003). The aim of reflexivity could be argued as the impact that the researcher has had on the research. What is central to this is an analytical process whereby the researcher questions how their beliefs, values interests, and assumptions have influence over the process. It has been referred to as a mode of examining the self, values, prejudices and influences and how this can lead to new insights being integrated into the research (Hand, 2003). This dynamic process of self-examination has been seen as beneficial as it allows researchers to gain perspective into their own personal bias, addressing preconceptions, whilst developing fresh insights and awareness.

Pellatt (2003) has examined the relationship of power and reflexivity in research. The researcher started to appreciate that they had power in their clinical position that could and should not be applied in the research activity. This caused them to reflect on their consideration for others. The researcher moved away from thinking about how they felt about interacting (interviewing) their peers, to contemplating their thoughts on the researcher interviewing them. An appreciation was being made of a change in the researcher's own values, along with a regard for other's thoughts and feelings. The researcher's practice is rooted in the area under investigation, and they have personal experience of the topic. Their situation could be considered that of an insider. Moore (2012) has discussed the influence of positionality when undertaking research. There is an advantage of a greater awareness, accessibility and understanding of the culture under investigation. However, this must be balanced against over familiarity, presumption and potentially losing the researcher perspective (Blyth et al, 2013). The role occupied by the researcher within their own stroke service placed them as a line manager for the 7 strong specialist nurse company. They have worked alongside each of these individuals over the last 10 years, personally recruiting them to my specialist nurse service. The researcher has seen the emotional investment that each one has made over time. Their experiences would have provided an excellent source of data for the study. However, given their proximity to the researcher as a manager (and to some degree as a friend), the potential for power imbalance and possible coercion, their involvement could not be given countenance.

Dickson- Swift et al (2007) have suggested that researchers involved in sensitive explorations need to have the ability to make assessments of how the research not only impacts on the participants, but also themselves. Sparkes and Smith (2012) have discussed the maintaining a reflexive research journal can help to shape analysis. The main focus of the reflexive approach was through giving thought to actions throughout the whole research process, documenting this in the researcher's research journal. This was further supplemented by notes made in and about the field and transcription notes. These actions allowed engagement in the analysis of not only the data and how it was collected, but also of the researcher's role within the research process. Etherington (2004) has termed this as 'critical subjectivity', the means of adopting a critical stance to oneself as a researcher. The focus of this has however not only been a critical reflection on this researcher's own place within the inquiry, but also on the process of knowledge generation and the factors that have influenced it (Guillemin and Gillam, 2004).

On reading over this methodology section this researcher feels that it is necessary to offer an additional commentary on the narrative approach used in this study. The researcher reports that they have been self- critical with regards to how they and others may perceive this study by asking to what extent it conforms to that of a narrative inquiry or one that is narratively influenced. The approach to narrative and how it is analysed can be varied (Riessman, 2008, p. 11). The adopted approach can be at the discretion of the researcher who may select and employ different methods that fall under the guise of a narrative investigation. This study has been aligned to that of a narrative methodology and it is believed that the approach committed to is justified as being one that holds narrative dimensions. Essentially this study concerns itself with exploring SSNs traumatic experiences related to hyper acute care. The understanding of these experiences is constructed on the stories of these events, the clinical culture in which they were composed and the feelings that resulted from them. The stories that have been collected as part of this investigation are the essential unit necessary to appreciating these specialist nurses' narrated lives.

This research has been influenced by the narrative teachings of Donald Polkinghorne (1988, 1995). These works have provided this researcher with a narrative structure that has been insightful for how to approach this inquiry. It has informed the choices with regards to the chosen methods. Furthermore, the appreciation of this narrative architecture has enabled this researcher to build their own grasp of the understanding of storied lives. The immediate approach of narrative analysis and analysis of narratives as described by Polkinghorne (1995) is justified by the desire to know the content and context of the story rather than being concerned with its composition and structure. The storied data was then subjected to a thematic analysis. The use of thematic analysis is not alien to narrative research (Riessman, 2008, p. 53-76). It has featured as the chosen analytical component in several narrative studies involving nursing populations (Davies et al, 2016. Petty et al, 2018. Castro and Andrews, 2018). By applying a thematic analysis to the specialist nurses' storied data, the researcher was able to extract the themes inherent within them, link it back to the STS nursing related literature and biomedical narrative theorists to expand and uncover new meanings.

The selected methods allowed the researcher to have the greatest appreciation of these nurses' experiences through their stories and be able to elevate them from the prosaic to the meaningful. It is felt that the approaches used to garner this insight are reflective of a narrative approach. The researcher believes this thesis to be both influenced by and inclusive of narrative methodology. Furthermore, is the belief that the findings justify the methods that were chosen and that the conclusions drawn from them are appropriate to refer to this study as a narrative inquiry.

3.12 Rigour, trustworthiness, and transferability

Tuckett (2005) has discussed the precepts relating to rigour in qualitative research reporting how research validity and reliability can be illustrated through the use of field notes, audiotaping, auditing and nurses' story. A number of these strategies were employed in this study. In addition, a research diary and transcription notes (examples featured at the end of the included data sections in the appendices) were maintained. On undertaking the data analysis, notes were also made which the researcher refers to as their own research log.

The role of truth and its place in narrative research has been previously debated (Ricour, 1984, p. 298. Riessman, 2003. p. 21). In narrative research storied evidence is gathered not to determine if events actually happened but is about the meanings of people's experiences related to it (Polkinghorne, 2007). Stories may describe the factual occurrence of events which offer a contextual value and emphasis to the interpretation (Lieblich et al, 1998). However, the focus lies on stories being the evidence through which personal meaning is generated. In this 'narrative truth', the subsequent interpretation is regarded as having truth value if the parties involved regard it as useful, the truth being taken to mean the perception of an event as understood by the person who experienced it (Bailey and Tilley, 2002). Narratives have been described as subjective, in a state of flux and fictional posing questions of validity (Hoshmand, 2005). However, despite narratives being described as fictive, they are not opposed to truth. Wiklund-Gustin (2010) has referred to narratives as ‘truthful fictions’-making sense from experiences rather than empirical facts. It could be stated that what was offered up for interpretation was the physical, psychological, occupational and social reactions to events that were both cogent and consistent. The researcher had confidence that this was the participants’ version of the truth as they experienced it. Although member checking was not performed in this research, the use of peer review as an alternative was considered. Peer review has been referred to as a type of ‘investigator triangulation’ (Tuckett, 2005) in which an objective other is asked to review the data collected and comment if this is a reflection of what happens in practice. One of the stroke research nurses who were not involved in any other part of this study was asked to undertake this. They are from a stroke specialist nursing background and spend most of their work time recruiting in the ED and acute stroke unit. They read over the collected data and volunteered that the findings were comparable to their experiences. In terms of other peer checking, the researcher also make reference to the records of their university supervisory sessions as it has also served as a further means of peer debrief.

Triangulation has also been discussed as demonstrating rigour (Bekhet, and Zauszniewski, 2012). The triangulation featured within the study was a methodological one describing the data collection by two differing means- electronically submitted data and interviews. The researcher holds that this enhanced credibility as using two different data sets, offers a more balanced explanation to readers, enriches the research and promotes greater confidence in the findings (Noble and Heale, 2019). It also validates the ontological stance of subtle realism whereby different methods produce different pictures of the individuals being investigated. Houghton et al (2012) have commented on the role of transferability in demonstrating rigour in qualitative research, stating that the researcher must provide the reader with descriptions about the interchange of findings to their specific contexts. The data analysis expressed this by use of contextual accounts, raw data examples using participant direct quotes and field notes.

3.13 Summary

This chapter has given an explanation to the research approach relevant to the investigation. The researchers' ontological and epistemological viewpoints have been addressed. The study aims have been illuminated alongside the succeeding research design. The theoretical basis of the narrative approach has been examined. All the relevant method's procedures have been described. Of particular interest has been the dilemmas posed by the multiple approaches to narrative data analysis. The researcher has discussed this and offered an approach which they feel is appropriate to the research's' purpose. The following chapters will go on to discuss the results derived from the analysed narratives.

Chapter 4: Results

4.1: Introduction

The following chapters will begin to offer an analysis of the collected data. Initially it will refer to the characteristics of the participants who were involved in this study (table 3). This data analysis has linked SSNs experiences of STS in their hyper acute practice to 4 themes- the cause and context in which these feelings occur, the SSNs experience of STS reactions, what exacerbates this and what strategies are employed to counter and alleviate it. These themes and their related subcategories are presented in Figure 8. The initial section concerns the context and cause of STS as described by the participants. The intention is to explore the stroke specialist nurses' subjective experiences of what they feel is contributory to becoming distressed. The specific aim is to form an understanding of these factors that they afford relevance. The interpretation of the data revealed several themes related to these nurses' experiences. Extensive data extracts are presented along with supporting evidence to emphasise this. The data extracts are individually described to give an appreciation of how they have formed the interpretations and to give clarity to readers who may be alien to stroke services and specifically stroke nursing practice. Description and discussion of the data will lead from there to offer meaningful interpretations of the stroke nurses experiences and lead to conclusions on the factors responsible for triggering STS in stroke specialist nurses. A concise summary of the findings will be offered as a conclusion. It will also address how this chapter contributes to meeting the research aims and what it adds to this thesis. Furthermore, it will refer to how this chapter has informed the narrative of the thesis itself.

4.2: Participant Characteristics

24 qualified nurses with the relevant stroke related experience were included as participants in this study. In total, 14 individuals' data was collected by face-to-face audiotaped semi-structured interview. 10 participants contributed their data electronically. Table 3 describes their collective characteristics. The participants whose data was used as exemplars in the following analysis sections have expanded references to their individual characteristics.

Table 3: Participant characteristics

Participant Sex	Female n= 22.
	Male n= 2.
Participant ages	31- 58 years (mean= 41).
Years in nursing	6- 37 years (mean= 21.5).
Years in stroke care	3 years- 20 years (mean= 11.5).
Participants by geographical area	England: n= 18
	Scotland: n= 5.

	Wales: n= 1.
Level of participants professional education	RN: n= 4.
	Diploma: n= 8.
	BSc: n= 6.
	MSc: n= 6.

The Cause and Context of STS
• Exposure to acute suffering • Young stroke presentations • Empathic engagement • The influence of moral distress • Interaction with families • Problematic healthcare systems
Narratives of Disrupted Psychological Landscapes.

• Apprehension/ anxiety • Insomnia • Intrusive thoughts • Crying • Hypervigilance • Avoidance
Narratives of Continuing Disruption
• Empathic investment • Dissonance • Powerlessness/ Hopelessness • The influence of life events • Work-Life balance • SSN role and identity • Lack of professional support
Narratives of Coping and Adaptation
• Narratives of professional and collegial support • Personal coping strategies: Catharsis/ family/alcohol/humour

Figure 8: Themes and their related subcategories

4.3: Trigger Situations. The Cause and Context of STS

Lavoie et al (2011) has discussed nurse's observation of suffering via three separate modalities: exposure as a witness, exposure as a victim and the circumstances in which the stressful/ traumatic event was encountered. The first part of the data analysis will refer to stroke specialist nurses' exposure to acute suffering. The analysis will highlight how the subthemes of involvement with young strokes, elderly people with stroke, high acuity and mortality, clinical uncertainty over interventions, outcomes and nursing roles, and empathetic engagement can be the basis for trauma development.

4.3.1: Exposure to Acute Suffering- Acute Presentations

This study relates to hyper acute stroke presentations focusing upon the first 72 hours after the event. None of the nurses who chose to take part in this study directly referred to prolonged suffering, but it could be suggested that suffering of any type is prolonged if it runs the length of this time frame. The principal cause of traumatic reactions was described by Melvin (2012) as repetitive exposure to serious illness and death. This researcher makes the observation that this is in keeping with the experiences of stroke specialist nurses, their data also having reported repeated exposure to ill and dying patients as being a factor for STS development.

Many of the stroke specialist nurses gave storied accounts of what they had felt to be traumatic or upsetting. A number of these stories referred to common stroke presentations-large strokes, decompressive surgery, catastrophic intracerebral haemorrhage, thrombolysis and thrombectomy (mechanical clot retrieval). While their stories included elderly patients, by far the majority reported as traumatic concerned young patients presenting with major strokes. The outcomes in these patients were generally not favourable and ranged from major disability to death. Several considerations can be raised from the data which begin to explain the nurses' trauma reactions related to these younger victims of stroke. All the stories refer to the acute nature of the presentation, but this is coupled to the sense that this should not be happening to someone so young that was previously fit and well. Many of the responses refer to rapid deterioration and death which was difficult for those involved to comprehend. The story offered by Laura referred to a 28 years old woman who was admitted with an extensive intracerebral bleed.

Laura's story

(Data collected electronically)

MW: Please describe in as much detail as possible your experience of hyper acute stroke care that resulted in you feeling stressed or traumatised (you may refer to as many examples as you like or need to).

> 'The following account is of a 28year old Mrs X admitted under the stroke team
>
> within an acute trust in *******. Mrs X was pre alerted to the stroke unit having suffered sudden onset of left sided weakness and headache with visual disturbance whilst driving. GCS 15/15.

Mrs X was met by me at the ambulance bay for a thrombolysis assessment. Her husband was with her. The paramedics informed me that Mrs X had just been incontinent and was distressed about this. I introduced myself and reassured her that we would freshen her up she confirmed her name. Mrs X was taken straight into the resus department. I began to explain to Mrs X the reason I was there and that I was going to carry out an assessment. As I turned to pick up my paperwork it was evident that Mrs X had suddenly deteriorated and her airway was compromised. I called for help and our intensive care doctors were called to assist. Mrs X was intubated and ventilated and taken to radiology department. The CT scan showed extensive intracerebral haemorrhage.

During this time I was trying to keep Mr X informed he was very distressed and I gave a brief explanation of what I thought was happening to his wife and that she needed to be put on a ventilator to keep her safe and that the CT scan would hopefully give us the answer. I did inform him that as a team we were very concerned about Mrs X and that he should inform other members of the family. Mr X chose to leave the resus department during intubation.

Whilst Mrs X was in radiology department the other family members arrived. I offered to speak to them as the doctors were tied up with other resus patients. I informed the relatives of the events leading up to admission and what had happened since. They were all distressed and crying unable to comprehend what was happening. They were naturally firing a lot of questions at me and one relative later informed me he was in fact a doctor and asked me directly if Mrs X could die from this.

> On transfer back for the CT scan Mrs X was transferred to the intensive care unit. All her family gathered at the hospital and when I returned to work the following morning I was informed that Mrs X had passed away. Her family had given permission for her organs to be donated.
>
> ‘I have been in stroke nursing for 19 years and 4 years as a stroke nurse specialist I have faced many distressing situations having to break bad news but often I am able to reason in my head that the person has lots of experiences, travelling, careers, marriage, children etc. Often families will say my wife/husband would not want to be disabled or needing care so this is a blessing. But being so young I felt Mrs X had been robbed of those opportunities. It made me question my faith and ask why? I often think of her and wonder how her husband is coping but these thoughts are momentary’.

In Laura’s story the plot is that of acute suffering in someone who is a young stroke presentation. Laura’s role in this story is threefold: clinically she is an SSN, she is the story’s narrator, main protagonist and she is also present in the role of a witness to the events described. We are drawn in by the drama of the acute events that she has been witnessed to. In her story she appreciates that the reader/ listener (her data was electronic) has an awareness of emergency stroke pathways as these parts of the narrative are not expanded on. The first element which is brought to the attention is the age of this woman- she is young (28). She has had a sudden neurological event that has required the emergency services to bring her to hospital. Her husband is in attendance. The first part of her story introduces the events in the routine fashion of a person admitted with an acute stroke who is being prioritised for potential intervention with thrombolysis. The woman at this point is still alert/ conversant and is seemingly more distressed by her episode of incontinence. Laura draws the listener deeper into the drama by detailing a series of events leading to rapid deterioration requiring intubation and the diagnosis of a large intracerebral bleed. As the situation worsens it is Laura who finds herself thrust into conversation with the woman's' relatives who are struggling to understand the situation. Laura has stated that she took on this responsibility given that all other medical colleagues are busy. Laura's role now becomes that of a communicator and in such is a surrogate for the medical team. The interpretation is that although information giving is part of her role and that she copes with the relatives' concerns, support appears to be lacking. The tension is increased by one of the relatives being identified as a doctor. The significance here is that the role possibly is one of someone who has knowledge and may be able to act as a spokesperson as they have some understanding and may be able to interpret the situation. The other family members present in this narrative also embody the role of concerned relatives who also need information to understand what is happening. Their role is further to bear witness to an unfolding tragedy in which they are impotent. The woman's journey terminates in ITU where she dies and is referred for organ donation.

This story has great personal significance for Laura. This is the story in all of her years that she has recounted as being traumatic. In it she expresses the themes of acute suffering, rapid deterioration and death. The age of this woman is significant. She expresses difficulty in understanding the situation she is confronted by that someone in the prime of life has died. Her position in the story is one of compassion but also one of having to confront a situation that should not be happening. The feeling of incredulity is perhaps surpassed by the thought of inequity at the thought of a future denied. Furthermore, the presence of distraught family and seeming lack of collegial support is interpreted by this researcher as adding to Laura's feelings of trauma. Laura personalises the story further in her reference to the outcome as a possible blessing when faced by the spectre of profound disability. She also noted how these events have made her question her sense of faith and asks why. For Laura there is resolution in that she is able to continue in her role. However, this story has clearly remained with Laura and is something that she often finds herself briefly reflecting on.

This is in many ways the most appropriate story to use for these data analysis. Frank (1995, p. 83) has discussed among his typologies a restitution narrative where the biomedical approach espouses that there is a cure for every illness. However, when the outcome does not mirror this (as in this case) the inverse of restitution, narrative chaos may ensue. In a chaos narrative futures appear desolate when compared to a past that offered so much (Sparkes and Smith, 2003, 2004, 2005). The end result is despair and loss of hope. Laura’s story is infused by these elements. Furthermore, she has introduced themes of acute suffering, uncertainty, death, and young people with stroke, family presence and support. These are themes that will be returned to throughout the course of these data analyses and the thesis.

Laura’s story can be compared to that of Claire’s narrative which similarly focused upon lives being robbed by the experience of stroke.

Claire’s story

(Data collected by interview)

Claire has been as SSN for 6 years. She works in a large inner city hyper acute stroke centre. Her story did not recall the death of a young patient. However, it told of her distress on contemplating what the future might be for a young man admitted with a severe acute stroke.

MW- ‘Can you describe any incidents or scenarios related to hyper acute stroke that made you feel stressed or traumatized?’

> ‘There was this one patient. He was quite young, erm, had lost his speech. He had a left MCA (middle cerebral artery territory stroke). He’s got no speech at all. A dense weakness. Incontinent. It’s all about your pain. So, then I find myself looking, oh gosh, he’s very young, he’s gonna be spending all of his life in a nursing home. You know and he’s young, what is the chance of him being happy? You understand although they might do all this activities in the nursing home that might not be what he wants as a young man’ (Claire).

In Claire’s story the primary character is the young patient and introduces the plot as concerning the experience of having suffered a large stroke. Claire’s role is that of a specialist nurse and who within the story is also cast as the narrator and witness to these events. She appreciates the listener as an insider by her reference to him having had an ‘MCA’ territory stroke. Claire vividly alerts the listener to the patient’s plight by giving name to a list of his profound symptoms. The story is significant for Claire in that she refers to her own sense of pain at confronting the situation that the man is in but by also contemplating what his future is likely to be. The man’s role is this narrative is that of one where they have been rendered as helpless by the misfortune of stroke. Claire places emphasis on his age and that given his disability, he is (in her view) unlikely to have a happy or fulfilled life. She recasts or adds to his role in this narrative as someone who is not only helpless but hopeless. The listener is drawn deeper into the story by Claire’s conclusion as questioning the man’s future happiness and the potential that has been denied to him by a severe stroke. Here hers is the voice of compassion and concern. Claire’s story forces the listener to focus again on the disparity of young lives disrupted by stoke set again within the theme of acute (and in this case the thought of long term) suffering. The comparison is made with Smith and Sparkes’ (2007) meditation on the reality of a desolate future set against what was a promising past. The interpretation made here is that although Claire has been witness to this man’s acute suffering, the consideration of these events long after the acute presentation suggests her story has no resolution.

Mattingly (1998, p. 79) has suggested that health professionals work to construct ‘success’ stories that are reflective of hope. However, she also states that while certain story outcomes are desired, others are to be feared or dreaded (Mattingly, 1993, p. 93). Frank (1995, p. 5) has sanctioned how the medical narrative has the ascendancy against which all other stories are adjudicated. It is reasoned that some stories will be heard and valued, while others not. The stories that Laura and Claire have contributed are such stories whose outcomes are feared. It is asserted that although these stories are dreadful in their outcome, they are nonetheless essential to these SSNs experience of distress and need to be amplified.

Stroke has been noted to be responsible for high inpatient mortality within the acute phase (Koennecke et al, 2011). These events have been recognized as demanding for nurses with the potential for despair, ethical dilemmas and conflict with other team members and relatives (Eriksson et al, 2014). Elements of this have been interpreted in Laura’s story and throughout the other stroke specialist nurses’ data. In addition, there is recognition of sorrow for those that survive but have their lives wrecked by these events. The crisis of disability extending beyond the acute event, with its impact on patients and relatives has been well documented (Thompson and Ryan, 2009. Lutz et al, 2011). The data illuminates the nurses’ responses to these ‘fractured futures’ where life with all of its potential is denied and shattered by stroke and which can be ascribed to any age of stroke survivor. These were the particular interpretations found in Claire’s narrative. However, the feeling is particularly poignant and more strongly felt when discussing people who have the misfortune to encounter stroke at a younger age. Similar sentiments were reported by Findlay and Sheppard (2016) and Fukumori et al (2020) who made particular reference to the distress and disparity caused when caring for young patients. Kendall (2007) has commented on the high value that is ascribed to youth with all of its potential. This researcher asserts that the realization of such potential as being interrupted or even extinguished, as interpreted in Laura and Claire’s narratives, is an immense cause of distress.

The nurses involved in this study may identify or feel more empathy with younger patients due to the perceived similarities within their personal lives. Several stories referred to similar ages of the patient, their personal lives and children. This ‘striking a chord’, as referred to by Shorter and Stayt (2007), the reflection from a personal perspective, is illustrated in Francesca’s story. Francesca is a clinical nurse specialist in stroke. Originally an EU trained nurse she has been involved in hyper acute stroke care for the past 6 years.

Francesca’s story

(Data collected electronically)

Francesca’s story was collected electronically and was garnered in response to my question of asking participants to describe their experiences of hyper acute care ad what they felt had left them feeling traumatised. She recalled having a call from the regional ambulance service that they were bringing in a patient with a suspected stroke:

> ‘It was 8am and I was holding the on-call bleep for that day. My shift had just started when the bleep went off. You know it’s not going to be a good day when the bleep goes off as soon you start your shift. You know you are most likely not going to be able to drink water or have lunch on time.
>
> I still feel the adrenaline when the bleep goes off. We reached A&E resus before the patient arrives. 34 years old female. Onset 7am left sided weakness. Cardiovascular stable said the A&E form. In your mind and in your team’s mind there is only one word that usually comes out: migraine. You always hope that this is a migraine!
>
> ‘**** (regional ambulance service) arrived and wheels their trolley. There she was young, closed eyes. A man, who we then know it was her husband walked just behind them. He kept saying her name and reassuring her that everything is going to be ok. At that time, I haven’t still convinced myself that she was having stroke. But the moment that we transferred her across from the **** (regional ambulance service) to the A&E trolley, the moment I heard the handover, the moment I realised she had no power in her left arm or leg I knew she was having a stroke. We all knew. She was 34 years old. In my mind I thought she could be my sister and the adrenaline returned. We had to save her. She could be my sister. My heart sank when I heard she had a baby, a 8 months year old baby. My sister had a daughter too. When her husband repeated her name I asked her where was she from. We were both from the same country. Again, she could be my sister.

Her husband only spoke English and he asked me if I could speak with her mum, who didn't speak any English. Her mother needed to know. And so I did. I spoke with her mum, trying to imagine If it was my mum, what could and should I say. But what can you say to a mother when her daughter is having a stroke? Was there even a best way to tell her? What words do you use? Her mother told me on the phone that her son was also in hospital. She didn't' know what to do because at that moment she had both daughter and son in hospital, in two different countries and she could not be in both sides. She told me she didn't know what to do and she asked me for advice: What should I do? I gave her a personal answer, without my nurse hat: If I were (name of patient) I would want my mum to be by my side. She replied to me that she was going to book the next flight available to ***** (English city). I ended up the call and sighed. I had to put my nurse hat back on.

We ended up giving her a clot busting treatment and she had a mechanical removal of her blood clot. She was admitted in the HASU and the days after her treatment she spent them sleeping the majority of the time. When her mother arrived, I was there. She hugged me and cried with me.

My emotional attachment with this patient was so that even when I wasn't the main nurse looking after her I would go and see her. As a nurse I created a relationship with this patient and family. It was an empathic relationship in which I was able to understand what the other was experiencing but also why I created that attachment. The similarities with my real life were incredible. I will forever remember this patient and her family because of the similarities with my personal life but also because at end of the day this is why I still love to be a nurse – I was there for my patient, for her husband, for her mother'.

Francesca’s story describes a storyline of an acute presentation of a young woman with an acute stroke. However initially she refers to the timing of her story and the feelings that this brings forward- being requested to see someone so early in her shift raises her sense of uncertainty at what she may have to deal with at that point but also the day ahead. She refers to her ‘adrenaline rush’ which could be one of either anxiety or exhilaration. From the history she has available prior to seeing the patient, Francesca initially thinks of the stroke mimic of migraine. The feeling then turns to one of hoping it is a mimic given the patient’s age. She introduces us to the paramedics in attendance, the woman, her husband and her own position within the narrative. Francesca initially feels the presentation may be ascribed to something else but then adds to the drama and sense of urgency when she is convinced of this now being a stroke.

Francesca has multiple roles in this story. She is the story’s narrator, is the witness to the events and is the SSN involved in the unfolding drama. While she is a protagonist the story involves several characters other than herself. Francesca positions herself (along with the team) as being that of a saviour (‘we had to save her’). However, she focuses more on her role as that of acting as a communicator and patron for the woman (the impotent sufferer), her husband (the impotent witness) and her mother (the impotent long-distance spectator) - all of whom need information. Her story now considers the situation on a more personal level. There are multiple similarities between her and the patient- age, nationality, language. The similarities are greater when Francesca considers them with that of her own sister and infant niece. Furthermore, the connection of nationality and potential communication difficulty require of Francesca to discuss what has happened with the woman’s mother. Francesca is placed in the position of advising the woman’s mother if she should consider international travel to visit her. Francesca again implicates herself personally- at this point she is advising not from the point of view of a nurse. Here her role diverges- she abdicates her advisor status as a nurse to adopt that of a personal counsellor before returning to her professional stance. The sigh she refers to at the end of the phone call suggests that the conversation has caused her either sadness or relief. At the end of this Francesca feels that she is able to resume her nursing identity and continue with her involvement in the process of delivering the emergency intervention.

The story resonates with deep personal significance for Francesca. She feels the ties of language, nationality and ‘incredible’ familial similarities have combined to produce a situation where a great emotional attachment was made. Ultimately the role and position that Francesca embodies is one of empathic engagement. Her story reports on the bond she made not only with the patient but also with her mother. Kleinman (1988, p. 54) refers to listening to the patient’s experience of illness, what he terms empathic witnessing, as a moral and therapeutic act. He states that it as ‘being an essential commitment to be with the sick person and to facilitate building an illness narrative that will make sense and give value to the experience’. Francesca recognizes her own investment as being empathic. Alongside empathetic engagement, the narrative also reminds the reader again of young stroke presentations, acute suffering and familial involvement. The researcher interprets that this is a story that is enmeshed into the narrator’s world. From Francesca’s final words it is an event with circumstances closer to her than normal but are ones that chime with those of her nursing values.

It has been suggested that empathetic engagement is a fundamental consideration in the development of STS (Pearlman and Saakvitne, 1995). While empathy is required of the care relationship, its very presence can increase the risk of trauma reactions (Robins et al, 2009). The papers discussing STS in nursing do make reference to empathy (Jonsson and

Halabi, 2006. Sabo, 2011). The interpretation of Laura, Claire and Francesca's stories positions empathy as a nursing value. However, in comparison with the cited literature, the potential of empathic investment is also ripe for STS development.

Distress was often expressed by the participants involved in this study with reference to acuity and all of its associated unpredictability. Adverse events and complications following interventions could result in an associated source of distress. This was found to be a feature of Paula's story.

Paula's story

(Data collected by interview).

Paula is a stroke specialist nurse with over 5 years related experience in this field. She works in a small local centre that provides a 24-hour stroke thrombolysis service. Paula's story continues the theme of acute suffering but introduces a subtheme of confronting unpredictability,

MW: Can you tell me about any incidents in your work as a stroke specialist nurse, specifically the hyper acute part of your practice, that have left you feeling distressed or traumatized?

> 'There's an incident that I recall as being traumatic, erm a lady who was brought in through the thrombolysis pathway. It was felt and I absolutely agreed it was in her best interests to be thrombolysed and we went through the pros and cons of it with her and she agreed and we thrombolysed her and she had a massive bleed and she died' (Paula).

Paula’s story is again one of great personal significance as it refers to an event that she refers to as traumatic. Her role is that of an SSN who has witnessed and then been able to narrate the events of her story. Her story consists of a plot that moves through the patient’s journey starting following admission with an acute stroke. Paula discusses this journey in the context of someone who is eligible for treatment under the thrombolysis pathway. In this she has considered the listener as having insider status given their presumed understanding of the said pathway. Paula has indicated that although this is her story it involves members of the/ a team- ‘it was felt’, ‘we decided’, however she does not expand on these characters in her narrative. The roles that ‘they’ occupy are however powerful as it is they who sanction the treatment given. Paula holds the strong conviction that this woman would benefit from being thrombolysed. Here her role is that of being an advocate for the woman while also finding endorsement with the treating team. She refers to the discussion with the patient with regards to risk/ benefit of thrombolysis and the patient agreed to the intervention. The patient’s role is that of the agreeable/ compliant stroke sufferer who is willing to accept the treatment offered to them. The theme of acute suffering is accompanied by that of unpredictability and complications in that following the intervention the woman went on to have a haemorrhagic conversion and subsequently died.

Paula went on to feel the need to offer a potential justification for the intervention that was given to someone with a relatively minor stroke,

> ‘for me what was traumatic was one that we’d made the decision that we were going to thrombolyse her and ultimately felt that that decision had killed her, although if you look at the evidence of stroke we know that erm, what the evidence is that mortality isn’t affected by thrombolysis it’s actually function that improves potentially. It’s not our fault we did it in her best interests and potentially she could have had a good

> outcome. I think making these kind of life changing life or death decisions, erm, in that hyper acute stage is incredibly difficult' (Paula).

Paula rightly refers to the evidence in justifying the treatment approach cited in her narrative. The predominant narrative within medicine is linked to restitution in that medical interventions are designed to restore patients back to their previous good health (Frank, 1995). Paula's role as a commentator on the events sees her debate the treatment and outcome. Paula refers to the potential of a restorative outcome if the circumstances had been different. However, what is interpreted here is that Paula is deflecting her sense of trauma here. Paula's position develops a defensive stance with regards to the intervention's outcome- '*it's not our fault'.* Paula is clearly distressed by the complication and outcome that this woman suffered following the intervention. Paula's narrative and the woman's outcome do not meet with how this healing drama was expected to unfold. Instead of a story of restitution, the interpretation is that the narrative here is shocked into chaos. This story illustrates the theme of acute stroke being unpredictable- with or without interventions such as thrombolysis. Furthermore, this is the story of one individual's experience of being involved in a potentially high stakes intervention (thrombolysis) where the outcomes can fall along a continuum ranging between complete recovery and death. This researcher states that for all SSNs who are involved in such treatments, there is an associated risk of being traumatized when bearing witness to unfavourable outcomes.

This narrative Paula recounts can be compared and contrasted with that of Maria whose story also referred to being involved in the delivery of hyper acute care interventions.

Maria's story

(Data collected electronically).

Maria is an experienced nurse working in an inner city hyper acute stroke centre. She has spent 15 years working in the specialty of stroke and 5 years as an SSN.

MW: Please describe in as much detail as possible your experience of hyper acute stroke care that resulted in you feeling stressed or traumatised.

> 'Treating patients with thrombolysis is particularly stressful because although you know the outcome could be good you also know harm can be done and it takes all your strength to hold the faith that this is the right thing for that patient and hope that they will be ok. I have seen a couple of young men who have had very large strokes who are so ill with large clots in the MCA (Middle Cerebral Artery) and your gut feeling is that this isn't going to go well but no clinical reason – one then fits, is rescanned has bled and dies the next day, the other has MCA syndrome and is rushed for cranial decompression surgery and ends up with severe stroke brain damage' (Maria).

Maria's story focuses on the storyline of stress occasioned when being a participant in the delivery of acute stroke interventions. Maria refers to the potential for good outcomes with thrombolysis. Her narrative is interpreted as a test of strength requiring both fortitude and faith. Mattingly (2006) proposes that hope is a moral obligation when confronting pain, despair and uncertainty. Maria refers to the need for hope when considering what the outcome for treated patients might be- the hope being that the outcome will be good. The role she presents is that of the hopeful protagonist facilitating treatments that she knows carry a high risk of complications. The hope she speaks of turns to the feared reality of devastation. The reader is brought deeper into Maria's story when she introduces the characters of two young men with large strokes. The narrative reintroduces the theme of young people with stroke who have poor outcomes and reiterates the uncertain nature of the acute illness course. Maria describes her experience (as Paula does) with regards to the evidence. She refers to her own sense of intuition as a 'gut feeling' that the outcomes will be poor- which in her story they are.

Both these stories can be compared and contrasted. The two stories do bear comparisons in their depictions of acute suffering and complications of stroke. Both stories are of importance to their narrators and have been worthy of their retelling with regards to precipitating feelings of trauma. Both include plots that demonstrate sequences of cause and effect. However, Maria's story is interpreted as being more pragmatic and with more reflective. It is, with its references to hope and faith, also regarded as more personal.

Hamilton et al (2017) have cited UK stroke specialist nurses as being actively involved in the selection and decision-making process related to the delivery of stroke thrombolysis. Although stroke specialist nurses may be involved in the decision-making process with regards to an intervention, the decision to treat is ultimately sanctioned by the consultant. However, it can be contested that being involved in the decision-making process itself can be stressful, particularly given the potential for an unpredictable clinical course. Furthermore, the analysis reveals the specialist nurses assumed the responsibility for outcomes that were poor.

The literature concerning STS covers a number of clinical areas (Emergency Department, ITU, Oncology, and Psychiatry) and presentations (major trauma, high dependency states, terminal illness). The presence of uncertainty is a feature of practice within these areas. Wardlaw et al (2003) and Lambrinos et al (2016) have identified how intervention with thrombolysis and thrombectomy can produce positive outcomes in terms of disability reduction and an individual's subsequent quality of life. However, such intervention is not without its perils (anaphylaxis, intracranial/ systemic haemorrhage- Innes, 2003). The outcomes following intervention with thrombolysis theoretically inhabit differing ends of the clinical spectrum between total resolution and permanent disability or death. However, in both those who have an intervention and those who do not, the clinical course is at times difficult to predict, with such high acuity often being characterized by patient instability and death. Although unstable conditions were referred to, uncertainty was not expressed directly. Uncertainty is manifest within the realm of clinical decision making and practice (Cranley et al, 2012) and acute stroke can be characterized by such problems of uncertainty and complications (Hjelmblink and Holmstrom, 2006. Langhorne and Pollock, 2002). Complications and prognostic uncertainty are often difficult to legislate for and nurses have reported negative psychological reactions when finding themselves thrust into these unexpected situations (Simmons, 2010). Risk, uncertainty, unpredictability and poor outcomes are the interpretations found running through the core of Paula and Maria's stories. These projected feelings lie at the root of their subsequent trauma. High acuity, multiple comorbidities and technological advances (telemedicine, thrombolysis, mechanical clot retrieval), mean that uncertainty in specialist stroke nursing practice is an inherent feature and factor in STS development.

All of the nurses referred to stories involving hyper acute stroke care. This takes in the time period usually described as the patients' first 48 following presentation. The main interventions for acute stroke (thrombolysis/ thrombectomy) must be undertaken within the first 4.5 hours (6 hours for thrombectomy) after the event has occurred. This in itself makes specific demands of those specialist nurses involved.

Prioritizing emergency treatment against a set time frame, where speed is of the essence, will arguably increase the stress for those nurses involved at the point of its delivery. The data suggests this to be the case for stroke specialist nurses who are contending with acute illness placed against a time dependant potential intervention and in which life-threatening complications may arise. It is argued that for the specialist nurses involved in hyper acute stroke practice, this may be unavoidable.

This segment has discussed how trauma reactions are precipitated in stroke specialist nurses following their exposure to acute suffering. Bunkers (2001) has opined that in order for nurses to make a difference, there must be a realization that they share a community with those who suffer. Furthermore, Naef (2006) has stated that bearing witness involves listening to, writing about and speaking of stories describing immense suffering. The entire stroke specialist nurses' stories discussed thus far bears witness to their stroke victims suffering. Their interpretation argues that exposure to these patients acute suffering is the single greatest factor in the stroke specialist nurses development of trauma reactions. These data reveal vivid descriptions of suffering as witnessed by the specialist nurses and it is by bearing witness that their psychological landscape is altered. The data illuminated stories of interventions, complications, clinical uncertainty, death (Maria/ Paula) and profound long-term disability (Claire). The data makes refers to hyper acute scenarios involving people from across the age spans. The effect of seeing young stroke victims was interpreted as particularly hard hitting. Young patients were described in terms of mortality (Laura/ Maria) but also in terms of lives being irrevocably changed (Claire). Empathetic engagement was seen as being influential where young stroke victims was referred to

(Francesca). This will be discussed in more detail in the later chapter discussing exacerbating factors for STS.

4.3.2: The Influence of Moral Distress

Moral distress which has been defined as the situation whereby practitioners are unable to operate according to their individual standards and is analogous to conflicts between team members as to the direction of care (Crippen, 2016). It has previously discussed as a key component of nurses' emotional strain (McGibbon et al, 2010). The respondents in this study also reported on their experience of emotional strain with regards to medical colleagues and their decisions as to whether to treat or not to treat (thrombolyse/ thrombectomy) people with an acute stroke. A number of nurses commented on such decisions made by medical colleagues that left them perturbed. An example of this is found in returning to Maria's story,

> 'I have a particular problem with ED Consultants who are looking for a reason not thrombolyse rather than give active treatment – They are almost waiting for it to improve or for time to run out and I am in no doubt that this patient should have treatment and am ready to go and the decision is slow or they decide not to – I find this extremely stressful because I usually am the one left to explain to the family why treatment was not given, we have a particular issue with mild strokes statistically in our Trust and we know we should Thrombolyse more. I feel we have let the patient down and that they may not achieve the best outcome. I feel frustrated and low in mood when this occurs' (Maria).

Maria's story introduces us to her involvement with consultants based in the emergency room. She refers to a plot whereby treatments are not initiated by these individuals. Rather than look to treat the patient excuses are sought not to. Maria asserts that she firmly believes that the patient would benefit from the intervention, and she is willing and prepared to be involved in its delivery. The lack of urgency and decision not to treat leaves Maria feeling under extreme stress as she often has to justify this to relatives. She refers to the thrombolysis pathway in her trust and how presentations deemed as ‘minor events’ are not treated even. The denial of treatment leaves her frustrated and low in mood. The personal significance here is great for Maria. She is forced into a position where she feels unable to enact a moral responsibility. She feels her sense of advocacy has been blunted and in this feels she has failed those in her care. The denial of treatment in this narrative rests the power of decision making with medical colleagues. However, the interpretation is that these ‘ED consultants’ are not dedicated stroke physicians. It raises questions with regards to competency, confidence and knowledge of current stroke treatment guidelines.

This can be readily compared with Maggie’s story.

Maggie’s story

(Data collected electronically).

Maggie has over 35 years nursing experience. She has been a stroke specialist nurse for the last 16 years. She works in a large metropolitan hyper acute stroke service. Maggie’s story referred to her feelings regarding an older person’s treatment who had presented with an acute stroke.

> ‘He had a CT scan which showed no evidence of a bleed and there was discussion amongst the team around thrombolysis. There was much debate about his age, previous ability and the fact that he was in a care home. I was not comfortable with

> some of this discussion. He had a severe stroke that was fairly obvious and there was some confusion about his previous ability. The discussion was around whether it ‘was worth doing ‘, the need to meet targets, good to get experience and other things along these lines that did not sit comfortably with me and I did say so at the time, but it was fair to say that I was probably intimated by the level of staff around me and felt like I was a lone voice’ (Maggie).

The patient underwent thrombolysis but unfortunately deteriorated and died without his family being present. Maggie then went on to say:

> ‘I think as well that I wasn’t entirely happy with the decision to thrombolyse feeling that such a significant stroke was unlikely to benefit and at the back of my mind was that the ‘what harm would it do, we may as well- nothing to lose’ attitude wasn’t right and that while I realise it is a clinical decision. I was troubled by this gent’s treatment. I was concerned that we had failed him and his family’.

Maggie’s story differs from that of Maria in that in this instance a person is treated who had sustained a major stroke and was felt unlikely to and indeed did not benefit from the intervention. However, in the unfolding drama of decision making, the patient remains a presence. Maggie does not indicate in her story that ‘the team’ consisted of, but a discussion was held with regards to the person’s treatment. The decision to thrombolyse in Maggie’s story is not one that has the interests of the patient at its core. Maggie feels that the rationale behind the treatment was not right in this case. She states her appreciation however that the decision to treat or not is ultimately a medical one. Maggie feels perturbed by this and voiced her opinion. She reports herself as a voice in isolation and felt intimidated by the group she found herself in. The coda to Maggie’s story is one where her disquiet was not resolved. Again, there is the sense that advocacy is denied and that the person and his family had been failed.

The stories from Maria and Maggie draw comparisons to each other with regards to the roles they occupy and the sense of having failed their patients. Maria and Maggie’s stories position them as advocates. Their attempts to act as advocates for their patients are thwarted by the medical teams who occupy the powerful roles of authority and can be seen as the antagonists of the narratives. The relationship between these two SSNs and their respective medical teams suggests that of conflict. The patient referred to in Maggie’s story is not afforded any voice or power within the narrative- their role is one that is of secondary consideration to the medical team. Maria and Maggie feel distress at not being able to enact their own moral responsibility. This moral inhibition could be seen as identity damaging. It has resonance with Nelson (2001, pp. 20-21) who has discussed identity damage and narrative repair. Individuals’ identities are damaged by powerful institutions or people who impose restrictions on their activity preventing them from occupying roles that are identity constituting. These individuals can then go on to internalize other people’s oppressive, dismissive or exploitative understandings of them and in doing so lose or fail to acquire a sense of themselves as being worthy of moral respect. Frank (1995, p. 159) has discussed narrative ethics as not being focused on the resolution of the conflicts of medical decision making but with personal becoming. While these narratives speak of the theme of moral distress through medical hegemony, the potential for conflict and of intimidation, there is also a failure to appreciate the contribution and value of these SSNs. Smith and Sparkes (2002) have referred to ‘narrative silencing’, the situation in which the emotionality of an experience and its articulation is denied. Both Maria and Maggie find themselves positioned in emotive situations. Their stories are articulated here in this research.

However, their ability to fight what they see as a moral injustice was not heard at the time of the events. It is suggested that rather than these being narratives of becoming, they speak more of something being denied. However, this researcher opines that what these SSNs are doing is ‘thinking with stories’ (Frank, 1995, p. 159), their act of becoming is through considering and engaging with the narratives of their experiences (Hudson-Jones, 1997).

The potential for collegial interpersonal conflict features heavily within the literature discussing the context of STS development (Yoder, 2008. Lavoie et al, 2010. Sabo, 2011. Giarelli et al, 2016. Findley and Sheppard, 2016. Phillips and Volker, 2019) and is interpreted in Maria and Maggie’s stories. Meurer et al (2011) has cited physician familiarity with and motivation to follow guidelines as barriers to emergency stroke intervention. A further area of contention relates to people presenting with rapidly improving symptoms and what are referred to as ‘mild strokes’, minor neurological deficits on stroke severity assessment (Smith et al, 2005). These patients who are not treated often have unpredictable outcomes with death, inpatient rehabilitation, long term care and functional dependency being cited (Balucani and Levine, 2011).

Moral distress in nursing populations has been discussed in terms of institutional/ organizational constraints (Corley, 2002). These data suggest that the constraint at work here is hierarchical. Burston and Tuckett (2012) have cited the doctors’ hegemony in the physician/nurse relationship as being a possible contributory factor to developing moral distress. Acute stroke care and ultimate decision making remain situated within a medical model (Baxter and Brumfitt, 2008). It is nonetheless suggested that where nurses are not involved in the decision-making process, are not heard or their views discounted, that this can lead to inter-professional and interpersonal conflict (Almost et al, 2016).

Ainsworth and Sgorbini (2010) offer that nurses experience a sense of failure where they are unable to change patient's outcomes. Kaya et al (2012) have reported on guilt and shame as a distressing negative self- evaluation where there has been a violation of values or incompetence. This researcher states that the distress recited in Maria and Maggie's stories is compounded by their sense of failure and conceivable guilt/ shame. Furthermore, it is asserted that in these scenarios the resulting emotions are not the result of failing to change what was a likely outcome, but of being complicit in a situation which was contrary to their own sense of patient advocacy.

Occasionally, the sense of moral distress was marked by circumstances outside of the specialist nurse's control. The following story refers to a decision where treatment was not initiated due to constraint of resources.

Jackie's story

(Data collected by interview).

Jackie has been a qualified nurse for the last six years. All of this time has been in stroke services. The last 3 years being as an SSN. Jackie works in a small local district stoke service that provides 0900- 1700 in hospital stroke thrombolysis. Outside of this time frame acute stroke patients are referred to the nearest hyper acute centre.

MW: 'can you recall ever being upset by something that you felt should have happened but did not?'

> 'There was this one young lady and she actually passed away, erm, around thirty (years old) and for clot retrieval, we got the patient ready, they rang up ***** (local

> tertiary centre) to say there was no one in theatre to do it, so we ended up having to stay here' (Jackie).

MW: How did you feel about this?

> Jackie: 'well there's nothing you can do. I don't know what was said but that was the reason, no one could do it, so we just did what we could and made sure she was comfortable'.

Jackie's story is brief but nonetheless dramatic. Her role is that of an SSN who narrates the events that she has been witness to. She refers to the acute presentation of a young woman whose role is one characterized by powerlessness. Jackie alerts us to the outcome of events before continuing her narrative, that being that the woman died. She hesitates (erm) before placing emphasis on the person's age which adds to the drama. The drama builds in the actions of preparing her for thrombectomy. Jackie introduces the characters of 'they'- this presumably is the medical team involved in this scenario. The story's crisis is revealed when there is no one in the local neurosurgical centre available to undertake the procedure. The interpretation is that the situation Jackie finds herself positioned in is one she has no control over. Her role in the process of rescue is denied. She does not appear to have all the information, but the situation appears to be due to a shortfall in service provision. The medical teams at both Jackie's hospital and the tertiary centre can be cast in the role of the story's antagonists – however, it is debatable to what extent they can be seen as truly complicit in this. The priority shifts (discontentedly) to one of ensuring comfort. Despite this the story clearly is one that Jackie recalls as significant in that a young person should have had access to a potentially beneficial treatment. The understanding here is that for Jackie, whatever the reason, what happened was wrong. There is a sense of having to just carry on here, to ‘make do’. However, a further element is infused into Jackie’s story - the sense of powerlessness to influence the care trajectory and its outcome and her own place within it.

In the literature, Yoder (2008) and Giarelli et al (2016) referred to physician’s decisions, demands and prognostic dishonesty as contributing to nurses’ stress. Several of the SSNs referred to episodes where the attending physician had not been honest with regards to the need for interventions such as thrombectomy or neurosurgery. In the earlier passage Maggie refers to an intervention where the treatment was apparently given for the sake of treating alone. Hoffman (2006) has stated that treatment with thrombolysis should not be based on politics, money or fear of malpractice. However, a number of reasons could be offered as to why there is intervention in what appears seemingly futile. It could also be argued that intervention is undertaken in such severe strokes where there is a ‘nothing to lose’ (Sandercock and Ricci, 2017) situation and where valuable clinical experience can be gained. There are also financial and performance incentives for stroke services that boast high thrombolysis rates. This researcher gives the opinion that the decision for intervention by reason and appropriateness should outweigh all other considerations. The specialist nurses themselves (Maria/ Maggie/ Jackie) are isolated in terms of the decisions that were made. There was no overt reference to role resentment or overt hostility as described by Mealer et al (2012) in these stories. However, the sense of having to ‘pick up the pieces’ alluded to by Sabo (2011) once the decision/ intervention had taken place can be interpreted in Jackie’s narrative. In addition, what can be found in all of these stories was a sense of failure on the part of patients and relatives and a powerlessness to intervene.

In contrast to interpersonal conflict, the inability to support other nurses was seen as a potential source of trauma. In Paula’s story of a patient having a haemorrhage following thrombolysis, she also found this to be the case,

> ‘Yeah, I think that it was really hard and traumatic for me to support the junior nurse that was the nurse that was on call for thrombolysis as well because I felt incredibly traumatised by the fact that the treatment that we had provided had ultimately led to her death. I know that the nurse that was looking after the patient really felt this, so for me to try and support her while I was still feeling pretty emotionally traumatised myself’ (Paula).

Paula revisits her story where the woman treated with thrombolysis had an intracerebral bleed as a complication of the intervention. She again reveals her/ the team (‘we’) feelings of responsibility for the outcome. Her residual feelings of trauma are compounded by the fact that she cannot support her colleague. Both Paula and the character of her colleague are left traumatized by these events. The coda to her story is interpreted as one of the traumatizing events betraying her feelings of inadequacy in trying to act in a supportive role to similarly affected colleagues.

The means to support nurses within these scenarios should be multiple (multidisciplinary team ethic, peers, clinician, managerial and organizational), employ numerous strategies (peer discussion, individual/ group debriefing, supervision) and be easily accessible (Blomberg and Sahlberg-Blom, 2007). Olofsson et al (2003) however, have referred to lack of support as a determinant of prolonged negative stress in nurses, with the characteristics of negative stress being realized as frustration, powerlessness, hopelessness and inadequacy- all of which can be interpreted in Paula’s narrative. This researcher maintains that people who are experiencing STS may not feel able to support their peers who may be experiencing similar symptoms. This in turn may potentiate feelings of impotence and possible guilt.

This section has discussed stroke specialist nurses experience of moral distress. Cody (2001) has referred to ethical principles as practicing non-maleficence, respecting human dignity, honouring the truth of person’s lives and being faithful to the person for whom we care. Furthermore, exposure to another’s vulnerability or suffering provokes moral obligation to that individual which can only be comprehended as a responsibility (Nortvedt, 2003). Hartley (2000) has stated that by bearing witness an ethical involvement is provoked meaning that we not only do not alter truths about victims, but also that there is an obligation to remain true to him or her. What is interpreted in Maria and Maggie’s stories is that these deeply held values that form these nurses’ moral fabric have been at best ignored and at worst have been violated. Laabs (2011) has identified nurses’ moral distress as evolving from external constraining forces preventing them from doing what they believe is morally right, displaying outrage at others immoral actions and being uncertain as to what is morally the right thing to do. All of these points are found within Maria, Maggie and Jackie’s responses.

Although the data discusses constraints on time and nurses’ feelings of trauma by not being able to support their co- workers (Paula), a major source of this moral distress relates to interactions with physicians and their decision making (Maria, Maggie, Jackie). There can exist within teams a power dysfunction that can ignite power conflicts and result in performance detraction (Greer et al, 2017). Such a power imbalance has been described by Daiski (2004) placing nursing at the bottom of the interdisciplinary hierarchy, with medicine being in a dominant position. This hierarchical structure is affirmed by epistemic injustice

(McKinnon, 2016). Medicine can be referred to as epistemically privileged given doctors training and position (Carel and Kidd, 2016), these ‘knowers’ being situated at the apex of the hierarchy. Nurses by contrast can be viewed as being situated marginally and are subject to identity prejudice and credibility deficits (Maitra, 2010). The effect of such epistemic injustice, hierarchy and power can lead to nurses having a lack of voice or even being silenced (Morrow et al, 2016) as seen with particular reference to Maria and Maggie. Malloy et al (2009) have offered the further view that nurses’ ethical compass is different to that of doctors and that this disparity also led to their opinions being muted.

The stroke specialist nurses data reveals this to be the case. Several of the data referred to the impacts as being low mood and feeling that they had let the patient and their family down. The data does not state the nurses as being silent, but their opinions were marginalized, and one went so far as to say they felt intimidated (Maggie). Ultimately the trauma of bearing witness to stroke is multiplied through conflict, the inability to enact a moral responsibility, compromised values and not being heard. The element of nurses not being listened to will be referred to again in the chapter describing factors that exacerbate STS.

4.3.3: Interaction with Family Members

Many of the respondents’ stories referred to interactions with relatives as being instrumental to their feelings of being traumatized. Several nurses commented on how they were forced to deal with an inquisition from multiple anxious relatives while trying to invest all their efforts into giving emergency care. In one instance what was described by the nurse as ‘a difficult situation’, delivering an emergency intervention while dealing with several anxious family members was remedied by asking the relatives to leave. Kathryn, recalled with what appears some irritation, of dealing with a set of relatives of someone with a severe stroke who underwent emergency intervention.

Kathryn's story

(Data collected by interview)

Kathryn works at a local district centre that lies geographically at the periphery of a large established hyper acute centre. The service provides 24-hour thrombolysis and makes referrals requiring thrombectomy around the clock. Kathryn has been involved as an SSN in the delivery of these services for 10 years.

MW: during the course of delivering hyper acute care have you ever felt any distress in your dealings with relatives?

> 'There was this lady that had come in. Big stroke. Big family. They sent her for thrombectomy and erm, unfortunately it didn't work, and she bled horrendously afterwards and passed away. And it wasn't about her actually, you know, it was more about the family that was, erm, afterwards that really couldn't come to terms with it and how many times I did have to sit down and say she's not going to recover, they kept saying well she's had all this, thrombolysed, she's then been taken to****** (regional neurosurgical centre), surely they must have been able to sort things out. Only when she died did they actually come to terms with it' (Kathryn).

Kathryn constructs her story around the plot a woman admitted with an acute stroke. She emphasises that this was a large event and alerts the listener to the fact that a large number of relatives are also present. She introduces elements of an unnamed team who referred the woman for intervention with thrombectomy. The woman does not respond to the treatment, has the complication of bleeding and dies. The narrative steers away from the woman’s outcome to the central drama of her family and their inability to cope with what has happened. The woman’s death appears to be of a lower importance when placed against the family’s behaviour. Kathryn, with some trepidation (erm) appears to be irritated by having to reiterate that the outcome will be poor. She is positioned in this story as having to adopt the role of a communicator, arguably without enthusiasm for it. Kathryn describes how the family then list all of the treatments that have been given to the woman. Her language here casts her in the role of authority- the individual with the knowledge who dictates the situation to the disbelieving and impotent relatives. The family express incredulity that this has not changed the situation. For Kathryn the story’s resolution lies with the family’s acceptance occurring only after the woman died.

This story maintains the themes of acute suffering, complications and death. However, it introduces how these issues are impacted where relatives are involved. This story is interpreted here as a combination of suboptimal communication and unmanaged expectations, with the presumption for these relatives that the treatment would be curative. Papathomas et al (2015) have debated that Frank’s (1995) narrative types may be equally important in shaping the experience of the ill person’s family. The psychological crisis that relatives are placed in is argued to be their own form of chaos. The fundamental basis of Frank’s (1995, p. 83) restitution narrative is that ‘for every illness there is a cure and the expected outcome is that the person will be returned to the status quo ante’. Thrombolysis and thrombectomy offer the chance of this but it is not a guarantee that this will be the outcome. This can be compounded in the wake of treatment failures, as echoed by Papathomas et al (2015) who refer to when it becomes evident that the hoped for or expected eventualities do not materialize, the narrative line is effectively wrecked and, in many cases, cannot be salvaged. Wilkin and Slevin (2004) have discussed the problems posed by relatives overly optimistic belief in the efficacy of treatments offered stating that if complications or death ensue, the situation becomes more difficult to accept. This can be attested to in Kathryn's story. However, it is also easy to appreciate how this could be a grieving state or possible trauma reaction in itself. What is difficult for this researcher to locate in Kathryn's story is her sense of compassion. It is difficult to interpret if this is a consequence of the situation or if this is just Kathryn's strategy to overcome it.

Crossley (2000) has stated how individuals often subconsciously project into the future, routinely assuming narrative coherences which in the event of trauma, are shocked into disarray. It is suggested that these relatives who are subjected to the trauma of their loved one's stroke have been subjected to their own form of narrative wreckage. Narrative wreckage occurs when the anticipated life path is disrupted. This is not the sole preserve of the sick individual but can occur in significant others (Papathomas et al, 2015). It is argued by this researcher that those significant others can be relatives and in turn, particularly where patient outcomes are unfavourable, project this onto nurses. It is this researcher's opinion that relatives and families' narrative lives also must be appreciated to understand their role in these nurses' distress.

Stayt (2007) has remarked that critically ill patients experience a physiological crisis while at the same time their families are being subjected to a psychological crisis. There exists a variety of studies reporting to relatives' reactions to acute stroke. Payne et al (2009) has identified how uncertainty over prognosis in acute stroke can be difficult for families. In addition to this, Rejno et al (2012) has commented on relative's unpreparedness for their relative's stroke leaving them in a state of shock. This provoked subsequent difficulties with understanding and adjustment, with themselves being traumatized by what has happened to their loved one (Wallengren et al, 2009). This researcher has interpreted this to be the case with the characters (relatives) in Kathryn’s story. Several of the studies included in the literature review on STS have described stressful situations precipitated by conflict with relatives (Yoder, 2008. Lavoie et al, 2010. Walsh and Buchanan, 2010). The contention raised in these studies included relatives attempts to influence care, threatened violence and general disrespect of nurses’ efforts. Although exposure to potentially life threatening or dangerous situations is an elemental predictor of stress reactions (Ozer et al, 2003), none of the sample reported any violence occasioned to them. It was recognized that interacting with relatives of acute stroke victims could be very demanding as well as emotionally draining. The demands made of Kathryn are considerable. However, the interpretation made sees her as more irritated than emotionally drained. A further consideration was also made to the difficulties of trying to meet relatives’ needs when working against time constraints and having to prioritize other patient assessments. However, it appears that relative’s inability to comprehend the acute illness is crucial to their own and the nurse’s subsequent stress.

One of the specialist nurses who was interviewed made mention of traumatic experiences affiliated to relatives’ difficult behaviour. James recalled a story of conflict with a relative that had a previous bad experience of healthcare provision.

James’ story

(Data collected by interview).

James has 20 years nursing experience over half of which has been dedicated to stroke care. He is the lead nurse for stroke services at a large hyper acute centre. Initially I had asked him at interview questions related to traumatic events. Initially he briefly mentioned ‘a relative problem’ before talking in more depth of young stroke presentations that had impacted on him. At length he returned to the issue of family and in particular one set of relatives who after a previous bad healthcare experience decided to ‘document’ this one,

> ‘So, with regards other emotional issues the one I mentioned earlier about the family member angry about previous healthcare and taking photographs of the er notes and documentation and I did walk away from that feeling really upset and annoyed with myself that (pause) I’d clashed with her because I thought that what she was doing was not right. So therefore I was right but she was doing something that she thought was right and we just weren’t going to agree on what she wasn’t and when you’re trying to care for someone at the same time as trying to deal with someone who’s doing something that’s against what we allow, and then I thought well what have we got to hide anyway what’s the problem, but it’s just it’s not something you come across and and again would you have acted differently and was that stressful yeah it was it was really fucking stressful. Because that added on another level of mistrust, because I reacted in a way that she didn’t like. Wahay (expression of surprise or delight) carry on take a picture of me with him if you like, let’s do a selfie you know of us. What are you taking pictures of? but you don’t want to be incandescent I suppose so that added in a whole different level of stress erm it’s time to reflect after that making sure that you learnt from these things and how did you deal with it did, I deal with it right did I not deal with it right and that’ (James).

James invites the listener into the narrative by referring to events that he discusses as emotional issues that led to feelings of anger. The plot is centred on James’ involvement with a person with an acute stroke and who also has some distrusting relatives in attendance. The main actors in James' drama are himself and the daughter. James has multiple roles within this. He is the care giver; the person attempting to maintain authority and positions himself as the protagonist aggrieved by the behaviour of the daughter who is cast in this narrative as the antagonist. There is also the patient who is a silent but meaningful presence within the events. It is to her that James is trying to deliver acute care while one of the family members uses a mobile phone to record what is happening. The situation is dominated by the relative and James who then confront each other while both believing that their own individual actions are right. James' conviction is that this behaviour is unacceptable especially as he is trying to care for someone. The roles occupied here speak of mutual conflict rather than mediation. The expletives betray his stress. James does inject some humour into his story, and I think this may be to play down what is for him a set of events that have made an imprint on him. He concludes by stating how he has reflected on the episode although his uncertainty at the end suggests he has not resolved what has happened or how he would react if it happened again.

The theme at the core of James' story relates to problematic interactions with the relatives of someone presenting with an acute stroke. His story poses a number of interesting and important considerations. Acute stroke is often a series of rapidly unfolding and occasionally unpredictable events that can place nurses into demanding situations (Rogers and Addlington-Hall, 2005). This story reflects how relatives are at significant risk of maladaptation when confronted by acute illness or trauma (Pryzby, 2005). Their behaviour in this instance is however more unusual, the catalyst being cited as a previously perceived negative care experience. It is without question that the priority here was to give emergency care to an acutely ill patient. Nonetheless, family members also need to be cared for and nurses are well positioned to offer them support to deal with stress (Beeby, 2000). Where relatives do not feel that they are supported this can lead to nurse-family adversarial relationships (Buckley and Andrews, 2011). Relative's mistrust is also heightened when nurses attempt to use power and control to minimise the family's role or involvement (Eggenburger and Nelms, 2007). It is not possible to know if the relatives in this case placed their own need for support above their loved ones need for direct care. It is possible however to appreciate their mistrust and their response to what they may have perceived as an attempt to maintain order. The data reveals that James acted upon what he felt was unacceptable. Coyne (2007) has referred to how nurses attempt to maintain order and routine at all costs but sometimes lack the skills to manage challenging behaviour. James ultimately questions his own approach to this confrontation, and it is suggested that he was unsure of his own or the correct course in such an extreme episode. The use of one expletive is also of interest. Swearing is an expression of emotion and in this context, anger and frustration. It adds emphasis but can also be seen as a means to catharsis (Jay and Janschewitz, 2008). Its appropriateness is dependent on both the speaker and listener relationship. While the use of expletives may be questioned as appropriate, arguably it was of value here as it provided an indicator of the participants' true emotions. While James injected some humour towards the end of this story, he was clearly affected by what was perhaps something more out of the ordinary. In this instance, the distress encountered by disobliging behaviour, whilst trying to deliver highly specialized, urgent care, is an arguably understandable response.

Frank (2012) and Mattingly (2010) have commented on the tendency of biomedical approaches to focus on the individual to the exclusion of wider social networks. Families may be side-lined in the care episode and at worst perceived as irrelevant and a hindrance to the discourses of medical care (Witham et al, 2018). There are elements of this in both

Kathryn and James' stories. The interpretation is that both stories regard their respective families not as irrelevant but do state them as being a hindrance. The opinion offered by this researcher is that Kathryn and James need to develop narrative competence (Charon, 2004); to listen to and appreciate the narrative lives of stroke patient's families and to recognize and appreciate what has meaning for them so that they are not marginalised.

This section has discussed how interaction with family members of stroke victims can precipitate stress reactions. Families can experience considerable emotional upheaval when faced with acute critical illness. Kathryn and James' stories reveal that there is a real difficulty for relatives to come to terms with what has and may happen. Both narratives are characterised by relative's maladjustment which is projected onto these nurses. There is conversely difficulty for these nurses to adjust to what they are forced to contend with. Acute illness situates relatives at the lower end of decision making and authority (Carman et al, 2013). Such disempowerment to affect the clinical course, coupled to potentially unrealistic expectations, appeared to result in what can be perceived as hostility towards the specialist nurses. It is suggested that from these data, the specialist nurses not only faced hostility, but that of intimidation. Intimidation has been referred to by Bolino and Turnley (2003) as being forceful and tenacious- a behaviour that may generate aversion or dislike and has been linked to clinical errors and impacts on patient safety (Lamontagne, 2010). It is stated that the data indicated a degree of intimidation used by relatives and that this was arguably there means to assert control, particularly in James' case. Nurses are in a profoundly powerful position to assist families to deal with their own trauma of bearing witness to loved one's acute stroke (Eggenburger and Nelms, 2007). However, the socio-political environment nurses inhabit has been referred to as constrictive by Kay et al (2013), arguably forcing nurses to appease relatives demands. Furthermore, family hostility, criticism and emotional over involvement can lead to adversarial relationships that have been associated with poor patient outcomes (Rosland et al, 2013). The suggestion is that the specialist nurses need to be adept at not only managing hyper acute clinical situations but also the expectations and demands of dealing with potentially traumatized relatives. The next section refers to the problems of working within a modern healthcare system and its particular relevance to stroke care. There are several points within the data that again refer to relatives. The following section may also serve as an illustration of how healthcare systems in themselves may add to families' anxiety.

4.3.4: Problematic Healthcare Systems

A number of the literature sources referring to nurses STS and the related trigger situations cite the influence of problematic healthcare systems (Yoder, 2008. Austin, 2009. Walsh and Buchanan, 2010. Melvin, 2012. Giarelli et al, 2016). In the context of exposure, several elements were consistently reported such as heavy work burden, constant prioritising, and high acuity, lack of time and general lack of resources.

These data revealed a number of areas where stroke specialist nurses felt that healthcare systems contributed to STS triggers. The suggestion is that the scenario described by Jackie indicating moral distress had a basis in systematic failings: no neuro-radiological interventionalist being available. Several specialist nurses commented on lack of bed availability within their respective emergency departments and hyper acute stroke units. A number of the SSNs reported on their attempts to review people who had a stroke urgently despite there being limited space in the emergency department to assess them. The unremitting need to accommodate patients, prioritize assessment and deliver emergency treatments serves to intensify the specialist nurses' stress. This is given an appreciation in Jennifer's story.

Jennifer's story

(Data collected by interview)

Jennifer is a senior nurse working within a major inner city hyper acute stroke service. She has over 25 years' experience working in stroke care. In this time, she has seen the development of stroke services including hyper acute units, endovascular interventions and the development of stroke specialist nursing services. At interview she discussed how the demands of acute stroke care had impacted upon her:

MW: outside of being involved with the actual acute stroke patient is there any aspect that you think might add to your distress or leave you feeling traumatized?

> 'The volume of patients is incredibly stressful. You use the word trauma and sometimes I can't think of a better word. Sometimes I do feel physically, you know, traumatized after coming off a shift. I've had some awful days where I've physically wanted to pass out. I've not had a drink; I've not had a wee. I've had constant calls from A+E and I've just had to sit down and say actually I can't do anymore. You're so busy down in the resus department you know and they aren't really aware of the time implications for how fast you have to see the patients and having to do things for the patient when they come in quickly. I'm traumatised I suppose. It's pressed when you're in a time frame. I think the pressures from the NHS, I think the pressures from patients and their relatives is massive and the pressure on the staff is just too much

> but obviously when you're dealing with a sudden onset like stroke is as well, it's quite, er, stressful (Jennifer).

Like many of the other SSNs, Jennifer's storyline was one of feeling stressed by the often-unrelenting volume of patients that presented as possible strokes and the demand for review by stroke specialist nurses. Jennifer's role, like the other SSNs in these stories, puts her at the fulcrum of hyper acute stroke assessment. The role she narrates herself as occupying is one characterized by duress. Her relationship with 'A and E' and the 'constant calls' she receives leave her bordering on enmity. The exigency for a specialist evaluation of multiple admissions prompted Jennifer to state her workload as not only stressful but traumatic. Jennifer linked her experience to the words used as an interview question. She feels that she cannot entertain a better descriptor than being traumatized and relates that to a number of physical issues. She further reported how the unremitting nature of stroke service demands made it difficult for her to continue. She clearly identifies the resuscitation department as the crucible of her distress, where staff does not appreciate the need for urgency. She refers to what she thinks is a traumatic effect with the impression here being one of someone under considerable pressure. Jennifer's story does introduce some pragmatism with her appreciation of the wider health service impact and the place of stroke within it.

Jennifer's story has similarities with the continuation of James' narrative. The theme referred to in Jennifer's story is one of an unremitting workload which adds to nurses' feelings of stress. James refers to how multiple referrals for a SSN review within the space of one shift can escalate stress to the point of unacceptable behaviours:

> ‘Oh there are times when you just about had enough and you’ve not eaten but when I was er when you’re on your own and you get 17 referrals in a day and you’re thinking right well fuck you and then you think I’m irrational now because I’m hungry, tired, dry and I’m behaving like an absolute twat to someone who normally I would get along with quite nicely and that makes you think what the fuck am I doing this for? Why am I doing this? And those are the times when its stressful for me is when you don’t get a chance to eat, you don’t get a chance to stop, you’re constantly on your feet from the moment you arrive at 7.30 (am) and you’re in A&E then wait till someone turns up for the nightshift hallelujah and er you can go home and you’re on your knees and I have sat in the office on a night just going not wanting to go home yet because I’m knackered and I’m still digesting the day and I’ve shouted at someone and that bothered me and now I’m going to have to go and find them to say sorry er because it wasn’t their fault just the systems fault you know. At the end of the day I’m a nurse not a superhuman I can only do so much but the expectation of us is very high I feel so it depends on your own self and how you feel where are you at and what do people expect from me and can I achieve can I meet their expectations and are their expectations realistic really sometimes their expectations are unrealistic but that’s maybe their naiveté’ (James).

James refers to the burden of multiple referrals and having no respite from this as he is working in isolation. The pivotal nature of this role can be identified as having similarity with Jennifer’s narrative. The stress of the workload and not having paid attention to his basic needs has made him feel irrational. He aims expletives at an unnamed source, but it is likely to be towards one of the many referees. His stress has situated in him in the role of being disagreeable if not one of conflict. He has insight that he may have offended someone and that this is unacceptable. In referring back to the source of his stress there is agreement with Jennifer that this lies in the province of emergency services. James meets with relief and rejoices when one of his colleagues takes over from him. He refers to the burden as leaving him exhausted. Rather than go home he reflects on the day and feels he needs to make amends with whoever he may have upset. His experience followed a continuum from the unreasonable to the contrite to the fatigued. James is keen to point out that the problem lies with healthcare systems rather than individuals. James' coda offers a dilemma. He makes an admission that he can only do so much, but there are great expectations of what he is able to do. James does not state that he strives to meet these expectations. He questions if he can reach them but concludes by stating that he feels the expectations placed on him may be unrealistic.

Jennifer and James stories meet agreement with each other. The theme of problematic healthcare systems involved in their stories mirror the experience reported by other SSNs. Great demands are made of these nurses but the inherent flaws within their services which contribute to these nurses' stress. It is suggested that is this not only the case but that where nurses are tired, thirsty, have not eaten, have a heavy workload and are witness to emotionally challenging cases, it is fertile ground for STS development. The data clearly illustrates that this role makes demands which are both physically and mentally taxing. It can be argued that these stories suggest these nurses are seeking their own form of restitution. Here they want to be perceived as powerful individuals who have the ability to overcome the obstacles that problematic healthcare services place before them. Chang and Hancock (2003) have referred to role stress as occurring when there is disparity between perceived role expectations and achievement. Interestingly, the unmet expectations of others and the nurse themselves has been reported as provoking an unsettled conscience where acute care rears ethical challenges (Jutberg and Sundin, 2010). James' thoughts here indicate that the expectations both of what he as a stroke specialist nurse has to offer to the service and of himself, is an additional source of burden.

Weir and Cadilhac (2007) have recognized stroke specialist nurses as instrumental to patients accessing stroke unit beds. Many stroke specialist nurses also have coordinating roles revolving around clinical throughput which sees them act as custodians for the acute stroke unit beds. However, the stroke specialist nurses raised concerns that managing beds as part of their role takes them away from what they see as the fundamental aspects of their role- assessment, diagnosis and intervention. As discussed by Ruth.

Ruth's story

(Data collected electronically)

Ruth works in a large metropolitan hyper acute stroke service. She has been a nurse for over 30 years, the last 4 of which has been as an SSN.

> 'Often feel stressed at situations where there are insufficient beds available for the demand from ED, very busy HASU unit and demand- we as a team assess approx. 330 patients per month, often there is too much demand at one time and no allocated space in ED for assessment, can become anxious when patients suitable for thrombolysis need to be seen quickly but there is difficulty getting this achieved when up against a time constraint and when other patients still need assessing' (Ruth).

Ruth's role highlights the elements of assessment, treatment and clinical throughput. However, the role she occupies within this story is one of a nurse contending with constraint. Ruth's story concerns her feelings of stress which are escalated by having to deal with issues of occupancy. Ruth situates her story in the emergency department and the hyper acute stroke unit. She clearly is involved in a very large hyper acute centre with a huge number of presentations needing to be seen. The feeling is that not only stroke services but those of emergency services would be overcome by this number of patients. However, Ruth clearly identifies the issues with regards to the stretched resources of time and the environment. Ruth reports this as causing her anxiety. The overall interpretation is once again of someone who is under pressure to perform in a situation of high demand.

It should be remembered that for many of the nurses at the heart of this inquiry, they are involved as part of a 24-hour service. This will often see them required to work in isolation throughout the night for up to as much as 12 hours per shift. Several nurses commented on the stress encountered by events that occurred out of hours, particularly during the night. These nurses expressed considerable difficulty in being able to provide an emergency intervention often with little or limited support, as detailed by Diane.

Diane's story

(Data collected by interview).

Diane has over 12 years' experience as a qualified nurse. Half of this time has been spent in stroke services as an SSN. She works in a regional hyper acute stroke centre.

MW: when delivering hyper acute care is there anything within the way the service operates that you feel could cause you distress?

> ‘Sometimes you know in the middle of the night if you’ve got a patient and you know you’re gut feeling is they’re going to be for thrombectomy and you’re going to have to call your consultant at home and then thinking about that you hope there’s not a clot on the scan ‘cause then you’ve got to go through that whole rigmarole- it’s just getting theatres organized and anaesthetics and consultants. It’s a nightmare in the middle of the night trying to do that I suppose’ (Diane).

Diane’s story plays out at night. Again, the role she inhabits is one at the centre of stroke care. However, her role in this narrative takes on that of a co-ordinator for the hyper acute episode. She acknowledges the insider status of the listener and their awareness of the situation – ‘you know’. She refers again to her instincts as a gut feeling that a patient is going to require thrombectomy. In a case requiring thrombectomy the patient will present with stroke symptoms but an insitu thrombus can only be demonstrated by brain imaging (CT angiography). Diane outlines the process, but the hope is that there will be no thrombus found in which case thrombectomy is not indicated. Where an intervention is indicated it is described by Diane as a ‘rigmarole’- something which is complicated or not straightforward. The hope here is interpreted as not being centred on the patient’s interests but to avoid a complex pathway that places the nurse at the fulcrum of its direction. Diane describes he situation as a nightmare but questions this (‘I suppose’).

It is possible to appreciate the stress that would be generated in this setting. Coordinating such an intervention, dependent on availability and time was referred to as ‘nightmarish’. It could be contended that the patients’ interests appear secondary to the nurses’ inconvenience. However, it could also be argued that this data illustrates how simply trying to deliver a treatment can be traumatic, prompting a hope that such an intervention is not required.

What is apparent from these reactions is the stress induced by the constant pressure demanded of the stroke specialist nurse service. What also becomes familiar is that often these specialist nurses are working in isolation for long shifts, a point that James raised in his narrative. The STS nursing literature refers to feelings of being alone and unacknowledged (Sabo, 2011. Findlay and Sheppard, 2016). However, this is not in reference to working in isolation but rather the feelings precipitated by the traumatic event. Whilst there will be a team of sorts in operation (specialist- dedicated consultant led team, generic- non specialist ED consultant), it is the specialist nurse who takes the brunt of these emergency referrals, frequently unsupported (by other stroke specialist nurses), some up to 12 hours per shift. One nurse reported how non-specialists 'back off' on arrival of the stroke specialist who is left to deal alone with whatever has been referred. This solitary means of working has left several of these nurses feeling deserted.

The feeling of being 'left to get on with it' also extended to the immediate stroke team. The conclusion to this section of James' story saw how he felt he had to assume the leadership and responsibility in a thrombolysis case after the consultant had left, becoming:

> '...the lynchpin for information and what's going on and what's happening because the consultant's just doing the thrombolysis and shafted off (consultant has administered the first part of the treatment in bolus injection form then has left), so I was left holding the fort and keeping it altogether' (James).

Here James has become the focal point for directing the pathway after the consultant has left. He is the point of communication between all parties involved- the patient, relatives and the ward-based team. He is effectively allocated the role of expert, leadership and authority by the departing consultant. The terms he uses to indicate that the consultant has left (‘shafted off’) can be interpreted as his antagonism and dissatisfaction with the situation. He has no choice but to be the said lynchpin. James has effectively been abandoned and forced to take command. The consultant’s role is somewhat divisive here. Whilst this can be interpreted as being complementary by the consultant in having faith in the specialist nurse, alternatively it also leaves James as being potentially vulnerable given the direct access to the highest level of support has been withdrawn.

Lawlor and Mattingly (2009) assert that often healthcare encounters are based upon expert models of service delivery. However, Seneviratne et al (2009) have discussed how acute stroke unit practices are challenged by constraints of space, time and high acuity. The paper also reported on how lack of bed availability meant patients were nursed in inappropriate areas. The following story, collected at interview, reveals how the combination of acuity, services constraint, unpredictability and family involvement resulted in a terrible situation. Despite this and the reaction it provoked, the nurses’ depiction at interview was delivered with total poise.

Charlotte’s story

(Data collected by interview).

Charlotte has been qualified as a nurse for 6 years. She has been involved in hyper acute care for the last 3 years. She works at a large regional hyper acute stroke centre.

MW- ‘could you please describe any experience that you have ever had relating to acute stroke that has left you feeling upset or traumatised, it doesn’t have to be thrombolysis or any other intervention, but something that happened within your practice’.

> ‘Erm, so the one that always stands out to me, erm, is we had a patient come in for thrombolysis, but we’ve got nowhere on the ward to put this patient. We’ve got a trolley now in our treatment room in our clinic room so what we had to do was put the patient on the trolley in our clinic room which is obviously not ideal, erm, obviously took the patient down to be scanned and back continued obviously the thrombolysis stuff, erm and then all of a sudden the patient started vomiting but then started bleeding literally from everywhere out of their nose, mouth, everywhere, erm, went completely unresponsive, erm, ended up going into cardiac arrest, erm and literally in the treatment room it was like a bloodbath. I’ve never ever seen it look that way before and that is the one thing that will always stick with me cos it was just awful and obviously her family were there and it wasn’t very nice’ (Charlotte).

MW- ‘How did it make you feel at the time when that was going on?’

> ‘Erm, it was really annoying to start with cos we’d had the patient in that area because we’d got nowhere else for the patient to go, so that in itself was really annoying and obviously for that then to happen- just not an ideal situation. It’s not fair on the patient, it’s not fair on the family and you know it just looked horrendous. It was just a horrendous situation’ (Charlotte).

MW- ‘Did you feel a bit like you lost control of what was going on?’

> ‘Yeah, because you don’t, it’s not something that you want to have happen all the time, erm, so you kind of do, you just don’t know where to start, erm, yeah, it’s really, yeah, you don’t feel like what else can you do? You know there’s nothing and having people at this patient from all angles, bleeding and catheters up noses and just

> horrible. I think that you, a lot of the time, get to see patients at their most poorliest, em, and I think that you're constantly having to think on your feet as to what could happen next. It's definitely a faster pace, er, it's not something where you can plod along and take a step back' (Charlotte).

Charlotte's story is one that retains its personal significance. She is not only the SSN involved at the heart of this story, but its narrator and principal witness. The impression is that given its exceptional circumstances it is likely to remain so. She situates her storyline of a hyper acute presentation requiring thrombolysis in the ASU. Charlotte appreciates that she is in the midst of an emergency situation from the outset with the patient being prioritized for thrombolysis. She alerts us to the environmental constraints and that given the gravity of the situation the team 'we had to do this'- that is to find somewhere to accommodate the patient. Despite being placed in the role of one of a rescuer, there is an underlying appreciation that the environment (the clinic room which housed the patient) is clearly not ideal. Charlotte guides the listener through the thrombolysis pathway. The drama changes suddenly as the person becomes unwell and haemorrhages. The vision Charlotte describes is truly horrific. For Charlotte it is a departure from the norm- she states never having seen anything like this before. The vision is embedded into her mind persisting still. Despite the horror of the situation, Charlotte's language plays down this describing it as 'awful' and 'not very nice'.

Charlotte recalls her annoyance at how the situation evolved particularly when considering the environmental constraint. She reveals her sense of disparity and concern that the situation was unfair on the patient and on the family who were also in attendance. This researcher interprets that Charlotte's opinion of what happened changes from the somewhat passive (awful/ not nice) to the more visually alarming- ‘looked horrendous’ ‘a horrendous situation’.

For Charlotte this is an unprecedented situation. In the unfolding story she refers to being placed within such a unique event that she finds it difficult to know what to do. Charlotte is resigned to there being nothing that can be done. She states how other characters (arrest/ medical emergency teams) have become involved. Their role, which is that of attempting a rescue, is interpreted as being welcomed by Charlotte. However, the horror persists despite their actions. In conclusion Charlotte accepts that nurses involved in stroke care will see ill patients with unpredictable clinical trajectories on a regular basis. She advocates being alert to this and thinking through what is happening.

Charlotte’s story can be interpreted in a similar fashion to that of Laura’s story. Laura’s narrative was cited as the most appropriate story to open this chapter on the cause and context of these nurses’ secondary traumatisation. Charlotte’s story is the most appropriate to conclude it as it describes a scenario involving all of these contributory factors in combination. Charlotte’s story later progressed to detail the physical and psychological reactions that she felt following these events. Although gruesome, complications such as this are difficult to legislate for. However, it could be concluded that attempting an acute intervention in a less than appropriate environment served to compound this outcome the situation again imparts acknowledgment of powerlessness and despair at being unable to alter this position. Yoder’s (2008) data inferred nurses’ perception of helplessness citing negative ruminations of ‘feeling trapped’, while Gunusen et al (2019) referred to nurses’ feelings of helplessness and powerlessness snaring them in a cycle of despair. It is suggested that stroke specialist are not only experiencing a powerlessness but potentially a helplessness both born out of an inability to escape bearing witness to such trauma. Such elements of despair are interpreted in Charlotte’s story. She was trapped in a role which forced her to bear witness. This researcher’s opinion is that the events are seared into her narrative. However, given the positive outlook on life that she referred to later in her story, she does not appear to be trapped in a cycle of despair.

This section has discussed the data related to problematic healthcare systems and how these elements are contributory to stroke specialist nurses’ feelings of traumatic stress. Stroke specialist nurses are impacted on by heavy workload, high acuity and the need for prioritization. In the approach to hyper acute stroke care, interventions such as thrombolysis and thrombectomy are rightly prioritized. The emphasis recalls Frank (1995) and Mattingly’s (1998) views on biomedicine as attempting to repair broken machine bodies. However, the need to achieve this places a strain on already pressurised resources and the nurses working within them. Burns et al (2013) have argued that organizational and service failures can lead to institutional abuse. The stroke specialist nurses’ data does not indicate abuse as such, but there are service and organizational inadequacies that hinder these nurses practice and run through their stories. It is contended that these service and organizational deficiencies, such as time and space, lay outside of the specialist nurses’ direct influence. It is therefore creditable that highly specialized acute care is maintained under such duress.

Winstein et al (2016) has advocated an interdisciplinary ethos for acute stroke care, citing improved patient outcomes as a result. However, interdisciplinary working is not without its problems. Not only is there the potential for conflict and disagreement among individuals (Miller et al, 2008), but there can be limited participation in decision making processes related to possible imbalances in power structures (Ndoro, 2014). It is stated that the specialist nurse role within such a team is blurred. This section has realized that specialist nurses occupy roles which offer a high degree of autonomy and clinical expertise. They are often used in the delivery of medical care in collaboration with stroke physicians (Burton et al, 2009). However, this study's' participants do not appear to work with the full support of their physician colleagues. Rowe (2010) has identified independent thought, clinical judgement, self- awareness and organizational culture as being fundamental to autonomous practice. The data reveals stroke specialist nurses who often work in isolation and have adopted a higher level of responsibility. The nurses involved in this study are at risk from duelling expectations- a situation of role discord arising from conflicting expectations between nurses' beliefs, the organizational stance and physicians' directions (Pendry, 2007). This circumstance is further compounded where nurses are afforded more responsibility than authority. This data demonstrates that this responsibility is a core requisite of the SSN role and is therefore an inevitability and that furthermore individual and organizational support for nurses in these roles is lacking.

4.4: Summary

This chapter has described the cause and context in which SSNs experience feelings of secondary traumatic stress. The cause and context for their trauma's evolution is multifactorial. This has included exposure to acute suffering and death- with a particular emphasis on the experience of suffering related to stroke in young people, the uncertainty and risks associated with being involved in the administration of high stakes interventions, empathic engagement, moral distress, interaction with families and the influence of problematic healthcare systems. The description of these events answers the research question affirmatively that these SSNs do report experiencing feelings that are commensurate with STS and that the circumstances in which they occur mirror that in the trauma literature in general and that concerning nursing.

What this offers is a new appreciation of the emotional burden that these stroke specialist nurses experience. It offers a fresh insight into what situations precipitate trauma reactions in these individuals. In terms of the thesis this chapter takes a logical step in describing these nurses' traumatic experiences in the context of hyper acute stroke care. It grounds the argument by outlining the first step in the trajectory of these SSNs trauma narrative. Furthermore, this chapter builds upon the theory of traumatic stress within nursing specialties. It also provides a new area of inquiry not only in terms of specialist and general nursing and the emotional cost of caring but is enhanced by the novel use of narrative in this area to enable a greater understanding of these subjects' lives.

Trauma reactions have previously been identified among stroke victims (Favrole et al, 2013. Field et al, 2008). What is paramount is that stroke patients have been observed as being traumatized by what has happened to them. Conceptually, STS is the response resulting from exposure to a traumatized individual, rather than the traumatic event itself (Komachi et al, 2012). The stroke specialist nurses' responses offer a unique and insightful perspective of bearing witness to patients' traumatic experiences in the course of their stroke. However, it is suggested that they are being traumatized directly by their immediate involvement. Regardless of whether the mechanism of trauma is direct or secondary, stroke specialist nurses appear to be exposed to these perils on a regular basis.

Traumatic reactions occur principally in response to witnessing other peoples (patients/ relatives) trauma, which is, suffering a stroke. However, the contexts in which these events occur are highly influential. Many of these nurses described catastrophic events (Laura, Claire, Maria, Paula, Jackie, Kathryn, Charlotte). Although people of varying ages were affected, the specialist nurses felt particularly saddened by younger patients as evinced in the stories supplied by Laura, Claire, Maria and Jackie. Empathetic engagement, a key determinant of STS development (Stanley and Sethuramalingam, 2015), was linked to the specialist nurses' responses to these younger patients and was given particular emphasis in Francesca's narrative.

The atmosphere of conflict and constraint has also been denoted as elements conspiring to produce stress reactions. There were several areas of the service which were described as demanding. The nature and complexity of hyper acute stroke care places the specialist nurses under added duress. The atmosphere of constraint is perpetuated by the need to make appropriate clinical decisions and prioritize patient care while managing different role demands and trying to meet nationally set targets. This was evident in many of the nurses' responses, but the personal demands of service provision impacted Jayne, Diane, Ruth, Jennifer, Maggie and James. Charlotte's story highlighted how constraint led to a desperate situation. Cronqvist et al (2006) has discussed the conflict arising between what nurses' feel should be done and what is expected of them. Many of the stroke specialist nurses made expressions of passion for their deeply held set of values. However, Maria and Maggie specifically discussed feelings of these morals being violated by decisions either being removed or imposed upon them.

Uncertainty has previously been discussed in the setting of stroke. However, this has been in regard to survivors (O'Connell and Baker, 2004); carers (Greenwood et al, 2009) and service provision (King and Semik, 2006). There are no papers available that discuss stroke specialist nurses' feelings of uncertainty. This research gives a novel appreciation of SSNs experience of uncertainty. Stroke specialist nurses are often confronted by scenarios of acute deterioration and fluctuations in patients' conditions. Maria and Paula's stories referred to this in terms of poor outcomes following thrombolysis. Although two of the stories referred to visions which were truly horrific (Jayne referred to a story similar to that of Charlotte involving an unpredictable situation of anaphylaxis and haemorrhage), the sense of trauma was no less realized by the acute and often unpredictable nature of stroke. Many of the respondent's data discusses intense experiences of different clinical trajectories that often couldn't be legislated for. It is these unforeseen and often unpredictable events that have colluded to produce stress reactions in the specialist nurses.

Kathryn and James' stories documented their difficulties with relatives who were struggling to adapt to their loved one's stroke. James was left particularly affected by his encounter. The predicament of trying to deliver hyper acute care while also trying to meet relatives needs can exacerbate already distressing situations. The families of people that present with acute strokes need to seek information and knowledge related to the clinical condition (Ryan et al, 2017). However, this demand is not always met, with staff reported as having little insight into relatives' information needs (Morris et al, 2007). Families may feel traumatized themselves on seeing their loved ones in distress. This, along with possible problems of insight can be projected onto the specialist nurses and so increasing their sense of tension.

In summary, the context of stroke specialist nurses stress is multifactorial. Lavoie et al (2010) have referred to the evolution of trauma reactions in the circumstances of being a victim and being a witness. Furthermore, reference is made as to the influence of the conditions in which the event occurs. Much of the data has offered thick descriptions of traumatic events positioned in the sphere of hyper acute stroke specialist nursing. However, not all the data presented here concerns itself with the elemental characteristic of STS, that is, being witness to someone else's' trauma/ suffering. There is a combination of additional influences referred to - acute illness in varying age groups plus/ minus intervention, increased mortality, ethical considerations, and inter-collegial conflict, interaction with relatives and service demands and expectations. All these elements, both in isolation or combination, potentiate the risk of adverse stress reactions and increase the possibility of STS among stroke specialist nurses.

4.5: Conclusion

This chapter has described and discussed the cause and context of STS within stroke specialist nurses. The causes appear to be multifactorial and can occur either in isolation or in combination. Stroke specialist nurses dealing with hyper acute presentations are exposed to these elements by the very nature of their work and are at risk of developing STS. The next chapter will address the data concerning stroke specialist nurses’ traumatic reactions, most notably how it has impacted on their psychological constitution.

Chapter 5: Narratives of Disrupted Psychological Terrain

5.1: Introduction.

This second chapter concerns the participant's experience of stress reactions following exposure to traumatic events encountered through their hyper acute stroke practice. This sections intention is to investigate the ways in which SSNs narrated lives are affected by traumatic stress with aim being to gain an understanding of how being exposed to distressing events can affect the SSN's psychological terrain. Data extracts from the participant's narratives will be presented along with the evidence to lead to meaningful interpretations of their experiences. A concise summary of these findings, the contributions to the thesis and the overarching narrative will be offered as a conclusion.

The individuals' reactions to bearing witness to trauma are legion and form a potent mixture of physical and psychological traits (Figley, 2002). The constellation of associated reactions has been recognized as ranging from the somatic to the psychological with headache, pains, nausea, lethargy, sadness, grief, depression, anxiety, insomnia, intrusive thoughts, event revival, numbing, shame and avoidance phenomena (Dutton and Rubenstein, 1995) being cited. Furthermore, Morisette (2004) has broken down the experience of STS into physical, emotional, behavioural and cognitive domains. Such reactions may occur in isolation or be concomitant. Either way, the predicament for the person experiencing them is lamentable.

Raingruber and Kent (2003) have referred to the strong physical sensations experienced by those suffering from STS as a 'Geiger counter' of meaning. Essentially, these physical sensations betray the seismic impact that traumatic stress has on individuals. The reviewed literature has made several references to STS in terms of the physical reactions of people exposed to trauma. These reactions took the form of varied somatic complaints including pain/ stomach ache (Gunusen et al, 2018), exhaustion (Perry et al, 2011), palpitations and breathlessness (Walsh and Buchanan, 2011), and the seemingly unattainable ability to feel physically recovered (Austin et al, 2008. Melvin, 2012). However, the SSNs narratives made little reference in terms of the participant’s experience of physical indispositions. The mentions of somatic complaints related to their traumatic experiences were brief and individually ascribed as stress headache, feeling tired and stomach complaints. Although these reports are few in these instances and although not disabling, it can be argued that they are not pleasant either. The bulk of the stories offered up from the SSNs experiences describe their intimacy with the psychological impact of trauma which will be discussed in the following section.

5.3: Narratives of disrupted psychological landscapes

The reviewed literature concurred with the view that psychological problems have become synonymous with traumatic experiences (Mealer et al, 2009). The classic psychological traits of STS have been identified by Figley (1995) as event revival, stimulus avoidance, dissociation, intrusive thoughts including nightmares and hyper arousal. In conjunction with this, general distress, anxiety, depression, panic attacks, insomnia and pessimism have all been emphasized (Austin et al, 2009. Walsh and Buchanan, 2011. Melvin, 2012. Gunusen et al, 2018).

Many of the SSNs stories related to their protagonists’ feelings of anxiety, fear and depression precipitated by their involvement in the hyper acute stroke episode. The nurses made descriptions of these feelings and reported the physical manifestations of psychological upheaval- crying, insomnia and irritability. The key theme of Sandra's story refers to her experience of anxiety.

Sandra's story

(Data collected electronically)

Sandra has worked in acute stroke services for 10 years half of which has been as an SSN. In her electronically collected story, she reported most of her work being undertaken in the emergency settings (ED/ MAU) and acute stroke unit. She referred to witnessing experiences similar to that reported by the other SSNs in this study. The accumulation of seeing multiple deaths and disability had a corrosive effect on her which left her feeling anxious,

MW: Did you experience any distressing symptoms related to these events (for example- insomnia, nightmares, low mood, intrusive thoughts, irritability/ impatience, crying). How long did you experience these feelings for?

> 'I would feel awful even before getting to work just sick at the thought of what lay ahead. Holding the stroke bleep and A and E. Just sitting here alone and waiting for that call. Almost praying it is not to go down (to the ED) and have to see somebody. You would have thought I had got used to it by now. I suppose I have but there are still days I almost cannot face it. Just fraught thinking what is going to come in' (Sandra).

For Sandra the plot is one of apprehension which is composed before entering the clinical arena. The story for her is important as she wants to convey to the reader her past experiences which have conspired to produce feelings of dread before she has reached work. The situation is worsened once in the hospital. When left alone Sandra contemplates what she may be confronted by, her anxiety being reminiscent of the impact of uncertainty. Her reference to prayer (probably/ possibly euphemistically) indicates her hope that she won't have to be called to see someone presenting with a stroke and the potential uncertainty surrounding such a review. For Sandra there appears to be a partial resolution to her anxiety as she refers to her experience and of adjusting to things. However, she still reports days where she is anxious about what might confront her.

Sandra's experience can be compared to that of Mandy, who also expressed her feelings of apprehension in this brief except from her narrative,

Mandy's story

(Data collected electronically).

Mandy has been a qualified nurse for 11 years. 7 years of this have been spent in hyper acute stroke services.

> 'I used to dread going into work in the morning, feel anxious all day that something would go wrong or someone would take unwell. I used to cry a lot too. I felt anxious and cried almost after every shift (Mandy).

Mandy's story reveals a palpable sense of dread when considering the working day. The brief storyline draws the reader in by Mandy's particular anxiety at the thought of encountering someone with an acute illness. Anxiety has been described by Gentry (2002) as a negative feeling driven by fear. It is suggested that this feeling would have been with this nurse on an almost daily basis given the nature of acute stroke illness encountered in this role. This is evidenced in Mandy's reflection on crying after every shift. The understanding of trauma is often grounded in an illness ideology, focussing on the negative associated consequences, emphasising poor adjustment and barriers to it being surmounted (Day and Wadey, 2016). Sandra and Mandy's clinical roles are that of experienced SSNs. However, in terms of their stories the role that they have been interpreted as inheriting is that of the communicators of anxiety and fear. This researcher has also interpreted a possible resentment related to their role and how it has made them feel. Sandra and Mandy are rendered vulnerable through their apprehension and anxiety. The experience of vulnerability prompts a response that is characterized by narrative despair where the life narrative is disrupted (Frank, 1995). The chaos or despair narrative has been deemed as being the most difficulty to hear because they are the least socially acceptable (Frank, 1995). They describe individuals who are unfortunate to feel out of control with their daily life (France et al, 2013). This researcher finds that the feelings of anxiety and apprehension described by Sandra and Mandy situates them within a despair narrative where they are unable to control their feelings and are at odds with the image of strong professionals.

Maria's narrative in the preceding chapter referred to her experience of catastrophic strokes resulting in very poor outcomes. Continuing her story, she refers to her role with reference to thrombolysis and that of supporting her sick patients and their relatives. She describes her own psychological turmoil in again graphic detail,

MW: Did you experience any distressing symptoms related to these events (for example- insomnia, nightmares, low mood, intrusive thoughts, irritability/ impatience, crying). How long did you experience these feelings for?

> Yes I quite often don’t sleep very well if we have had a big stroke in and they were Thrombolysed and I can’t wait to get to work to see how they are and I am anxious they have bled. I often wake up at night about 4am and can’t get back to sleep my head goes round and round with intrusive thoughts. I sleep much better if I am not working the next day or on holiday. I get irritable if I get tired though I am usually ok at work it tends to be at home that I get snappy! I have been upset- cry after talking to relatives if the patient is sick or dying. I do sometimes feel I don’t want to go to work in the morning because of what I might find from the day before but I always go and once I am working I am fine. I do get low in mood for a while but not more than a day and I have never had time off or had long term problems in all the years of nursing’ (Maria).

Maria’s story, along with that of Sandra and Mandy, is interpreted as being strongly suggestive of the key characteristics of the psychological experience of STS- anxiety, intrusive thoughts, irritability and crying. These themes are present in each of these data and are building the narrative of these nurses’ psychological terrain being disrupted. The three stories can however be interpreted in contrasting ways. Maria’s story focuses on what has happened in terms of patient care whereas Sandra and Mandy are perturbed by the thought of what might happen. From this the distinction is drawn that Maria is anxious with regards to who she has cared for in her role and their outcome, while Sandra and Mandy are apprehensive about what stroke related situation their role may force them to contend with. There are further details regarding the experience of feeling low in mood and a genuine sense of dread about what may happen once at work. However, in Maria’s story, these experiences do not appear to have had an effect in terms of her being able to attend to their duties and she reports herself as fine once she is in work. The data also reveals a theme that several of the stroke specialist nurses commented on- short term low mood and disturbed sleeping patterns. These feelings appear to run alongside their feelings of anxiety and apprehension.

The following data from Jayne's story further illustrates this.

Jayne's story

(Data collected by interview)

Jayne works in a regional hyper acute stroke centre that provides a 24-hour stroke service including thrombolysis and thrombectomy. She has 15 years as a qualified nurse all of which has been spent in stroke services. She has been an SSN for 9 years. In her role as an SSN she recalled in vivid detail her experiences of patient complications following these interventions. She recalled how these experiences had resulted in her having anxiety and subsequent insomnia,

MW: with reference to what you have seen within your role has there ever been anything that has caused you to lose sleep?

> 'Definitely, I've definitely lost sleep I mean I've rang up or texted one of the girls that are on the shift next day to see how they are. I do wake up thinking how they've done yeah there's certain situations where I've definitely phoned to see if they're OK, especially if they're particularly unwell or you know any thrombolysis hasn't gone particularly well' (Jayne).

Jayne's experiences share similarities with the other SSN's data. In Jayne's story her role becomes that of informing the listener of her anxiety and intrusive thoughts related to the patients she has cared for. She inducts us into the story of her concern about the patient's condition and how this wakes her from her sleep. The story conveys the drama of her anxiety as she feels that she cannot wait to hear of the patient's status and relies on gaining this through her colleagues who remain on duty. Jayne follows this course where interventions have not gone to plan, or the patient is unwell. This researcher's interpretation is that Jayne's feelings and actions are not a routine feature of her day-to-day practice but are in response to ill stroke patients. She seeks reassurance in following up on her patient's progress and presumably finds comfort from this as it is an activity that she appears to have done on a number of occasions. She did not indicate how she felt if she was informed that the patient's progress was not good.

The theme of anxiety and subsequent insomnia identified in Jayne's story (and Maria's) can be linked back to the narrative of caring for acute patients with these data demonstrating the SSNs being preoccupied with acutely unwell stroke patients, particularly where they have undergone treatment with thrombolysis. The cognitive impacts of this obsessiveness could also be linked further to intrusive thoughts that are also interpreted in these nurses' stories. Intrusive thoughts are referred to as the distressing recollections of events and can including images, thoughts or perceptions (Shipherd and Fordiani, 2015). This feature of traumatic stress reaction has in turn been linked to insomnia and feelings of uncontrollable worry (Harvey et al, 2005).

The experience of distressing thoughts and insomnia was not exclusive to witnessing acute stroke related suffering. James had earlier described his story of clashing with an uncompromising family while trying to care for someone with an acute stroke. His narrative made specific reference to how he felt at the time. Interestingly, he was one of the few SSN's who referred to somatic complaints at the time and how he felt queasy in this situation. However, the uncomfortable events that he was involved in affected him in other ways:

‘That caused some insomnia because, erm, it kept on playing around like, er, I was visualising the scenario in the third person view I kept on thinking about it. That went on for a few days I suppose that and I kept on thinking about it, not like a post-traumatic flashback or anything like but it was that if that’s a sort of words you could use that’s what I would use you know. It was just like flashing through my mind and thinking about this’ (James).

James’ story describes his experience in the language of STS- preoccupation, intrusion, flashbacks. He describes his experience in terms of someone else looking at the situation. He describes himself as returning to the situation in his mind and ruminating on this. James disputes the terminology of what he is feeling and although he initially denies his experience of being one of flashbacks, he then affirms the experience as such.

Rourke (2007) and Beck and Gable (2012) have referred to the distressing phenomenon of ‘flashbacks’, the re- experiencing of distressing events through intrusive thoughts and nightmares, both with vivid imagery. In the above story the James confirms the impact on his sleep but goes on to describe his experience of intrusive thoughts. The interpretation is that James’ traumatic experience has permeated his consciousness to the degree that his psychological landscape was disrupted in its immediate aftermath. However, although his intrusive thoughts and insomnia lasted only a few days, his following narrative describes the longer-term impact with regards to interactions with relatives,

MW: ‘given your experience is there anything related to hyper acute stroke care that you would look to avoid?’

> ‘Erm no no I wouldn’t say that I’d purposely now try and avoid anything, erm, am I wary I? I wonder if I’m wary more wary than I was before of, of, of, erm, emotional attachment maybe maybe maybes I’m a bit more matter of fact, erm, we had a lady just the other week (pause) family very upset tearful whereas once before I might have cried with them er and got upset myself quite easily whereas now well I certainly didn’t this time’ (James).

MW- ‘so do you try to avoid emotional attachment?’

> ‘It was very (pause) ah yeah it’s a good point not that I avoid it I just think it’s its I find it easier now to to be very fact but supportive obviously not like an automaton erm where you don’t have emotion the emotions are there but I suppose for me they don’t want their health care professional crying with them they need a bit of strength so I suppose that’s what they need so that’s what I give them’ (James).

Both excerpts from James’ narrative reveal trepidation. There was hesitancy in his responses denoted by the use of ‘erm’ and repeating certain words. At the pause referred to in the first passage I recall James taking a deep breath and not saying anything for some seconds. The impression was that he was affected by the story he was recounting. This researcher’s interpretation is that his story speaks of a reluctance to be overly committed and of putting on a front to guard his real feelings. James reveals more of himself here. He sees a difference between what he believes his role is in supporting relatives and what he assumes relatives would like or need. Hospitals and other health related or medicalized settings diminish and destroy identities resulting in a loss of the self (Frank, 2004). This researcher holds the impression that this is the case with James. His past experiences have left an imprint on his thoughts, feelings and actions. He positions himself as the aggrieved party who has had to change in the light of what has happened. His adopted protective strategy has a basis in if not avoidance, at least some element of distance and detachment and I think has diminished the way that he engages with patients and relatives.

The following data can be contrasted with James' story. Returning to Laura's narrative, she also recalls intrusive thoughts spawned by distressed as opposed to disobliging relatives- again referring to the death of a female in her late twenties following a large intracerebral haemorrhage,

> 'I could not stop thinking about her and how her body looked so perfect on the outside. I kept seeing her husband's distressed face. When I got home I found myself distressed again. I kept thinking about how I would cope if I was faced with a situation like this if this was my husband or child. It made me feel anxious that something may happen to my family. This feeling was with me for about a week' (Laura).

The role being played out in Laura's story is one regarded by this researcher as preoccupation. In Laura's story she is placed in a position where she is unable to reconcile what is and what should be. The relatives face and the woman's body form part of her intrusion which has invaded her thoughts away from the clinical area. The sense of distress is worsened by reliving these experiences and the thought of what should or could have been. In what is essentially a despair narrative, the consideration of denied opportunity as discussed by Smith and Sparkes (2007) and Nelson (2001) is again audible. Laura's disquiet forces her to consider her own family and she is anxious that something as bad could befall them also. Laura's experience suggests the anxiety is not unfounded as stroke can happen to anyone at any age. This causes her to question how she would cope. Again, the feelings are transient in that they lasted a week. However, this story has remained with Laura in the long term for it is what she recalls as being the cause of her greatest trauma in response to my initial question.

In each of these stories it is this researcher's interpretation that the traumatic event has been seared into the consciousness of these stroke specialist nurses. These are the stories which for their narrators have remained their most readily recalled as traumatic when discussed in the context of hyper acute stroke. Clark (2014) has referred to narratives of moral identity- what one's values are, what one cares about and responds to. This researcher finds that these SSNs values are patient based and they care deeply about their caring role. However, this investment has consequences. It is evident in these narratives that these events have led them to experience such emotions as anxiety, apprehension (Sandra/ Mandy), depression (Maria) and intrusive thoughts (Jayne/ James) - all themes related to the psychological experience of STS.

Hyper vigilance is the increased state of anxiety and exaggerated intensity of behaviours to detect threat, the expectation to be victimized or lose trust in one's own instincts. Kintzle et al (2013) have identified increased startle response and hyper vigilance as further behavioural changes that can be the result of traumatic exposure. None of specialist nurses' stories included any reference to experiencing increased startle response. However, one nurse, Pam, did express her anxiety as that being reflective of hyper vigilance.

Pam's story

(Data collected by interview).

Pam’s story described a series of events whereby a young man with an acute stroke went into a rapid and fatal deterioration. Pam had made multiple attempts to bring this critical situation to the medical team’s attention but felt like she had been ignored. In her story she reported how her behaviour had changed in light of this,

MW: with regards to what you’ve witnessed, did you feel any apprehension, anxiety or at all nervous about looking after acute stroke patients?

> ‘I tell you what I did experience, that I was more conscious of my action and what I was doing, so when I looked at someone and thought oh well, they don’t look very well, I’d go back and check them and double check them so I was a bit more self-conscious and I was checking them myself, checking things to make sure we weren’t missing anything’ (Pam).

Pam’s story refers to her actions with an ill individual. Her response in interview was measured and calm but the behaviours she refers to depict someone who is anything but. The picture Pam constructs is of someone whose experience has caused them to check and recheck their instincts and actions. The interpretation is that Pam is positioned between behaviours of seeking self- reassurance and trying to dispel the self- doubt that the clinical incident precipitated. Pam appears more reassured by checking things for herself; her need for reassurance extends to the team (‘we hadn’t missed anything) that had previously let her down.

Pam’s story is unique in her reference to hypervigilance within these SSN data. The critical incident referred to in her story has clearly a great significance for her. Pam was in her 50’s when she was interviewed and had many years nursing experience. However, it was this story that had the most significance for her in terms of her feeling traumatized. This story played a vital role in leaving its imprint on her in terms of her behaviour in work. However, this also extends beyond that, as she recalled,

> ‘I think I literally cried the minute I went in through the door. You know when your family say, ‘how’s your day?’ and it all comes flooding out and I think you try and keep that professional thing and not let your emotions show but I always do when I go home and I sit and want to have a good cry. It will stick with me for a while and it still obviously sticks with me now’ (Pam).

It is clear how feelings generated by clinical incidents go on for periods of time extending far beyond the initial event. This extends beyond the clinical area and to invade home life which has been cited in the STS nursing literature (Austin et al, 2009). Pam talked of this and the fact that her experiences caused her to be emotional at home despite trying to maintain her professionalism even there. It is clear from her responses that these feelings have remained with her. Again, there is similarity with the other specialist nurses in that these stories remain with them beyond the immediate event and remaining with them and shaping their lives in the future.

Claire expressed similar sentiments of not being able to leave behind what she had been witnessed to. However, in Claire’s narrative it is possible to detect an undertone of rancour at having these feelings and the situation that has caused them.

MW: Did you experience anything like low mood, intrusive thoughts or crying after experiencing something distressing?

> ‘I can feel upset when I’ve left work. I’ll be thinking about things at the weekend or in the evening that have happened during the day. I don’t think you could do a job like this. What do you do? Just when you put your coat on at night you just forget what’s happened during the day?’ (Claire).

Claire informs the listener of her sense of upset after she has left work. She thinks about what has happened even at later points after she has left the clinical area. These feelings alert the listener to feelings of intrusion. For Claire it is not possible to do normal things without thinking about her work experiences. The interpretation made by this researcher was that while she seeks affirmation here, she also betrays irritation.

Her story continued,

> ‘With some of the patients yes I really do cry. Oh gosh I cry (laughs); I cry yes with one that really affecting me. I find myself not totally depressed but it’s always at the back of my mind. It’s always there and it’s that feeling of being overwhelmed and I’m thinking oh my lots of patients I’ve cried for, yeah, so it’s always not like I haven’t slept, but at times I’m thinking it’s always constantly on my mind’ (Claire).

Claire refers how her experiences have left her tearful. In the interview she laughed when referring to being tearful. Her laughter is regarded as her way of trying to diminish or attach less significance to the deeply personal reaction of crying. Her narrative indicates that it is not every patient that provokes this reaction- only the individuals that ‘really’ affect her. Claire refers to her low mood but denies depression. Instead, she relates these feelings to the thoughts she cannot expunge. She refers to these thoughts as being a constant and consuming feeling when she contemplates the many patients she has cried for. The thoughts do not result in insomnia. There is also a paradox in that she refers to at times being plagued by these thoughts constantly. The interpretation is that the experience of distress has intruded Claire’s thoughts to the point that she is both preoccupied and low in mood.

Claire was asked to expand which particular people or events made her feel like this. Her story had previously referred to young people with stroke who were left with significant disability. She referred to how this further affected her,

MW: what is your personal reaction to witnessing young people with stroke who suffer life changing disability and death?

> ‘I grieve in a sense for the patient that doesn’t come well out of it. You’re grieving for the ones you’ve lost (pause) with everything there’s always good and there’s always bad, so for me personally it grieves’ (Claire).

Claire’s reaction to witnessing both disability and death in young people with stroke is one of grief. It is of interest that she feels a sense grief for people who don’t ‘come well out of it’. The interpretation here is that she does not mean individuals who have died but those with life altering disability. The grief here mirrors the lament she previously expressed on considering what these people’s life could have been and what it now is. She then does refer to the young people that have died and grieves for this loss. The pause, although short, indicated that she was thinking about these experiences. She refers to the different outcomes of her experience. What she attempts to convey is that for every good outcome and experience, there is an opposite one. For Claire her sense of sorrow for the loss of young life and futures is a deeply personal experience. Her sense of grief is more than sadness. It is painfully moving.

She continued her story in response to my question:

MW: given the experiences that you've referred to and everything you've witnessed do you ever think that you would consider an alternative to hyper acute care?

> Claire: 'I can't, like, erm, stroke nursing, itself isn't a very fashionable. Nurses don't actually like stroke nursing because all the pain that it is and the despondency of the patient. No, I'm always interested in stroke. I don't find myself thinking oh I need a change. No. Something, I really, really enjoyed' (Claire).

Claire's story invited the listener to consider her feelings that were provoked by her involvement in hyper acute care. The role established in her narrative is that of an informant to tell the listener of all the feelings that she has experienced (intrusion, low mood, grief) and how these have impacted her. However, her response to the experience in the last excerpt appears to leave her position as conflicted. She expresses with some hesitancy how she cannot find stroke nursing pleasurable and states her opinion that it is not a popular choice of job for nurses in general. She cites the 'pain that it is' and despondency of the patients. The interpretation made by this researcher is that she trying to justify nurses' dislike of stroke because of what patients endure. However, what this suggests is that it is not a nursing flaw but the patient's predicament that makes them to look elsewhere. Despite her dislike of stroke, she has retained her interest in the speciality and does not consider a change of role. However, her enjoyment of this is expressed in the past tense.

Fetter (2012) has highlighted the role of grief in nursing practice. It can be reasoned that the presence of grief situates nurses at the epicentre of environments that are marked by sadness and loss. It can be argued that stroke specialist nurses are witness to accumulated grief through the high mortality associated with stroke. However, their experience not only concerns grieving for individuals with shortened lifespans, but also those who have shattered futures. Palmer (2007) has stated that narratives of despair concern stories of pain, mourning, grief and loss. These elements are identified as running through Claire's story. In discussing the quest narrative Frank (1995, p. 128) states that losses are mourned but the emphasis is on gains. The focus is not on regret but on becoming, growth and discovery. In Claire's narrative she has attained some insight into her emotional experience and how it has affected her. However, this gain is at the cost of realizing a certain loss of passion for stroke care.

Gerow et al (2010) have opined on the difficulties grief poses for nurses in that they have to portray strength and control, while contending with loss. This research further conversed on nurses' worldview of coping with grief as involving religious beliefs and spiritual wellbeing. Gunusen et al (2018) reported prayer and faith as a particular source of comfort, especially where these nurses could not alleviate their patients suffering. Throughout the whole of the data collected only Laura referred to her spiritual beliefs (page 122). In her story of a young woman's stroke and subsequent death, she is identified as being deeply shaken by the experience. Laura referred to her experience as making her question her faith. In questioning her faith, she further searches for an answer as to why this has happened. Laura's story finds her considering her spiritual convictions following in the light of traumatic subjection. It again exemplifies the profound consequences of STS on the individual nurses’ core beliefs but also how significant these traumatic events are for them as individuals.

In Maria’s story a different set of beliefs are held to question. Maria’s story saw her being witness to a failed thrombolysis in a young man resulting in subsequent decompression surgery. She refers to the events whereby he,

> ‘... has MCA syndrome and is rushed for cranial decompression surgery and ends up with severe stroke brain damage and you wonder whether he would have been better dying’.

Maria reintroduces the plight of a young man with a severe stroke focusing the reader on the sense of urgency for intervention. The outcome is poor. In Maria’s narrative she positions herself as questioning if death would be a better outcome for the man. The interpretation is that For Maria, the young man’s future life is difficult to contemplate. Maria considers death for this person as a kinder outcome than a life filled with endless suffering. Freeman (2003) has referred to the term of ‘narrative identity foreclosure’. In these tragedy narratives, the outcome is perceived as a forgone conclusion where life is seen as being effectively over and therefore devoid of hope. Maria’s story resonates with this. However, this researcher finds that this story is a narrative of despair rather than disharmony with Maria’s values of wanting to see someone suffer. With reference to relatives Maria then added how she felt compelled to portray robustness in the face of despair,

> ‘I see the relatives right through the whole process and live through every stage with them and its is incredibly distressing – you have to be very strong to maintain a professional but caring façade when you feel hopeless and very sad inside’.

Maria's narrative describes her compassion for and the process by which she supports relatives. This is also distressing for her. The argument is that Maria's distress is threefold- witnessing young people's trauma due to stroke, the trauma of watching a family try to comprehend their loved one's crisis and finally having to upkeep a strong front while not exposing her underlying feelings. Maria's emotions are held in check to be strong for the relatives she is interacting with. What she sees as her professional role makes this demand of her. In Horrocks and Callahan's (2006) study of the role of emotion and narrative in identity construction, they state that tension exists between expressing emotion and maintaining an organizational image. Maria attempts to do this by maintaining a façade. However, the interpretation made here is that Maria is suppressing her own truth, albeit not to the detriment of the person with a stroke or their relatives. The stories collected in this study cogitate on stroke specialist nurses' perception of themselves within their chosen role and the impact traumatic events has had on this. The feelings described in Maria's story can be compared and contrasted with that of Monika, whose narrative also provoked in her a strong response.

Monika's story

(Data collected electronically).

Monika has been a qualified nurse for 30 years. She has been an SSN for the last 8 years. She works in a regional acute stroke service. Monika's story refers to a woman in her 50s admitted following a collapse and low GCS (7/15). The woman who was accompanied by her husband was diagnosed with breast cancer the day before her presentation. The woman has suffered a catastrophic haemorrhagic stroke. The gravity of what she is facing hits Monika suddenly,

> ‘I felt completely overwhelmed. Mixed feeling of sadness and anxiety at how we would tell her husband. All the way through my working life I have never been given specific training in how to deal with breaking bad news. I have been on courses which skim this subject but focus more on the actual wording and breaking it to the family not how we cope with doing it.
>
> I felt completely useless and didn’t know what to say to him. I could see the consultant talking to him but didn’t hear what was said. I felt sadness and was trying not to show too many emotions. I didn’t want to cry in front of the patient’s husband. I wanted to be supportive and tried to supress the sadness’ (Monika).

Monika finds herself caught in an emotional landslide. Her story’s plot focuses on her interaction with the husband of a woman with a catastrophic stroke and describes the feelings generated by this. She considers herself as having feelings of unease and sadness with how the woman’s husband will be informed of his wife’s terminal stroke. The predominant role of Monika’s narrative is to inform the reader how she feels ill equipped to meet this challenge. She refers to past educational activities in breaking bad news. However, she feels that this prior knowledge will not suffice. Monika’s sense of inadequacy continues. She does not know what to say to the husband. The role of the consultant here is again one of authority, knowledge and communication. She sees the consultant doing this but does not hear what is being said. This can be interpreted in two ways; either the words are inaudible, or she is on account of the emotional avalanche not able to comprehend the discourse. In comparison to Maria’s story, Monika suppresses her emotions and aims to support the relative. At this point Monika is left alone with the patient and her husband in the resuscitation department. She continues,

> ‘The man kept saying why. Is it the cancer? I tried to be as clear as possible. I told him it was bleeding in the brain. A blood vessel had burst. The cancer wasn’t linked. It was probably caused by long term hypertension. Being able to explain the clinical points gives us some protection and almost distances me from the raw emotions the man was feeling’ (Monika).

Monika describes how the woman’s husband cannot comprehend what has happened. The role of the relative in this situation is one of being an impotent and unwanted spectator in their loved one’s decline. Monika is now able to engage in the interaction giving information to the relative. Her role becomes one of communication. However, this is interpreted by this researcher as one in which Monika has no choice as the consultant has gone. Monika informs the woman’s husband of the medical reasons why the event has occurred. She feels that having knowledge and being able to use it is a form of protection. She speaks of the value of knowledge as affording her a feeling of distance from the emotion that the husband is feeling. Her explanation is literally clinical. This researcher opines that it is that the clinical information given along with the suppressed emotion creates a shield between Monika and the husband who is buckling under the emotional onslaught.

> ‘Obviously I have dealt with lots of sad situations throughout my working life (I have been a nurse for 30 years). Many emotions come through anxiety, relief, sadness. I think the strongest feeling I have now is relief it isn’t me or my family. This makes me feel guilty’ (Monika).

Monika refers to the mix of emotions she has had during her 30 years career- anxiety, relief, sadness. At this point she discussed her coping strategies with reference to hyper acute stroke care and trauma (this will be discussed in greater detail in chapter 4 of the data analysis). Her story again has similarities with that of Maria in the experience of anxiety and sadness. The sense of relief Monika refers to can be interpreted in several ways. In stroke nursing it may be that the relief is generated by thrombolysis going well- where the patient has recovery of function with no complications. Alternatively, it could be interpreted as someone who is relieved that their patient is no longer suffering (death). The strongest emotion Monika concludes with is the sense of relief that it is not her or her family in the situation of a catastrophic stroke. However, such relief has precipitated feelings of guilt.

Monika's story is compassionate but is also suffused with anxiety and feelings of being inadequate. Initially she does not know how to deal with the situation. Similar to the other SSN stories she suppresses her feelings. There is a sense here of her feeling that she does not live up to her own expectations- especially given her long service. She partially explains this in terms of a training deficit. Her narrative hints at some dissonance but she certainly uses knowledge to create distance, which is interpreted as her protective mechanism. Her sense of both relief and guilt leaves her uneasy. These are powerful emotions that can also be indicative of shame. Shame has been defined as a distressing situation emerging from a realization of a basic personal ineptitude (Kaya et al, 2012). The perceived sense of incompetence may emanate from feelings of weakness and loss of control over the ability to manage the emotional situation.

The interpretation here is that Monika feels unable to attain her own desired standard and fulfil her own expectations. She gives the impression of being able to eventually engage the relative despite feeling overcome. Her finishing lines are however fascinating. The sense of relief emanates from identification with herself and her family. Being able to 'survive' has however evoked a dissonance with nursing values of putting others needs before one's own. There is possible recognition of this in the sense of moral culpability.

Fontenot et al (2012) have discussed cognitive dissonance as individuals being engaged in activities incompatible their core beliefs. This disruptive cognitive schema has also been cited in the nursing literature reporting on STS symptoms (Austin et al, 2009. Walsh and Buchanan, 2010. Giarelli et al, 2016. Gunusen et al, 2018), with the discussions giving consideration to both nurses' professional and personal feelings. Bolton (2000) has remarked on nurses often having to present a mask behind which their true feelings are hidden and not disclosing their emotions. Several of the SSNs stories portray these behaviours but arguably at a cost to their respective hosts (Maria/ Monika). Cooper and Hogg (2007) have described the key characteristics of cognitive dissonance that can result in embarrassment, shame, regret or anger. This researcher has interpreted that these data reflect this on a number of levels - that these elements are manifest as the result of the situation, of being powerless to alter it or of being powerless to feel different.

No response was made that suggested a desire not to be involved in hyper acute stroke care. Despite being involved in situations where traumatic experiences were encountered, no nurse expressed a will to avoid this. Only Maria described feelings of avoidance, however, this was more on account of the personnel involved rather than being witness to something of a possible traumatic nature:

> 'I do sometimes want to avoid being around if the Consultant who doesn't believe in Thrombolysis is on duty because it is so stressful and frustrating but I don't actually go through with it!' (Maria).

Maria raises an interesting point here. Some stroke services rely on others to maintain the service in their absence. Not every team will have a dedicated stroke clinician who is present ‘out of hours’. This has been to some extent negated by telemedicine/ remote reviews. However, Maria’s service at the time of her data submission alerts the reader to this deficit. Some stroke presentations will be handled by senior ED consultants rather than dedicated stroke consultants. In Maria’s story her stress is triggered by someone who’s knowledge and perhaps confidence in hyper acute stroke management is lacking. While she can again be seen in the role of a likely advocate, there is also enmity. The consultant is painted in the role of the narrative’s antagonist. The theme of avoidance does not relate to Maria’s patient care. However, it does generate for her feelings of stress and frustration and is reminiscent of the earlier consideration of her being potentially rendered silent. Furthermore, the subthemes of moral distress and conflict can be detected.

Many of the nurses’ responses were suggestive of thoughts on how they felt about stroke specialist nursing in the light of witnessing traumatic events. The reactions here have varied between fear and stoicism. Despite some reservations, none of the specialist nurses conceded that they no longer wanted to work in their specialist nursing role.

Although none of the nurses wanted to avoid being involved in hyper acute care, some did express some degree of anxiety about what they may have to surmount given previous events. Paula’s story concerned the case of a woman who died following a thrombolysis related complication (haemorrhage). With regards to future people requiring thrombolysis she voiced this apprehension,

MW: Can you tell me about how this incident made you feel? Did it result in any physical or psychological problems for you?

> ‘Erm, I think ,erm, the erm, the scenario that I told you about with the patient we thrombolysed that died I think that, erm, a knock on from that was some anxiety about the next thrombolysis call so that kind of ,erm ,and also, erm ,almost impacting on my thrombolysis and my decision making, erm, so the next patient that came in that we were like ooh should we thrombolyse, shouldn’t we thrombolyse you would err on the side of not thrombolysing because of what happened which is absolutely wrong’ (Paula).

Paula’s narrative starts in dysfluent fashion signposting the listener to her uncertainty. She refers back to the source of trauma in her story and then describes her anxiety with what might happen in the case of a future event. She makes the audience aware that a similar scenario might impact her decision making. Her story offers a debate over intervention- the ‘should we-shouldn’t we’ could be interpreted as her own personal thoughts or that of what she believes the involved team might be thinking. These thoughts are personal to her given how she takes ownership of the scenario (my thrombolysis/ my decision). Biomedical approaches have been regarded as sidestepping issues of ethics (Mattingly, 1998). Narrative theory and analysis by contrast allows for such considerations (Mattingly, 1998. Polkinghorne, 1995, Ricouer, 1991). Paula’s story exemplifies this. Initially she expresses a cautious approach. However, she sees this approach of not prioritizing someone for a potential treatment, as rightly unethical. Her narrative affords her ethical insight- the moral component being beneficial (Legay, 2014). Her role can be seen in this narrative as being one that has the patient’s interests at heart. However, although Paula’s story takes a moral turn here, the themes of anxiety, apprehension and uncertainty remain its predominant features.

Paula’s story continued to further describe her uneasiness in response to this question, MW: Do you think that anxiety carriers over in your practice? Have your experiences ever made you feel like you want to avoid certain situations or not want to work in hyper acute stroke specialist nursing?

> ‘Yeah, so that anxiety of going to the next and when’s that thrombolysis bleep going to go again and am I going to have to make this decision again and are we going to kill someone again. It’s that kind of feeling of total responsibility for someone’s life’ (Paula).

Paula’s sense of anxiety remains present at considering the next person who might require thrombolysis. Her tension escalates with thoughts of the thrombolysis pager going off. Similarities are present here with Sandra’s narrative where the ‘stroke bleep’ and its meaning are a focal point for unease. Paula refers to what she considers her dilemma- will *her* decision lead to someone being killed. She still feels a sense of responsibility and in referring to it as ‘that kind’ accords it significance.

Czaja et al (2012) has cited apprehension as a factor in post- traumatic exposure, further stating that the sense of it can be abnormal or inappropriate in proportion to the problem under scrutiny. Paula’s sense of trepidation is genuine given the seriousness of the outcomes she is fearful of. Her feelings are interpreted as being rooted in the sense of responsibility. However, the interpretation made by this researcher is that Paula’s sense of role responsibility is skewed. The events in her story have affected her considerably. However, the plot of her story is about a complication not an intentional death. Interventional decisions are made by stroke consultant physicians. SSNs are often involved in this process but the ultimate sanction lies with them. The themes of Paula’s anxiety, apprehension and uncertainty are intrinsically linked to her understanding of what she sees her responsibility as. This can be contrasted with Jennifer’s story. Jennifer’s story commenced with a more pragmatic outlook regarding the complication of haemorrhage following thrombolytic therapy,

> ‘I think patients that bleed post thrombolysis are part of the course’ (Jennifer).

MW: do you think its experience that has meant that you’re able to contend with seeing this? Some of the other nurses who have been involved in this (research) have been really affected by things not going to plan.

> ‘I don’t know whether I’m harder than most, but I think erm, I think you learn from these things so that when the crap has hit the fan and something has gone wrong, we think why has it gone wrong and we try and learn from that and (pauses) some things are a never event, but post thrombolysis bleeding and things like that isn’t so. I can honestly say from a clinical, critical point of view I would not put myself in a situation just because it went bad beforehand. Does that make sense? I can understand maybe some of the junior doctors or junior nurses- sort of five deaths post thrombolysis might be a bit wary but it’s you know, it’s not our decision, at the end of the day it is the medical decision’ (Jennifer).

It is possible to claim that there may be an element of role desensitization at play in this data. However, it is also possible to argue that Jennifer’s years in her role have led her to a view that is more realistic, more accustomed to the fact that complications such as post thrombolysis bleeding and resultant death can occur. Her position is one of pragmatism.

Jennifer initially refers to her own sense of uncertainty if she is tougher than other nurses, something interpreted as being a protective mechanism. Jennifer reports with some hesitancy (erm/ pauses) on the process of experiential learning. She declares that she would not avoid something just because of a prior bad experience or outcome but looks for affirmation here (does that make sense?). She refers to how those with less experience, specifically junior doctors/ nurses, might see things differently. There is also a realization that it is possible to feel bad about poor outcomes following thrombolytic or endovascular intervention, without it being the nurses' responsibility.

There is a contrast that can be made here with Paula's narrative. Jennifer accepts post thrombolysis haemorrhage for what it is- a complication. Paula has obviously been deeply affected by the events of her story. In no way is her experience diminished but her time in stroke specialist nursing compared to that of Jennifer is not as vast. This may explain some of her anxiety surrounding post thrombolysis bleeding, death and responsibility.

Jennifer went on to state in her story 'I am hard. I've been doing this a long time'. She stated that developing such a carapace was a by- product of the years that she had been in nursing and stroke services. The interpretation is that the feeling of being or appearing psychologically tough is a protective mechanism. In Jennifer's narrative the feeling is linked to experience and suggests that this invulnerability is cultivated through many years at a highly specialized level. It is a strategy to avoid humiliation- to be seen as weak. However, Jennifer went on to describe her distress in the light of a direct complaint by relatives with whom she felt had developed a close relationship,

> 'When this really horrible complaint came in, I was gutted to the point where I couldn't go out. Four days off over Easter, cried my eyes out, went home like drank,

> never drink at home- but just hitting the vodka. They said something really horrible about me and I just had a complete breakdown’ (Jennifer).

The nursing literature states hardiness as being the potential for protection against stress. Jennifer wrestles with her perceptions of how she has changed and whether the experience has toughened her. However, her story indicates that given certain circumstances, even those that view themselves as hard, are not immune to psychological disequilibrium.

Abdollahi et al (2014) has contemplated the concept of hardiness in nursing and has drawn conclusions from the relevant literature that nurses who are deemed as being hardy are more resistant to stress. It is suggested that some nurses may view themselves to be ‘tougher’ than others, that their ability to endure difficulties is because they have become hard by being placed in such situations. The following stories offer differing views on experience of bearing witness to traumatic events and how their narrators think their beliefs and behaviours have changed. Charlotte continued her story,

MW: Do you think that seeing this (distress) on such a regular basis, that it changes how you feel about being a nurse?

> ‘Sometimes I think if anything it’s changed me as a person, er, to be honest, I think. I wouldn’t say it’s made me hard ‘cause I’m not a hard person, but I do think it makes you. I don’t know if we kind of develop a bit of a barrier and you know you have that wall up sometimes. I wouldn’t say, I wouldn’t say it makes me hard ‘cause I’m not like a hard person. You have that block sometimes. I think your head makes you that way. But then sometimes it does really get to me and affect me. But I just think like how I’m going to manage this job when I’m older’ (Charlotte).

There are a number of points to consider in this Charlotte's story. Charlotte initially thinks that the role (and in response to the question, what she has seen) has changed her as a person. However, she is not convinced by this herself. Her position is one of self- doubt. She denies has not made her hard and she reveals that personally she does not see herself as a hard person. The interpretation is that Charlotte has her own view of what a hard person looks/ behaves like and she does not conform to this vision. She refers to being hard 4 times in this excerpt. What she appears to be doing is reassuring herself that she is not this way and is fearful of becoming a tough individual. She distances herself from adopting the negative intrinsic change of becoming hard. Price (2007) has observed how individuals core schemas- the most fundamental of belief systems; rules, attitudes, underlying assumptions, conditional beliefs- are altered in the light of trauma. Charlotte at interview was not convincing of being a tough character. However, Charlotte's cognitive schema has been altered by her suggestion of having that 'block'. This is arguably in response to what she has witnessed and is not something she may have direct control of- 'your head makes you that way'. This is interpreted to be a protective element in response to what she has experienced and how it affects her. Charlotte discloses an apparent worry of how she will cope in the future and contemplates how the future may change her as both a nurse and a person.

A further dimension can be gleaned from this portion of Sandra' story that also relates to her experience of toughening up,

MW: did you ever feel that you no longer wanted to work in this area?

> 'There are times where I have felt like that. I have felt sometimes like there are things I have not wanted to have seen or been in the middle of, but I have just had to get on

> with it. I think you get used to it. You have to or you couldn't continue to do it. I think if you are going to do this any length of time it is going to change you. I think that I have either got better at dealing with it or I have become hardened to it. I think we all get harder as we go on. I do not know if we get hardened to it and then the worst thing is we do not know we are hardened to it' (Sandra).

In Sandra's story she recalls times where she has felt that she no longer wanted to be in the SSN role. She does not specifically refer to episodes that have caused her distress. This is however a possibility given that on occasion she has been witness to or been involved in situations she would have preferred not to have been. She refers to having had to adapt to this but apparently without enthusiasm ('got on with it'). Her position can be interpreted as wavering between pragmatism and being resigned to this strategy. She asserts that the adaptation is necessary or there would be a crisis of not being able to function. Sandra illuminates the SSN experience as being transformative. She offers her opinion that she has either become acclimatized to the role and what she is confronted by or that she has become tough enough to endure it. Sandra gives her opinion that SSNs get tougher with experience in nursing (and perhaps life). The story's coda is that Sandra thinks the worst outcome is that SSNs have become hard but do not appreciate or have the necessary insight to know that this is what they have become.

It is interesting to compare this part of Sandra's story with the anxiety ridden narrative that was introduced at the start of this chapter. Sandra indicates initially that she thinks that she has got used to what she sees as part of her role but does not definitively state how. Her tensions remain an issue but are more sporadic. The second part of her story indicates a behavioural change (becoming harder) that has allowed her to continue. However, Sandra suggests that nurses who have become hard may lack insight into this change. Here her story prompts a recollection of Nelson (2001) and Frank and Thomas-McClean (2004) and their discussions on narrative concerns of damaged identities, psyche and wellbeing. While becoming hardened may prove to be a protective element against the effect of trauma, in turn it may be at the cost of becoming or at least appearing insensitive.

Nurses’ responses described here are variable. It is intriguing to note how some have reported on how their own set of values and beliefs, both personal and professional have been impacted upon. Resilience has been defined as the ability to recover and return to those former behaviours present before the period of disruption (Waller, 2001). Mealer et al (2012) has promulgated how resilience is associated with healthier psychological profiles in nurses. Resilience is multifactorial in basis, with age, experience, education and clinical environments being influential (Grafton et al, 2010). It is suggested by this researcher that the stroke specialist nurses responses to trauma may be affected by their ability to be resilient.

5.4: Summary

This chapter has described the SSNs experience of the reactions associated with secondary traumatic stress. The feelings that these nurses describe are commensurate with the experience of the reactions that people who have been exposed to secondary trauma encounter. While the somatic complaints that these nurses experienced were seldom referred to, the SSNs reported how their psychological wellbeing had been impacted. References were made by these SSNs to the experience of reactions such as anxiety, apprehension and grief. Several references were made to behavioural and cognitive changes such as distancing, dissonance with core values, avoidance and the development of emotional toughness. The experience of these reactions had implications for their personal lives and those of being a nurse. The description of these reactions answers the research question affirmatively that these SSNs do report experiencing feelings that are commensurate with STS and that this has impacted their psychological landscapes. These findings are congruent with that in the trauma literature in general and that concerning nursing.

This section of the thesis donates a new appreciation of the reactions that these stroke specialist nurses experience following their exposure to traumatic events. It offers a fresh insight into the psychological impact that STS has on these individuals. In terms of this thesis this chapter takes a further step in describing these nurses' reactions to the trauma sustained through their hyper acute practice. It adds further weight to the argument by moving on from the initial step in the trajectory of these SSNs trauma narrative of the cause and context of STS to describe nurses' emotional reactions to it. Furthermore, this chapter adds to the theory of traumatic stress within nursing specialties. It also adds to the appreciation of this new area of inquiry not only in terms of stroke nursing and the emotional burden of caring associated with it, but also uses the novel approach of narrative to enhance our understand of the lives of these subjects.

Kleinman (1988) has been critical of biomedical approaches in which clinicians focus on disease, symptoms, biomedical reductionism and practitioner privilege rather than documenting the experience of it. Dein (2016) in discussing narratives healing implications for psychotherapy and psychiatry has also referred to the reductionist emphasis of explaining mental ill health in terms of biology, psychology and symptoms. The SSNs involved in this research referred essentially to their experience of STS in terms of anxiety, apprehension and depression. This in turn led to insomnia, irritability and preoccupation. Much of the literature on STS refers to these elements as 'symptoms'. In this thesis the researcher has tried to move away from this form of labelling. The aim has been to try not to explain these nurses' reactions in biomedical terms, but to try to veer off from symptomology to describe what they experienced.

Both Figley (1995) and Morrissette (2004) have described STS reactions in terms of physical, behavioural, emotional and cognitive categories. The SSNs stories made little reference to physical stress reactions. Sheppard (2016) offers the opinion that initially the reactions are of an emotional nature and thereafter end in physical manifestations. However, it is argued that there is cross linkage and cross over between these areas. Examples could be made that behaviours such as crying (Mandy, Monika, Pam, Claire) or insomnia (Maria, Jayne) could be the result of emotional traits such as anxiety or despair. The behavioural element of avoidance could be contrasted with that of obsessiveness. It is offered as debatable to what extent one reaction links or even precipitates another. While these reactions may occur in isolation, the data analysed here has shown that the SSNs often experienced a number of combined negative feelings following their trauma exposure.

Peters (2018) has gone on to state that alongside the physical, emotional, behavioural and cognitive elements of STS, there also exists social, spiritual and intellectual effects. The social effects can be observed in some of the SSNs responses where their feelings have been residual to the point that this has been carried into the home (Maria, Jayne, Pam). Furthermore, one nurse reported how she had following her traumatic episode come to question her sense of faith (Laura). In terms of the intellectual component, none of the nurses questioned their ability to problem solve or make decisions. However, some of the data suggests the specialist nurses' self- appraisal as being in negative terms (Maria, Monika). The SSNs reported how there was disconnectedness with their values, how they saw themselves as a nurse and patient outcomes. It is argued by the findings of this research that what the SSNs experienced falls beyond their mere categorization of the physical and psychological.

Cranfield (2005) has argued that STS reactions that are less than one month in duration are considered normal. Several of the SSNs commented on the duration of their reactions as lasting for a few days up to a week. However, these experiences were easily recalled by the stroke specialist nurses. The impression is that while the actual duration of time that these negative feelings were experienced was small, the impact was considerable. Furthermore, the disabling nature of these feelings would suggest a minimised capacity for the nurses' self- care, with repercussions for patient safety and satisfaction (Cohen-Katz et al, 2004).

Sinha (2016) has discussed how trauma as an extreme life event can generate a sustained neurobiological response triggering the onset and maintenance of insomnia. Furthermore, trauma may result in stimulation of the amygdala-limbic/ brainstem system promoting activation and alertness- a state of hyperarousal (Williams et al, 2006). The experiences reported here are consistent with the hyper arousal noted as defining features of STS and are well aligned to the findings of the literature on the phenomenon in nursing populations.

Many of the SSNs reported on having experienced disturbed sleep. Maria, Jayne and James' stories all referred to this. Insomnia has been cited as a risk factor for depression (Spoonmaker and Montgomery, 2008). Furthermore, STS has been correlated with depression (van der Wath et al, 2013). Although many of the nurses commented on their feelings of sadness, several nurses also referred to low mood, with another stating that they had experienced depression.

Hegney et al (2013) have discussed the emotional cost of nursing as resulting in cynicism, poor self- esteem and survivor guilt. Furthermore, Houck (2014) has offered a link between traumatic stress and accumulated grief. Grief and guilt both featured in the stroke specialist nurses data with Claire in particular describing her sense of grief on considering patient's poor outcomes. Many of the nurses' adopted a mask of professionalism in response to this (Maria, Monika). Delgado et al (2017) have described nurses' reactions to grief as ranging from stoicism to acknowledgement and engagement in a shared loss. The stroke specialist nurses data suggests that these nurses have difficulty in being able to reconcile this and in a possibly protective strategy have maintained a more impersonal stance. This would again imply an inconsistency between their behaviour and their thoughts creating a dissonance (de Vries and Timmins, 2016). Several nurses adopted a tough veneer as a coping response (Jennifer, Sandra). However, Charlotte was fearful in respect of how becoming tough might change her. Diehm et al (2019) have identified three domains as being specifically linked to secondary exposure to trauma: intrusive thoughts, arousal and avoidance. Avoidance (which is also referred to as detachment, disengagement and distancing), is the practice of choosing to be removed from aversive situations (Missouridou, 2017). While this behaviour can be viewed as protective, it can by contrast also be seen as dehumanizing (Paley, 2014). James' story highlighted how he adopted a personal protective stance of trying to avoid emotional attachment. Secondary traumatic stress has been seen to pose a serious violation to ethical principles and has therefore the capacity to place people at risk (Everall and Paulson, 2004). However, despite the compromise to the stroke specialist nurses belief systems, none reported that they felt the care they gave was inadequate. Hart et al (2012) have identified nurses' experience of psychological emptiness as the result of frustrations within the workplace whereby nurses feel stripped down and unable to reconcile their beliefs and emotions. The data findings and their interpretation in this thesis demonstrate that the stroke specialist nurses experience emotions which are raw, but ones that are also far from empty.

5.5: Conclusion

This chapter has discussed the physical and psychological impacts of STS on stroke specialist nurses’ hyper acute practice. The descriptions given of STS reactions in this stroke nursing population are congruent with those in the nursing literature on STS. By far psychological effects are predominant within the data examined. The impact described is however varied. Many nurses gave arresting descriptions of how trauma had affected them. However, none indicated their need to avoid similar situations. The descriptions captured suggest that traumatic experiences could have deleterious effects for those exposed to them. Yet the reality is that these nurses are able to endure this and maintain their highly specialized practice. The following chapter will address what the stroke specialist nurses felt added to these feelings in terms of exacerbating and perpetuating them.

Chapter 6: Narratives of Continued Disruption

6.1: Introduction

The following chapter concerns the factors that the stroke specialist nurses felt exacerbated their feelings of secondary traumatic stress. The intention is to explore the factors that the SSNs believed to make their experience of traumatic episodes worse. The specific aim is to formulate an understanding of how these elements accentuate the specialist nurses' traumatic experiences. The analysis of the data has revealed a number of exacerbatory factors. Extensive data extracts are presented along with supporting evidence to emphasise this. Description and discussion of the data will lead from there to offer meaningful interpretations of the stroke nurses experiences and lead to conclusions on the factors responsible for aggravating and perpetuating the experience of STS in stroke specialist nurses. A concise summary of the findings will be offered as a conclusion. It will also address how this chapter contributes to meeting the research aims and what it adds to the thesis. Furthermore, it will refer to how this chapter has informed the narrative of the thesis itself.

The first section will refer to the area of empathetic engagement.

6.2: Empathic engagement

It is suggested that many of the noted STS reactions and even the context in which STS occurs can be viewed in themselves as exacerbating factors. The ability to foster empathy is central to the process of caring, but it can also precipitate trauma reactions. Arguably, if there is no empathy, there will be no trauma. Several SSNs commented on their feelings of empathic engagement and how it affected them. Francesca's story described her feelings as such (page 128). In Francesca's story she informed us of the many similarities she shared with her patient (age/ nationality/ language/ siblings). This led to her forging a close bond with the patient and her family. The similarities were tangible leading to an empathetic and emotional attachment. However, she went on to discuss her sense of empathy in relation to stroke care,

> 'In stroke care I get vey more attached to my patients and their families and so if someone dies or if the outcome's poor then I think it probably upsets me more and I may go home and think about it' (Francesca).

Francesca positions herself as someone affected by caring for people with stroke. She informs the reader that stroke care is the area where she finds greatest attachment to those in her care and their families - she is comparing her previous experiences with other patients to those with stroke. Through her role of being an SSN she has realised her compassion and empathic engagement with stroke patients. She imparts that if someone dies or the outcome is poor, she thinks that it probably impacts her more and she may go home and think about it.

A key tenet of nursing practice is the investment of empathy (Wilkin and Elevin, 2004). However, Duarte et al (2016) have recognized the role of empathy as a risk factor in the development of STS. It has been described in this context as being that of a double-edged sword (Sabo, 2006). Shorter and Stayt (2007) have discussed meaningful engagement and emotional attachment, the bond formed between nurses and patients and their families and in how these relationships grief reactions became more accentuated. Francesca's story refers to this and specifically the cost of stroke in terms of death and disability. Despite her attachment, her reaction to death and poor outcomes in these individuals is not entirely convincing as she thinks that it *probably* upsets more and that she *may* think about it.

In Monika's story she referred to how she came to identify with her stroke patient and envisaged her own family's response should she be as unfortunate to find herself in this predicament,

> 'I empathised. I was close in age to this lady and felt sadness. I could imagine my family in this situation' (Monika).

Monika's brief excerpt gives conviction to her feelings. Monika clearly positions herself as having empathy with this person. She identifies with the woman through the similarities in age. There are similarities here in the way that Francesca identifies with the person with stroke in her story. She imagines herself and her family in the situation of stroke. While there is empathy, these visions are also disturbing for Monika as they leave her fearful.

Yoder (2008) has suggested that there is identification with patients who have similar characteristics to those caring for them. Van Der Cingel (2011) believes that having the ability to identify with another and be empathic requires the use of imagination. The data appreciates the nurses' feelings through the prism of empathy by imagining themselves in the patients' place. However, it can be interpreted that imagining oneself or one's family in the context of a stroke may be distressing in itself. Another nurse had similar thoughts, particularly referring to how age and the random nature of stroke evokes her empathic concern,

> ‘I think it’s more the empathy of it, you know when you see a patient coming in you know, wow, that could be me cos we’re not exempt from it and we see so many young people, so the care is always there’ (Claire).

For both Monika and Claire their SSN role places them in the proximity of patients of their own age and younger. Both their stories convey signify their compassion and the role of empathic engagement in their distress. Claire refers in her story to what she considers as empathetic engagement. She persuades the listener that for her it starts immediately as soon as they present. She signifies that the listener has knowledge of such presentation (‘you know’). She reveals her expression of shock/ surprise (‘wow’) at the realisation that it could be her in this predicament. She qualifies this by rightly suggesting the randomness of stroke illness and specifically considers this in younger people.

Claire equates young presentations as always prompting care. This is difficult to interpret. The impression she gives is one of the empathy for young stroke patients as always being there. However, her investment appears to be at her own emotional expense. She feels selfless initially in that she believes that everything is invested in the patient. However, the resulting interpretation signifies that there is a personal cost to this- where there is empathic engagement, there is difficulty in being able to give more when so much has already been given.

In James’ story, his experience of trauma was created from being involved in a difficult family situation. For James this had a lasting impact on his empathetic investment in the caring relationship. He commented how his sense of empathy was affected extending beyond the patient to also involve the family,

> ‘I realised in myself that you do things day in day out over time you become slightly somewhat jaundiced yourself in care for people who are going through. If you’re doing it day in day out it just becomes a very chore like job. Maybe I’ve reached that stage here. I don’t think so. I still think it’s, I’m a little bit less engaged with the families. I understand that what they’re going through and I try to explain to them to the best of my abilities, yeah. Maybe just getting tough. Not tough. It’s just you need to be there for them. Before you could get emotionally involved, couldn’t you quite easily? Whereas now you know what you need to do you know your job inside out you can explain things to them in a way that they’re going to understand. You make that connection that way’ (James).

Everall and Paulson (2004) have suggested that where there is disruption of empathic ability, there ensues a struggle to see the client as a person resulting in a subsequent loss of respect. It is suggested that James’ story implies that caring has been reduced to something merely functional. There is an admission to being less engaged and some deliberation on what they are experiencing but stops short of true empathetic engagement. Riessman (1993, p.3) has discussed how narrative allows individuals the opportunity to discuss events where there has been a breach between the ideal and the real self. The interpretation is that James’ story and his role within it are characterized by conflict which is exemplified by the breach between forming empathic relationships and his new ideal of avoiding them. For James the empathic connection is diluted in favour of being able to explain rather than commit to engagement. His role now prizes being seen as strong over emotional investment. The interpretation taken from this is that James’ behaviour is reflective of his prior traumatic episode. The lack of attachment is protective. The risk for James is however one of disengagement, disconnectedness and detachment. This form of emotional separation has significant association to secondary traumatic stress (Thomas and Otis, 2010). While this behaviour has been seen to offer succour in the short term from STS (Ludick and Figley, 2017), it has been recognized that detachment interferes with therapeutic relationships. Whereas James story does not state an outright disconnection, there is the possibility for it to become engrained by exposure to similar episodes when adopted as a potential shielding mechanism.

This section has discussed how the theme of empathetic engagement can exacerbate feelings of secondary traumatic stress. Simon et al (2006) have offered the view that as feelings of secondary traumatic stress increases, empathic response decreases. Besser et al (2012) have also described how attachment behaviours increase the vulnerability to traumatic stress symptoms. Furthermore, the recognition that empathy has been lost can provoke distress in itself (Giarelli et al, 2016. Findlay and Sheppard, 2016). While the stroke specialist nurses responses signal their empathic engagement (Francesca, Monika, Claire), none state any form of over attachment to their stroke patients. In contrast, none of these nurses demonstrated themselves to be truly emotionally distant or remote. One nurses' data (James) suggested a wariness in regards to forming emotional attachments. However, it is maintained by this researcher that this seemingly protective behaviour stops short of genuine disengagement.

It is argued that the initial data presented in this section records these specialist nurses' empathy as being unaffected. The cost was albeit an increase in feelings of sadness. Newell and McNeil (2010) have commented on the cognitive changes that may emanate from empathic engagement with those who have involved a traumatic event. It is possible to speculate how continually imagining oneself in the place of a stroke victim could be potentially damaging.

6.3: Feelings of powerlessness and hopelessness

In this study, powerlessness was a recurring theme throughout the data referring to STS trigger situations. However, this researcher argues that stroke specialist nurses also encounter powerlessness which differs from that as a result of moral distress. Stress often appeared to be encountered in scenarios by which the specialist nurse felt a sense of impotence to alter the clinical situation and its likely outcome. Several nurses reported the sheer frustration where patients had not been able to be treated as they had not attended within the therapeutic time window of 4.5 hours, as Maria's story documents,

> 'Sometimes if they come in and they're just outside the time for thrombolysis, you know a big stroke, you feel frustrated because you can't do something for them. That's probably the biggest frustration' (Maria).

Maria's story discusses a patient's presentation in general terms. She draws us to the problem of people who present late with stroke outside of the therapeutic window of 4.5 hours. She signifies that the reader may also have had experience of this (you know). She forces us to think of the frustration where nothing can be done for large strokes not presenting in time for intervention. She refers to this as the biggest frustration. The frustration is that these people, if they had presented earlier may have been treated (likely) and may have improved. The focal point of this section of her story refers to powerlessness. There is nothing that can be done to change this situation as the therapeutic window for intervention has been closed. Powerlessness is a key feature of Frank's (1995) chaos narrative. Here there is no restitution as there is no possibility of attaining the goal of a cure. The interpretation is that the powerlessness is subsequently projected onto Maria.

Maria went on to alternatively report feelings of powerlessness after being witness to treated patients who had no response to their intervention,

> ‘Seeing patients who have no result from thrombolysis is very difficult particularly for the relatives who have so much hope- you do feel like you have failed them’ (Maria).

Maria’s story then refers to patients with no response to thrombolysis. She makes particular reference to the impact on relatives who have hope that improvements will be made because of it. Maria states her feelings of failure here. In these two instances Maria can still act in her role to support patients and relatives. However, the role of someone being able to be involved in rescue or restitution is effectively denied. In the first instance, it is interpreted that she is referring to her sense of failure towards the relatives. However, this also includes that towards the patient. It can be argued that this could signify an acknowledgement of the limits of medicine. However, this researcher also finds that this is a reflection of Maria’s sense of powerlessness that there is nothing that can be done to change this situation.

Powerlessness was referred to in the STS nursing research in terms of not being able to change patients’ situations or their own (Walsh and Buchanan, 2010. Melvin, 2012. Gunusen et al, 2019). Kornhaber and Wilson (2011) have described inadequacy, apprehension, vulnerability and frustration as the principal characteristics of powerlessness in nursing. It is conceivable that the sense of powerless could be felt immediately on the specialist nurses’ realization that nothing can be done to intervene clinically. However, the further interpretation is that Maria is confronted by loss of hope for these patients and their families. Hopelessness has been expressed as a theme in nurses’ experiences of STS (Austin et al, 2008. Perry et al, 2011. Sabo, 2011. Walsh and Buchanan, 2011. Gunusen et al, 2018). The concept of hope within a stroke unit setting has been investigated by Tutton et al (2011). The paper revealed that hope was expressed by stroke unit staff, but this was tempered by realism, with a balance sought between giving hope whilst avoiding false hope. It could be implied that nurses who harbour feelings of hopelessness will be unable to alleviate such feelings in their patients. The themes of powerlessness and hopelessness were also evident in Janet’s story.

Janet’s story

(Data collected by interview).

Janet has been a qualified nurse for 20 years all of which has been spent in acute stroke care delivery. She works in an inner city hyper acute stroke centre. Janet was asked to describe any incidents that she felt had left her feeling traumatized. Janet gave a story described a woman who presented in her mid- fifties with a large MCA territory stroke. The woman was initially referred to neurosurgery for consideration of a decompressive hemicraniectomy. The referral was declined in favour of continued monitoring and to refer back if there was any deterioration. Some hours later the woman went on to develop a rapid deterioration after developing MCA syndrome. The woman was referred back to the neurosurgical unit but unfortunately the opportunity to intervene was then deemed to have passed. Janet narrates the situation and her feelings,

> ‘We referred her back to neuro (neurosurgery) who then said ‘ooh it’s too late now’ and it, and, and that, it’s so frustrating, it’s the, not the first time that’s happened and she did pass away here and you know it was quite a sad one cause the daughter was beside herself lying with her mum in the bed just cuddling her and telling her how much she loved her in the hope she’d hear it and I’m stood there watching it and getting angrier and angrier about it. A fifty-year-old lady is going to die and you are

> absolutely powerless to do anything about it and that’s er, that’s it then. I’ve seen that again and I’ve seen it too many times actually’ (Janet).

Janet situates her story in the ward. She is afforded the role of protagonist and witness in these events. She refers to the first characters as being ‘neurosurgery’. They are unnamed and remote from the story’s action; however, their role is significant in that they make the decision that the woman’s condition will not be altered by neurosurgery. Janet reveals her frustration at this and informs us that this scenario of non- intervention has played out before. In this respect the role of the neurosurgical team can be aligned to that of an antagonist in this story. Janet is saddened initially by this. She introduces the characters and roles of the woman (dying) and her daughter (distressed and impotent relative) and the emotive scene she is bearing witness to. Janet’s position within the narrative remains that of bearing witness. She watches on as the tragedy unfolds becoming all the angrier at the situation. She describes the feeling of powerlessness she has at an inevitable outcome she feels she has witnessed too many times.

Janet’s story has echoes of the moral distress referred to in chapter one. However, the woman was initially referred and deemed at that point to not require neurosurgical intervention. Following her rapid decline, surgery was still considered as not in her best interest. Janet’s frustration was readily apparent as she repeated her words over. Janet’s feelings of powerlessness are interpreted to have several foci. She is powerless to redress what she believes is a lost opportunity and there is impotence that the outcome cannot be changed. There are comparisons here that can be made with Maria’s narrative. She describes genuine emotion in terms of her frustration, sadness and anger at the situation. The description she gives of the daughter’s trauma is interpreted here as Janet’s hopelessness. It is this researcher’s impression that she, the patient and the daughter are consigned to is a despair narrative in which their 'world has been unmade' (Frank, 1995, pp.103). However, the interpretation in addition to this, Janet is also powerless to escape bearing witness to the most distressing of scenes.

Frank (1995, p. 94) has opined that where illness is chronic or terminal the preferred narrative of restitution is redundant. Valent (2002) has referred to nurses' feelings of having the inability to rescue patients. There is a sense of hopelessness in their efforts to seemingly make a difference (Killian, 2008). It is appreciable that there are many stroke patients who will present who unfortunately cannot be treated. However, it is possible to suggest that the nature of hyper acute care forces these nurses to confront something on an all too regular basis from which there is no diversion. The following data highlights the gravity of the situation,

> 'I think we take on more of the stressful situations and the difficult cases, the deteriorating patients, we deal with it more often, so we're in the most at-risk group than anybody' (Jennifer).

Jennifer agrees with the corrosive effect of being witness to repetitive stress and distressing events. Jennifer feels that given the number of times SSNs are involved with difficult cases and ill patients, we see it more often than most. She therefore signifies that SSNs are in a high-risk group for developing traumatic stress reactions. The more someone is exposed to traumatic events- the greater is the risk of developing trauma related reactions. Judith's story offers a picture of the specialist nurses' stoicism. However, there is a concession that this must have consequences.

Judith's story

(Data collected electronically).

Judith works in a regional hyper acute centre. She has been a qualified nurse for 12 years and has 7 years' experience as an SSN. Within Judith's story, she gives her opinion on the detriment of accumulated trauma,

> 'Seeing this all the time, constantly having to deal with massive events, all the bleeds, the poor outcomes and so much death, it all adds up. You carry on but I can't help but think that all this trauma, this build up, it can't be good for you. It wears you down' (Judith).

Judith's story is comparable with Janet and Jennifer's story of multiple subjections. Her role of being an SSN makes the problem of repetitive exposure a reality. The position that Judith (along with Janet and Jennifer) occupies is that of being the spectator of tragedy. The repeated vision is one that she almost tires of seeing again and again and suggests she is weary. She feels that this is something that is endemic to the role. She refers to the events that are distressing – 'massive events, large strokes, all the bleeds, the poor outcomes and so much death'. She feels that this will have a cumulative effect. She infers that despite this she is able to continue but it forces her to consider that with the accumulation, witnessing it will be detrimental. As these experiences accumulate, the effort will be erosive.

Beck et al (2015) has referred to STS and an agonizing sense of powerlessness. These quotes are reminiscent of the reported feelings of powerlessness. These repetitive situations appear unalterable, but there is again also the feeling of exposure being unavoidable. The nature of the stroke specialist nursing role appears to lend itself to accumulated traumatic observation. There appears to be recognition that repetitive exposure is a risk and its effects are enervating.

The essence of STS reactions is bearing witness to others trauma. The analysis of these data illustrates that stroke specialist nurses are at risk of multiple exposures to traumatic events. The accumulative experience of these multiple subjections has been reviewed as exacerbatory by Jennifer, Janet and Judith. This was particularly linked in the literature to accumulated episodes of deterioration and multiple subsequent deaths, with the effect being termed as erosive (Dominguez- Gomez, 2009. Adriaenssens et al, 2012. Melvin, 2012. Fukumori et al, 2020. Phillips and Volker, 2019).

June's story

(Data collected by interview)

A considerable number of stories referred to patients presenting with catastrophic ischaemic events and intracerebral haemorrhages where palliation was the only therapeutic option. June recounted her emotive experience of a scenario involving an older person with a grave prognosis who had been found collapsed in her backyard, lying there sometime in heavy snow,

> 'I get a call early hours of the morning and as soon as I walk through resus (pauses) I just physically seeing her lying there in the bed (pauses)I could see it was a massive stroke, she had a bear hugger (device used to maintain the body's core temperature) on cos I think her temp was about twenty nine or thirty something like that and it just really took my breath away and I was sort of like on the verge of tears cos it was just so upsetting to see her there as she was and I went and introduced

> myself to her and she still had full speech and everything. She knew where she was, she could tell me everything that had gone on and just with her being so upbeat like that, you know, she didn’t realise the true extent of exactly what happened. Just to be able to spend that time with her and have a nice conversation with her, er, I enjoyed that part of it but knowing that she was unlikely to survive, that was quite upsetting. She really touched me’ (June).

June introduces us to her story as being situated in ED resuscitation room in the early hours of the morning. This raises an awareness that June works as part of a 24-hour stroke service. As her story unfolds, she pauses twice as she describes the woman’s situation. She is affected by what she has seen and what she is describing. She alerts us to the woman lying in the bed and could see immediately that she has suffered a massive stroke. The patient’s temperature is low and she has a ‘bear hugger’ on. June signifies her emotion. The scene clearly affects her. She describes it as ‘breath-taking’. Close to tears she feels distressed. June introduces herself to the woman. Even though the woman has had a large stroke, she still has speech and can recall everything. The woman is described as ‘upbeat’. She does not appear to be in any distress. She is not aware however of how grim her situation is. The opinion is that this adds to June’s own distress.

June’s compassion shines through this. She enjoys and derives some comfort from being able to spend time with her and talk. But she realises she is unlikely to live. She is upset again by this. The interpretation of June’s distress was the sense of powerlessness and hopelessness to change the outcome for someone that she had developed an empathic relationship with. The event has considerable significance for June as she described it as being something affected her emotionally ((‘it really touched me’).

June’s story went on to report this woman’s geographical proximity as being close to her own house. Travelling to work took her past this lady’s former home. June saw this as a constant reminder of this individual’s plight. A psychological component of STS symptoms has been realized as ‘flashbacks’ where the scenario is replayed in the sufferer’s consciousness. The suggestion is that June’s distressing memories were re-enacted by this most mundane of activities.

June’s story involving this older person recounts a profoundly moving clinical picture describing the worst outcome. Nelson (1999, p.85) has stated how ‘the older person who is caught in a narrative of decline needs a counter story that allows them to sustain or retain a practical identity that is threatened by something that they cannot control’. In June’s narrative the counter story does this. It is unique among these data in that June is able to hold a conversation with the person who is effectively dying. Furthermore, the drama involves only two characters- the woman and June herself. June’s role facilitates talking and listening- furthermore, it affords the woman a voice. The woman may be approaching a state of terminal decline, but her identity and character is preserved. June is also a part of this counter narrative in which her own identity and character are illuminated. The view offered in this scenario is a glimpse of specialist nursing at its best- clinical expertise in concert with sensitivity. Despite the distress encountered by the situation, the capacity to offer and give compassionate care is undiminished at the actual time of its occurrence.

This section has discussed the data analysis referring to the stroke specialist nurses feelings of powerlessness, hopelessness and accumulated trauma. The participants offered up emotive stories of powerlessness to intervene (with thrombolysis/ decompressive surgery) or to change outcomes either with or without treatment being given. The data realized profoundly moving stories that was indicative of hopelessness. Lupton (2003, p.70) has recognized that to despair, to lose hope as being frowned upon as strategies for dealing with disease. It is asserted that these stories are the ones that Mattingly (1998, p.79) refers to as being dreaded as they are characterized by hopelessness. Additionally, the repetitive exposure to patients traumatized by stroke has exacerbated feelings of STS in the SSNs. Furthermore, each new event can build upon prior traumatic experiences. The accumulation of these events serves to perpetuate feelings of STS through an imposed sense of powerless and confinement.

Despite the pessimistic nature of these data, these stories are not the autograph of the vanquished. Regardless of the adversity across all of these sections there is no suggestion by these specialist nurses that they do not want to continue in their chosen role. Palanski and Yammarino (2007) have discussed the context of integrity in terms of consistency in adversity, being true to oneself and as a moral and ethical behaviour. These stories demonstrate that the specialist nurses were still able to provide care which was uncompromised by the bleakest of outcomes. The following sections will look at how feelings of STS are exacerbated by the nurses’ personal factors and the ability to maintain a family-work life balance.

6.4: Personal life and professional support

The influence of personal life events as an exacerbating STS was not a common finding within the study’s’ data. Only one story resonated with this. It recalled Maggie’s experience of an older person dying alone after a failed thrombolysis and her despair at not being able to contact the relatives. Maggie referred to how her own recent personal experience permeated her thoughts and contributed to her distress,

> ‘When I look back at this there were other factors that perhaps had made this worse, one of our close friends had died in a preventable accident and we found out about it in a less than sympathetic call from his colleague. I wonder now if that had some bearing on this family not being there and why it was so significant to me at this time. I suppose that sometimes there may be impingement of our private lives that affect our working lives and this may well have been a factor’ (Maggie).

Maggie introduces another section of her story in which she discusses how she feels that other factors impacted on her traumatic work-related experience. She tells a story of personal loss- death of a friend at the time of her own trauma. The loss was preventable and was communicated to her (and family) in a brusque manner by one of the individual’s work colleagues. Maggie thinks of her own work trauma. She compares the experience of her patient dying without family with that of her friend. Maggie feels that this is significant in adding to her distress. She makes the supposition that there can be an impact from our private lives on our professional ones. She feels this might have been influential on her disrupting her psychological wellbeing.

Slattery and Goodman (2009) have proposed a hypothesis whereby those that have suffered previous life traumas may relive these experiences through the exposure to others trauma. Perry et al (2011) and Cieslak et al (2013) have also implied that past personal events, co-existing physical and emotional stress might intensify trauma reactions. Maggie’s story cites her personal events as being influential in her traumatic experience. This researcher agrees that pre-existing emotional stress linked to practice based trauma can be inflammatory (Collins and long, 2003). Only Maggie’s story cited this. The contention is that the nurses involved may not have had a co-existing emotional stress, or that they did not acknowledge what may be present as contributory. The following section will look to provide evidence of a link between work life balance and if this worsens the experience of secondary traumatic stress.

Almost all of the participants in this research expressed no feelings of a negative impingement on family life that exacerbated their experience of STS. One nurse however, offered a conflicting view of her experience:

MW: did you develop any anxiety, apprehension, insomnia or low mood related to what you had witnessed as being distressing?

> ‘I don’t think I experienced anything particularly like that (reactions). The only thing I do notice is that you do become quite reflective and like become a little bit dissatisfied with life a little bit during that period because you think I should be living. I’m here at work every day and I’m not living life and I’m I should be going home and doing stuff and I don’t know why I think like that, and I think I notice that things are getting to me because you’re reflecting all the things that you do and then you become a bit low in mood because you’re not doing these things you should be doing. You know, other things take over’ (Kathryn).

The nursing literature reporting on STS cited the effect on family life and work life balance (Gunusen et al, 2018). Austin et al (2009) informed how nurses put their patients’ needs before that of their families and with recognition of resentment on how the caring role was becoming of detriment to the family. The nurses however appeared unable or unwilling to change this. Initially in Kathryn’s story there is a denial of being affected in terms of stress reactions. However, it is suggested that work role has impacted negatively on her home life. The further consideration is that there is a psychological affect- having to reflect, dissatisfaction and low mood. What is also articulated is a sense of resentment- resentment at what has provoked these feelings, resentment for feeling this way and resentment that work generated emotions have interfered with life outside of it.

Although many of these nurses commented on how they would discuss things with their families once at home, none reported feelings that their family life had been infiltrated. Often family was seen as being a major source of support to them. The next section will endeavour to observe how support in work, or more so its lack, accentuates feelings of STS.

During the course of this inquiry nearly all of the nurses made reference to the issue of seeking help for their reactions. The data uncovered a void in the amount and quality of support that was either available or offered to theses SSNs. Furthermore, the data suggested that some nurses did not seek help as they feared the consequences of admitting they felt emotionally compromised. An exemplar of this is located in Claire’s story.

MW- ‘can you please tell me about the support available to you in your role? Do you feel there is enough support?’

> ‘I don’t know. I don’t think that happens well (support). They might say well come to us and say but at the same time it’s quite personal, isn’t it? So, it’s really difficult for you who should be able to cope with all that. To go and say well actually I’m not coping well and I’m this because if you feel all this people will say OK, she hasn’t coped with this, let’s put her in here today cos she’s not coping with that side or it’s all that’ (Claire).

Claire commences her story in uncertain terms. She is of the opinion that support is not given in obvious ways. She indicates that the support is unstructured and available at her own need. She expresses that it is not easy where the support is lacking in a role like hers. She discusses the role of management and expresses her fear of trying to access managerial support. Claire appears not to want to be perceived as weak by admitting that she cannot cope. Furthermore, she is fearful of what the repercussions might be by being seen in this light (get moved to a different role). She continued,

> ‘Erm, it’s not only, it’s not you’ll talk to but who would you talk to cos you won’t digress everything to your manager so you need someone else where you can say this is what’s happening, this is how I feel’ (Claire).

Claire therefore does not seek help. She not only confirms this but also indicates an underlying mistrust of management. She further indicates that she would seek out someone else because of this. She asserts all of this by saying (finally) ‘this is how I feel’. Knight (2018) has reported that unsupportive work environments can intensify the effects of indirect trauma. There also appears to be a problem being able to address or seek help for their feelings of stress. Claire’s story offers a number of considerations. The underlying position Claire has chosen to adopt is one of isolation. Furthermore, the interpretation made of from her data is her belief that nurses do not want to disclose themselves as distressed given they do not want to be seen as weak both personally and professionally. She is effectively closing off a potential avenue of support and in denying herself this opportunity could potentiate her feelings of discomfort.

A fundamental aspect of supportive relationships between nurses and their clinical managers has been cited as trust (Calnan and Rowe, 2006). The further thoughts expressed was a feeling of repercussion both from peers and management. A similar anxiety was noted in a study reporting on STS by Jonsson and Halabi (2006), where staff feared the consequences from management if they were identified by their responses, with one nurse openly stating a fear of how she will be viewed by her peers in the light of any such admission. There is also reference to being taken out of the firing line. This was also found in Claire's story. Claire is an SSN employed within a large specialist nursing team who can be rotated within her service. While this may be protective, it could possibly be damaging professionally, occasioning shame or possible low esteem. There also appears a distrust of management in not wanting to impart feelings. This can therefore be viewed as limiting specialist nurses' access to allay their distress.

It is suggested that nurses who work in more isolated circumstances may need to create their own network of supportive peers. Despite what was referred to as the supportive nature of the individual specialist nursing teams, several nurses reported their feelings of inadequacy to help their peers. Paula referred to this in her story of a woman, who died as a complication of post thrombolysis bleeding,

> 'You could say are you OK? How are you feeling? But then you know if you do that then you've got to have the skills to be able to deal with that, so what happens when they says, actually says, I'm not coping, I can't deal with what happened today' (Paula).

Paula's has previously discussed in her story her sense of inadequacy when trying to support colleagues who have also witnessed trauma. She starts by suggesting her action to check if her colleagues are coping (Are you ok? How are you feeling?'). The position she would aspire to is a supportive one. However, her story outlined her fear disquiet that if colleagues stated that they were not that this requires action. However, Paula then finds herself in a dilemma. She alerts the listener to her fear that if this course of action is taken, the counsellor needs to have the necessary skills to be able to resolve the issue. She asks the question of the listener- what happens when they say ‘no?'

Heffernan et al (2010) have suggested that nurses require a fair and objective awareness of their own feelings when confronting thoughts and emotions that are uncomfortable. The interpretation here is that Paula’s narrative is unresolved. She recognizes that she may not have the requisite skills to help her colleagues and therefore feels inadequate in supporting them and thereby exacerbating her own trauma. There is acknowledgement that she would the find it difficult to contend with their peer’s emotions and of her foreboding at potentially making matters worse.

The foundations of managerial support are based on approachability, availability and flexibility (Galvin and Timmins, 2010). Accessing support for these specialist nurses was problematic. Either support was seen as non-existent or access to it was stymied with nurses having to seek out their own means of aid.

> ‘I get support from my stroke consultant, but I have to go looking for it, it wouldn’t be offered’ (Jayne).

Jayne’s story refers to the theme of support. She introduces us to her consultant but does not give us anything more than identifying him in the role of being supportive. We are given some insight into the consultant’s character- support is given but only when Jayne seeks it. In this case this form of sustenance was something that needed to be derived rather than it being readily available. The finding is that the support offered is on the consultant’s terms and is limited. Jayne continued,

> ‘The management, matron hierarchy offer no support we as specialist nurses are not included in ward meetings etc. so I personally have no support within the hospital organization unless I look for it’ (Jayne).

Jayne focuses our attention on the support within the organization which is also deficient. She ensures we are aware that there is no means of support from usual avenues- the management and matron’s structures. SSNs are not included in the ward meetings. She again draws us to her conclusion that she has no formal personal support in the organisation unless she seeks it herself.

What is most apparent is a lack of support with stroke specialist teams being viewed in isolation from other teams. What appears worse is that there appears to be a policy of exclusion with the stroke specialist nurses and the specialism being seen as separate entity from the rest of the organizations services. One of the main theatres of stroke care is the emergency department. Several of the SSNs (Maria/ Jackie) made a particular point of discussing how they are reliant on help from the staff of these hospital units. However, it appears that this is also not always available. This mirrors the findings in Jayne’s story that the overall theme is one in which support from nursing and clinicians is lacking.

Where support was evident, it was felt that it was still inconsistent. In Jayne’s narrative she stated how some of the medical consultants demonstrated an interest in both the SSNs and the ASU staff they worked with by checking up on them at the end of each shift. This practice was not uniform to all of the senior medical staff and called into question the potential of working relationships as Jayne described,

> ‘There’s some that are the opposite and it seems to be a day’s work and you know they are not that interested. So, it’s gonna, yeah, I think there’s enough to make it a good supportive atmosphere- but I wouldn’t describe it as being that supportive’ (Jayne).

Jayne records how some of the senior medical team instead have seemingly little interest in how the staff in the acute stroke unit are faring. They conclude their medical duties then leave. This is significant for Jayne as it detracts from the experience of support and teamwork. She expresses regret that there is the potential for a supportive atmosphere, but this is not the present reality. The opinion of this researcher is that Jayne is disheartened by what is essentially a missed opportunity to develop supportive relationships.

Cooke (2006) has stated that with increased responsibility comes tighter control the elements of which were described as characterized by distance, distrust, destructive criticism and defensive culture. The stroke specialist nurses’ data did not reveal evidence of being tainted by destructive criticism. However, what was apparent was more in keeping with distance, possible disinterest, and with more focus given to other aspects of clinical management ‘priorities’. Maria’s viewpoint was that the lack of management support was ‘depressing’.

Several nurses commented that there was no means of any formal support. The SSNs linked this to their being seen as a separate service within a service. Where there is no mechanism of support there is also a reduced capacity for relief and with-it conserved distress. In the following data from Monika, she succinctly highlights how formal support is lacking,

> ‘We do not have regular feedbacks or reflections in an official way. There are no team briefs or huddles to de stress’ (Monika).

Monika raised this void in response to her traumatic event. The impression is that she may well have benefitted from the availability of one of these support systems to help her deal with what happened to her. Monika’s admission meets with that of June who also made note of never being witness to management support. June stated that support was not offered just to her but was never afforded to others within the team. Furthermore, an opinion was made indicating that supporting nurses was not seen as a management priority and that there was inconsistency in terms of who offered help, as Ruth’s story noted,

> ‘Management usually supportive up to a point but sometimes their focus on patient flow at all costs causes difficulty; some are more approachable than others’ (Ruth).

Ruth outlines the discrepancy in the support offered by management. Ruth suggests that there is an element of support. However, giving support is seemingly not high on management’s list of priorities. Support is relegated in favour of what is seen as the real priority- clinical throughput. This is not Ruth’s sole concern. Her story refers to individuals within the management structure who are amenable to giving support. What this indicates is there are also others who are not again signifying an inconsistency in support.

Jennifer found support lacking from both within her own stroke service and from those outside of it. In her narrative she referred to being unable to unburden herself of her feelings. There is furthermore a possible hint at bitterness of both having these feelings and being unable to expunge them,

MW: would you say that you have good support in or outside of the stroke service?

> ‘I don’t get much support internally. I don’t get much support externally. Hence the reason I think you carry this crap around with us’ (Jennifer).

In Jennifer’s story the theme remains one of no formal support. Jennifer asserts with rancour about the non- existence of support systems within both her stroke service and in terms of wider management. Jennifer sees the implications of this- that without support there is no means of unburdening these feelings (what she refers to as ‘carrying this crap’) of distress.

Mealer et al (2012) have discussed how nurses reflect and analyse their traumatic experience. This paper however offers the opinion that where nurses have tried to attain some perspective on their experiences; the subsequent analysis resulted in discomfort. The comparison can be made with this section of Jennifer’s story, the coda of which also refers to the perils of introspection,

> ‘You start to think, I’ve seen the pressures and it’s the trauma I see and I am going to see as well, so I’m going to over analyse’ (Jennifer).

Jennifer ruminates over her lack of support. This then leads her to introspection. This however causes her further detriment as she over thinks her situation. The interpretation is that Jennifer’s over analysis renders her static and prevents her from moving away from her trauma.

This section has illustrated how lack of peer, management and clinical support affects the experience of STS. Wahlberg et al (2016) have discussed the benefits of institutional/ organizational support. By contrast, Hunsaker et al (2015) have stated the detriment caused by low levels of managerial and service support. Ray et al (2013) has suggested that institutions that work with traumatized individuals should aim to acknowledge and normalize the impact it can have on the worker and the organization itself. It is suggested by this researcher that the problem is twofold- the support offered is inadequate or that no support is offered at all. In these stories organizational and departmental management s inactivity antagonises the situation for these nurses. In terms of support their role in these stories is ineffectual. The stories from Jayne, Ruth, Jennifer and Paula all referred to other members of the team who could be supportive in their role but were found wanting. However, these stories also suggest an undercurrent of resentment at the lack of and missed opportunities for support. The lack of effective support could suggest that until such measures are established then feelings of traumatic stress could exist in perpetuity. The following section will discuss how the nature of the SSN role itself may be contributory to and perpetuate STS.

6.5: The SSN role

The data under review realized a number of specialist nurses viewing their role as something different from the established view of nursing, as this quote from James’ story demonstrates,

> ‘Erm, I think the role is, identity as a nurse is somewhat different anyway your identity as what is a nurse you know it’s difficult it’s a multitude of things to nurse, er, or what we do is slightly different -ordering tests and making decisions and examinations, you’re not exactly nursing as such so the identity of a nurse is slightly blurred within this role’ (James).

James’ response starts tentatively. He starts by suggesting that the SSN role is something different. He asserts that nursing and its identity has different meanings as it is comprised of different elements. He does not describe what these elements are to him or others. His response at this point seems unclear. He is clearer in regard to the SSN role as being different. The impression of what he means here is there being a difference from the more traditional view of nursing. He now refers to the elements that steer SSNs away from this-investigations, clinical decisions, and clinical examination. James believes that this is not nursing and that in the case of SSNs, the nursing identity is blurred.

Andrew (2012) has commented on how the health service needs nurses who are competent in more than one domain and questioned nurses’ identity as occupying a position at the fringes of medicine. Furthermore, Scholes (2008), has commented that nursing identity should not compromise inter- professional working and that nurses should work within inter disciplinary teams to complement patient care and develop new services. However, Vaismoradi et al (2010) has referred to changing roles and identities across professional boundaries as having gestated a culture of uncertainty. The stroke specialist nursing role with its blurred boundary between nursing and medicine accords well to a situation of ambiguity. Pietila et al (2018) have discussed narrating uncertainties within a liminal state. According to their paper, Liminality describes a situation where an individual finds it difficult to classify the self in socially recognized positions, indicating that people may be this or that or both. Although the authors describe this in terms of illness, this researcher finds it has some resonance with SSNs who may find their role falling into a buffer zone between medicine and nursing. Agreement is met with the writers who propose that this could leave individuals marginalized and without true status in the community in which they live.

According to Frank (2010) new stories that do not fit with existing ones ‘make trouble’. Frank (1995) has previously cast those who practice modern medicine as the ‘active hero’ of illness narratives. It is suggested that in the case of stroke care such characters are those of the clinician/ doctor. The existing stories of stroke illness have been authored by such individuals. However, in the narrative of stroke medicine, it is argued by this researcher that the new and ‘troublesome’ stories that are emerging in this research belong to SSNs. The opinion is offered that their role suggests them as an alternative to the hero of the clinician in the illness narrative. These stories that position SSNs as such an alternative could be argued as being troubling as they do ‘not fit’ with the traditional view of who the hero is and challenge the biomedical narratives based purely on treatment and cure (Witham et al, 2014). Furthermore, increased patient acuity, multiple comorbidities and enhanced use of new technology are all viewed as increasing uncertainty in healthcare settings (Simmons, 2010). These elements are omnipresent within stroke specialist nursing practice. The associated unpredictability of practice could be seen as not only a contributory factor to stress, but also perpetuate it.

Although stroke specialist nurses often cite themselves as belonging to a multidisciplinary team, they are often found working autonomously. The level of responsibility, particularly when contemplating decision making, was an intense source of stress, as this excerpt reveals,

> ‘I also worry if I have seen, investigated and treated a patient and then sent them home- I have very little support at the hospital stroke specialist wise and I do worry that I have missed something’ (Maggie).

Thompson and Yang (2009) have considered that when nurses make decisions, they use reasoning and judgement intuitively to grapple with uncertainty. However, the text from Maggie’s story illuminates the roles stroke specialist nurses have in making high level decisions, often with limited support, about patients care. Specialized roles impart greater responsibilities previously situated in the domain of medicine. A change in role boundaries creates uncertainty in relation to professional identities which can lead to increased stress in specialized nursing populations (Jones, 2005). Maggie has taken on a greater responsibility but seemingly without an adequate support system. These two elements contrive to make her anxious about a potential omission. Jennifer’s story continues the theme of anxiety, uncertainty and doubts fostered by her specialist role,

> ‘I always go home and think have I made the right decision? Especially when I’m quite autonomous…I’m in A+E and I can go up to 2 or 3 patients a day and say no it’s not a stroke but I still kind of you know, worry about that. At my level it’s all about decision making. The hyper acute point of view you’re making these snap decisions. Anxious, yeah but I think a lot of that was to do with did I make the right decision, should I have done more, you know, going through all the bits, what if he’d have all that before, should you have done this? Why didn’t you say something and second guessing myself all the time’ (Jennifer).

Jennifer’s story is situated at her home and the emergency department. She states that she always considers her decisions after she has left work indicating her preoccupation. She draws us into the drama of her reviewing acute stroke patients. She makes the listener aware that her role involves the element of diagnoses. She refers to two or three patients that she has diagnosed as not having had a stroke. She signals the listener as being aware (‘you know’) of the anxiety that this might cause. The source of her anxiety is if she has not made the right diagnosis or missed the diagnosis (of stroke). Jennifer focuses the listener on the importance of diagnosis in her role and that in hyper acute stroke care, the ability to make correct and quick decisions is all important.

Jennifer remains anxious but had insight into what the cause of this is. The source of her anxiety concerns her decision making- was the right decision made, should I have done more? She feels the listener can appreciate her feelings and has prior knowledge of this (‘you know’). She refers what I believe are the clinical components of the role and refers to hindsight. The constant questions she asks of herself are permeated with anxiety and uncertainty. Her role and position in this narrative are ones of self-doubt. The sense of entropy suggests that she could find herself in disorder.

Each of these participants had offered up stories of their precipitating traumatic experiences. Maggie and Jennifer’s roles offer examples of these SSNs responsibilities. However, the narrative still present in these roles is anxiety. The SSNs worries regarding decision making could be viewed as being symptomatic of what had previously occurred. However, the secondary consideration proposed is that the anxiety in decision making could be seen as sustaining their traumatization.

The unremitting nature of the role and responsibility was evident throughout the SSN data. However, it was felt that the rewards in financial terms did not match up to the demands of the role,

> ‘I think stroke is hard work and it’s demanding in general, and I think you either enjoy stroke or you don’t (laughs). I’ve probably felt at times there are definitely easier jobs you could do and you think that for the money we’re paid for the band that we are and the responsibility we have. My experience is that the staff that are here are here for the duration of the course. The ones that come and don’t last 2 minutes it’s because it’s hard work, that’s not underestimating how stressful, we know its hard work’ (Jayne).

Jayne informs the listener that she believes that stroke care is arduous. She says with some humour (laughs) that it is something that some nurses will take to and others not. Jayne informs us that she has previously considered other roles in comparison to stroke nursing that were less taxing. She indicates that for the level of responsibility SSNs have, the monetary rewards are not enough. Jayne refers to the SSNS (staff) that she works with are the people who are committed to working in stroke care (specialist). She believes the nurses who have left after a short duration of working in the stroke specialist nurse role has done so because it is taxing. Not only is the role stressful but it is hard work.

Diane’s story finds similarity with that of Jayne,

> ‘You’re here to deal with thrombolysis, to deal with the acute patients, to deal with all it throws at you, but yeah, what respite do you get? A lot of the time they (specialist nurses) don’t want to admit, you know, it’s been hard today’ (Diane).

Maytum et al (2004) have further identified how professional roles and work overload can contribute to feelings of stress. Jayne and Diane’s responses refer to the theme of the unrelenting complexion of stroke specialist nursing. The reference to it being hard work can be viewed in terms of it being both physically arduous but also emotionally exacting. Jayne suggests that there may be easier roles within nursing in comparison to being an SSN and that financially the recompense does not mirror what these nurses perceive as giving. Diane refers to the unremitting nature of the SSN role. Diane’s narrative again indicates that support is lacking and that the SSNs continue despite the stress of a high workload. Furthermore, she reveals how these nurses do not want to be looked upon as weak by alerting others to how arduous their task is. Their distress is potentiated by having no means of relief, but also the fear of asking for it.

Witham et al (2020) have stated ‘from a narrative approach, people make sense and interpret their lives through stories, justifying and positioning themselves. It constitutes and grounds identity formation and therefore exploring the underlying concerns through a narrative approach can potentially identify some of the wider cultural contexts in which these positions are framed’. These SSN stories allow an insight into the culture in which they operate and an appreciation of their view of their role within it. The interpretation is that they operate to a high level within their respective services but that the culture they operate in does not always value or support them in their work. Sabo (2011) has referred to cultures that lacked both understanding and engagement with their nurses. The main features of these areas were that staff reported feeling unheard and isolated. This was also located within the SSNs stories. Occasionally this took the form of outright disregard or ignorance. In Pam’s story she talked of her despair at trying to alert the senior medical team to a seriously ill acute young person with a stroke, who later died, MW- how did it make you feel that no one was listening to you?

> ‘Apart from being cross, being frustrated more than being cross, not being able to get someone to listen to me. You’re not listening to me, you’re not listening to me and this is what’s going to happen’ (Pam).

Pam’s role and position in this story is one of being an advocate but one that is concerned and ultimately ignored. Pam starts her story by informing the listener of her emotions. She is vexed by trying to impress on someone her sense of urgency and need. She appreciates what the outcome will likely be. Despite her desperation, which is palpable in her story, she both feels and is ignored. The physician in this narrative holds the position of being an antagonist. Through his actions, a wreckage narrative unfolds that results in damage for the patient and for Pam. Foucault (1995) has referred to what he has termed parrhesia- the courage to speak or critique whilst being placed under fearful circumstances. Pam did state later in her story how she felt fearful about how she had spoken to a senior doctor. In Pam’s story there are echoes of Nelson (2001) and Thomas-McLean’s (2004) references to being devalued, worthless, alienated and identity damage. Her story can be compared with the earlier one from Maggie who had also described her sense of intimidation in dealing with the medical team. However, Pam did find some resolution to her story. She was able to discuss and debrief with one of her consultants and one of the anaesthetics staff in the weeks following the event. However, the narrative has a clear significance for her. As she has previously stated, it has remained with her since suggesting that for Pam, it is only a partially resolved story.

Smith et al (2009) have cited three areas having an impact on the nature of stress in nursing- where staff are not listened to, where they are not respected and where they are not supported. In this scenario Pam was traumatized by the rapid deterioration and death of one of her young stroke patients. However, the situation is exacerbated by her concerns being overlooked. While in this instance there was ignorance, many of the other nurses confided that they felt there was no one to turn to when placed in a traumatic situation and having to confront its aftermath, as Monika's story illuminates,

> 'I usually talk to my nursing colleagues at hand over. I had a long shift to go before I could speak to anyone about this. I work alone so felt abandoned. I did cry at one point in the morning shift but was alone and couldn't speak to anyone (Monika).

Monika's position in this story is one of isolation. She impresses on the reader her feelings that she has been cast adrift. We are made aware that she is a lone worker and given the traumatic events she has been involved in, feels the void of not having someone to discuss the situation with. We become aware that she works in isolation. Being a lone worker, she has a long shift to endure before she can speak to another SSN in person. She admits to being tearful later that morning (the event happened first thing on her shift at 0700 hours) but reminds the reader of her being alone with no one to talk to. Her role has effectively rendered her silent by either having no one to talk to or through having to attend to clinical duties. Her loneliness is crushing and is exacerbating the situation that she finds herself in.

Phelps et al (2009) has discussed the potential impact on psychological well-being of working in the caring professions in the aftermath of trauma and cited carers' sense of isolation as factor in traumatic stress reactions. Monika's story along with the other SSNs has consensus with this opinion. There is a realization by these specialist nurses that the feeling of being alone is not conducive to their sense of well-being. Furthermore, there is almost a sense of despair at these nurses' feelings of having no one to be unable to reveal themselves to. These data reveal a true sense of isolation and genuine lack of professional support that can exacerbate the feelings spawned from witnessing traumatic events (Collins and Long, 2003).

The interpretation is that these professionals feel marginalised by their situation. The lack of someone with whom they can interact and discuss their fears appears to be the denial of a much-needed support and a basic human need. In contrast, Maggie was able to discuss her traumatic experience with her colleagues. This however provoked greater unease,

> 'When I discussed it with colleagues, they empathised but 'these things happen' tended to be the response and I wonder are we complacent about death and how it affects people?' (Maggie).

Maggie discusses with her SSN colleagues the events that caused her distress. The colleagues are recorded as empathising with Maggie's story. However, their hollow response leaves her disappointed ('these things happen'). Maggie adds to this by questioning how death affects people and how people become complacent about it. The question Maggie asks is unresolved and in such causes her further disquiet.

Poirer (2002, pp. 48-45) in discussing narrative in medicine has referred to how different professionals see and respond to the world in different ways. Maggie's role in this story is one of being on a search for resolution, reassurance and trying to make sense of other nurses' attitudes. The narrative is about support or what support Maggie would have liked and what she got. Alternatively, it may be construed as what others felt she needed. Her questions regarding complacency re envisage that of the hardened nurses described in chapter 2 data analysis who were toughened in the course of their experience. However, this response is interpreted as falling into a triptych of ambivalence, blunted empathy and realism. The feeling is that this is likely them manifesting their own coping strategy, albeit at the cost of provoking disquiet in others.

Caringi et al (2017) have offered that while peer support can have a powerful mitigating effect on stress, unsupportive interactions with such individuals in the workplace can actually increase it. It is possible to interpret Maggie’s data referring to mortality as an example of her colleagues’ complacency. This could be argued as the result of repetitive exposure. Her colleagues support in accepting this stops short of true empathy in favour of a more matter of fact approach.

In each of the stories in this section there is a sense of longing for these nurses to be supported in their role and the work that they do. Frank (1995) and Mattingly (1998) have talked in the language of mechanical repair in their illness typologies acknowledging the need for outside agencies to accomplish the ‘fix’. A comparison can be drawn with these SSNs need for support from managers, organizations and nursing and medical colleagues to help give them sustenance. It can be opined that the insight they offer with regards to lack of support could form the basis of their own quest manifesto narrative (Frank, 1995) prompting reform to address this.

6.9: Gender Intersectionality

This chapter has discussed SSNs feelings of powerlessness with regards to their patient’s illness and their inability to intervene or change outcomes. However, another important aspect of powerlessness raised across the course of these analyses that requires further appreciation is that of gender intersectionality. O'Hagan (2018) has discussed intersectionality as the construction of inequality, oppression and exclusion of individuals by organizations and institutions based on such categories as race, class and gender. Holvino (2010) has referred to inequalities that limit options and power can evolve through identity (the identities that define how individuals are seen and see themselves), institutional (the ways in which gender and class relations and stratification are built into organizational structures, processes and ways of working to produce relations of inequality and privilege) and social (the way in which societal structures, beliefs and ways of engaging at a societal level produce and reproduce inequality) practices. Organizational and institutional practices reflect strong gendered cultural norms regarding the role of women as nurses. In western society the public and professional understanding of nursing care is that it is still associated with being a female care giving role (Jordal and Heggen, 2015). Essentialist cultural beliefs places women as being better suited to emotion specific tasks, with gender framing emotional responses within the stereotypical view of women having greater sensitivity (Cottingham, 2014. Badolamenti et al, 2017). Ingrained stereotypes reinforce female subordination (Gauci et al, 2021). These beliefs and attitudes situate female nurses in a patriarchy where their values and interests are diminished compared to that of the privileged position that males occupy within the healthcare organizational hierarchy (Ferguson and Anderson, 2021).

Gauci et al (2021) have identified multiple modes of female nurse discrimination. The forms of inequality that they are subjected to include men being afforded more support, female nurses being overlooked in terms of their expertise or opinion and being considered less worthy of undertaking certain clinical roles and responsibilities, denied opportunity to use their skills and knowledge. Furthermore, as female nurses aged, they became diminished, marginalized and considered as incompetent for more challenging roles. In addition to this was the perception that where nurses were mothers their priorities were directed to their home life, the feeling being that they lacked career commitment and would be unable to meet job expectations.

Carmassi et al (2021) have reported that work related stress reactions and burnout were demonstrably greater and had a greater impact in female emergency healthcare workers. The paper cites women’s unique social life, trying to balance work and home life, the need for professional recognition and the view of their greater caring capacity compared to males (opined by this researcher as being a reinforcement of sentimentalized gender stereotyping) as being contributing factors. However, Hay et al (2019) argue in favour of other forces that conspire to produce gender inequality among healthcare providers. Power and hierarchy manifests in health systems in ways that offer benefit to some people, supporting and championing them to the disadvantage of others. This includes gender and social inequalities that position and value physicians over nurses. Furthermore, the problems facing female nurses are increased by substantial overwork with higher patient/ provider ratio’s, inadequate institutional and peers support, disrespect despite requisite training and credentials and disrespect from perpetrators such as physicians, supervisors, peers, patients and in the opinion of this researcher, relatives (Hay et al, 2019).

These stories have found this researcher identifying multiple instances of where gender inequality could be ascribed to what the SSNs experienced. Badolamenti et al (2019) have discussed emotional labour as workers expressions of emotions according to embedded social and cultural norms. The writers offer that this is deeply linked to gender identity with women being culturally connoted as more willing to become emotionally involved and bring their emotions into play. Furthermore, as women are considered more culturally suited to caring, their exposure to emotionally challenging cases will be greater. The stories recounted by these SSNs are emotive and often refer to tragic circumstances. Many of these nurses reported their empathy and emotional investment in their patients and families (Laura, Claire, Francesca, Maria, Maggie, June, Monika, Janet). Several of these nurses reported crying within their narratives (Claire, Maria, Pam, Monika, Charlotte). These behaviours could be construed as conforming to female nurse gender stereotypes. However, this researcher interprets these behaviours instead as the emotional reactions to traumatic exposure.

Newman (2014) has referred to women being placed in subordinate positions due to their sex rather than their skills, competencies or job role. The stories presented by Maria, Maggie and Pam clearly position them all as being overlooked. Their expert opinions are overlooked and the opportunity to apply their knowledge is denied. They are effectively being silenced. This can be argued as epistemic injustice, the privilege of decision making and intervention resting with the medical personnel involved. However, the disrespect shown to them here could be equally attributed to their position of female specialist nurses. They are not appreciated and rendered as subordinate. Furthermore, each of these nurses was experienced not only in the role as nurses but also in terms of their life years. Gauci et al (2021) has referred to nurses in their later years as becoming ‘invisible’, marginalized and diminished by their very age. This researcher propounds that the scenarios discussed here offer a combination of moral distress impacted further by contributions being overlooked on account of gender and age.

Laura’s story raises a number of considerations related to gender. Assumptions can be made with regards to the first part of her story where the paramedics alert her to the young woman's distress at being incontinent. The sex of the paramedics is not known. It is questionable as to them informing Laura on the basis of her being the first nurse they had contact with or the fact that Laura is female and was deemed as more appropriate to care for the young, distressed woman. As her story progresses, she takes on the role of communicator as the 'doctors were busy'. The duty is part of Laura's remit. However, it can be argued that she is marginalized. It can be interpreted as an instance which she is deemed more suited or more worthy of compared to the medical team who are presumably involved clinically. There is a similarity with Monika's story where she too finds herself having to undertake this role. The scene described by Laura involving the relative who is a doctor is also of interest. The relative is undoubtedly seeking information. However, the disclosure of being a doctor positions them as being epistemically privileged. This could position Laura as subordinate. Finally, Laura refers to herself as often being placed in situations that have been distressing. This has resonance with most of the SSNs stories that have reported similar positions. Many have had evidentially long careers as nurses. This raises some further thoughts. Gender inequality situates these nurses as being distressed on account of them being female, empathic and caring. However, it is this researcher's assertion that their length of service, role and exposure has placed them into these situations from which distress emanates rather than the erroneous engendered response.

It has been suggested that female nurses are thought of as doctor's handmaidens and that their role is merely an extension of that already performed as wives and mothers (Royal College of Nursing, 2020). Austin et al (2021) has referred to female nurses balancing out multiple identities- providers, wives, mothers, partners, sisters, daughters. The entrenched views reported by Gauci et al (2021) were the misconceptions that women are unable to commit to their role as a nurse when they also occupy other such roles. Austin et al (2021) found nurses reflecting on certain situations where the questioned ‘what if this happened to my family or my child’. In the data Laura and Monika specifically referred to these sentiments. Francesca’s story also refers to thoughts of her family. This researcher argues that these feelings are not the result of a perceived engendered deficiency. They are rather an essential part of their story’s expression and their experience.

Several of these nurses’ stories (Maria, Maggie, Jackie, Janet, Monika) appear to place their narrators in a subordinate position to their medical colleagues. The prescribed course of action, or lack of it, is determined by the medical teams involved. What follows thereafter appears to be at best delegated and at worse dictated to these nurses. These actions could be construed as affirming the view of nurses as doctor’s attendants. The nurses in these scenarios may well complete the orders ascribed to them. However, they are far from willing accomplices acquiescing to the will of these epistemically privileged perpetrators. Rather than handmaidens they are made to bear witness to situations that ultimately result in moral distress.

Women have been cited as having higher levels of stress, with an inability to enact strategies of control, commitment and challenge (Abdollhi et al, 2014). Typical male stereotypes place them as strong, confident, superior/ dominant and assertive compared to those ascribed to women as being caring, empathic and compassionate (Idelji-Tehrani and Al Jawad, 2019). This raises the debate between being tender and being tough. In Charlotte’s story she is fearful of appearing tough or hard. However, this appears less of her conforming to the gender type of the gentile and sensitive nurse, but rather her concern for this intrinsic personal value being lost. Jennifer and Sandra’s stories refer to toughness or ‘being hard’ as a protective mechanism. Arguably they have adopted male gender traits to appear strong. However, this appears to be at the cost of appearing insensitive. Whatever the individual coping strategy, the cost appears to be to the nurses' core schema rather than the patient.

Hay et al (2019) has discussed gender inequality in terms of inadequate institutional and peer support. Running through these nurses' stories is a genuine lack of organizational, departmental and individual support. The narratives offered by Jayne, Monika, Ruth and Jennifer all refer to their need for support. The quest for this is personal and often proves fruitless. The source of comfort in the stories by Jayne, Diane, Paula and Jackie lies with the figure of the consultant. This figure of succour is one that is connected to the stroke team but is one nonetheless who is placed at the apex of the service hierarchy. It is questionable as to whether the absence of support is due to gender inequality or if it is symptomatic of services and organizations in general.

The element of gender in these stories is important. Stereotypes and the inequalities that gestate from them need to be challenged. This researcher suggests that it is acceptable to be emotional about the work that these SSNs and nurses in general do. In terms of STS, these emotional reactions are the natural consequence of caring. They are not the sentimentalized trait of being a nurse who is also female. It is this researcher's suggestion that organizations, institutions and individuals need address gender intersectionality to promote cultures that are more reflective of equality. Furthermore, it has been suggested that in using narrative to appreciate intersectionality can result in granting epistemic privilege to previously marginalized voices (Chadwick, 2017).

6.10: Summary

This chapter has described the factors that these SSNs felt contributed to exacerbating their experience of secondary traumatic stress. It is apparent that there exists overlap between causes and effects of secondary traumatic stress identified within the stroke specialist nurses data. However, it is further contended that the factors which contribute to heightening nurses' feelings of STS are multifaceted and complex. The feelings that these nurses describe are commensurate with the experience of the people who have been exposed to secondary trauma and what they believe worsens their experience. References were made by these SSNs to how the elements of empathic engagement, feelings of impotence and helplessness, repetitive exposure, outside life events and work- life balance, lack of support and the SSN role were contributory in exacerbating their trauma. The description and discussion of these elements affirmatively answers the research question with regards to how these nurses' experience of STS is worsened. These findings are congruent with that in the trauma literature in general and that concerning nursing.

This chapter provides a new appreciation of the factors that exacerbate these stroke specialist nurses reactions to traumatic events. It offers a fresh insight into the components that continue to impact these SSNs following the initial trauma encountered in the hyper acute stroke arena. I believe that in terms of this thesis this chapter takes a further step in describing what added to and perpetuated these nurses' traumatic experiences. It adds further weight to my argument by continuing the trajectory of these SSNs trauma narrative from the cause and context of their STS and their descriptions of their emotional reactions to it and on to what made their situation worse. Furthermore, this chapter adds to the theory of traumatic stress within nursing specialties. It also adds to the appreciation of this new area of inquiry not only in terms of stroke nursing and the emotional burden of caring associated with it, but also uses the novel approach of narrative to enhance our understand of the lives of these subjects.

Badger et al (2008) have described empathy as the gateway of vulnerability. Empathic engagement can be viewed as a double-edged sword (Sabo, 2008). It is an essential requirement of therapeutic relationships but can also precipitate distress. Udipi et al (2007) have identified that repeated empathic engagement with distressed patients in a cycle of caring constitutes a further risk of accumulated stress. It is contentious that as these specialist nurses display an empathic approach, they may become trapped within this cycle and therefore perpetuate their traumatic experiences. However, adopting a protective stance of detachment or disengagement can result in reciprocal damage to the therapeutic relationship. The SSNs referred to the emotional impact of having empathy, noting how having identification with patients increased their feelings of sadness (Monika, Claire, Francesca). This still seemingly did not prevent their ability to empathise. While the level of disengagement is debatable, the risk of it was evident.

Nurses were often forced to confront these devastating situations which were exacerbated by feelings of powerlessness, especially where intervention made no improvement, resulted in complications or where no intervention could be undertaken. This was keenly felt in Maria, June and Janet’s stories. The high incidence of post stroke mortality and the spectre of enduring disability also instilled the nurses with a sense of hopelessness. The repetitive exposure to suffering patients as described by Janet, Judith and Jennifer has significant meaning for the experience of secondary traumatic stress (Morrison and Joy, 2016). This element can be viewed as a primary cause but as exposure accumulates it can prolong and precipitate further feelings of traumatic stress. The core of these feelings again echoes pangs of powerlessness and hopelessness at not being able to intervene, to support patients or change their outcomes (Salmond et al, 2019. Rice et al, 2013). Powerlessness has also been described in this chapter with reference to gender. It is argued by this researcher that gender inequality has a bearing on how these female SSNs are perceived, heard and valued. It is also however argued that gender inequality when allied to epistemic privilege can further marginalise these nurses resulting in under recognised or ignored contributions further promoting feelings of distress.

Collins and Long (2003) and Killian (2008) have referred to how a history of previous stressful life events, including personal loss, is associated with secondary traumatic stress. These experiences can add to existing stress or serve as a reminder of past stressful events that the carer may then re-experience. Although there was only one specialist nurse who revealed this in her data (Maggie), it is arguable that this is a significant factor in adding to carers stress. A similar finding was realised regarding work-life balance. Mullen (2015) have discussed the negative effects of being unable to maintain a satisfactory work-life balance. The data was not vast in respect of the specialist nurses feeling that a disruption in this respect increased their distress (Kathryn, Claire). However, the data that was offered suggested a resentment of work-related stress impinging on life away from the clinical province.

Lack of clinical, peer and managerial support was a major component in worsening the specialist nurses’ stressful experiences. The analysed data from Monika, Jayne, Claire, Diane and Jennifer reported numerous areas where support was found lacking. These were discussed as the specialist nurses having to seek their own means of support, the nurses themselves not wanting to be seen as weak, fear of repercussions and lack of management interest and interventions. Hensel et al (2015) have professed that healthcare organizations do not prioritise strategies to address STS as it is felt to be of low incidence, and it causes limited impairment. The authors further state that discussing issues related to trauma are avoided in work due to the potential to generate further distress. The data from this research makes a considerable argument that where these issues are not addressed and discussed; feelings of STS will not be met with a remedy.

The nature of stroke specialist nursing registered a number of components which contribute to elevating the SSNs feelings of STS. Lee et al (2016) states that negative self-perception can result both from and in feelings of reduced accomplishment. Similarly, Andrews et al (2011) has stated that nurses' negative self-concept can be germinated from an inability to act in a professional autonomous manner. The stories offered by Maggie and Jennifer discussing the SSN role, uncertainty, autonomous practice and decision making, concur with this. The sense of isolation and work overload are further contributing factors in exacerbating the specialist nurses experience of traumatic stress.

6.11: Conclusion

The factors that exacerbate nurses STS reactions are multiple. Feeling ignored, being isolated and unexpected collegial complacency would all contribute to exacerbate nurses' experience of traumatic events. Empathic behaviours, nursing identity and role demands seems to compound nurses' trauma. In addition to this is a lack of formal and informal support systems. Adequate support systems need to be in place to mitigate against this to protect nurses' and ensure care is not compromised. The following chapter will aim to detail how these SSNs employ professional and personal strategies to allow them to cope with the experience of and potential for STS.

Chapter 7: Narratives of Coping and Adjustment

7.1: Introduction

This chapter will record the data analysis referring to the participants reported coping strategies. The intention is to describe the processes that the SSNs have adopted as protective mechanisms to manage their feelings of traumatic stress. The aim is to form an understanding of how these interventions mitigate the experience of STS as described by the stroke specialist nurses. Data extracts will be offered alongside the evidence to accentuate this. The data will be discussed to allow for a relevant interpretation of the means by which the participants alleviated their feelings of trauma. A summary of these findings will be offered as a conclusion. It will also address how this chapter contributes to meeting my research aims and what it adds to my thesis. Furthermore, it will refer to how this chapter has informed the narrative of the thesis itself.

The nursing literature revealed a number of initiatives used to counteract the risk and effects of STS. This comprised of either personal or professional manoeuvres to either avoid STS development or where present, alleviate it. The first section refers to the importance of supportive colleagues.

7.2: Narratives of collegial support, perspective and personal coping

In the data nurses cited collegial support as being an important source of encouragement. This took the shape of both formal and informal avenues and involved both nursing and medical disciplines. The relationships forged with senior medical staff (consultants) was seen as particularly beneficial with a key consideration being the feeling of approachability, as Diane explained,

> ‘We support each other as a team cos we are such a small team that helps with the consultants. They’re approachable and they say to us ‘’we had an horrendous day yesterday’’ and if we do feel under pressure or overloaded, we know that if it’s 2 o’clock in the morning you can still pick up the phone and you know they’ll be OK. I mean we’re not frightened to ask for help. I think we’ve got a nice relationship with them where if you were to ring them it’s because we need their help when we do pick up the phone, they are a good support’ (Diane).

In Diane’s story the plot is one of support and in particular that afforded by the stroke consultant. Diane alerts us to the potential issue of needing mutual support as she works as part of a small team. She further makes the reader consider when support may be necessary or required- ‘horrendous day’ ‘and if you feel under pressure or overloaded’. Diane informs us that this can be very early in the morning and that they (her/team) are not frightened to ask for help. She highlighted the relationship as being nice and indicates consultant happy to give help when telephoned. This suggests there is a good relationship. However, the help that the nurses ask for, particularly in the middle of the night is advice rather than being a physical presence. However, it could be suggested that in a situation of being under pressure or feeling overloaded, advice is not a practical solution.

At interview Jayne injected some brief humour into her story before commenting on the importance of relationships with her consultants,

> ‘Alcohol, chocolate (laughs), to be honest for me it’s my colleagues but then also I’m not afraid to feedback to the consultants. I think we’ve all got a good relationship with the consultants that you can be completely honest about what happened, what have I got that might have gone bad or what they might do next time. I think it’s just about

> being honest with the consultants that you're working with because if they don't know what the issues are then they can't be sorted and using your colleagues. Really, you're in the same boat, you've been in similar situations, and they might come up with solutions that you might not have thought of' (Jayne).

Jayne injects humour into the story of her coping strategies, (alcohol, chocolates). Her story is made using sincere terms and she cites her colleagues as supportive. She introduces the character of her consultant; highlighting how feedback to consultant is something she is not fearful of. This signifies a trusting open relationship with consultants, one which is built on honesty and without recrimination. The relationship emphasises that learning from the clinical experience will help to improve future practice. Jayne confronts the need for honesty between the SSNs and her stroke consultants and colleagues. If the individuals are blind to the service, patients and staff problems, then the issues cannot be rectified. The narrative is interpreted as one of support but also effective communication. Jayne's story creates a sense of a community whereby there is a team who are all in the same situation. By combining thoughts and efforts, solutions may be found that may not have been found by an individual approach.

Perry et al (2011) have stated collegial support as beneficial, but where this is lacking, the risk of stress reactions is heightened. It is suggested that teamwork and environments geared to supporting each other should be the focus for all teams involved in providing healthcare services. Yoder (2008) has cited a lack of honesty in nurse-physician relationships as key in the evolution of secondary traumatic stress. A positive finding has been made where there are good nurse-physician relationships, with improved patient satisfaction and outcomes being cited (Henkin et al, 2016). The data is indicative of relationships built on honesty and trust. This allows for effective communication in the nurse-clinician relationship as described by Robinson et al (2010). Jayne and Diane both refer to the supportive roles played by their senior colleagues. The characters of their consultants are not described in depth during their narratives, but they clearly afford a supportive relationship. Jayne's story illustrates the importance of honesty and also effective dialogue. Furthermore, in this both Diane and Jayne offer views of the team approach to confronting clinical situations. These data make a specific reference to the element of teamwork with such a team ethic being reported as resulting in a positive job environment (Ajeigbe et al, 2013). The opinion of this researcher is that in a collaborative clinical atmosphere there will be both enhanced patient safety and satisfaction and enriched working lives.

Where nurse-physician relationships flourish there exist not only effective communication but the establishment of shared common goals (Lindeke and Sieckert, 2005). This is also evident in Diane and Jayne's stories. The stories detail the value of approachability and also suggest a mutual respect. Importantly, it further implies an atmosphere of learning from each other, no matter the status.

Paula's story also discusses the relationship she has with her consultant and that of the multidisciplinary team present at her small stroke service,

> 'Erm, I talk to the consultant I work with so if I've got any issues or concerns, he's incredibly supportive and I can if I can get 5 minutes with him which is the only challenge I can go and talk to him about things. Erm, I've got I get on with the ward sister and the nursing team so and the multidisciplinary team I think we've a good team approach and because we're so small everyone knows everyone so if there was an issue we can support each other, I think that happens' (Paula).

Paula’s story continues with the role of support and the people who grant it. Paula informs the listener how she has a consultant who offers considerable support if she has any areas of ‘concerns’ or ‘issues’. She does not however elaborate on what these are, but they are presumably clinical in nature. For Paula the problem is one of access to the consultant as a means of support. She describes this as a challenge. This draws similarity with Jayne’s story where she refers to the problem of accessibility to her own consultant for support and having to seek it rather than be offered it.

Paula confides her relationship with ward team / ward sister and MDT. She thinks that this is a good team approach. She refers to her service as being so small which aids familiarity and should an issue arise individuals can support each other. She is not convinced but thinks this happens. The situation Paula describes appears to be supportive. However, the interpretation is that rather than being completely inclusive, Paula is someone who is either seen as being someone separate from the ASU team or sees herself in that light. She identifies the different entities that make up a team rather than the teams. However, on reviewing this part of her story the interpretation made by this researcher is that she appears to affirm the consultants support as greater than her other colleagues.

Paula’s story continued to describe how she also found reflection helpful,

> ‘I always like to see myself as a reflective practitioner however there’s different levels of reflection so you can talk something through on a kind of oh yes, I’ve reflected on that I feel much better but actually if you sit down and write it down and start analysing your thoughts that’s a much better idea’.

In addition, Paula has highlighted in her story how she also finds reflection helpful. Paula informs the listener how she likes to view herself as someone who engages in reflection, although she is aware that the process might be different for other individuals. She informs the listener that discussion is one mode of reflection that might be followed. However, Paula favours an approach that in is more measured. She prefers to sit down and compose her reflection and then give this deeper consideration. The theme interpreted here is again an individual coping strategy. This one favours reflection that has structured approach where she can critique her own thoughts and experience.

In Jackie's story she has also adopted a number of measures that enable her to cope,

MW: In what ways or what approaches do you use to enable you to cope with distress?

> 'I'm very lucky that I've got a fantastic consultant I work with and I can sit down as we are now and talk to him about how I feel and he, er, will rationalize it with me and we'll go through, erm, you know, why I feel like that' (Jackie).

Jackie considers herself most fortunate to have a supportive consultant. It is apparent that this individual is willing to invest time with her to explore her feelings, is able to go through events with her and make sense of what has happened and why she feels like this. She then refers to her relationship with her colleagues,

> 'When we're on our own and it's not good for you. The other stroke specialist nurses' we've got a really good relationship and we all talk and that's very therapeutic in itself really isn't it. I think there's been a couple of particularly stressful occasions you know with patients that have been poorly and I do feel that when you go up to the

> ward and you’re with others, you do feel it’s healthier than coming here (specialist nurse office) on your own and dwelling on it’ (Jackie).

Jackie speaks of her relationship with the other SSNS in the team and describes this as good. She does not inform the listener to the nature of their discussions, if they are formal, groups sitting or individual. She thinks of this as being beneficial in therapeutic terms although looks to the listener for confirmation (isn’t it). Furthermore, Jackie has voiced how she finds support in her colleagues in the ASU. She refers to stressful times with sick patients. She goes up to the ward/ unit (ED ground floor/ ASU first floor) where she can be with and around others. She literally positions herself among others. She feels that having company and being away from stressful environment of the ED or being alone in the basement SSN office, is a healthier option.

Gunusen et al (2018) study made specific reference to exploring interventions to mitigate against traumatic stress. The paper elaborated on supportive social networks, defusing activities and the need for discussion with and listening to colleagues. Having the opportunity to talk and to be listened to by colleagues was considered as a major coping strategy. A key characteristic of factors that were seen to possibly exacerbate STS reactions was identified as working in isolation. While this may at times be unavoidable, several of the specialist nurses took steps similar to Jackie to ensure that they were around people from the wider team. Jackie’s data draws comparison with Paula’s story. She also has identified the acute stroke unit and the wider multidisciplinary team as being an avenue for support. Jackie’s story suggests that the sense of community inhabited by the stroke specialist nurses can guard against the potential for isolation. Furthermore, is the reference to the benefits of therapeutic communication that can be used itself to overcome emotional experiences that cause distress (Levy-Storm, 2008).

Jackie's story concludes with her feelings which I believe are of a more personal nature and describe how perspective and gaining from the experience can in itself be a coping strategy. Her sense of satisfaction and perspective stand as an anathema to STS,

> 'I feel happy when I leave here. I get a lot from the job. You know I don't know what the word is. Satisfaction. Job satisfaction, especially if it does work (thrombolysis) you know and that is such an amazing feeling. We thrombolyse, you go to HDU, ITU the next day and they're brighter, then that just makes it worthwhile' (Jackie).

Jackie is in a happy frame of mind when she leaves work. She stated how she finds her work is rewarding and finds satisfaction in what she does. She draws the listener to the scenario of intervention with thrombolysis and describes the feeling where there is a good outcome as being amazing. The coda to Jackie's story reveals a sense of fulfilment – patients are thrombolysed and then seen the following day where patients are found to be better. The role Jackie's story plays is interpreted as that of a personal restitution narrative. It is in stark contrast to failed interventions or ones with complications. In her role as a witness to good outcomes she has shifted the focus from what could go wrong to that of actual recovery.

Crossley (2002) has discussed narrative in the context of individuals' ability to overcome trauma. He argues that adapting to trauma is a process of narrative reconstruction. Here new stories are created to provide new coherences that give meaning to the experience. Mattingly (2006) has described how stories of transformation can help individuals deal with bleak and uncertain situations. Reflecting on Jackie's story, the position of moral distress and subsequent biographical disruption that she was originally confronted by is in complete contrast to her story's conclusion. This researcher's finding is that Jackie's story is transformative in describing a counter narrative to that of tragedy and despair. There are also elements of a quest narrative evident In Jackie's story (Frank, 1995). She appears to meet the challenge of caring for stroke patients full on, embracing the scenario rather than avoiding it. Figley (2002) and Conrad and Kellar-Guenther (2006) have reported that a sense of satisfaction and fulfilment can negate secondary traumatic stress. This is reflected in Jackie's story. Although it was not referred to as a response to a specific traumatizing event, her sense of pride in her role and their observation of patient's recovery could arguably temper any stress that she may have initially felt.

McDermid et al (2016) have commented favourably on individuals who are of a positive disposition. Having or embracing a positive outlook has been seen as a counteractive strategy against anxiety and uncertainty that can undermine self- confidence. O'Baugh et al (2008) has described a positive attitude as one mirroring acceptance, determination and looking on the bright side. Jackie's story confirms this and demonstrates her ability to confront trauma with positivity.

Paula and Jackie's stories have highlighted the importance of collegial discussions. It is suggested that interacting with peers offers both a means for nurses to discuss what has been stressful and offers an opportunity to learn from it, as June's story illustrates,

> 'One of the things I like to do and I think some of the other members of our team does, is we'll discuss certain cases and certain situations and I might see a couple of nice patients and we'll have a chat about the nice ones but on the flipside you'll say oh we had this really awful case the other day and it was, you know, really sad and you'll discuss it because that's the way I like to learn and by discussing it with other people you can share what you've learned' (June).

The initial part of June’s story had seen her witness deaths and disability the cause of which she was powerless to change. She decided on a set of coping strategies similar to that of Jackie and the other SSNs. June positions herself with her colleagues to whom she relates best. June records her preference for discussion with her (SSN) team members. She believes that her colleagues who like to follow this means of supporting each other. June and her colleagues talk over cases and events of significance. The cases they discuss fall into two categories- those with good outcomes and those who do not fare well (awful/sad cases). The interpretation is that June finds this beneficial. The role being addressed here is not only support but also an opportunity to learn. Frank (2004) has suggested that storytelling can play a role in repairing narrative wreckage, as he states how the self is gradually reclaimed in the act of telling. This researcher holds the opinion that June’s (and Jackie’s) approach where the telling of stories related to patients and their own experiences are an example of lives shaped by these. June’s narrative describes how sense and meaning are made from sharing stories of patients’ lives with her colleagues. For June there is a benefit in hearing each other’s story and in the supportive interaction this creates.

Peterson et al (2008) has described how peers support groups using a problem-based method could be useful in reducing work related stress. Cronqvist et al (2006) has referred to nurses having to take the initiative to arrange and access support. This is found to be the case highlighted in both Jackie and June’s stories. As a coping strategy, discussion amongst peers appears beneficial. Furthermore, Secombe (2008) has described the effectiveness of peers as part of clinical learning that is alluded to in June’s story. Like Jackie, June adds perspective to her story,

> ‘I don’t think back on those occasions and sort of reflect on them but still have then some memories are nice, and some are not nice. They are, they are sad, but you can’t change what’s happened’ (June).

As with Jackie, June concludes with her personal thoughts. The summary June makes reveals that her stories of distress are traumatic; however, the outcome cannot be changed. What is interpreted here is that she is pragmatic and realistic and has gained a sense of perspective that has allowed her to discover some resolution that has led to her being able to move forward rather than to ruminate.

Another means of reflecting on what had occurred and being able to learn from it was identified by the specialist nurses as debriefing. The following stories from Diane and Maria, offer their similar interpretations of what they term as debriefing in their practice,

> ‘We have ½ an hour handover between shifts and I think that’s quite a bit of a debriefing session between us and the end of the day shift all the moaning (smiling) and sort of reflect about the shift and we’ll do the same thing next morning’ (Diane).

Diane does inform us in her story that debriefing does feature among the SSNs in her service. These sessions happen during the handover period at the change of shifts. She thinks that this constitutes something like debriefing. She finds the process useful as an opportunity to raise opinions and reflect. However, Diane recognizes that the activity is limited to the service’s SSN members and not the wider team. These meetings give the appearance of some regularity; however, they also appear to lack formality. It can be suggested that time and workload may be a limiting factor. Such factors may also be an issue why the formal debriefs with the wider team that are believed to be what Diane would like, are not a current feature of her service.

Maria reports her experience of what she sees as debriefing,

> ‘My colleagues in ED are very supportive and we often discuss spontaneously difficult decisions as a debrief, and I feedback how patients are doing so they all get some kind of closure on the case’ (Maria).

Maria has also discussed debriefing as part of her story. She identifies her colleagues in the emergency department as being involved in debriefs concerning patients where decision making has been difficult. She refers this as a ‘debrief’, giving feedback on patients and feels this affords some closure. Again, this is not a formal activity. It is something that is undertaken spontaneously rather than being planned. Maria does not identify or give voice to the colleagues who are involved in this process. She does not specify the details of which or what patient decisions were difficult. The outcome is described as affording closure which is interpreted as being beneficial. Both Diane and Maria’s descriptions do not suggest this activity as representing formal debriefing. The descriptions are more indicative of discussions. However, both raised the activities as deriving some benefit even if not a true reflection of an organized debriefing session.

One nurse in particular (Pam) discussed debriefing as a positive following a critical incident involving a deteriorating young person with a stroke. She described this as a formal structured meeting with a stoke consultant and a consultant anaesthetist. Her chance to debrief came many weeks after the initial episode. Despite this she was happy to have this opportunity. However, although this was not mentioned in her interview, it could potentially have given her time to dwell on what had happened, thereby prolonging her distress. The access to and provision of debriefing is regarded as inconsistent across the different services where these specialist nurses practiced. Huggard (2012) has cited debriefing being of immense benefit as a support mechanism for mitigating against psychological and emotional effects of caring. Furthermore, Gardner (2013) has stated debriefings potential for explaining and making sense of what has happened, being able to look over what went well and what went badly, and then learning from this what could be done differently. The means of debriefing referred to in Diane and Maria's data however does not appear to be formal and without a true structure its worth may be questionable.

This section has also highlighted what the SSNs considered to be debriefing as being a beneficial coping strategy. Debriefing has been identified by Reierson et al (2017) as having the key attributes of feedback, reflection, knowledge development and psychological safety. The debriefing mentioned by the SSNs appears informal and largely unstructured. However, what can be seen is reflection, feedback and learning. There are similarities with the actions of the SSNs in terms of peer support and reflective strategies and it is possible to suggest debriefing in this context as a useful adjunct to these activities.

Many of these SSNs have reported teamwork as being beneficial. It is also one in which a narrative approach to healthcare can be explored. Clark (2014) acknowledges narrative approaches as being able to create accurate and rich descriptions of the patient's story and the team that works with that story. A narrative approach can facilitate the sharing of stories from the patient, provider and other significant players involved in the respective episode (Clark, 2014). Narratives can then capture the experience of inter-professional team members that can lead to a shift in their identities, an increased appreciation for the perspectives of others and a more holistic view of patient care (Pottie et al, 2002). It is opined that if these nurses can share their patients and their own stories with that of other team members, there may be a greater appreciation of how problems can be addressed.

Stone et al (2016) have suggested international and inter professional collaboration as a core requirement for nurses in a globalized world and has recognized forums as a means of achieving this end. In the stories given by these SSNs, meeting and collaboration was advocated between specialist nurses at both local levels and the wider stroke community that included international forums. At a local level Maggie found support through her trust's other specialist nurses forums and non-medical prescribing groups. There are a number of medical and stroke nursing forums in existence at present. These afford all disciplines concerned with stroke care the chance to meet, discuss and share practices. It was an avenue by which Maria was able to create mutual support and consensus around decision making.

In James' story his views on forums and group support appear mixed,

> 'I think they need to have a forum in which they can talk openly or speak to each other about their thoughts and feelings erm coping strategies are better shared and then kept isolated, erm, everyone deals with stress in a different way and you can seek solace in group, I'm not saying, sounds almost like we should have group hugs, but I think talking about things and how someone deals with it also lets someone else know that erm how they have dealt with it also lets someone else know that erm how they have dealt with something that they may emulate themselves or have not thought of or how they could do something differently to avoid situations where they're going to feel that they are under stress or they're going to feel that their

> emotion is going to bother them later so I think that a group time to discuss time to talk erm and learn from each other' (James).

James' story is interesting. He positions himself as being something different from SSNs ('they'). He is in favour of forums for SSNs where they can share experiences as a specific coping mechanism. This echoes the opinion of Burton et al (2009) who in referring to stroke nurses suggested the importance of networking and peer support, with networks that expand beyond the sphere of nursing alone. James indicates that sharing problems is a better course of action than retaining concerns independently. He does however feel that individuals will adopt different coping strategies. His story suggests that some will find benefit from group discussions; however, others may perceive this form of support differently. James feels that people might benefit from discussing their feelings at a later point if they still feel the need to and group sessions might be helpful.

The interpretation of James' story is that he does believe there is some benefit for SSNs to discuss their experiences in a group format but does not indicate if he feels this would be of personal benefit. He appears not to be referring to national or regional stroke forums as the appropriate venue for this. This researcher holds that SSN support groups could form part of the agenda for discussion at these forums given the implications of this research. However, it is further proposed that individual stroke services or teams should address the need for and establish their own support systems. Essentially, coping mechanisms can be through group or individual means. What would appear to be vital to the process is the ability to reflect upon what has occurred and learn from it. Clark (2014) has recognized the need for teams to create narrative communities in which discourse and dialogue are valued. SSNs could use these communities to create and recreate clinical stories and narratives which add depth and new perspective. It affords the opportunity for what Clark (2009) terms perspective transformation, where individuals can compare differing interpretations of similar stories leading to reflection and the chance to consider different perspectives from their own. This is something that stroke teams could explore certainly at a local level.

James concluded his story with his final thoughts on his and other SSNs coping strategies,

MW: what coping strategies do you use to deal with distress?

> ‘I think generally talking amongst colleagues and certainly within the team is helpful erm alcohol is another route erm no I’m quite a chatty person anyway I’m very open, so I generally tell people if I’m feeling or if people want to talk about their experiences erm what did you do? How do you feel? How do you feel now? Erm but no other than that just the usual I need a drink, or I could do with a pint. Being there its conversations, you could have with other friends who are in the profession whether it’s at home or out and about but yeah, I would say I was mainly vomiting, purging myself onto other people can happen. I feel much better now I’ve vomited all that out thank you so someone who’ll listen basically. I should have maybe a football in the office like Mr Wilson from the, er, film shipwrecked or whatever it’s called, just vomit our frustrations on it, yeah that’s an idea, get a worry doll (laughs)’ (James).

James asserts his belief in the value of communication within the team and in general. With some hesitation, he briefly refers to alcohol before returning to his own nature, his social life and how he will discuss with others about his experiences and feelings. He makes a brief reference to the rolls played by colleagues and family. James expresses how he ‘vomits/ purging himself on to others’. This is interpreted as James describing his own means of catharsis, off-loading his feelings by talking with others. He is grateful for and relieved by this. His final thoughts are linked to humour, getting a worry doll and laughs. However, the belief is offered by this researcher that underlying this jocularity is a serious point, this being his search for someone or something that can absorb his concerns.

Perry et al (2011) and Melvin (2012) reported on individual coping strategies outside work that included hobbies, prayer and social activities. This was a similar finding among the stroke specialist nurses data with various hobbies and forms of exercise being noted. None of the specialist nurses referred to their spiritual beliefs as a source of succour. James' story can be compared to several of the other SSNs who also referred to the use of alcohol. Paula's coping strategy involved a more indulgent view,

MW: Can I ask what strategies on a personal and professional level, do you find useful in helping to cope with or guard against developing traumatic stress?

> 'I would say personally outside of my job is going and getting drunk and I think going partying and I think that if you speak to any nurse in a high stressful job they work hard, they play hard and I think there is that kind of and I'm the first to admit I like to party. I like festivals I like you know I'm Paula outside of (hospital) the nurse too and I think that's a coping mechanism for the high stress job that we have' (Paula).

Paula's coping strategies outside of work have a much different complexion. Paula makes the clear differentiation that outside work her personal means of de stressing is by getting drunk. She believes that any nurse to whom this is asked and who works in a role which is highly stressful, she feels would act similarly. She qualifies this by almost excusing this behaviour as almost a reward or recognition (they work hard/ they play hard). She is unapologetic in her admission that outside of her job she likes to let go. She seeks some affirmation here before her next sentence in which she says she is Paula outside of work, the nurse too and she believes in her personal strategy as a coping means for the high stress job nurses have.

The theme of coping here is a very personal story. Paula is honest, unashamed and unapologetic. In her coping mechanism she appears less restrained. However, what works for her might not work for others. Her story interesting as Pauls retains her identity of being herself and at the same time being a nurse. The opinion is that she does not see herself as two different entities. She gives the most honest representation of who she feels she is.

Kachadourian et al (2014) investigated the relationship between trauma exposed individuals, post-traumatic stress disorder and binge and hazardous drinking. The study realized an association between trauma exposure, PTSD and problematic alcohol use. Happel et al (2013) have commented on nurses' use of alcohol as a coping strategy. In a study exploring secondary traumatic stress among emergency nurses by Duffy et al (2015), a considerable number of nurses reported using alcohol as being helpful in relieving work-related stress. Several of the nurses involved in this research study referred to alcohol use as a way of winding down. This ranged from the odd glass of wine (Jennifer- 'I've had a really bad day, I'll have one glass of wine and I'll just chill out for about an hour'), the sociable pint (James) and the more liberal approach (Paula).

James, along with Janet and Jennifer, also offers a humorous outlook on coping. McCreaddie and Wiggins (2008) have commented on the positive link between health and humour stating how it can moderate the adverse effects of stress, enhancing the ability to cope. It has also cited as being beneficial to team working as it is a means by which bonds can be constructed and cohesion created between colleagues (Mesmer- Magnus et al, 2012).

Humour does however need to be applied with discretion. It has been suggested by Rowe and Regehr (2010) that in certain situations humour may be perceived as demonstrating a lack of compassion. Furthermore, McCreaddie and Wiggins (2008) have warned that nurses who engage in humour run the risk of not being taken seriously. Perhaps this view should be balanced by the value afforded by the use of humour as a coping mechanism (Bolton, 2004).

The nurses' humour that was located in these stories was generally offered at their own narrator's expense. Although the humour at work here appears self-deprecating, it is suggested that it constitutes a light in what has been at times a collection of dark dialogues, returning the extraordinary back to the realm of the ordinary.

Despite the emotions that have been carried with these nurses away from the work environment, none of the nurses reported this as affecting family relationships. Having a family was seen as a major factor in catharsis and coping in general. Some of the nurses referred to family as a welcome distraction from their experiences, whereas others actively looked to their family to deposit their concerns. This is exemplified in Janet's story,

MW: what coping mechanisms do use to help you against distressing events?

> 'My coping mechanisms inside and outside of work are pretty minimal I'm ashamed to say. I think I might have to have a mental health assessment (laughs). There have been instances where I've gone home and sort of had to offload it to my husband

> and shed a tear. He's not in the NHS or anything like that at all so a lot of it he doesn't really get, but he, you know, he says the right things'. (Janet).

Janet confirms her coping strategies as being limited. She also uses humour when describing this suggesting that she thinks she may require a psychiatric assessment. Although her response was interpreted as humorous, what she suggests is not without foundation. Following trauma for those who are trapped in a cycle of crippling anxiety and depression a mental health assessment may well be an appropriate course of action. The coping strategy in Janet's story is positioned with her (husband) family. The theme here is one of familial support and in Janet's case it is constructed around the person of her husband. We are given only a brief insight into the role of his character in Janet's story. Janet identifies that there have been times where she has looked to her husband for support. What she describes also has elements of catharsis. This has caused her on occasion to be emotional. Janet states that her husband has no nursing or medical insight. This is possibly of benefit to Janet as she is looking to a strategy of jettisoning rather than reasoning. Janet concludes by stating that although there is a lot he doesn't get, he says the right things. The interpretation is that for Janet using her husband as a sounding board is probably enough.

Monika also referred to her family as being important in her coping strategy. However, she also adds perspective to her story,

> 'I have learnt to remove myself from these situations and am able to go home and get on with my life. I find following a particularly harrowing shift like that I get more positive and see that life is precious and I feel happiness that I have a family and comfortable life. I try to use all those emotions in a positive way. It makes me feel

> life is short try to enjoy it. I spoke to my husband about my day. I find some comfort in talking to my family. They are non-medical and I get to see these situations in a lay persons view. (I obviously keep everything anonymous)' (Monika).

In Monika's story she recollects how she feels she's learned to remove herself from these situations and get on with her life. What she is suggesting here to the reader is her coping strategies outside of work. Melvin (2012) has explored the possibilities of detachment as a coping mechanism citing behaviours of separation. Monika has also been positive in terms of safeguarding her own interests in distancing herself from these circumstances and is able to carry on with life. Recalling her story, we saw at the time of her trauma an individual who had little if no support. This scenario was one that was interpreted as her being trapped in. Monika now situates her story at home and introduces the character of her husband. Monika describes the events of the day to her husband and finds solace in her family. There is similarity with Janet's story here in that Monika also makes the reader aware that none of her family is in healthcare. A comparison here between Monika's story and Janet's in that this is likely to be a case of someone offloading rather than one that is seeking a challenge.

Both Janet's and Monika's stories are interesting in that the source of comfort in both of these instances was their spouse. The temptation would be to view nurses' partners as their psychologists (Goldblatt, 2009) or as the most readily available means to support. However, spousal support has been realized as a mediator in the relationship between potential stressors and role strain, with job satisfaction being related positively to such availability (Patel et al, 2008). The interpretation is that these individuals are vital in offering solace to their loved one.

An important point would appear to be that the discussions are held with family members who are not involved in the healthcare profession. It is suggested by this researcher that as these family members do not have a full appreciation of their loved one's strain, they may listen with impartiality and not hold views which could be potentially conflicting.

Monika does however expand on this. She records that she gets to see someone else's interpretation of her story that has no medical background. This researcher's finding is that this indicates that the events are discussed rather than it being a recounted monologue. Monika does however reassure the reader that the content of her discussion is one that is anonymised. Monika also uses her sense of perspective and optimism to help her manage her feelings towards upsetting events. Monika refers back to her distressing experience but even then, she feels she can be positive when considering the support she has in her family life. She feels she uses her emotions to positive effect. This is interpreted as Monika finding perspective to help her remain buoyant and move forward. Her experiences make her consider that life is short and is something people should try to savour. Monika appears to be reflecting on her story where a woman of the same age as her died from a stroke. Her message is in reference to this that life (as with stroke) can be unpredictable and should be made the most of.

Walsh and Buchanan (2011) commented on how nurses' stress was amplified by believing that bad things were happening to people who were undeserving of illness. Nurses' ability to take perspective has been discussed by Duarte and Pinto- Gouveia (2017) and has been adjudged to not be associated with STS. A number of nurses portrayed an outlook that was rational about their situation. Several of the SSNs commented how experience in terms of life years and experiences made them more philosophical, allowing them to put into perspective caring for acutely ill stroke patients (Jackie/ Monika).

Caldwell and Grobbel (2013) have termed reflection as a process by which professionals can learn from their experiences. Bulman et al (2012) has expanded this definition to deem reflection as a process of critically reviewing experience from practice to inform and change in a positive way. The specialist nurse’s data included reflection as being positive in gaining perspective. Furthermore, they employed both written and verbal techniques to attain this.

Monika concludes her story with reference to the benefits of reflection,

> ‘I find writing a reflection of the day’s events helps me put it into some sort of perspective. I discuss things with a friend who is a nurse. Talking in a nonspecific way more like “it’s been a terrible week” etc. Offloading the stress of our day-to-day events seems to help’ (Monika).

Monika’s story can be compared with that of Paula in that both narrators discuss reflecting on their roles and experiences favourably. Their reflections are composed away from the clinical environment. Monika also chooses to write down her reflection of events and feels that this allows her some further perspective. Although Monika had no one to talk to at the time of her trauma, she does identify a friend who is also in nursing, who she talks things through with. She does not expand on this individual’s character, but the impression garnered is one of mutual support. Monika indicates that this is not case specific but is a discussion in more general terms. She concluded her story by being able to offload the stress of the day as helpful. The theme of Monika’s coping involves multiple strategies. These include having a sense of perspective and remaining positive. Her story also reveals elements of catharsis and reflection that help her adjust to and move on from her trauma.

This section has discussed how the stroke specialist nurses viewed positive thinking and reflection as being of benefit in their adjustment to potentially traumatic episodes. It is possible to regard reflection as not only a means of coping, but also could be viewed as a protective enterprise against further episodes of traumatic stress. If nurses can consider what has caused them distress, it is reasonable to suggest that they can modify their future practice to dissipate such an effect.

Many of the stroke specialist nurses reported as a coping strategy making a distinction between their work and home life with several describing their ability to maintain equilibrium in balancing the two areas. The key feature appears to be the ability to leave work related issues within the workplace. As Kathryn suggested in her story,

> ‘To me work is work and home life is home life. I give my best while I’m here but then that’s it. When I leave work, it gets left here I don’t take it home with me’ (Kathryn).

Kathryn makes a clear distinction between her life in work and that outside of it. She states that while in work she invests all of herself in it. There is a sense of finality when she leaves work (‘that’s it’) and she makes a conscious decision that she detaches from all connected to work when she leaves. This disconnection is however unconvincing given the previous section of her story where she stated her irritation at finding herself considering her work when at home (page 230).

For Francesca her identity of being a nurse stops once she is outside of her clinical area,

> ‘If there is one thing I have always learnt through my nursing education and as a nurse is that you have to try and leave work at work. My worries or feelings towards

> an event or a patient do not cross my personal life. They may exist while I have my nurse hat but the moment the hat is off, I'm not a nurse, I'm me! (Francesca).

Francesca informs the reader of the lessons from her nurse education that she has carried with her into her practice. She attaches great importance to this as' if there's one thing I've learnt'. The message of her lesson is that you try and leave work in work. Francesca alerts us to the rule she lives by, that no matter what her anxieties or emotions are towards a clinical event or patient these do not enter her personal life. She makes the further distinction that her emotions may be there while she is involved in care. She uses the phrase 'nurse hat'. When she is not doing her job then she is herself. She makes clear that there are two separate versions of which she is the nurse and the person.

Her story finds similarity with that of Claire,

> 'So, for me I've got you know, when they say you've got split personality that's me (laughs). When I'm at home I'm like, OK this is me at home. When I leave home and I step through the door this is me different. So sometimes it's hard to differentiate erm, problems. With work problems as well, I try to remember when I was training. I don't know if that's one of the things they said- leave your problems outside otherwise you won't focus on your patient care, so I think I've adapted to that. The moment I step through those doors, that's it, I completely forget about home and I don't remember one single thing. If the school rings about my children, then ye, otherwise I completely forget until I see them. Yeah, so really, it's having that said, leave outside erm I don't know you know it depends on the individual. I cope more just thinking it through, thinking it through and it will play through my mind and I will think about something and that's my coping' (Claire).

Claire continues with her story in a similar mode to that of Francesca. She injects some humour into her description of having a ‘split personality’ and makes an admission to being a different person to the person she is at home. When her role presents problems, she also recalls her training. However, she cannot precisely recall what the message was, but it is almost in reverse to Francesca’s- don’t take home problems into work or focus will be lost. Claire feels that she has followed this advice. Once she steps into the clinical area her thoughts are focused entirely on her role. She makes the listener aware that nothing distracts her from this. The underlying message is roughly in keeping with that of Francesca. However, Claire’s story remains contradictory when recalling her earlier extract where she states that you cannot just return to normal life after completing a shift (page 188).

Several of the papers describing STS in nursing populations referred to the importance of maintaining a distinction between practitioners’ personal and professional lives (Austin et al, 2009. Perry et al, 2011. Melvin, 2012). These nurses (Kathryn, Francesca, Claire) appeared to have no problem in being able to differentiate between their work life and personal life. The opinion of this researcher is that as much as these SSNs try to convince the audience that they can maintain a distinction between work and home lives, it is questionably if this is entirely possible. Furthermore, the extent to which these nurses can filter out their identity as a nurse when considering themselves as different entity at home is also contentious. It is argued that their whole identity involves them being a nurse. It is part of who they are.

These nurses decided to be involved in this research. Each has described events that have affected them in their role. These events have stayed with each of them. They have been significant enough that they have wanted to tell these experiences not only to a stranger, but to inform a wider audience of their trauma. The assertion is that these experiences are something that has become part of their fabric as nurses but also something ingrained in them as people.

There appears to be an imprinted philosophy here from training onwards. Nurses give their all in the clinical province, but what they may encounter as part of that is prohibited from permeating into their lives away from it. This however is not congruent with the experience of STS where nurses are haunted by their experiences.

This section has referred to the support afforded to the SSNs from their family members. However, the specialist nurses appear to present a distinction between their work and home lives. These data indicate that the nurses see themselves as two distinctly different identities. Kathryn, Francesca and Claire's data positions them as being different people from that of their work role and that in their home life. Their stories support the distinction of the nurse being divorced from the person that is outside of the time spent in this role. This researcher however debates to what extent this can actually be achieved. The argument is made that being a nurse is part of an individual's identity therefore making it difficult to subdue the personal and private lives.

The stroke specialist nurses have reported coping strategies that identify a number of social supports including both colleagues and family. As Charlotte describes in her story,

> 'We've got a very good set of nurses and we do really support each other. We do have days when you want to have a good cry and some of the nurses here do get very upset, er, very emotional. You know we're always there to support. To be honest as nurses I think we are very supportive to each other' (Charlotte).

Charlotte’s graphic encounter with trauma has also led her to adopt multiple ways to mitigate the experience. She initially refers to her colleagues as the first source of support. Her story is situated among her stroke nursing colleagues although none of them are referred to individually. She does however give us an insight into their characters and alerts the listener to some of them as being tearful. She directs us to the issue that some of these colleagues do become very upset and at times is very emotional. Yildirim and Aycan (2008) have referred to support as the interpersonal relationships and social interactions that help to protect individuals from stress. Charlotte makes it known that supportive roles exist between her and these nurses supportive of each other. In an early nursing literature review, the meaning and nature of catharsis was described by Kettles (1995) as the mode by which humans become purged of their distress. The paper by Lavoie et al (2011) on traumatic stress reactions in nurses discussed a sense of catharsis as a coping strategy, making references to nurses’ ability to talk and be listened to by each other. Many of the nurses in this study referred to crying as a means of catharsis and this is reflected here in Charlotte’s story. However, the story does raise questions as to if the level of support is enough considering how emotional these nurses are described as. Charlotte continues by describing her own emotions and release,

> ‘Things just build up and then I have a massive cry about every six months, erm, it makes, it makes me very emotional but then that’s my release’ (Charlotte).

Crying has often been seen as a means of catharsis (Parikh et al, 2004). Charlotte’s quote reports a sense of release where after she feels better. Charlotte also finds herself at times to be emotional. She informs the listener that her feelings escalate and then she has an outpouring (a massive cry). She reports this as being every six months and that in this period it makes her very emotional. She then reports what this researcher understands as her release. It is possible to suggest that it may be difficult to help navigate someone through their emotions. However, the sense of escalation Charlotte describes is unchecked before it becomes too much.

This study has identified the stroke specialist nurses need for catharsis in relation to the traumatic episodes that they have borne witness to. The main behavioural trait in this part of Charlotte's story is that of crying. Whether talking or crying, what the nurses are arguably seeking is 'off load' their feelings, to attain a sense of release. The interpretation is that there is an emancipatory quality to these descriptions offered by the SSNs who appear to have freed themselves from their feelings. It is debatable as to what extent they have found themselves truly freed of their memories. Furthermore, as in Charlotte's cyclical case, it may be that some individuals need to reach their own breaking point before they can continue. Charlotte moves her story away from the clinical area to situate it at home,

> 'I've obviously got my family at home. Erm, I try to kind of block things out that I've dealt with. I'll kind of go home, may talk about it if I've had a bad day but once I've sort of got it out of my system, I'm OK. I do my family things and obviously sometimes the family don't fully understand the extent of what we have to do. They try to understand as much as they can, erm, but again they don't kind of prod and poke. They just let me off load and then that's it then' (Charlotte).

Charlotte has a family but does not refer to them in any great detail. Initially she raises that, with a little hesitancy (erm), she tries to block things out that she has encountered. The interpretation is that Charlotte would like to leave behind what she has been witness to and not expose her family to this. However, she then continues that if the day has been distressing, she may talk with her family about what has occurred. Many of the nurses' stories discussed how they retold their stories as a means of catharsis. This often featured work colleagues or the people who they lived with. Kaminer (2006) has referred to the healing process in trauma narratives. She believes that retelling is an essential component of narrative repair advocating that through the retelling of stories catharsis can be attained. Charlotte again raises feelings of catharsis in that once she has got this from her system she feels better. This can also be compared to James description of ‘purging himself’ by talking to others about work events. There are further comparisons with the previous stories regarding family member’s non healthcare status. Charlotte gives this indication by saying that they do not understand or that they try to as much as they can. Again, the feeling is that Charlotte and her family do not enter a debate here from her quote of them not ‘prodding and poking’, It is apparent that her family listen but do not engage deeply. In this respect the roles that Charlotte’s family inhabit are similar those of Janet and Monika. Charlotte concluded that to her they allow her to get it all out and for her this is enough. She refers again to her team and the benefit of socializing,

> ‘We do have a lot of work nights out and I’d probably say that’s our way as a team to kind of just kind of breathe and relax to be honest’ (Charlotte).

Charlotte’s story also briefly touched on how the team spirit was enabled through plenty of socialising and nights out. The focus of these social events appears more geared to relaxation than discussion of the day’s events. The conclusion to Charlotte’s story (and this data analysis conclusion) ends by quoting her sense of perspective and positivity. Despite the vivid depictions of traumatic events and all that contributes to the evolution and experience of STS, these things when viewed with some perspective can be overcome,

> ‘Try to take a step back. Think about what’s going on. Even though that situation at the time feels really bad it could always be worse. But just try and do it cos it will get better. Take a step back, take a deep breath and just think I can do this, it’s OK’ (Charlotte).

7.8: Summary

This chapter has described the factors that these SSNs felt contributed to mitigate their experience of secondary traumatic stress. The feelings that these nurses describe are commensurate with the experience of the people who have been exposed to secondary trauma encounter and what they believe alleviates their experience. The factors which contribute to alleviating nurses’ feelings of STS are again multifaceted. References were made by these SSNs to how the elements of collegial, family and social support, perspective, catharsis, humour and alcohol were helpful in dealing with their trauma. The description and discussion of these elements affirmatively answers the research question with regards to how these nurses’ experience of STS is mitigated. These findings are congruent with that in the trauma literature in general and that concerning nursing.

This study offers a new appreciation of the factors that alleviate these stroke specialist nurses reactions to traumatic events. It offers a fresh insight into the strategies that are used by these nurses to counter the distressing impact of trauma occasioned in the course of delivering hyper acute care on these SSNs. This chapter takes a further step in describing how these nurses’ found relief from their traumatic experiences. It adds further weight to the argument by completing the trajectory of these SSNs trauma narrative from the cause and context of their STS, their descriptions of their emotional reactions to it, what factors exacerbated their situation and finally what brought them succour. Furthermore, this chapter adds to the theory of traumatic stress within nursing specialties. It also adds to the appreciation of this new area of inquiry not only in terms of stroke nursing and the emotional burden of caring associated with it, but also uses the novel approach of narrative to enhance the understand of the lives of these subjects.

Nelson (2001) has discussed how identities are reconstructed and the self-reclaimed through narrative repair, stating how the individuals who tell stories that oppose negative and oppressive representations, repair the damage to their identities from master narratives such as biomedicine. The SSNs data in this section has described their coping strategies to allow them to confront their trauma. It is proposed that the act of telling their story is in itself an act that is liberating.

Hayes et al (2010) have detailed the factors that contribute to nurses’ job satisfaction and wellbeing in acute hospital settings as inclusive of adequate coping strategies. Laal and Aliramaie (2010) have referred to coping strategies as one of the key elements of nurses’ ability to confront stress reactions, stating that the adopted coping strategy may be as important as the stressful event itself.

The stroke specialist nurse data made reference to a number of coping strategies. A high value was placed on collegial support. This support was largely informal with colleagues and was situated both in and outside of the clinical environment. White et al (2004) have commented in these situations that the focus is mostly geared towards talking rather than being advised and this would appear to be mirrored in the SSNs remarks. Particular reference was made to the support offered to the stroke specialist nurses from their consultant physician colleagues (Diane, Jayne, Paula, Jackie). What is evident is the special relationship between stroke specialist nurses and their consultants. Hyper acute stroke care has been revolutionized by the advent of thrombolysis, thrombectomy and telemedicine. Martin et al (2010) has stated that were new models of care with an emphasis on the role of technology are evident, there needs to be close interpersonal relationships and collaboration. The nature of hyper acute stroke care is dependent on good interpersonal relationships and a cohesive team approach as highlighted by Gibbon et al (2002). The stroke specialist nurse and consultant physician relationship has a basis in mutual trust, honesty and respect. It is suggested that these close working relationships are therefore well suited to be supportive in both directions.

Peers support was also viewed as particularly beneficial, with active dialog promoting a strategy of therapeutic communication. Aycock and Boyle (2009) have reasoned that peer support is a vital option for emotional expression. However, it is further suggested that not all peer support is therapeutic, as support may only be offered where challenging an individual to reflect on feelings and attitudes may be absent. Reflection would appear to be a key determinant along with maintaining perspective in terms of learning from what has happened and affecting a change. Reflection could be through individual or group means. O’Neill et al (2019) have discussed how this is arguably best facilitated in groups where experiences and perspectives can be shared, debated and acted upon. A further useful related support is arguably that of regional and national networks and forums, although access may be difficult for every individual. Donaghy and Devlin (2002) have suggested teambuilding, setting and maintaining team objectives and educational opportunities as a positive supportive measure. However, their study warns about initiating such measures where staff already feels anxious regarding workload pressures. Huggard (2013) has also cited debriefing being of immense benefit as a support mechanism for mitigating against psychological and emotional effects of caring. The data referring to the SSNs support strategies is however variable. While there appears a commitment to team working, the element of debriefing as described by Diane and Maria, appears to be more loosely applied.

Alongside collegial support can be placed that of the specialist nurse’s family and in particular the nurses’ spouse. Spouses have been cited as mediators for potential stress and role strain (Patel et al, 2008). There is perhaps the impression of catharsis here with the nurses’ spouse in that there is the sense of being able to off load their emotional payload (Janet, Monika). However, there exists a potential for danger where spouses are used as mediators- that being that they are potentially vulnerable to transmitted stress and distress. Cortese et al (2010) have discussed nurses’ work-family conflict which can lead to job dissatisfaction. Interestingly, a number of the stroke specialist nurses made a clear distinction between their work and their family life (Kathryn, Claire, Francesca). It is the suggestion of this researcher that despite the value of family support, there needs to be a balance between this and the nurses’ work- family life.

The data revealed how many of the stroke specialist nurses reported their attempts at catharsis through talking, crying (Charlotte) and peer/ family support. Taylor (2014) has discussed the restorative value of catharsis through sharing experiences and learning from peers. It is important to recognize that feelings of fear, anger and sadness are a natural consequence of loss and suffering. However, catharsis might imply nurses’ attempts at jettisoning their unpleasant memories and moving on. This approach is not without some merit. It has been suggested by Niiyama et al (2008) that ruminating coping strategies involving continuous talking about traumatically stressful events to someone else could result in the persistence of these memories and subsequent trauma rather than alleviating it.

It has been reported that 10-15% of nurses will abuse alcohol in their professional careers to counter work-related stress, isolation and high activity demands (Servodidio, 2010). The stroke specialist nurses data indicated that only a proportion of the participants used alcohol in the course of their coping strategies. However, none of these nurses openly admitted to this as causing them a problem either in or out of work. Furthermore, none of the participants admitted to the use of illicit drugs as a coping mechanism. Alcohol was often referred to in conjunction with socialising. The effects appear to be valued by those participants who referred to these activities. However, while socialising appears to have benefits in reducing isolation and affording the opportunity to talk, liberal use of alcohol as a coping mechanism cannot be endorsed.

Interestingly only one nurse reported on their sense of job satisfaction (Jackie). Although this was not in response to a traumatizing event, it was still cited as a coping mechanism. Radey and Figley (2007) have referred to ‘compassion satisfaction’. This state lies at the opposite end of the stress-compassion continuum. Here nurses are witness to suffering but are invigorated and gain a sense of fulfilment by attending to alleviate patients’ pain. It is debatable as to whether this data affirms this, but it certainly resonates with a sense of satisfaction and accomplishment. Arguably this could be another example of having a positive outlook/ approach. The data highlighted a number of nurses referred to a sense of perspective which having a positive outlook was a part of (Jackie, June, Monika, Charlotte). Garrosa et al (2008) have referred to the characteristics of nurses’ hardy personality citing that they challenge stressful life events by thinking about them positively. This in turn engenders an optimism that the nurse will be able to cope with the situation (Garrosa et al, 2010). It could be argued that this is one possible means by explaining why some nurses fall prey to developing STS and others do not.

Czaja et al (2012) have identified a coping strategy among nurses as seeking a career change. None of the stroke specialist nurses cited this as being an option to them. It could be suggested that there may be limited opportunities for this. Alternatively, it could be offered that they are generally all satisfied in their roles and have good coping mechanisms or are resilient in nature. Borucka and Ostaszewski (2008) have suggested that the key concept of resilience is positive adaptation despite adverse life conditions and traumatic events. Furthermore, Park et al (2018) have stated that resilience evolves with time based on repeated exposure to various situations, coping with and overcoming them. It is suggested that these elements are faced by SSNs on a regular basis and that in overcoming the trauma encountered by hyper acute care, have developed their own resilient features.

The data interpreted in this chapter appears to concentrate mainly on the stroke specialist nurses coping strategies with little reference to managerial and organizational support. Sinclair and Hamill (2007) have stated that organizations should adopt strategies such as formal peer support groups, clinical supervision with the suggestion of facilitation by a counsellor or psychologist, group debriefing- again facilitated by counsellors or psychologists and educational strategies. There may exist a constraint on time and resources which may mean that this is not amenable to stroke specialist nurses. The stroke specialist nurse data refers to peer support and debriefing; however, this appears to be informal and has the impression of an activity sought be the nurses themselves rather than a managerial or organizational initiative.

Ramjan et al (2016) have referred to debriefing as a means to identify those individuals who may need further assistance to cope. The stroke specialist nurses in this study identified debriefing as a coping mechanism, however, none of the participants confided that they either needed or wanted further help from a counsellor or psychologist. Furthermore, Aycock and Boyle (2009) have cited access to counsellors and psychologists for nurses as problematic. No education strategies for countering STS were referred to by the SSNs. It is suggested that these nurses have had to source their own coping mechanisms as the formal support from managers and organizations is inadequate.

Kellogg et al (2018) have referred to positive and negative coping strategies for individuals confronted by stress. Positive strategies could be said to include social supports, maintaining perspective and maintaining humour. The use of humour has been reviewed positively in terms of tackling STS by Craun and Bourke, (2014), who have identified it as having beneficial effects on individuals' wellbeing. Other coping strategies for STS could also include the use of hobbies, exercise, travel and religion (Von Rueden et al, 2010). Interestingly, none of the SSNs referred to any of these latter ploys. The focus remained firmly on strategies involving colleagues and family. The use of alcohol and processes of denial and disengagement can be viewed as negative processes. Only one nurse referred to 'blocking things out' (Charlotte). Whilst this affords protection, it can be likened to the behaviour of disengagement. There is debatably a further element of this in the nurses' strategy of maintaining a work life balance- keeping work at work and home life at home. What is evident however is the disparity between this and family and in particular spousal support.

7.9: Conclusion

Ultimately, STS is occasioned by bearing witness to other people's trauma. In this setting the trauma is related to hyper acute stroke. This chapter has discussed the means by which stroke specialist nurses develop and adopt coping strategies to confront their feelings of secondary traumatic stress. The specialist nurses reported a variety of personal and professional interventions to both alleviate and protect themselves from the effects of STS. It is suggested by this researcher that these multiple approaches to mitigating STS described by the SSNs could be similar to those employed by other nurses across a number of different healthcare settings and scenarios. However, a further suggestion is made that a combination of both personal and professional strategies are required to shield and moderate nurses from the effects of STS. The following chapter will aim to offer a further appreciation of STS and SSNs in the form of the study synopsis and discussion of this study’s implications.

Chapter 8: Synopsis and discussion

8.1: Introduction

This chapter contains a synopsis of the key findings of this research. The four main themes and their subcategories realized by this study have been discussed in the preceding chapters. A summary of these findings will be made here. This chapter will offer a commentary on the methodology applied in this study. It will also describe the strengths and limitations identified as part of this investigation. It will also deliver a reflection on how undertaking this study has impacted upon this investigator as a practitioner, researcher and as a person. The chapter will discuss the implications of this research for clinical practice, stroke services and the organizations within which these services are situated. It will make recommendations on possible avenues of further inquiry. It will now address the contribution that this research has afforded to the evidence base.

8.2: Stroke Specialist Nurses and Secondary Traumatic Stress

The overarching narrative of this research has followed the trajectory of SSNs experience of STS and is in this sense a unique contribution to the understanding of the emotional complexities of specialist stroke nursing. This has formed a linear pattern that commenced with the evolution of their secondary trauma, the context in which it arose and what additional factors contributed to it. These nurses told the story of how they were affected by what they had been witnessed to. This included the narrative themes of bearing witness to acute suffering, young people with stroke, empathic engagement, the influence of moral distress, interaction with the families of acute stroke patients and working within services with inherent problems. A particular emphasis was given to how their psychological landscape was invaded by their experiences. The narrative themes pervading these nurses disrupted psychological landscapes were evident in their feelings of apprehension, anxiety, intrusion and hypervigilance. This subsequently resulted in emotional responses such as crying along with behavioural and cognitive changes such as insomnia and distancing/ avoidance. The nurses' narratives continued to detail how they believed their situation of STS was exacerbated. Their narratives of continuing psychological disruption were characterized by the themes of the impact of empathic investment, dissonance, feelings of helplessness and powerlessness. Furthermore, the influence of personal life events, work life balance along with the professional issues of the SSN role and identity and lack of professional support contributed to the perpetuation of trauma reactions. Finally, their stories of professional and personal coping strategies described how they were able to come to terms, adjust and move on from their traumatic experiences.

Although it did not feature as one of the SSNs exemplars in the main body of the thesis, it is appropriate to include the significance that one of them felt this research had for them and the wider SSN community,

> 'Thank God you're doing this piece of work, the distress might be highlighted now, it might erm open the eyes of not only the people who work in it but people who manage it to how stressful and acute it is' (Jennifer).

Mattingly (1998) suggests narratives as essential to understand human discourses on suffering. To appreciate the narrative of trauma it must be articulated with reference to its social context (Garro and Mattingly, 2000). These nurses' trauma related stories and the context in which they arise have not been given prior amplification. Those with the power in dominant cultures such as healthcare institutions can determine the narratives that circulate within that culture (Dutta, 2008). This narrative privilege determines whose stories are heard and whose stories are not (Witham et al, 2020). This research indicates that these nurses' experiences of STS have been silenced by the master narratives of successful stroke interventions and subsequent recovery.

Stories allow people the opportunity to make sense of their lives and present the opportunity to change one's view of the world (Lagay, 2014). Frank (1995, p. 110) has stated that people can only be helped by others once they are willing to share their story. The traumatic experiences that these SSNs described have affected and shaped their lives. However, they must be given the opportunity to tell their story before they can reconstruct their lives and build new stories. Storytelling has the ability to facilitate the repair of something that was previously fragmented (Nelson, 2001). It is appreciated that stories have the power to heal, to restore, to transform. These stories offer the means for the SSNs to come to terms with their traumatic experience and move on from it.

Stroke specialist nurse roles have previously been discussed in the literature. However, the narrated lives of SSNs in terms of hyper acute practice have enjoyed no previous appreciation. Furthermore, there has been no investigation of the emotional burden placed on these nurses and in particular no inquiry of their experience of and response to traumatic events. This research adds to the knowledge base related to SSNs and acute nursing services and in doing so provides a unique contribution. It enhances the understanding of the application of narrative to nursing, with an emphasis on specialist nursing and its place in modern healthcare provision. Furthermore, this thesis also enables an addition to the knowledge base on traumatology in nursing. Ultimately, it widens the appreciation of the role of SSNs and their relationships with patients, relatives and other healthcare professionals.

This research has explored the context and cause of STS, SSNs experience of STS and the factors that both exacerbated and mitigated against this experience. While reference to physical manifestations was limited, many of the SSNs reported psychological impacts mirroring the feelings of STS. These feelings were predominated by low mood, anxiety, apprehension, tearfulness, flashbacks, nightmares and insomnia. Several nurses referred to compromised or transformed personal and professional values. This cognitive dissonance was accompanied by subsequent feelings of guilt and shame. Furthermore, while their clinical judgement was not affected, there was an unease regarding responsibility and the clinical decisions they had made. Alongside this a sense of apprehension in dealing with other hyper acute stroke related scenarios came to prominence. Hyper acute stroke care was characterized by high workload, high acuity and continued exposure to the trauma of stroke. In essence, this was the cause and context of SSNs experience of STS. Interactions with relatives of stroke victims, potential conflict with medical colleagues and problems inherent within services contributed negatively to the SSNs distressing experiences. Cross over was noted between the findings of the cause of STS and what exacerbated it, with the main factors stemming from patient contact and lack of supportive systems. Similarly, coping strategies were located in both personal and professional domains.

The findings of this research reflect those stated in the literature. STS has been reported in many nursing areas/ specialities: emergency department nursing (Dominguez- Routledge, 2009. Duffy et al, 2015. Morrison and Joy, 2016), high dependency/ intensive care (Stayt, 2007), oncology (Abendroth and Flannery, 2006), paediatrics (Maytum et al, 2004), psychiatry (Mangoulia et al, 2015), midwifery (Beck et al, 2011) and nurses involved in sexual assault services (Townsend, 2009). The context and causes of STS, its impact on the individual and the means by which it is either exacerbated or relieved described in these studies is mirrored in the findings of this research. While the areas and experiences recounted in these papers have their own set of circumstances, the critical aspect that unites all of them and that of the SSNs in this research is the exposure to traumatized individuals. The vast majority of patients presenting as a hyper-acute stroke are encountered through emergency services. It is suggested that the experience of nurses in emergency department services, where the need to prioritize and meet the needs of acutely sick patients and their relatives, most closely matches those of SSNs. There are also elements of intensive care and oncology nursing (critically ill/ highly dependent/ dying patients and relative interactions) which are similar to the narrative of the SSNs in this research. However, what must be contended is the extent to which certain specific components of the SSN role place them in peril of STS development when compared to other nurses. These following sections will submit a novel appreciation of how the SSN role, and its associated responsibilities conspires to produce STS in these subjects.

8.2.1: The SSN Role

Jovic (2019) has suggested that deeper thought is apportioned to the roles played out by characters identified in narratives. This includes what position they occupy and how they function in that role, how they are positioned in the narrative and what is their relationship to other characters within the story. The data analysis revealed that these SSNs occupy multiple complex roles that are not confined to their staple of being a clinical expert or the narratives protagonist. These have included being a witness, being an advocate, a listener and a communicator amongst others. Furthermore, their stories have referred to elements that have shone through or darkened their role such as grief, powerlessness, and conflict and by contrast, hope, empathy and compassion. Each and all of these nurses have however ultimately played a role in constructing a new understanding of their, their colleagues, their patients and their families' experience of hyper acute stroke care and how it is impacted by trauma.

Institutions face an ever-growing battle in maintaining cost effectiveness while providing and maintaining the quality of care. The nurse specialist role has been described as central to this process (Gurzick et al, 2010). Specialist nursing roles have been highlighted as including rapid access to care, seamless patient flow across services and being a lead coordinator of the patients' care trajectory (Casey et al, 2017). Kiernan (2012) has stated that although individual responsibilities may vary, specialist stroke nursing input is valued in the assessment, diagnosis, management and continuum of stroke care. The SSNs involved in this research have proved to epitomise this in their practice. However, it is possible to argue that juggling these multiple role elements with their associated responsibilities could be contributory to stress. It is suggested that SSNs and their managers need to strive to find a balance between what specialist stroke nurses are able to provide and the demands of the service. This may be easier said than done given the difficulty of being able to legislate from one day to the next what the clinical demands of the SSN are. SSN workload is of particular concern. Working long shifts in isolation is not a feature unique to SSNs. However, this research has referred to the SSNs faced by multiple clinically demanding situations. These nurses may be confronted by requests for multiple patient reviews/ assessments. Each review has the potential to be life altering for patients and their relatives, both with and without endovascular interventions. It should also be remembered that stroke care is often time dependent, incentive/ target driven and involves differing technologies and multidisciplinary involvement. The resulting stress is palpable and can be further compounded by uncertain or poor outcomes.

8.2.2: SSN and identity

Deppoliti (2008) has referred to how the construction of identity is influenced by the situation nurses find themselves in. The key aspects of SSN practice in hyper-acute stroke scenarios are comprised of assessment, diagnosis and management. It is offered that this situates these nurses in a watershed zone between traditional nursing and medicine which could in turn propagate uncertainty. It has been suggested that nurse specialists do not lose the essence of nursing as they take on an increasing and highly specialised workload and that competency frameworks and national standards could harness specialist nurses' skills and develop them further (Vidall et al, 2011). Such frameworks could delineate the true specialist nursing component of these nursing roles while potentially leading to greater recognition of the value specialist nurses bring. The findings of this research described SSNs who had considerable clinical expertise. However, it was evident that empathy, advocacy and compassion for their patients were still at the core of their practice. The SSNs involved in this research offered up their stories that were emotive. It has been suggested by Horrocks and Callahan (2006) that narratives full of emotion serve as a window to identity and that the individual experiences of emotion and the choices used to express these emotions reflect the individual's sense of self. It is therefore suggested that further narrative explorations of SSNs role and experiences are necessary to understand how they see themselves and how they believe they are seen.

8.2.3: SSNs and interactions with relatives

Kruithof et al (2012) has stated that stroke not only affects patients but also their families. Creasy et al (2015) and Lutz et al (2011) has identified the twofold effect of stroke whereby carers/ families do not have time to deal with the abruptness of stroke and that nurses are subsequently confronted by a difficult situation in dealing with them. It is recognized that a sudden onset of illness can be seen in a number of clinical scenarios. This research has identified relatives who could not adjust to the abrupt onset of stroke and those who believed that interventions would be curative. Leung et al (2011) has referred to relatives' unrealistic expectations of optimistic results through treatment and healthcare professionals' reluctance to 'burst the bubble' of hope. Interaction with relatives proved a particular source of stress for SSNs. This was exacerbated when trying to meet their needs while delivering an emergency intervention. Delivering emergency interventions is again something not unique to SSN practice. However, hyper-acute stroke and thrombolytic interventions can be unpredictable in terms of outcome (recovery, partial recovery, no improvement, symptomatic haemorrhage, death). This research observes that in these scenarios where the outcome can be high stakes, the level of distress is magnified for the SSNs involved in the delivery of such interventions while contending with relatives who are also under such similar strain.

8.2.4: The impact of encountering young stroke victims

The SSNs involved in this study almost universally referred to dealing with younger stroke victims as a particular source of distress. Stroke occurs indiscriminately across all ages. However, evidence suggests that the incidence of younger stroke victims is on the increase (Magwood et al, 2017). Rather than the SSNs becoming accustomed to this demographic, the findings portrayed nurses who still revealed disbelief at encountering younger stroke victims. These nurses felt themselves shattered by having to confront young lives being blighted and futures being denied by stroke. The sense of empathy and identification with patients of similar age groups and social circumstances sharpened these emotions. It is suggested that as SSNs will encounter greater numbers of stroke patients in the younger age range in the future and in such exposure to their suffering may prove to be unavoidable. The implication is that this is and will remain a trigger for SSNs feelings of STS.

8.2.5: Bearing witness

Nurses’ close proximity to patients positions them to see and engage with patient’s existential distress. However, nurses still appear to be challenged about how to deal with this distress (Fitch et al, 2012). SSNs are confronted by patients traumatized by stroke on a regular basis. Page et al (2019) have discussed the individual choice that nurses have in bearing witness to patients and relatives’ distress or not bearing witness. Some of the nurses who chose to bear witness consequently experienced disquiet as a result. It is proposed that adopting a policy of turning away could be equally disquieting as although affording some protection, it may leave nurses questioning their intrinsic values. It is suggested that the role SSNs inhabit forces them to bear witness. The trauma of being exposed to stroke victims suffering appears inescapable for these nurses. Furthermore, the nature of the role and findings of this study suggests that avoiding behaviours are impossible.

8.2.6: SSNs and moral distress

It is questionable as to whether SSNs are more at risk to moral distress than other nurses. However, their role and their relationship with medical professionals in the delivery of hyper-acute stroke care certainly conspires to place them in situations of potential conflict. For the SSNs conflict arose out of a sense of not following what they perceived to be the right course of action. Where nurses do not adhere to their own ethical code, a sense of violation is felt in betraying their principles (Wolf and Zuzelo, 2006). The findings of this study indicate that the essence of the SSNs' conflict and subsequent distress lies in relationships with medical staff and decision making. Weller et al (2014) has cited evidence to suggest that doctors and nurses do not always work collaboratively in healthcare settings. Although the SSNs are rightly seen as a corpus of expertise, this body was often not consulted or ignored. It is recognized however that this was by medics who were not part of the established stroke team. Purvis et al (2014) have stated that among the barriers to stroke interventions like thrombolysis, is negative attitudes from emergency department doctors who are unwilling to support its use. Unequal power structures in institutions and medical decisions that nurses have little power to influence add to nurses' distress. Autonomous practice is shackled by such institutional constraint resulting in further distress and powerlessness (Rittenmeyer and Huffman, 2009). The findings of this study agree with this statement. The SSNs found conflict with doctors' decisions and dishonesty as a major source of distress. These nurses still acted as advocates for patients but were at times found to be impotent to influence the process and outcome of clinical decision making.

8.2.7: Meeting the demands of a hyper-acute stroke service

It can be argued from that this data shows that the SSN role in delivering hyper-acute care lends itself well to the development of STS. Long hours often worked in isolation with an at times unremitting workload and high levels of clinical responsibility seemingly add to the potential for STS to gestate. Jirek (2020) and Macchi et al (2014) have advised that organizations should look to manage and limit caseloads to avoid situations of overwork. However, it is suggested that such altruistic thoughts are difficult to achieve with stroke specialist nurses working in the hyper acute arena. SSNs workload is often variable. The level of acuity and volume of patients is difficult to legislate for. This can result in continued exposure to traumatized stroke patients where there is little or no respite.

Effectively, this has resonance with the suggestion by Boyle (2015) that nurses are unable to remove themselves from the source of their distress. It has been assumed that STS occurs more in certain nursing roles (Dominguez-Gomez and Routledge, 2009. Mealer et al, 2009. Young et al, 2011). While there is agreement with Sheen et al (2013) that individual traumatic experiences should be considered on an individual basis, it is argued that hyper-acute stroke nursing conspires to promote traumatic experiences which are difficult to negate. However, a feeling of pride was expressed in the work that these nurses were involved in. Despite the distress that they encountered, the quality of care provided did not suffer. Delgado et al (2017) have explored nurses' resilience in the context of their interactions with patients/ families and colleagues. Several of the SSNs reported protective mechanisms such as surface acting along with other resilience promoting factors such as empathy, sense of self and insight (Aburn et al, 2015). Alternatively, several SSNs saw external supports as helping them adapt to traumatic stress (McAllister and Lowe, 2011). Despite the course followed, these specialist nurses found a form of resilience that allowed them to continue to provide high quality hyper acute care. It is suggested that these factors could represent a further area for exploration.

In summary there are similarities with the experiences of other general nurses with that of SSNs and experiences and feelings of SSNs. However, it is suggested by the findings that there are elements inherent with the role of the SSN which could specifically place them at risk of STS development. There will now follow a discussion of the significance and implications of this research is for services, organizations, education and research.

8.3: Implications for services, managers and organizations

This research has raised several considerations regarding specialist stroke services and the organizations in which they are situated. Slatten et al (2011) has discussed how the experience of STS can result in increased levels of sickness, absence, increased staff turnover and inversely affect work performance and job satisfaction. This has clear implications for the wellbeing of practitioners, the quality of patient care and services they provide (Christodoulou-Fella et al, 2017). The SSNs in this study revealed stories of a traumatic nature and reported feelings which were commensurate with those of STS described in the nursing literature. MacKusick and Minick (2010) have reported on the effects of STS in terms of staff retention, commenting that nurses who left the profession prematurely on account of this did so because they saw it as their only viable means of escape. Despite this, only one of the nurses referred to considering a change of role. The data has found variances in service or organizational support offered. There is also a lack of appreciation of the emotional burden these specialist nurses were subjected to and its impact. Horman and Vivian (2005) have recognized the threat of emotional contagion whereby individuals' stressful emotions can impact on organizational climates, becoming part of the embedded system and spreading among workers. Organizations need to be mindful of the impact of STS on its workers and take measures to counter this. The suggestion is made that healthcare institutions place an emphasis on support through peers and supervision whilst adopting programmes of trauma informed caregiver development.

Loseke (2012, p. 265) has identified how narrative can be used to influence organizational policies and procedures. This research illustrates to the SSN leads and management that their services stroke specialist nurses face considerable pressures and they should seek the appropriate strategies to help alleviate this burden. Hunsaker et al (2015) and Kolthoff and Hickman (2017) have advocated supportive working environments as being expressed through shared governance policies and procedures, with the focus being centred on work-life balance, assignment rotations and flexible scheduling. Sanders and Ashman (2018) have discussed the governance measures as applied to their respective acute stroke nursing team. Their paper highlights the crucial aspect of addressing key roles and responsibilities, levels of accountability and expanded scopes of practice. The findings of this thesis show that these avenues of support are lacking at best or non- existent. It is therefore suggested that this should be a priority for SSN managers to institute these steps and to include on-going and effective programmes of practice monitoring and audit. Furthermore, managers and organizations should look to be proactive with regards to supporting SSNs rather than reactive in response to a given crisis.

An approach to tackling emotional reactions to traumatic stress reactions is that of organizations incorporating policies that build awareness and resilience (Sorensen et al, 2016). A recent paper by Sprang et al (2021) has highlighted that as organizations become more STS informed there is a reciprocal reduction in reported levels of traumatic stress reactions. This argument agrees with that of Akinsulture-Smith et al (2019) who identified how the impact of trauma work on service providers is mitigated by organizational awareness and support programmes. Peters (2018) and Cross (2019) advocated activities such as preceptorship, mentorship, mandatory awareness programmes, support/ discussion groups and educational activities as improving insight and coping. Harker et al (2016) along with Oginska-Bulik and Michalska (2020) have proposed cultivating resilience as being a factor in preventing psychological distress, STS and supporting mental health that enables the individual to meet the professional requirements of their role. Kerig (2018) has favourably discussed a curriculum that introduces participants to techniques designed to promote resilience in the face of traumatic exposure. This includes appraisals, self-efficiency, emotional awareness and effect regulation across three stages- pre-exposure preparation, coping in the presence of trauma and recovery in its aftermath. Smith et al (2021) espouse the positive impact on resilience building was fostered through discussion groups where stories and experiences of trauma were shared and reflected on. The findings of this research suggest that organizations that provide hyper acute stroke services consider policies and programmes that encourage the development of these forms of activities in order to support their specialist stroke nursing teams.

8.4: Financial implications of STS

Gentry et al (2002) have stated that all professional caregivers will at some point in their professional lives be at risk of STS development. Where STS becomes a reality, it is accompanied by inevitable and significant financial implications for the healthcare services and organizations (Leinweber and Rowe, 2008). Sabin-Farrell and Turpin (2003) have identified the financial ramifications of STS citing how resulting increased levels of sickness, absence, and staff turnover can result in lost monies. In addition, Elwood et al (2011) have also referred to the potential cost to organizations in providing support and supervision to counter STS. Furthermore, organizations would have to contend with having to pay for a substitute to replace staff that are either off sick or have left or even be faced with loss of revenue through not being able to provide a particular service. In these times of financial restraint, increasing costs and changes in funding structures, STS could recognizably impact heavily on monetary resources.

None of the stroke specialist nurses in this study reported increased levels of sickness or absence. It is possible to suggest given the findings of this thesis that the cost may be greater in terms of their emotional wellbeing as opposed to impacting financially on their services and organizations. However, it is reasoned that as healthcare workers become more susceptible to the risk and development of STS, organizations will find their financial resources tested by the demand to support staff and lessen its detrimental impact (Townsend and Campbell, 2009). The organizational supports referred to by the participants in this study are at best variable and at the worst, non-existent. This study provides a sincere remainder to stroke service leads, organizations and stakeholders to give serious consideration to financial investment in programmes to negate STS.

8.5: Leadership implications

Within stroke services the specialist nurse embodies leadership as a clinical expert and role model. There does however appear to be a discrepancy in terms of who affords the SSNs themselves leadership, with wide variations being apparent in this respect. Nursing management and leadership was variable and, in some circumstances, non- inclusive. Furthermore, the SSNs experience of leadership and means of support lay more with medical colleagues rather than that of nursing. This was however inconsistent and on occasions the SSNs were undermined by medical teams resulting in moral distress. The findings of this research contend that SSNs means of support and leadership lacks structure. Organizations need structure. Without it environments become chaotic, perpetuating the stress that disrupts teams (Pross and Schweitzer, 2010). The demand is made for authentic leadership whereby a culture of caring, meaningful recognition and respect, professional development and debriefing promote a healthy work environment (Sacco et al, 2015).

8.6: The role of education

Beck (2011) has stated that nurses need to be educated about their own vulnerability when working with traumatized patients. However, Richardson et al (2016) has recorded that service providers are rarely instructed on how to deal with their own feelings of fear, anger, shame, inadequacy or failure. This inquiry could be used to prompt educational initiatives on STS not only in stroke specialist nurses but to include the whole and wider healthcare teams that they are a component of. Educational programmes providing information on risk factors, reactions and consequences, with a strong emphasis on self- awareness, self- care and stress management could help professionals to deal more effectively with their emotions thereby potentially reducing STS (Adimando, 2018). It is suggested that educational programmes on recognition, prevention and addressing STS should extend across all NHS organizations and academic institutions to help healthcare personnel deal with their responses to traumatic events.

8.7: Formal and informal support mechanisms

However, it is not only a question of what managers and organizations have or are able to offer in terms of supporting nurses. Schmidt et al (2014) have stated that there needs to be a transformation to promote psychological wellbeing. The findings of this study also indicate that the SSNs need to consider personal change. Whilst some if these nurses reported access to support as internally as being variable, many looked towards colleagues, friends and family for comfort. The data has stated some of these nurses as having guilt and shame about their practice and in such internal support might not have been something they were likely to pursue. Help seeking decisions are often influenced by confidentiality and stigma, with the belief that fellow professionals might harbour prejudice towards those who disclose feelings of stress (Clement et al, 2015. Cankaya and Durman, 2010). Due to fears regarding loss of confidentiality and stigma people with stress in healthcare settings often look to social supports rather than professional or collegial aid (Galbraith et al, 2014). Nurses in need of organizational psychological support should feel free of recrimination. Organizations need to be honest and open if nurses seeking their help are to have confidence in their assistance.

Yilmaz et al (2018) have described the benefits of supportive programmes for STS, which in turn could also represent a valuable investment in healthcare resources. It is suggested that the approach to developing and initiating such programmes to counter STS be given careful consideration. The introductory chapter of this thesis has referred to the lack of consensus and clarity with regards to STS. It has not been afforded a diagnostic status under the DSM or ICD. However, it is suggested that there exists enough of a recognition ascribed to it to bracket it under the label of a psychological malady. It can be argued that this tendency towards pathologization offers two problems for healthcare managers to consider: how should it be addressed in terms of ‘treatment’ and by whom? This raises questions of availability/ access and the quality and appropriateness of what is on offer. Pardoe (2010) has praised the advantage of teams that have within their ranks clinical psychologists who may prove beneficial in offering appropriate support of this nature. However, not all clinical teams are afforded this level of specialism. However, there are alternatives that managers and organizations could consider. Potter et al (2013) have spoken favourably of a resiliency programme that empowers nurses to recognize the threat of traumatic events and self-regulates the related stress. In addition, the components of intentionality, self-validation, connection and self-care are designed to manage stress and reduce intrusive experiences. Li et al (2014) have also discussed programmes focusing on psychological wellbeing, with a basis in group cohesion and organizational commitment. This specifically highlights support through didactics, skills labs, clinical experience with a preceptor/ mentor and debriefing.

The two latter initiatives represent an approach that could prove valuable to organizations wanting to promote the psychological wellbeing of their nurses. The fundamental aim should be one of nurses gaining awareness and insight into what could potentially lead to STS in their work and how to protect themselves from it. It is suggested that SSNs and their managers should seek out opportunities to promote this.

This research has identified a number of implications for services and organizations in which SSNs work. It has highlighted that there is an impact on the quality-of-service provision and how STS in SSNs could result in detriment not just for the quality of care but also has considerations for finances, leadership and education. There now follows a brief commentary on the approach used in this study before going on to highlight the areas that could be investigated as future research initiative. A discussion will be offered on the impact of this thesis and the academic experience on this investigator as a clinician, a researcher and as a person.

8.8: The narrative approach

This study is concerned with nurses' stories of their experiences and followed that of a narrative enquiry. Carter and Little (2007) have articulated on the justification for chosen methods in qualitative studies, referring to the key elements of epistemology, methodology and methods. The narrative methodology and methods followed in this thesis are justified as this chosen approach allowed the research to evolve leading to the production of the best data to answer the research question whilst remaining true to my epistemological position. Consideration could be given to the alternative approaches of interpretive phenomenology (Tuohy et al, 2013) given its emphasis on the interpretation of stories with shared and recurring themes and ethnography (Rashid et al, 2015) with its focus on mapping the structure and function of cultures. However, the narrative approach also shares a similar interest in the importance of cultures. Furthermore, the narrative approach offered a greater intimacy with the area under investigation as this investigator was autobiographically situated in the research. The narrative approach permitted the best understanding of the culture of stroke specialist nursing. In addition, this narrative inquiry was the most appropriate means of understanding how these nurses' experiences have shaped their outlook on their practice.

This thesis has referred to the work of several luminaries in the sphere of narrative theory. Many of these authors were referred to as being influential in informing the data analysis, most notably Donald Polkinghorne, Arthur Frank and Cheryl Mattingly. The narrative approach and typologies that they have described were reference points to guide the analysis. Their work is recognized as having application to the experience of ill people and has been referred to in studies of those suffering from a wide range of conditions. It is argued that nurses also form part of the ill person's narrative and that these narrative types can also be appreciated in the context of nursing practice.

8.9: Future Research

It is suggested that investigation is required into the coping strategies of those who are exposed to traumatic events but who do not develop STS (Duffy et al, 2015). A number of the papers discussed long term effects and describe the effects in terms of year's duration. Agreement is met with Sabo's (2006) suggestion that the direction of future research should embrace longitudinal studies of chronic exposure, long term effects and organizational support. This study has focused on SSNs working in the hyper-acute arena. However, another area for the investigation of potential trauma linked to stroke is the rehabilitation setting. This particular area will differ in the incidence of increased mortality and hyper-acute interventions. However, the trauma encountered here may possibly lie in having to bear continued witness to lives irrevocably shattered by stroke. Nurses working in these areas may be exposed to the trauma of patients who are unable to achieve significant gains from rehabilitation and having to deal with relatives' expectations. Furthermore, this line of inquiry could instead of focusing on specialist nurses be extended to the ward-based nursing complement.

The subjects in this study mainly reported on the episodes that they had felt precipitated stress reactions. The stories offered up mainly reported on isolated events. A further area of research could focus on those nurses who have been subjected to multiple traumatic episodes. Another aspect that as yet has not been mentioned is that the data has revealed that stroke specialist nurses, despite the trauma they encounter, are committed to the work they do. This poses questions of robustness and resilience which could also provoke further investigations. Many of the studies cited in the literature review and indeed much of the captured data referred to coping mechanisms centred on the importance of family support. However, the data did not speak of this as a potential for detriment. Galletta et al (2019) has discussed work- family conflict and emotional exhaustion among nurses. Furthermore, Sharma et al (2016) has identified the underlying role of stress in work- family conflict. Given the implications of this study, it is proposed that SSNs work/ life balance and family support verses conflict could be the focus for further appreciation.

A particular focus of distress recounted by the SSNs was related to their encounters with young patients and the devastation reeked upon them by stroke. Magwood et al (2017) have referred to the substantial increase in the incidence of younger stroke victims. This suggests that SSNs will encounter more people of younger ages entering stroke services. Consequently, it could be argued that this may increase the feelings of STS that the SSNs in this study have referred to. The nursing literature reports on the experiences of younger people with stroke and its impact on them and their families (Lawrence, 2010), the psycho-social impact (Thompson, 2013) and the specifics of young stroke victims and implications for work, housing, employment and sex (Rowat et al, 2009). However, there are no studies specifically looking at the nursing experience of caring for young stroke victims. This is an area for further inquiry with particular emphasis on how nurses (specialist or stroke unit based) are impacted emotionally.

Sheppard (2015) has commented on how her research in this area was driven by listening to the stories of former nurses and their experiences and unresolved feelings related to compassion fatigue. During the recruitment phase of this study, one SSN who initially expressed an interest in participation later declined to take part as she was leaving stroke services on account of it being ‘too stressful’. An area for investigation could be with such specialist nurses who have left stroke services and whether STS played any part in their decisions to leave.

This investigation has realized multiple stories of distress. This, along with reading some of the related studies, has at times been unsettling. The whole process of interviewing, transcription, coding and writing up reports can in itself cause distress by repeated exposure to respondents’ trauma material (Dickson-Swift et al, 2009. Coles et al, 2014). This has raised the question of the effect of being exposed to others traumatic stories in the role of a researcher. This area could also be ripe for inquiry among researchers undertaking such similar studies of nurses’ traumatic experiences.

8.10: The personal impact

My position at the start of this study was one of being an experienced advanced nurse practitioner and now that of a nurse consultant. I have been involved in research at a local level which has mainly been associated with clinical trials and brief quantitative studies undertaken within my own research team. I am a novice qualitative researcher. My worldview has been for the last 14 years one of an advanced nurse practitioner- assessment, investigation, diagnosis, prescription, an identity that has been fashioned in the clinical domain. This study has forced me to step away from what has been and is familiar. There was a sense of trepidation in undertaking this research and in becoming a doctoral student. I questioned my motives for undertaking the study. Introspection led me to believe my reasons to be to ‘get on’, to impress other people and to rediscover a sense of worth. I also had to reason with myself why clinical incidents were having such an emotional impact upon me.

There existed a tension between my role as a practitioner and that of a researcher. My clinical role is arguably rooted in expectation- in myself and particularly of others. There are elements of clinical leadership within my remit where I make demands of others where there is little or no negotiation. However, I saw this as contrary to the principles of research involving other people. The doctrine I had subscribed to for over a decade, one of largely dictation, had to be replaced by direction.

I believe that at the start of becoming involved in this research process, I may have succumbed to academic hubris. Undertaking a PhD came with the danger of assuming a mantle of superiority. Newbury (2011) has written of the sense of being patronizing in the assumption of generating new knowledge, stating that respondents supply the knowledge, researchers interpret it. I came to appreciate that without respondents there would be no new knowledge. However, prior to data collecting, my feeling towards interviewing my peers was not one of equality. My overriding thoughts were that collecting data to analyse was essential to my main concern- completing the study. This feeling of placing my own needs and desires above all else was culturally and ethically wrong. Interviewing my first subject changed that. There was engagement, empathy and humour. Moreover, I believe that the respect and value learned at this point has led to me developing a sense of humility and gratitude towards all who were involved in this research.

Thinking over this section and reviewing some of the notes made, there is the potential inclination to be over self-critical. I have at times felt undeserving of this academic opportunity and the chance it has brought to listen to and become part of someone else' story. However, reflecting on the learning with and from others has been a privilege that has helped me grow as a researcher, practitioner and as a person.

Lyle (2009) has championed reflexivity in the course of narrative construction. Furthermore, Murphy et al, (2016) have referred to reflexivity in narrative inquiry as 'process of becoming', implying a transformative effect on those involve in its prosecution. This has resonance with this research experience. I feel that becoming more aware of myself and my own philosophical stance has been transformative. It has led me to a point of reconciliation between the tensions posed between being a practitioner and a researcher. Perhaps more importantly, self-reflection has made me confront how I value others and their experiences.

I have learned, as Frank (1995, pp. 158-60) suggests ‘to listen to my own story as I would listen to others’.

8.11: Strengths and Limitations

This researcher’s previous experience of qualitative research had been limited to undertaking a systematic review as part of an MSc in clinical nursing. While having a reasonable knowledge of qualitative methods from previous academic courses, this researcher had no experience and little comprehension of narrative methods. However, a team of three academic supervisors with a wealth of knowledge and expertise in critical supervision, qualitative methods and in particular the narrative approach proved invaluable to this inquiry’s undertaking. The processes of academic supervision helped to shape and formulate arguments and through critical discussion, foster confidence in the chosen approach and give affirmation to the findings.

The researcher’s clinical role has been an advanced nurse practitioner and now as a nurse consultant. The primary focus of their clinical work during these last 16 years has been in the specialty of stroke medicine. They have also had experience of a role managing a 7 strong team of stroke specialist nurses. They have therefore an in-depth knowledge of the area of stroke practice and the roles and challenges faced by stroke specialist nurses. This insight has informed the conduct of this research. The subjects were recruited from multiple clinical areas across the UK. This allowed an appreciation of the local differences in their specialist nursing roles and regional stroke service provision that may have contributed to their experience of STS.

These data were collected from a purposive sample over a prolonged period of two years and by one researcher. Collecting data electronically allowed access to participants over a wide geographical space. However, it was not possible to know with certainty if the participants were distressed by recounting their experiences. While participants who contributed their data electronically were safeguarded from the researcher's influence, non-verbal data such as facial expressions, body language, voice tones and tears, were lost to the interpretation.

8.12: Contribution to the evidence base

This thesis makes a significant and original contribution to the understanding of stroke specialist nurses work and its evidence base. The findings state the feelings expressed by these SSNs as commensurate with that of STS. The impact has potentially profound implications for nursing, stroke patients and their care, their relatives and stroke services as a whole. Stroke specialist nursing has evolved dramatically over the last 25 years. The initial focus of SSNs work was placed on the post stroke elements of giving advice and community interventions. What is more, as stroke services have evolved, and with particular emphasis on hyper acute interventions (thrombolysis, thrombectomy, telemedicine, hyper- acute stroke units), the role of the SSN has also had to evolve with it to meet the demands of these innovations. This researcher opines that this evolution and specifically the nursing component within it have not been given greater recognition. This researcher asserts that the roles performed by these nurses are not fully appreciated by disciplines who work outside of stroke services. A similar lack of acknowledgement may be present in those who are involved in stroke services but who are not involved at the coal face of the hyper acute service. This research highlights the important role that SSNs play in the delivery of hyper acute stroke care dispelling what is the superficial understand in favour of a more complex picture.

The most important aspect of this investigation however lies in illuminating the emotional impact of hyper acute stroke practice and contextualising what contributes to it. Stroke specialist nurses experience of trauma and its effects are multifactorial and can occur either in isolation or in combination. Stroke specialist nurses dealing with hyper acute presentations are exposed to these elements by the very nature of their work and are at risk of developing STS. This study illuminates the relationship that these specialist nurses have with their acutely ill patients and their relatives. Furthermore, this research provides a greater insight into the environment and community in which hyper acute stroke services are situated. The direction and delivery of hyper-acute stroke care is dependent on a multidisciplinary approach. However, this research demonstrates the relationships underpinning this ethos as complex and at times compromised. SSNs are an essential component in the machinery of hyper-acute stroke care. However, their multifaceted role places them within the proximity of potentially traumatic events such as life changing disability and death. The narrated experience of STS extends beyond the hyper acute scenario and continues to permeate these nurses’ lives. Despite the emotional burden of the SSNs’ work, this work reveals that they continue to deliver highly specialized care.

This study aimed to perform a qualitative exploration of stroke specialist nurses’ feelings of STS encountered in caring for patients with hyper acute presentations. These elements of SSNs’ practice and experiences have been given no prior appreciation. This study elucidates these factors and is therefore unique in terms of its contribution to the evidence base. While STS in itself is not an isolated phenomenon in nursing, its appreciation in terms of stroke services, SSNs and specialist nurses in general has no parallel. This research is therefore a novel and significant contribution to the evidence of SSNs narrated lives and how their work has left an emotional imprint upon them. The narrative method employed in this research is also original in terms of the study of STS in nursing groups. The use of a narrative lens has been central to understanding these nurses’ work and feelings. It has enabled this researcher to expose the dramas at the heart of these nurses’ emotive experiences and pull together their diverse elements to shape a distinct appreciation. This has ultimately led to constructing a new understanding of the phenomenon of these nurses practice and its associated emotional impact. These stories represent more than just sensitive accounts. They offer what are at times often intense and unflinching visions with a vitality that uncovers the complexity of these nurses’ experiences. Through the narrative apparatus these emotions have been made accessible, captured and given expression. The research is therefore visionary in terms of understanding the SSN experience. It provides a new insight in terms of the hyper acute area and the specialist nurses that inhabit it. This thesis also makes the case to understand the intricacies of these nurses’ emotions in the context of their practice and the place in which they operate. It represents an important foundation for understanding how the SSNs are and how they should be perceived. The conventions and prejudices that shape how these nurses are perceived are challenged by this investigation. There is also a transformative aspect to this research in that it allows its audience an insight that navigates them away from previously held perceptions that situate these nurses within the confines of traditional practice or as a mere support act.

This study is a massive opportunity to learn the truth of these nurses’ experiences which should be embraced. It provides a fresh insight into the effect of secondary trauma as experienced by a specific nursing population who provide expert care within a hyper acute speciality. This study contributes an understanding of the lyrical manifestation of trauma but is also a celebration of specialist practice and overcoming. Within these stories there is lament but also affirmation. There is uncertainty but also promise. Ultimately this thesis makes the specific contributions of explicating and validating the experience of SSNs. It also serves to provoke feelings and cause a debate about the emotional impact of specialist stroke nursing and specialist nursing as a whole. In such this research has an appeal to not only nurses involved in hyper acute or any division of stroke care, but to all specialities and disciplines. It is an original addition to the cannon of knowledge related to the study of traumatology in the helping professions and also trauma reactions in general.

8.13: Dissemination

This research was the subject of a presentation to the Royal College of Nursing Research conference held in Birmingham, UK in April of 2018. It was also the focus of poster presentations held at the University of Glasgow (OPSYRIS- organisation for PSYchological research in stroke- October 2018) and Northwest region stroke update at Aintree Hospital, Liverpool (June 2019). It has also resulted in the publication of original research described in appendix 13. This publication has been distributed electronically to all the SSNs within the Cheshire and Merseyside through the secretariat of the Cheshire and Merseyside Integrated Stroke Delivery Network (ISDN), the stroke teams covering Broadgreen, The Royal Liverpool, Aintree University Hospitals and Liverpool Heart and Chest Hospitals. It is envisaged that in the near future it will be presented to the regional stroke stakeholder's forums and at the UK stroke conference later this year.

8.14: Concluding thoughts

This study aimed to perform a qualitative exploration of stroke specialist nurses' feelings of STS encountered in caring for patients with hyper acute presentations. This experience appears to be multifactorial and can occur either in isolation or in combination in response to these elements. Stroke specialist nurses dealing with hyper acute presentations are exposed to these elements by the very nature of their work and are at risk of developing STS.

This research has identified STS in stroke specialist nursing populations. However, it is suggested that this research resonates not only with SSNs as individuals and groups, but across all specialist nurses' clinical practice and nurses and healthcare workers of all disciplines in general. This study has also realized how STS may impact on services and organizations. It has also raised implications for education and has suggested possible areas of further inquiry related to the subject.

The data itself has raised findings in several key areas, namely, the context and cause of STS, the effects of traumatic stress and its implications for the individual, patients and services, exacerbating factors and means of achieving relief. The initial theme was that of causation. This has saw categories emerge such as acuity, young patient presentation, moral distress, problematic healthcare systems, inter collegial and family conflicts, exposure to suffering and empathetic engagement. The second theme discusses individuals stress reactions. Although this included physical reactions, by far the greatest response to STS was psychological. Furthermore, this realized consequences for patients in terms of distancing and disengagement. Interestingly, there is a cross linkage between exacerbating factors and the cause and effect. Empathy, a key component of caring was referred to as a double-edged sword. A sense of powerlessness, lack of support and the unrelenting nature of the role all featured. Finally, relieving strategies saw the importance of peer and family support, work life balance and maintaining perspective. The data has also raised issues regarding nurses' hardiness, resilience, empathy and reflections on the services that they are often seen as being at the heart of. This synopsis has uncovered the potential impacts for stroke services and organizations and has offered some suggestion that may counter the effects of STS on SSNs. It is offered that to achieve positive patient/ relative experiences, attain better nursing outcomes, maintain quality services and improve staff retention, there needs to be a combined effort from educators, administrators, policy makers, organizations and SSNs themselves to counter the detrimental possibilities of STS.

8.15: Summary

This chapter has offered a synopsis of the key findings of this research. Reference has been made to this study's' original research aims and how these have been addressed. This section has evaluated the strengths and limitations realized in undertaking this work. Finally, it has discussed the potential areas of further investigation related to this topic and how this study has made a contribution of new knowledge to the area of stroke specialist nursing and the emotional impact of hyper-acute stroke care.

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Appendices

Appendix 1: Abstract Preliminary Prevalence Study- Compassion Fatigue in Acute Stroke Unit Nursing Staff

PR Fitzsimmons, M Wilkinson, P Lopez,

Department of Stroke Medicine, Royal Liverpool University Hospital

Introduction

Compassion fatigue may affect healthcare professionals and is comprised of burnout (work related psychological exhaustion, cynicism and underperformance) and secondary trauma (trauma experienced vicariously after witnessing others undergoing traumatic events).

Compassion fatigue significantly impacts on patient safety and satisfaction, with burnout being particularly associated with nursing absenteeism.

We aimed to perform a quantitative study of compassion fatigue risk in acute stroke unit (ASU) nursing staff.

Methods

Each member of nursing staff at a university teaching hospital ASU was asked to anonymously complete the validated ProQOL5 compassion fatigue self-assessment tool.

Results

32 nurses returned completed ProQOL5 questionnaires (71% response rate).

19 (59%) were at low and 13 (41%) at medium risk of secondary trauma.

6 (19%) and 26 (81%) of ASU nurses were at low and medium risk of burnout respectively, none were at high risk of burnout.

Educational background, grade, years of nursing experience and shift pattern did not significantly affect the risk of burnout or secondary trauma in this sample.

Burn out risk scores were significantly higher than paired secondary trauma scores; Mean burnout score 26.5 (95%CI 24.7-28.4), mean secondary trauma score 22.19 (95%CI 20.1-24.3), $p<0.0001$.

Conclusions

Our data suggests the majority of ASU nurses are at moderate risk of burnout, with a smaller proportion at moderate risk of secondary trauma.

Matched burnout risk scores were significantly higher than secondary trauma scores, suggesting ASU nurses are at higher risk of burnout. Management strategies aimed at reducing compassion fatigue in ASU nurses should initially focus on reducing burnout risk.

Appendix 2: Clinical Scenario- reflective account (MW)

The following account occurred within the setting of an acute stroke unit in a general hospital in the Northwest of England. Mrs. S was brought in by ambulance to the emergency department following a sudden onset of left sided weakness and a visual problem. All of her family had been present with her at home at the time of her becoming unwell and had made their own way into the hospital. She was rapidly evaluated by the stroke team and found to have left facial droop, dense left arm and leg weakness and visual/ sensory inattention. Her CT brain scan demonstrated no haemorrhage and she was taken to the acute stroke unit where she was given IV thrombolysis. The initial period following the intervention involves close monitoring for the first two hours. I undertook these duties. Her family remained present throughout. Over the course of the next two hours the patient made an excellent response to the intervention. Discussion continued through this time frame with the patient and her family. Her improvement had been so dramatic that at two hours her neurological deficits had completely resolved. Naturally all parties present were delighted by her rapid recovery; however, I did inform her family that monitoring needed to be continued and that we needed to observe her closely as she ‘was still not out of the woods’. I then ‘handed over’ her case to the nurse who would continue to look after her that afternoon. After 10 minutes I returned to the patient to inform her and her family that my colleague would now continue her monitoring. It was at this point that I noted she again had a facial droop. It quickly became apparent that her left arm and leg were now flaccid and that she had a visual and sensory inattention. Her observations were stable but in this setting an acute haemorrhagic transformation following thrombolysis needed to be excluded. A CT brain scan was completed but demonstrated no changes. The patient and family were informed that a likely re occlusion of a cerebral blood vessel had occurred resulting in her deterioration and that we needed to continue to monitor her for any improvement or indeed further relapse. She remained in the acute unit for seven days during which time there was no neurological improvement.

I experienced a number of feelings both at the time and as a consequence of these events. I have worked with stroke patients for roughly 20 years- the last 10 of which have been in the acute area. I have also been involved in numerous cases where I have known patients who have had further events and with whom I had previously developed a good rapport. I have looked after many people who I have met outside of work who have had strokes and even a proportion of people with whom I have worked suffer strokes. Down the years, I have also been involved in many cases where thrombolysis has featured with outcomes varying from full recovery to death. The case in question affected me like no other. I initially found the familiar feeling of being nervous yet excited at being involved in this emergency situation and being part of the many ‘hands at the pump’ to work rapidly to deliver the intervention. This continued through the first two hours of her care. Along with this was the developing rapport with the patient and relatives but also recognition that I was providing them with support at a critical and often intense time. I think that there was also a sense of elation from the patient and her family that she had made such excellent progress. I also admit that it is or was difficult not to be swept along in these moments, especially when being hugged/ slapped on the back by family members who are claiming to have just witnessed ‘a miracle’. However, I have seen patients in similar circumstances deteriorate and such wariness prevents a wholesale celebration along with the patient/ relatives. I appreciate that stroke is often characterised complication and unpredictability- which in this case was rapid and could not be legislated for (the usual outcomes post thrombolysis being: full recovery, partial resolution, fluctuating neurology, no response at all, haemorrhagic transformation, death). The clinical spectrum was run in the course of 3 hours- profound neurological deficits to full recovery and back again to severe and what turned out to be permanent disability. The full array of emotions was also run through: anxiety to hope to elation to despair then devastation, all of which were felt by everyone present- patient/ family/ me.

The following days I found that my thoughts were overwhelmed by what had occurred. I was becoming pre occupied by the case and felt unable to concentrate. My sleep was disturbed and I would often ring up colleagues asking how the lady was and if her family were all right. I dreaded the thought of attending to patients in the AED who may require thrombolysis as it just served as a reminder. I did feel more irritable and reproached myself for feeling like this. I discussed these feelings with a number of my close work colleagues- but not the senior medical staff or management. I felt weak but did not want others to see me as so. I did not seek support from my GP or counselling. I felt that I knew what was wrong with me but also that no one would know what this was like. At no point did I however feel disconnected or insensitive to patients or lose the essence of my beliefs.

The lady in question underwent rehabilitation under the same service but in another part of the hospital that I rarely go to. Unfortunately, she made no recovery. My feelings in regards to the events gradually improved, with the exception of feeling anxious about acute admissions. The lady did return to clinic at 3 and 6 months where I reviewed her. I did not experience any distress on these occasions and my rapport with her and her husband remained good. She remained under the review of my early supported discharge colleagues who made me aware of how much her and her family valued what I had done for her. What was a cause for upset was when she returned at 9 months. I knew that this was the point at which it was likely the conversation would centre on reaching a plateau and discharge. I could of and should have seen her on this attendance. My courage failed me and she was subsequently seen and discharged by her consultant.

My overall feeling is that I have not reacted like this before or since to clinical events such as this. There have been similar events but with certain differences. Perhaps that this scenario was played out in full view of an expectant family may have had some influence. Perhaps the accumulation of 20 years of stroke care has a bearing. Possibly the feelings were a reaction to an altogether distressing case where all felt helpless (and on reflection in my own case- helpless to help). If I am honest- then I should also feel shame. If I am honest-I have an appreciation of self-preservation.

Appendix 3: Interview Guide

1. Please describe in as much detail as possible your experience of hyper acute stroke care that resulted in you feeling stressed or traumatised (you may refer to as many examples as you like or need to).
2. Did you experience any distressing symptoms related to these events (for example- insomnia, nightmares, low mood, intrusive thoughts, irritability/ impatience, crying). How long did you experience these feelings for?
3. Did you at any point want to avoid situations that remind you of what happened?
4. Did you ever feel that you no longer wanted to work in this area?
5. a) What coping strategies did you use to deal with this situation? b) Did you seek support from your peers or organization? c) Was your stroke service/ organization supportive?
6. Is there anything that you would suggest for other Stroke Specialist Nurses working in this area who may have experienced similar events and feelings?

Appendix 4: Field Notes - example number 1.

Large Teaching Hospital West Yorkshire.

Date of Interview- 06/05/2016.

Date Field Note Written- 06/05/2016.

Initially I was apprehensive about getting the interview process under way. This was to be the first interview that I was to undertake a being a novice qualitative researcher I was unsure how things would go. I kept ruminating over these thoughts for the two and a quarter hour train journey. I also had prior knowledge of the person I was due to interview. We had both undertaken a distance learning post grad certificate in stroke and had regular conversations through the course online forum/ chat room. I knew them to be an expert in the field and also they held a post which was very similar to the one I undertake. This was reassuring as I was sure their depth of knowledge and experience would inform my research.

The walk to the hospital from the train station was one that was well known to me having previously studied in the city. The hospitals Victorian façade had not changed at all from what I had remembered. However, much of the rest of the hospital had been modernised accordingly. Although we had not arranged a meeting place, I was there in good enough time to go to the clinical environment where I knew my colleague could be contacted. I was welcomed on the unit by the ward manager and made to feel welcome. Indeed, she was aware of our meeting and contacted my colleague via bleep. As we waited for the response, I could see that this unit was in all appearances very similar to my own with what appeared the same personnel being present. I was asked briefly by the ward manager, where I had come from and what my work/ my hospitals departments and services were like. The conversation was curtailed when the phone rang, and I was asked to meet my colleague outside of the café.

I soon recognized my colleague outside the café on the ground floor. We shook hands and shared a warm welcome. I was then led across a small car park to where the specialist nurse office was. We talked about the regional national conference that had taken place in my hometown, how my journey had been and my prior knowledge of the city. We entered another portion of the hospital and descended to what felt like was the basement to where the office was located.

This office appeared somewhat cluttered and had the appearance of a storage room. It displayed all the signs of being a busy place. There was not only everything that you would expect in office- computers, diaries, stationary items, a mountain of coats, but also a sink, kettle, fridge and a microwave. I declined the offer of a coffee. I felt comfortable in the environment, despite the clutter. Although I did not consider this to be the ideal environment to be undertaking a research interview, the rapport I had immediately established with my colleague put me at ease.

Our conversation for the next hour centred on our respective services, mutual issues relevant to our areas, our roles and their similarities and differences. I then discussed my research- its background and its aims. We then went through the consent form and when we were in agreement both signed this and started to undertake the interview (this was audiotaped).

The interview itself was undertaken over the course of the next 60 minutes. Each question was answered with care, much consideration and detail. In the course of the interview, my colleague reencountered a story of a clinical event which had obviously affected them. I noted that their voice did quiver when relaying one part of the story and that their eyes did look ‘misty’. They carried on through the rest of the interview without any further pause. As the interview proceeded my subject referred to their experiences with humour. Profanity and colloquialisms also littered the responses as the interview progressed. I have reflected on this and feel this added to the authenticity of the responses. Would I use such language in an audiotaped interview? I am not sure. However, I feel that my subject was being genuine to themself and was giving a true reflection of how they felt. I need to be mindful that these are the responses to the questions asked.

We concluded the interview and talked further, mainly about our other experiences related to practice. We looked at the possibility of collaborating on a piece of work together and I was given the contact email addresses of the other specialist nurses in the team to ask if they would be interested in taking part in the research. We agreed to keep in touch and parted on good terms.

My impression was that first interview went well despite the earlier apprehension. As stated, the office where the interview was conducted was not ideal. This office was shared with other members of the team who did require access to it. This could potentially have disrupted the interview. Perhaps the interview could have taken place somewhere else. It could be suggested that my subject could have asked the other team members to avoid this office while the interview took place.

This was the first interview and I feel my inexperience may be evident in my part within the interview. I asked my questions, but I did not expand on them, seek clarification from the subject or ask them to explain their position. However, the responses I felt were appropriate and presented me with rich and varied stories of the participants' experiences. I remember at the time of the interview thinking to myself that this was the kind of data that I wanted to capture. I also recall feeling excited by this thought and the prospects for future data collection.

During the interview I was aware that my colleague did at one point look upset but composed themselves. On reflection, I should have ensured that they were not distressed and if they wanted to stop or continue. I need to consider my participants wellbeing above what I want to get from the interview. I think that this has been a major learning point among many regarding this experience. It is a point that I will certainly refer to both before and if needs be during any future interviews.

Appendix 5: Field Notes - example number 2.

District General Hospital East Midlands.

Date of Interview- 31/07/2017.

Date Field Notes Written- 31/07/2017.

The scenario referred to in this reflection did follow some unusual circumstances. I had previously arranged to visit this hospital to undertake an interview with someone who had expressed an interest in taking part after being contacted through the National Stroke Nurse Forum. Following contact, we had agreed on a date, and I travelled to the East Midlands to undertake he interview. When I got there, I found that my subject was not in work and could not be contacted. I had a brief discussion with another of the nurses working there who described a very interesting story. I felt at the time it was unfair to interview her without her prior knowledge of my study. I contacted the person who I was due to interview a few days later. She was most apologetic, but I feel this had simply been a case of miscommunication. She did agree to make herself available later. We contacted each other a few months later and agreed to meet for an interview. She also stated that two other members of the team were interested in taking part.

I travelled down by train on the day in question and took a taxi out to the hospital. The hospital was a mixture of old and new buildings. It was clean and well sign posted. Having attended before I knew exactly where I was heading to. The receptionist remembered me from my last visit. I was taken into a small interview room off the main corridor in the acute stroke unit and it was there that I was introduced to my three subjects. Again, one remembered me from my previous visit. I discussed my study and its aims and then all agreed to take part. These subjects were interesting in that they exemplified the diversity of stroke service provision and what constitutes stroke specialist nursing. The consent forms were all signed and then it was decided on the order of who would be interviewed.

On attempting to get the first interview underway, I found that my audio recorder was not working. I had checked it the night before and it was fine. However, now I could not get it to function. My first interviewee went in search of an alternative recorder while I struggled with my equipment. Finally, after some panic, I got it working and we started the interviews.

The three interviews were undertaken in succession. I felt that all delivered good data. However, I felt that my first interviewee, probably the youngest of all involved in this study, delivered the best answers in all the interviews undertaken. Her poise was noteworthy considering the story she recounted was particularly harrowing. I thanked all my participants for their contributions and stated to them all that I would keep in touch.

I think I learnt a lot from this scenario. It would have been easy to blame people for not being present when they had agreed to be (for interview). However, no one is perfect, and people have busy working lives and family commitments. If I had not agreed to come back, I would have missed out on some very valuable stories/ data. I think the other consideration must be given to equipment failure. I did panic that I had come a long way and that I might not be able to complete the interviews. I felt not only foolish, but that I was letting down the people who had agreed to give me their time to be interviewed. However, I did remember to hang on to some composure and consider alternatives (secretaries did have Dictaphones so all would not have been lost).

These three interviews proved to be the last conducted as part of this study. All these interviews have proved a learning curve in terms of my development as a novice qualitative researcher. It has not always been easy. I did not expect it to be. However, I do feel ultimately it has been a rewarding, if taxing experience.

Appendix 6: Letter of confirmation of study ethical approval

MANCHESTER METROPOLITAN UNIVERSITY FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE

MEMORANDUM

FACULTY ACADEMIC ETHICS COMMITTEE

To: Mark Wilkinson

From: Prof Carol Haigh

Date: 16/10/2015

Subject: Ethics Application

Title: Hyper Acute Stroke: the nursing impact. Exploring feelings of secondary traumatic stress. A qualitative inquiry.

Thank you for your application for ethical approval. The Faculty Academic Ethics Committee review process has recommended approval of your ethics application. This approval is granted for 42 months for full-time students or staff and 60 months for part-time students. Extensions to the approval period can be requested. If your research changes you might need to seek ethical approval for the amendments. Please request an amendment form. We wish you every success with your project.

Prof Carol Haigh and Prof Jois Stansfield Chair and Deputy Chair Faculty Academic Ethics Committee.

Appendix 7: Participant information sheet

MANCHESTER METROPOLITAN UNIVERSITY

MMU Birley Campus

Department of Health, Psychology and Social Care.

Information Sheet for Participants

Title of Study:

Hyper acute stroke care: the specialist nursing impact. Exploring feelings of secondary traumatic stress. A qualitative enquiry.

Ethics Committee Reference Number:

Participant Information Sheet

This is an invitation to take part in a piece of research.

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

What is the purpose of the research?

The proposed study aims to investigate how stroke specialist nurses are affected during working with acutely ill stroke patients. The aim is to explore how these groups of expert nurses cope with the considerable demands placed upon them in caring for such dependent individuals. The study aims to explore how stroke specialist nurses performance and physical/ mental wellbeing may be compromised by repeated exposure to sudden onset of severe disability, those who have suffered trauma as a result of stroke, unpredictable or uncertain outcomes and increased mortality. Such repeated exposure may lead to feelings of secondary traumatic stress.

Why is the study being performed?

A particular element of compassion fatigue is secondary traumatic stress. It is also termed vicarious traumatization and is characterized by the negative aspects of providing care to those who have experienced extreme or traumatic stressors. This manifests itself as feelings of being overwhelmed, exhausted, unhappy, disconnect, insensitive and lacking sustaining beliefs. It can result in insomnia, forgetfulness; an inability to separate one’s personal from their professional life and avoidance of activities that serve as reminders of the trauma. It has serious implications for nurse retention, absenteeism and turnover, alongside patient satisfaction and safety. These feelings have been investigated in nurses working in oncology, psychiatry and emergency departments. However, it has not been studied in nurses working in acute stroke care. A recent point prevalence study this researcher undertook (with colleagues) identified that nurses working on acute stroke units are at risk of secondary traumatic stress. This proposed study aims to explore stroke specialist nurses experience of these emotions and inform the evidence base on what hyper acute specialist stroke nursing entails.

Why am I being asked to take part?

A major component of the stroke specialist nurses work is in the hyper acute care of stroke patients. This entails emergency assessment, investigation diagnosis and interventions (for example thrombolysis). Stroke specialist nurses may develop vicarious traumatization as a consequence of repeated exposure to acutely ill stroke patients who have severe neurological disability. This may be compounded by unpredictable patient fluctuations, complications, increased mortality and target driven this study's aims to illuminate the experiences of stroke specialist nurses and the emotions that they experience in caring for their acutely unwell patients. As a stroke specialist nurse with experience of caring for patients at the hyper acute stage, your contribution to this study is of great value. In considering involvement in this study you will not only be helping to add to the knowledge base of stroke specialist nursing, but inform those outside of the specialty of your nursing experiences.

Do I have to take part?

You are under no obligation to take part in this study. If, after reading this information sheet and asking any additional questions, you do not feel comfortable taking part in the study you do not have to. If you do decide to take part you are free to withdraw from the study at any point, without having to give a reason. If you do withdraw from the study any data that has been provided by you up to this point will still be included in the study. If you decide not to take part or withdraw from the study, this will not affect your relationship with any of the staff at the Manchester Metropolitan University.

If you do decide to take part you will be asked to sign an informed consent form stating your agreement to take part. You will be given a copy of the consent form together with this information sheet to keep.

What will happen to me if I agree to take part?

Initially you will be provided with a copy of this information sheet and given the opportunity to ask any questions/ clarify any concerns with regards to this study. A consent form will also be provided should you wish to participate. A prior arrangement will be made as to the venue for the data collection. If you prefer I can arrange for this to be at your place of work (and arrange an appropriate place with your research department/ line manager). The full purpose of this session will be explained. Cues will be offered by means of relating my own experiences with regards to the area under research. The intention is to capture data in spoken narrative (audiotaped) and by written texts. Pseudonyms can be used to maintain anonymity. The data collection should only require one session and can be as long or short as the participant desires but should be no greater than 2 hours. At the end of the data collection session a further opportunity to ask questions or discuss any matters arising will be given. It is envisaged that this study will incur no financial costs. As participation is voluntary, it may mean asking that you partake of this study in your own time. However, it will be discussed with your relevant line managers to seek their cooperation in securing a mutually agreeable time in working hours to conduct the interviews.

Are there any disadvantages or risks in taking part?

It is possible that the experiences or ‘stories’ you may discuss may refer to events which may be emotive. It is also possible that referring back to these episodes may in themselves cause distress. While these commentaries are of great value to the topic under investigation, the comfort of the participant is paramount. If such events do arise in the course of any dialogue, you are free to suspend or terminate the interview at any time and will not be expected to continue it unless you so wish to. This will be explained again before any data collection is undertaken.

What are the possible benefits of taking part?

There is no direct benefit to the study participants. This study aims to offer novel perspectives on the stroke specialist nursing experience and the impact on individual expert practitioners. It is hoped that these new insights will be beneficial in giving an appreciation of stroke specialist nurses both within the specialty and the wider nursing population as a whole. The further benefit is offered that where secondary traumatic stress is evident, interventional support programs could be introduced to reduce its effects. Potentially, this could lead on to a further research project evaluating such programs effectiveness. On an individual basis, there is a benefit in that this represents an opportunity for the participant to tell their ‘story’ with openness, honesty and freedom from recrimination. It may represent opportunity that previously might not have been afforded to them.

Who are the members of the research team?

The name of the Principal Investigator for this study is Mr. Mark Wilkinson. He is responsible for all aspects of the research process. No one else will be involved in any part of this research (although one of the Royal Liverpool Hospital Stroke Research team may assist with technical support i.e. audio recordings. They will not be involved in any of the data collection or interpretation).

I can be contacted directly by this email:

Mark.Wilkinson4@stu.mmu.ac.uk

Who is funding the research?

This PhD research study is being funded by the Royal Liverpool and Broadgreen University Hospitals (NHS trust) Stroke Services Research Department.

Who will have access to the data?

All information collected during the course of the research will be kept confidential and anonymized. The participant will not be identifiable at any point. It will only be used for the purposes of the study. No data will be accessed, used or reviewed by any person other than the investigator and the supervisory team. The data collected will be stored in a locked cupboard within a secure room (Royal Liverpool Stroke Research Team Office). It will be inaccessible to all but the investigator. All data collected will be retained for the duration of the study. On completion of this all data will be securely archived for a period of 10 years after which it will then be destroyed.

On completion of the project it is envisaged that the investigator will seek to disseminate the results/ findings of the study. This is likely to be through presentations at related conferences or published in scientific journals at some point in the future. At no point will anyone involved in the study be identifiable other than the investigator. I would like to offer you the right to obtain a copy of any publications that result from this research. My contact address in this case is:

Mark Wilkinson,

Stroke Research Office,

2X/ 2B link corridor,

Royal Liverpool Hospital,

Prescott Street,

Liverpool,

L7 8XP

If at any point you have any concerns with regards to your involvement in the study or feel that your interests/ rights have been compromised, neglected or denied, these can be raised with the following contact:

MMU Ethics Committee

Registrar & Clerk to the Board of Governors
Head of Governance and Secretariat Team
Manchester Metropolitan University
All Saints Building, All Saints
Manchester M15 6BH
Tel: 0161 247 1390

I confirm that the insurance policies in place at Manchester Metropolitan University will cover claims for negligence arising from the conduct of the University's normal business, which includes research carried out by staff and by undergraduate and postgraduate students as part of their course. This does not extend to clinical negligence.

I would like to extend a sincere thank you for your consideration in taking part in this project. Your participation and contributions are an essential part of this project and as such are most appreciated.

Appendix 8: Participant consent form.

Consent Form

Title of Project: Hyper acute stroke: the nursing impact. Exploring feelings of secondary traumatic stress. A qualitative enquiry.

Name of Researcher: Mark Wilkinson

Participant Identification Code for this project:

Please initial box

1. I confirm that I have read and understood the information sheet

Dated …. for the above project and have had the opportunity to ask questions about the interview procedure.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason to the named researcher.

☐

3. I understand that my responses will be sound recorded and used for analysis

for this research project.

☐

4. I give permission for my interview recording to be archived as part of this

research project, making it available to future researchers.

☐

5. I understand that my responses will remain anonymous.

☐

6. I agree to take part in the above research project.

7. I understand that at my request a transcript of my interview can be made

available to me. ☐

8. I give consent for the use of anonymised quotations in subsequent publications.

☐

____________________ ________________ ____________________

Name of Participant Date Signature

Researcher Date Signature

To be signed and dated in presence of the participant

Once this has been signed, you will receive a copy of your signed and dated consent form and information sheet by post.

Appendix 9: Example of data collection (interview).

MW: Can you tell me about any incidents in your work as a stroke specialist nurse, specifically the hyper acute part of your practice, that have left you feeling distressed or traumatized?

SSN: Mm so hyper acute care as in thrombolysis? Or ok. Ok well there's an incident that I recall as being traumatic erm a lady who was brought in through the thrombolysis pathway erm and she had perhaps a NIHS of maybe between 5 or 10. So quite a minor stroke but we had a clear onset of symptom time and she was assessed by er all of the right physicians and the team. It was felt and I absolutely agreed it was in her best interests to be thrombolysed and we went through the pros and cons of it with her and she agreed and we thrombolysed her and she had a massive bleed and she died and I think and going through sort of the way we work here at xxxxxxx and my role as a specialist nurse is to erm drive the service forward to develop and support the nurses so although I attend the thrombolysis calls when I'm here I'm not here 24 hours a day and so the nurses that work in the acute stroke unit have the thrombolysis on call phone and they attend all the calls and they are the nurses, the thrombolysis nurses as such but so I'll try. But for me what was traumatic was one that wed made the decision that we were going to thrombolyse her and ultimately felt that that decision had killed her although if you look at the evidence of stroke we know that erm what the evidence from the IST 123 trial is that erm that the erm mortality isn't affected by thrombolysis its actually function that improves potentially but erm yeah I think that it was really hard and traumatic for me to support the junior nurse that was the nurse that was on call for thrombolysis as well because I felt incredibly traumatised by the fact that the treatment that we had provided had ultimately led to her death. So erm and I know that the nurse that was looking after the patient really felt this so for me to try and support her while I was still feeling pretty emotionally traumatised myself and trying to think actually and rationally about no no we haven't she she may well have died anyway from her stroke. It's not our fault we did it in her best interests and potentially she could have had a good outcome. I think making these kind of life changing life or death decisions erm in that hyper acute stage is incredibly difficult. I think thinking about other stressful times is erm (pause). Is how devastatingly life changing stroke can be so for patients that aren't even eligible for thrombolysis having to talk to their family and explain what's happened and and the thing is you don't know what you don't know. . so as a health care professional we have all of our knowledge we have our experiential knowledge our learnt knowledge learning all the time and yet it's very easy to forget sometimes how little knowledge the lay person may have and you try and explain things as factually and and I try and explain things as as clearly and honestly as I can so I am a very open and honest person I think giving that information is really important erm and and seeing the devastation and the realisation in often family members eyes and faces when when you give these facts but it never becomes a normal practice for us because every patient is an individual but you do learn to… your own coping managing coping mechanisms to to cope with emotional trauma and things like that so erm yeah those are the sorts of things I can think about . Is that the sort of things that you're talking about?

MW: Yes, that is absolutely fine. Can you tell me about how this incident made you feel? Did it result in any physical or psychological problems for you?

SSN: Erm I think erm the erm the scenario that I told you about with the patient we thrombolysed that died I think that erm a knock on from that was some anxiety about the next thrombolysis call so that kind of erm and also erm almost impacting on my thrombolysis and my decision making erm so the next patient that came in that we were like ooh should we thrombolyse shouldn't we thrombolyse you would err on the side of not thrombolysing because of what happened which is absolutely wrong and its being able to talk that through I'm very lucky that I've got a fantastic consultant I work with and I can sit down as we are now and talk to him about how I feel and he er will rationalises it with me and we'll go through erm you know why I feel like that what the right decision is down to the evidence because at the end of the day we're evidence based practice aren't we erm so yeah erm do I have sleepless nights no I think what's important is I was an A&E nurse before I was a stroke specialist nurse and my job as an A&E nurse for 14 years I trained in London I worked in (a large teaching hospital) in London. Massively busy A&E department and then in 2 other units in London for 7 years before I moved here and erm I think my time in A&E was a huge er not more stressful but probably differently stressful very much life or death all the time very much up and down erm and where was with stroke although you have that in the hyper acute and thrombolysis bit it's a different type of pressure and emotional stress I think and trauma erm I don't know you do feel it I think as well you get more attached to patients so you can't compare my role as an A&E nurse where it's very much front door deal with the patients move them on . Now in stroke care I get very more attached to my patients and to their families and so if someone dies or if the outcomes poor then I think I probably its upsets me more and I may go home and think about it. I can't say I've lost sleep over it no. I don't think I I I'm quite an openly reflective person anyway so if I'm really upset about something I will talk it through and rationalise it and I feel maybe that that's what I've learnt do do since A&E days is to to reflect er conclude but it move on because if I carried everything with me Id burn out and wouldn't I and break. Maybe I do at times I don't know. I hope I'm answering alright.

MW: yes you are. Do you think that anxiety carriers over in your practice? Has your experiences ever made you feel like you want to avoid certain situations or not want to work in hyper acute stroke specialist nursing?

SSN: Yeah so that anxiety of going to the next and when's that thrombolysis bleep going to go again and am I going to have to make this decision again and are we going to kill someone again. It's that kind of feeling of total responsibility for someone's life but then if you turn it round and this is where my rational head comes in its actually your total option and availability to change someone's life by giving them thrombolysis and potentially the quicker you give it the better their chance of improvement so erm yeah I think perhaps so for example today and it's not really hyper acute stroke care but we had erm you know when you're looking at in patients best interests and erm the er work we're always working on patients best interests and often our patients don't have capacity so were were working on their behalf and erm and often from the word go we're making decisions on their behalf and I think that er feeling that you're making the right decision causes anxiety making sure your working in that patients best interests because you might have your views but are you working for that patients views and you know yeah it's a very complex care stroke care . It's so complex from across the board it covers everything.

MW: and with regards to remaining in stroke specialist care? Has your experiences ever caused you to consider working in a different area of nursing?

SSN: Erm I don't think so I love my job. I was ready to get out of A&E. I think if you'd been doing a research project on burnout in A&E and actually erm I mean there's some research out there that if you stay in your job for more than 10 years you you you're on a level you need to move on because you're not challenging yourself you're not improving. And I did 14 years in A&E and I was definitely ready to go then erm I know I've done 4 and a half years in my post I love it you know I think I do make a difference I think I can erm make a difference for stroke care not just individually but also across the board so as my role is very much service improvement and (pause) so yeah no I do enjoy my job I find my job hard at times I find it frustrating. I find the bureaucracy of the NHS more frustrating than my patients I think stroke care as a whole if we had the resources and training and the support to do it we could provide fantastic care. The evidence is coming out that that we can really improve patient's quality of life with good multidisciplinary team nursing stroke care. But I think nursing we as nurses we really need to erm shout put our heads above the parapet and shout and say actually there was this article erm evidence that came out from SNAP last year wasn't there about erm actually it's not 7 day consultant ward rounds that make a difference to outcomes to stroke patients but having the right numbers of nurses and having good nursing teams and so no in answer to your question I'm probably not answering the right sort of stuff but…

MW: not at all. It's all really useful. Can I ask what strategies on a personal and professional level, do you find useful in helping to cope with or guard against developing traumatic stress?

SSN: Yeah, yeah so sort of clinical reflection, clinical supervision erm I've as I've said I'm a very vocal reflective person . I always like to see myself as a reflective practitioner however there's different levels of reflection so you can talk something through on a kind of oh yes I've reflected on that I feel much better but actually if you sit down and write it down and start analysing your thoughts that's a much better idea and I think that when I started in this job for the first year and a half 2 years I did that I was actually a research rat for a colleague of mine who was doing a PHD in facilitating erm being a facilitator for nurses and what that role was and she facilitated my learning or me in the first year of my job. I did a huge amount of written reflection erm and er I find that to be incredibly useful erm something I need to do more of. Very easy to get out of the habit of reflection but something I definitely need to do more of. Erm I talk to the consultant I work with so if I've got any issues or concerns he's incredibly supportive and I can if I can get 5 minutes with him which is the only challenge I can go and talk to him about things erm I've got I get on with the ward sister and the nursing team so and the multidisciplinary team I think we've a good team approach and because we're so small everyone knows everyone so if there was an issue we can support each other I think that happens erm coping mechanisms for stress I would say personally outside of my job is going and getting drunk and I think going partying and I think that if you speak to any nurse in a high stressful job they work hard, they play hard and I think there is that kind of and I'm the first to admit I like to party I like festivals I like you know I'm (SSNs name) outside of (SSNs place of work) the nurse too and I think that's a coping mechanism for the high stress job that we have and perhaps I do that less now which is interesting and I think maybe when I was in A&E and I had more of a stressful and emotionally charged stressful job I perhaps partied harder whereas now although maybe it's just my age but yeah going out socialising being around other people part of your coping mechanism . Is it alright to tell that?

MW: yes I think so. Thank you for being honest. This is my last question. What advice would you offer to any stroke specialist nurse colleagues in terms of avoiding or reducing the potential of secondary traumatic stress in their hyper acute practice?

Erm communication, reflection teamwork erm support from your colleague's erm always working in the patient's best interest's evidence based practice. Erm factual using the facts and ultimately we're here to provide the best care for our patients and nothing that we can do (pauses)everyone’s at risk of stroke, nothing that we can do will stop that from happening and when the patient gets here what we can do is if we can provide the best evidence based care we can we’re giving the patient the best chance of a better outcome and not every patients going to have a good outcome and we’ve just got to stick I think the biggest bit of advice I would give to anyone is evidence based care and research and that kind and I think that something I’ve really developed in since I’ve been an stroke specialist nurse is understanding you know in A&E it was very much you’re doing your job and you’re getting on with it and you’re one of the workforce whereas now in my role I have a slightly different outlook its erm much more about erm yeah that evidence based care really.

MW: thank you so much. All finished.

SSN: it’s a pleasure. Just hope it’s what you’re after.

MW: it’s great. Thank you.

Example of Transcription notes/ Analysis from data presented in Appendix 9.

‘Mm, so hyper acute care as in thrombolysis? Or ok. erm and she had perhaps a NIHS of maybe between 5 or 10. So quite a minor stroke but we had a clear onset of symptom time and she was assessed by er all of the right physicians and the team. It was felt and I absolutely agreed it was in her best interests to be thrombolysed and we went through the pros and cons of it with her and she agreed and we thrombolysed her”

Story of a hyper- acute episode with intervention in the form of thrombolysis with an unexpected, poor outcome that the respondent felt was traumatic. Reference is made to this presentation being a ‘minor stroke’. At this point a number of outcomes could be possible- no clinical change, improve spontaneously, slow improvement with rehab, improvement following thrombolysis, deterioration with or without thrombolysis. Intervention with thrombolysis was appropriate and undertaken as per protocol. Arguable that the initial trauma is witnessing someone with a stroke.

“Massive bleed as she died”

Second trauma is the unpredictable compilation of massive bleed (haemorrhage transformation- the most feared of all complications associated with thrombolysis, which occurred early in this case) resulting in death.

“But for me what was traumatic was on that we’d made the decision that we were going to thrombolyse her and ultimately felt that that decision had killed her although if you look at the evidence of stroke we know that erm what the evidence from the IST 123 trial is that erm that the erm mortality isn’t affected by thrombolysis it’s actually function that improves potentially”

Justifies the intervention with reference to evidence. The responsibility for undertaking the intervention which ultimately led to death, appears collective (we'd made the decision). The intervention was justified with reference to the outcomes of the evidence- risk v benefit, but in this case the outcome was poor and for this nurse, traumatic.

"Traumatic for me to support the junior nurse that was on call for thrombolysis as well"

Third trauma is arguably realized where they felt unable to support others (nurses). There is an apparent sense of inadequacy.

"I was still feeling pretty emotionally traumatised myself and trying to think actually and rationally about no, no we haven't she she may well have died anyway from her stroke. It's not our fault we did it in her best interests and potentially she could have had a good outcome."

Traumatised as could not legislate for outcome. Makes own attempt to rationalize things. References the unpredictability of stroke, its clinical course and outcomes. There is still the problem of responsibility and that there may have been a different outcome. The reference to undertaking the intervention in her best interests suggests being absolved of the result.

"Devastatingly life changing stroke can be so far for patients that aren't even eligible for thrombolysis having to explain and talk to their family and explain what's happened"

Ineligibility for intervention with thrombolysis (and, although in this case, thrombectomy) - feeling of powerlessness that this intervention cannot be given. It appears compounded by then having to explain to families why patients cannot have such treatments.

“seeing the devastation and the realisation in often family members eyes and faces”

Witnessing family’s reactions/ reactions described as devastating. The nurse not only has the patient to attend to, but also has to address the needs of the family and bear witness in turn to their trauma.

“some anxiety about the next thrombolysis call so that kind of erm and also erm almost impacting on my thrombolysis and my decision making erm so the next patient that came in that we were like ooh should we thrombolyse shouldn’t we thrombolyse you would err on the side of not thrombolysing because of what happened which is absolutely wrong”

Feeling anxious/ apprehensive about being involved in further presentations requiring thrombolysis. There is no reference to avoiding behaviours. Responsibility- ‘my’ thrombolysis/ ‘my’ decision making. Then refers the team (we thrombolyse). Assumes responsibility for the decision (or at least a part in it), although ultimately this is a medical one. Realizes that cannot let apprehension override the evidence. It would be unethical not to thrombolyse where it is justified for the fear of complications.

“Yeah so that anxiety of going to the next and when’s that thrombolysis bleep going to go again and am I going to have to make this decision again and are we going to kill someone again”

“er feeling that you’re making the right decision causes anxiety”

Anxiety/ apprehension about further exposure and the decision to thrombolyse. Again assumes responsibility for intervention and poor outcome- decision is not the nurses re thrombolysis, but takes this on as their own, assumes it.

“consultant I work with and I can sit down as we are now and talk to him about how I feel and he er will rationalises it with me”

Supportive consultant. Has the opportunity to take time to discuss the scenario, how it has impacted the nurse themselves and rationalises intervention. Sounds like reassurance.

“A different type of pressure and emotional stress I think and trauma erm I don’t know you do feel it I think as well you get more attached to patients”.

“Now in stroke care I get very more attached to my patients and to their families and so if someone dies or if the outcomes poor then I think I probably its upsets me more and I may go home and think about it”

Forming emotional attachments with stroke patients. Referred to this as being more apparent than in previous (ED) role. This is more personalized through nature of SSN role and proximity to the patient and relatives. Does not refer to detachment or avoidance. Feels the impact extends to outside of work (when at home) and deliberates/ reflects on what has happened.

“move on because if I carried everything with me I’d burn out and wouldn’t I and break.”

Emotional attachment and the upset resulting from this. Possible sense of catharis. Recognition that need to ‘move on’, rid themselves of these feelings/ emotions. Gives the appearance that if this were not the case the result could be damaging.

“find the bureaucracy of the NHS more frustrating than my patients I think stroke care as a whole if we had the resources and training and the support to do it we could provide fantastic care’’

Frustration due to lack of resources and constraint. Recognition that if there was investment that the care would be better.

“if there was an issue we can support each other”

Collegial support appears to be available.

“now although maybe it’s just my age but yeah going out socialising being around other people part of your coping mechanism.”

“getting drunk and I think going partying and I think that if you speak to any nurse in a high stressful job they work hard, they play hard and I think there is that kind of and I’m the first to admit I like to party I like festivals I like you know I’m (SSNs name) outside of (SSNs place of work) the nurse too”

Honest reference to the use of alcohol as a coping strategy. There is an appreciation that the role can be tough/ hard and that there needs to be a hard approach (for this individual) to unwinding. Strong reference to social support systems and recognizing that there is a life outside of work.

“Erm communication, reflection teamwork erm support from your colleague’s erm always working in the patient’s best interest’s evidence based practice”

Reducing stress through communication, teamwork, colleagues and referring to/ practicing within the evidence base. Reference to working within the evidence base appears protective- can justify interventions, even when the outcome might be poor.

“Yeah, yeah so sort of clinical reflection, clinical supervision erm I’ve as I’ve said I’m a very vocal reflective person. I always like to see myself as a reflective practitioner however there’s different levels of reflection so you can talk something through on a kind of oh yes I’ve reflected on that I feel much better but actually if you sit down and write it down and start analysing your thoughts that’s a much better idea”

“not every patients going to have a good outcome”

Describes the benefits of reflection (and methods of reflecting) but also trying to be realistic.

Appendix 10: Example data collection (electronic data)

Transcription/ Data Collection Sheet.

Age-56

Sex-F

Education-MSc Advanced Healthcare Practice

BSc Community Healthcare Nursing

Registered General Nurses

Non-Medical Independent Prescriber

Post Graduate Certificate in Education

Years in Nursing-37 years

Years in stroke practice/ role-

15 years in Stroke

5 Years in present acute role

Please would you be so kind as to describe your experiences with regards to the following questions:

1. Please describe in as much detail as possible your experience of hyper acute stroke care that resulted in you feeling stressed or traumatised (you may refer to as many examples as you like or need to).

There are several areas where I have experiences stress and trauma as a result of assessing and treating patients in the hyper acute phase;

- In my role I meet at arrival and commence the initial assessment of patients for Thrombolysis – I have a particular problem with ED Consultants who are looking for a reason NOT TO Thrombolyse rather than give active treatment – The are almost waiting for it to improve or for time to run out and I am in no doubt that this patient should have treatment and am ready to go and the decision is slow or they decide not to – I find this extremely stressful because I usually am the one left to explain to the family why treatment was not given, we have a particular issue with mild strokes statistically in our Trust and we know we should Thrombolyse more . I feel we have let the patient down and that they may not achieve the best outcome. I feel frustrated and low in mood when this occurs – I assume due to the adrenalin rush!
- The next area is just the fact that I personally see so many patients young (particularly distressing) and old (very sad) who have these acute events. Who have been fine one minute and in a life threatening situation the next?
- Treating patients with Thrombolysis is particularly stressful because although you know the outcome could be good you also know harm can be done and it takes all your strength to hold the faith that this is the right thing for that patient and hope that they will be ok. I have seen a couple of young men who have had very large strokes who are so ill with large clots in the MCA and

your gut feeling is that this isn’t going to go well but no clinical reason – one then fits, is rescanned has bled and dies the next day, the other has MCA syndrome and is rushed for cranial decompression surgery and ends up with severe stroke brain damage and you wonder whether he would have been better dying. I see the relatives right through the whole process and live through every stage with them and its is incredibly distressing – you have to be very strong to maintain a professional but caring façade when you feel hopeless and very sad inside.

- Also seeing patients who have no result from Thrombolysis is very difficult particularly for the relatives who have so much hope – you do feel like you have failed them
- When relatives delay calling 999 for lots of reasons and miss the Thrombolysis window and they feel guilty – talking to them is hard because you are thinking why didn’t you call 999 and you are actually saying something different!
- I also worry a lot if I have seen investigated and treated a patient and sent them home – I have very little support at the hospital stroke =specialist wise – and I do worry that I may have missed something
- Conversations about not escalating, not feeding and TEP / and are always difficult

2. Did you experience any distressing symptoms related to these events (for example- insomnia, nightmares, low mood, intrusive thoughts, irritability/ impatience, crying). How long did you experience these feelings for?

Yes I quite often don't sleep very well if we have had a big stroke in and they were Thrombolysed and I can't wait to get to work to see how they are and I am anxious they have bled. OR I have discharged a patient from ED without Consultant support and I am worried I have done the wrong thing – I often wake up at night about 4am and can't get back to sleep my head goes round and round with intrusive thoughts. I sleep much better if I am not working the next day or on holiday.

I get irritable if I get tired though I am usually ok at work it tends to be at home that I get snappy!

I have been upset- cry after talking to relatives if the patient is sick or dying

I do sometimes feel I don't want to go to work in the morning because of what I might find from the day before but I always go and once I am working I am fine

I do get low in mood for a while but not more than a day and I have never had time off or had long term problems in all the years of nursing

3. Did you at any point want to avoid situations that remind you of what happened?

I do sometimes want to avoid being around if the Consultant who doesn't believe in Thrombolysis is on duty because it is so stressful and frustrating but I don't actually go through with it!

4. Did you ever feel that you no longer wanted to work in this area?

No I absolutely love my job it is a massive privilege to do it and for a nurses to have a role like this is unusual. I get a huge amount of positive feedback from my ED colleagues which really helps however the management's lack of support is very depressing

5. a) What coping strategies did you use to deal with this situation? b) Did you seek support from your peers or organization? c) Was your stroke service/ organization supportive?

My colleagues in ED are very supportive and we often discuss spontaneously difficult decisions as a debrief, and I feedback how patients are doing so they all get some kind orf closure on the case. I get support from my stroke consultant but I have to go looking for it it wouldn't be offered . We also discuss at the ED Governance meeting monthly if anything was particularly stressful. The management, matron hierarchy offer no support we as specialist nurses are not included in ward meetings etc so I personally have no support within the hospital organization unless I look for it.

6. Is there anything that you would suggest for other Stroke Specialist Nurses working in this area who may have experienced similar events and feelings?

To find other specialist nurses to meet with and discuss issues – I find the non-medical prescribing group helpful as we are all specialist nurses.

Try not to be a lone worker if possible – you get the blame for everything!

Identify exactly what the stressors are and try and modify the risk to yourself

Make sure the management know how stressful the role can be at operational meetings etc. although I am not sure they really care

Identify yourself if you are having physical symptoms – occupational health may offer counselling which has been really helpful to colleagues in the past

Please return to:

mark.wilkinson4@stu.mmu.ac.uk

Appendix 11: Example of story constructed/ configured from data

There are several areas where I have experiences stress and trauma as a result of assessing and treating patients in the hyper acute phase; in my role I meet at arrival and commence the initial assessment of patients for Thrombolysis – I have a particular problem with ED Consultants who are looking for a reason NOT TO Thrombolyse rather than give active treatment – The are almost waiting for it to improve or for time to run out and I am in no doubt that this patient should have treatment and am ready to go and the decision is slow or they decide not to – I find this extremely stressful because I usually am the one left to explain to the family why treatment was not given, we have a particular issue with mild strokes statistically in our Trust and we know we should Thrombolyse more . I feel we have let the patient down and that they may not achieve the best outcome. I feel frustrated and low in mood when this occurs – I assume due to the adrenalin rush! The next area is just the fact that I personally see so many patients young (particularly distressing) and old (very sad) who have these acute events. Who have been fine one minute and in a life threatening situation the next? Treating patients with Thrombolysis is particularly stressful because although you know the outcome could be good you also know harm can be done and it takes all your strength to hold the faith that this is the right thing for that patient and hope that they will be ok. I have seen a couple of young men who have had very large strokes who are so ill with large clots in the MCA and your gut feeling is that this isn’t going to go well but no clinical reason – one then fits, is rescanned has bled and dies the next day, the other has MCA syndrome and is rushed for cranial decompression surgery and ends up with severe stroke brain damage and you wonder whether he would have been better dying. I see the relative’s right through the whole process and live through every stage with them and it is incredibly distressing – you have to be very strong to maintain a professional but caring façade when you feel hopeless and very sad inside. Also seeing patients who have no result from Thrombolysis is very difficult particularly for the relatives who have so much hope – you do feel like you have failed them. When relatives delay calling 999 for lots of reasons and miss the thrombolysis window and they feel guilty – talking to them is hard because you are thinking why you didn't call 999 and you are actually saying something different! I also worry a lot if I have seen investigated and treated a patient and sent them home – I have very little support at the hospital stroke specialist wise – and I do worry that I may have missed something. Conversations about not escalating, not feeding and TEP / and are always difficult.

I quite often don't sleep very well if we have had a big stroke in and they were Thrombolysed and I can't wait to get to work to see how they are and I am anxious they have bled. Or I have discharged a patient from ED without Consultant support and I am worried I have done the wrong thing – I often wake up at night about 4am and can't get back to sleep my head goes round and round with intrusive thoughts. I sleep much better if I am not working the next day or on holiday. I get irritable if I get tired though I am usually ok at work it tends to be at home that I get snappy! I have been upset- cry after talking to relatives if the patient is sick or dying. I do sometimes feel I don't want to go to work in the morning because of what I might find from the day before but I always go and once I am working I am fine. I do get low in mood for a while but not more than a day and I have never had time off or had long term problems in all the years of nursing. I do sometimes want to avoid being around if the Consultant who doesn't believe in Thrombolysis is on duty because it is so stressful and frustrating but I don't actually go through with it.

I absolutely love my job it is a massive privilege to do it and for a nurses to have a role like this is unusual. I get a huge amount of positive feedback from my ED colleagues which really helps, however the management's lack of support is very depressing. My colleagues in ED are very supportive and we often discuss spontaneously difficult decisions as a debrief, and I feedback how patients are doing so they all get some kind of closure on the case. I get support from my stroke consultant but I have to go looking for it, it wouldn't be offered. We also discuss at the ED Governance meeting monthly if anything was particularly stressful. The management, matron hierarchy offer no support we as specialist nurses are not included in ward meetings etc. so I personally have no support within the hospital organization unless I look for it. To find other specialist nurses to meet with and discuss issues – I find the non-medical prescribing group helpful as we are all specialist nurses. Try not to be a lone worker if possible – you get the blame for everything, identify exactly what the stressors are and try and modify the risk to yourself. Make sure the management know how stressful the role can be at operational meetings etc. although I am not sure they really care. Identify yourself if you are having physical symptoms – occupational health may offer counselling which has been really helpful to colleagues in the past.

Examples of transcription notes/ analysis from data presented in Appendix 10.

“I have experiences stress and trauma as a result of assessing and treating patients in the hyper acute phase”

Theme of acute suffering. Stress and trauma encountered through SSN role of assessment and treatment of hyper acute patients.

“I have a particular problem with ED Consultants who are looking for a reason NOT TO Thrombolyse rather than give active treatment – The are almost waiting for it to improve or for time to run out and I am in no doubt that this patient should have treatment and am ready to go and the decision is slow or they decide not to – I find this extremely stressful because I usually am the one left to explain to the family why treatment was not given”

Theme of relationship with colleagues strained when they do not follow or have knowledge/ expertise of the guidelines/ protocol. Frustration heightened as the belief is that intervention would benefit the patient but this is denied them. Arguably causing moral distress. Stress compounded further by interactions with family- stress as having to explain actions/ decisions of others.

“we have a particular issue with mild strokes statistically in our Trust and we know we should Thrombolyse more . I feel we have let the patient down and that they may not achieve the best outcome. I feel frustrated and low in mood when this occurs”

Again not following protocol. Feels despondent/ frustrated/ low when ‘mild strokes’ not thrombolysed go on to have poor outcomes. Again this speaks of moral distress whereby patients who might benefit from interventions are denied them.

“The next area is just the fact that I personally see so many patients young (particularly distressing) and old (very sad) who have these acute events.”

Theme of age of presentation. Reference to the impact of bearing witness to suffering at the extremes of age- young and old presentations with stroke.

“Who have been fine one minute and in a life threatening situation the next? Treating patients with Thrombolysis is particularly stressful because although you know the outcome could be good you also know harm can be done and it takes all your strength to hold the faith that this is the right thing for that patient and hope that they will be ok. I have seen a couple of young men who have had very large strokes who are so ill with large clots in the MCA and your gut feeling is that this isn’t going to go well but no clinical reason – one then fits, is rescanned has bled and dies the next day, the other has MCA syndrome and is rushed for cranial decompression surgery and ends up with severe stroke brain damage and you wonder whether he would have been better dying.”

Theme acute suffering linked to unpredictable nature of stroke. Theme of young patients with devastating/ catastrophic complications/ outcomes. Feels like the outcome is down to fate- might be good/ might be bad. Trauma of seeing these (young) patients go through acute suffering. Dissonance? Feel patients would be better dead than suffering.

“relatives right through the whole process and live through every stage with them and it is incredibly distressing – you have to be very strong to maintain a professional but caring façade when you feel hopeless and very sad inside”

Theme interacting with relatives of acute stroke victims. Distress at bearing witness to relatives. Having to adopt a mask of professionalism but feeling hopeless.

“no result from Thrombolysis is very difficult particularly for the relatives who have so much hope – you do feel like you have failed them. When relatives delay calling 999 for lots of reasons and miss the thrombolysis window and they feel guilty”

Bearing witness to no result from intervention: powerless to change and feelings of failure. Witnessing relative’s sense of guilt re not seeking earlier help. All accumulates sense of stress/ trauma.

“I have very little support at the hospital stroke specialist wise – and I do worry that I may have missed something. Conversations about not escalating, not feeding and TEP / and are always difficult.”

Nature of the role. Responsibility of SSN role- fear of having missed something and lack of support from specialist (stroke) team.

“don’t sleep very well if we have had a big stroke in and they were Thrombolysed and I can’t wait to get to work to see how they are and I am anxious they have bled”

Following themes: examples of stress reactions. All classic descriptors of the physical/ psychological lived experience of STS. Above example-insomnia related to anxiety about outcomes.

“I do sometimes feel I don’t want to go to work in the morning because of what I might find from the day before”

Apprehension. All reports here are synonymous with physical/ psychological experience of STS.

“I do get low in mood for a while but not more than a day and I have never had time off or had long term problems in all the years of nursing.”

Transient low mood but does not result in absence.

“I do sometimes want to avoid being around if the Consultant who doesn’t believe in Thrombolysis is on duty because it is so stressful and frustrating but I don’t actually go through with it”

Avoiding behaviours but not sustained.

“I absolutely love my job it is a massive privilege to do it and for a nurses to have a role like this is unusual. I get a huge amount of positive feedback from my ED colleagues which really helps”

Role seen as a pleasure/ privilege which is valued by others (ED).

“however the management’s lack of support is very depressing. My colleagues in ED are very supportive and we often discuss spontaneously difficult decisions as a debrief”

Support from ED but management in general is lacking.

“I get support from my stroke consultant but I have to go looking for it, it wouldn’t be offered”

Support from own stroke team is not offered willingly. Main body/ means of support appears to lie outside of the dedicated stroke team which is surprising.

“We also discuss at the ED Governance meeting monthly if anything was particularly stressful”

ED debrief re stressful situations. Appears to have greater support from those outside of the stroke speciality.

“The management, matron hierarchy offer no support we as specialist nurses are not included in ward meetings etc. so I personally have no support within the hospital organization unless I look”

However, organizational support appears lacking. Has to seek out own means of support.

“To find other specialist nurses to meet with and discuss issues – I find the non-medical prescribing group helpful as we are all specialist nurses.”

Benefit/ value of peer support. Possibly understand what they are going through as specialist nurses. Will understand the issues pertinent to them.

“Try not to be a lone worker if possible – you get the blame for everything, identify exactly what the stressors are and try and modify the risk to yourself. Make sure the management know how stressful the role can be at operational meetings etc. although I am not sure they really care. Identify yourself if you are having physical symptoms – occupational health may offer counselling which has been really helpful to colleagues in the past”

Numerous individual strategies for stress/ trauma relief. Suggest the need for management and individual to gain awareness of what the problem is and what actions need to be taken.

Appendix 12: Data in storied form (electronic response)

Stroke thrombolysis nurse (name removed from original document).

I was on an early shift which started at 07 am. At 07.30 I received a call for resus where a patient was being admitted with sudden collapse and GCS 3. She was 55 years old.

When I arrived in resus the lady was breathing with an airway and GCS was 7. We took her to CT scan. On route to scan the paramedics told me the lady had been diagnosed with breast CA the previous day and had been talking with her husband most of the night about fighting the cancer. She collapsed at 6am when she got up to make a coffee.

I already felt the overwhelming feeling of sadness for her family. I tried to focus on the process of Ct and the need to get her back to resus as soon as possible.

The CT scan showed she has suffered a massive primary intra cerebral haemorrhage. It was a catastrophic event. The consultant said there was no chance of survival.

I felt completely overwhelmed. Mixed feeling of sadness and anxiety at how we would tell her husband. All the way through my working life I have never been given specific training in how to deal with breaking bad news. I have been on courses which skim this subject but focus more on the actual wording and breaking it to the family no how we cope with doing it.

I went to the relative's room with the consultant. I remember the consultant talking slowly and quietly to the husband. He said she is not going to survive this. Her husband started shaking he held his head in his hands and said you are saying she is going to die. Isn't there something to do, please do something?

I felt completely useless and didn’t know what to say to him. I could see the consultant talking to him but didn’t hear what was said. I felt sadness and was trying not to show too many emotions. I didn’t want to cry in front of the patient’s husband. I wanted to be supportive and tried to supress the sadness.

I asked if there was anyone we could contact. I offered him a drink. After a few mins we went into the resus to see the lady.

An A&E nurse was there doing her obs. and taking blood.

The man kept saying why. Is it the cancer? I tried to be as clear as possible. I told him it was bleeding in the brain. A blood vessel had burst. The cancer wasn’t linked. It was probably caused by long term hypertension. Being able to explain the clinical points gives us some protection and almost distances me from the raw emotions the man was feeling.

I remember the A&E nurse looking at me.

I said to the husband do not try and make sense of this just be with her. There is no sense no reason for now. Just sit with her.

I felt like I wanted to cry. I empathised. I was close in age to this lady and felt sadness. I could imagine my family in this situation.

Obviously I have dealt with lots of sad situations throughout my working life (I have been a nurse for 30 years). Many emotions come through anxiety relief sadness. I usually talk to my nursing colleagues at hand over. I had a long shift to go before I could speak to anyone about this. I work alone so felt abandoned. I did cry at one point in the morning shift but was alone and couldn’t speak to anyone.

We do not have regular feedbacks or reflections in an official way. There are no team briefs or huddles to de stress.

I have learnt to remove myself from these situations and am able to go home and get on with my life. I still think of this lady and will always remember her and her situation. I spoke to my husband about my day. I talked about the husband's feelings but I do not remember talking about how it made me feel. I find some comfort in talking to my family. They are non-medical and I get to see these situations in a lay persons view. (I obviously keep everything anonymous).

I think the strongest feeling I have now is relief it isn't me or my family. This makes me feel guilty.

I find following a particularly harrowing shift like that I get more positive and see that life is precious and I feel happiness that I have a family and comfortable life. I try to use all those emotions in a positive way. It makes me feel life is short try to enjoy it.

I find writing a reflection of the day's events helps me put it into some sort of perspective. I discuss things with a friend who is a nurse. Talking in a nonspecific way more like "it's been a terrible week" etc. Offloading the stress of our day to day events seems to help.

Example of transcription notes/ analysis from data presented in appendix 12:

"I was on an early shift which started at 07 am. At 07.30 I received a call for resus where a patient was being admitted with sudden collapse and GCS 3. She was 55 years old."

Theme of hyper acute presentation in a relatively young patient. Hyper acute episode with a seriously ill patient at the onset of the shift. No time to adjust or prepare- illustrates that cannot legislate for pattern of work.

"the lady had been diagnosed with breast CA the previous day and had been talking with her husband most of the night about fighting the cancer. She collapsed at 6am when she got up to make a coffee."

Hyper acute presentation. Patient's prior history is already traumatic. Relative/ patient faced with abrupt icterus- also have no time to adjust but already have pre-existing stress.

"I already felt the overwhelming feeling of sadness for her family"

Hyper acute presentation: SSN overwhelmed by sadness as outlook appears to be bleak.

"The CT scan showed she has suffered a massive primary intra cerebral haemorrhage. It was a catastrophic event. The consultant said there was no chance of survival"

Devastating ICH with no chance of recovery. Randomness coupled to abrupt nature is devastating for all concerned- patient, relative, SSN.

"I felt completely overwhelmed. Mixed feeling of sadness and anxiety at how we would tell her husband. All the way through my working life I have never been given specific training in how to deal with breaking bad news. I have been on courses which skim this subject but focus more on the actual wording and breaking it to the family no how we cope with doing it."

Overwhelmed and saddened by the clinical scenario that they are confronted by. Anxious about speaking to the family and their reaction. Interesting that the SSN in this situation is involved in speaking to the family. Feels has not had adequate training to deal with this. Adds to the anxiety.

"Her husband started shaking he held his head in his hands and said you are saying she is going to die. Isn't there something to do, please do something?"

Theme of interacting with relatives and bearing witness to their suffering. Witness to husbands trauma and sense of disbelief.

"I felt completely useless and didn't know what to say to him. I could see the consultant talking to him but didn't hear what was said. I felt sadness and was trying not to show too many emotions. I didn't want to cry in front of the patient's husband. I wanted to be supportive and tried to supress the sadness."

SSN feeling of inadequacy. Having to be stoic when really wanting to crumble rather than detachment behaviours.

"The man kept saying why. Is it the cancer? I tried to be as clear as possible. I told him it was bleeding in the brain. A blood vessel had burst. The cancer wasn't linked. It was probably caused by long term hypertension. Being able to explain the clinical points gives us some protection and almost distances me from the raw emotions the man was feeling"

Speaks to relative in clinical terms and feels this was protective/ offered distance. Unable to avoid/ escape the situation but needs to shield themselves.

“I remember the A&E nurse looking at me” - No support from ED nurse but is the SSN aware that her behaviour/ emotion has been noted?

“I felt like I wanted to cry. I empathised. I was close in age to this lady and felt sadness. I could imagine my family in this situation”

Tearful. Empathic. Similar in personal characteristics. Thinks of herself in such a situation.

“I had a long shift to go before I could speak to anyone about this. I work alone so felt abandoned. I did cry at one point in the morning shift but was alone and couldn’t speak to anyone.”

Usually uses colleagues to support. Working in isolation at this time- felt abandoned. Had no support and cried. Feeling of having to just make do or get on with it. Has to carry on but needed support. Question is should she have or had to?

“We do not have regular feedbacks or reflections in an official way. There are no team briefs or huddles to de stress” - No formal means of support.

“I have learnt to remove myself from these situations and am able to go home and get on with my life. I still think of this lady and will always remember her and her situation. I spoke to my husband about my day. I talked about the husband’s feelings but I do not remember talking about how it made me feel. I find some comfort in talking to my family. They are non-medical and I get to see these situations in a lay persons view”

Work life balance and support of family seen as a source of comfort.

“I think the strongest feeling I have now is relief it isn’t me or my family. This makes me feel guilty”

Feeling of guilt/? shame. Glad this was not them. Did the scenario impact on their core values? Probably not as able to give care to the best of their ability but did result in their feelings of guilt that it was not them.

“I find following a particularly harrowing shift like that I get more positive and see that life is precious and I feel happiness that I have a family and comfortable life. I try to use all those emotions in a positive way. It makes me feel life is short try to enjoy it.”

Using perspective as a means to carry on.

“I find writing a reflection of the day’s events helps me put it into some sort of perspective. I discuss things with a friend who is a nurse. Talking in a nonspecific way more like “it’s been a terrible week” etc. Offloading the stress of our day to day events seems to help.”

Perspective through reflection. Discussion with colleague/ peer. Sense of catharsis in being able to jettison/ offload the stress/ emotion.

Appendix 13: Version accepted for publication

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Abstract

Background: Secondary Traumatic Stress (STS) has been defined as the stress resulting from helping or wanting to help a traumatized or suffering person. The hyper acute nature of stroke specialist nurses work places them at risk of developing STS.

Aims: To explore the factors that are influential in stroke specialist nurses experience of secondary traumatic stress development within hyper acute practice.

Methods: This study is qualitative with a narrative design. Data was collected from a purposive sample of stroke specialist nurses (20 female and 2 male) working in hyper acute services during the years 2016 and 2017. Data was analysed using Polkinghorne's approach

Results: This research identified four themes: exposure to acute suffering and death-young presentations, moral distress, interactions with relatives and problematic healthcare systems.

Conclusion: The findings from this study suggest that stroke specialist nurses are exposed to multiple triggers which are commensurate with the potential for STS development. The findings contribute a new understanding of the emotional burden of hyper acute specialist stroke nursing that has implications for patient safety and satisfaction, services provision and staff well- being.

Keywords

Stroke, acute, specialist nursing, secondary traumatic stress, narrative research.

Introduction.

Secondary traumatic stress (STS) is characterized by the negative aspects of care precipitated by the person experiencing secondary trauma- the trauma that is experienced after witnessing others undergoing traumatic events (Figley, 1995). Characteristics include insomnia, forgetfulness, intrusive thoughts, hyperarousal and cognitive and behavioural avoidance of trauma reminders (Boscarino et al, 2004). Ultimately this may affect provider's ability to render services, maintain personal and professional relationships and can result in poor professional judgements and emotional exhaustion (Mangoulia et al, 2015).

STS has significant organisational issues for healthcare providers. It has repercussions for staff wellbeing and retention, may compromise the care provided and the quality of service overall, and has a negative impact on patient safety and satisfaction. The identification and reduction of secondary traumatic stress represents a worthwhile investigation for healthcare organisations due to the implications of an increase in staff productivity, reduced absenteeism, increased patient safety and satisfaction (Breen et al, 2014).

Hyper acute stroke care relates to the clinical experience in the first 72 hours. It is characterised by acute neurological illness, emergency admission and intervention, unpredictable or uncertain outcomes and increased mortality. Stroke specialist nurses (SSNs) are at the forefront of the service and pivotal to the care episode (Fitzpatrick and Birns, 2004), with UK SSNs appearing to be more actively involved in the selection and decision-making process for interventions such as thrombolysis (Hamilton et al, 2017).

Stroke specialist nurses working in hyper acute care may develop secondary traumatic stress (STS) through repeated exposure to caring for unpredictable acutely ill stroke patients and through being the focal point of time dependent, emergency interventions that are often target/ results driven.

The common theme present in the nursing literature is that stress reactions are induced by being exposed to other people's suffering. Lavoie et al (2011) have suggested three separate means of bearing witness to suffering- exposure as a witness, exposure as a victim and contextual exposure, that is, the circumstances in which the stressful/ traumatic event was encountered. The predominant cause of traumatic reactions appears as repetitive exposure to serious illness, futile care and death (Sabo, 2011). A further consequence of futile care has been the potential for conflict with relatives (Yoder, 2008), resulting in an altered approach to caring (Walsh and Buchanan, 2010). A further precipitating factor was cited as conflict involving physicians. Physicians are referred to in the context of their decisions or demands, futile care, potentially aggravating the situation by not being honest regarding patient's prognosis (Yoder, 2008) and ascribing errors to nursing staff (Jonsson and Halabi, 2006). Mealer et al (2012) also suggested possible inter-professional role resentment as a source of friction, citing poor communication, poor support systems and hostile working environments as escalating stress. The literature refers to trigger situations evolving in response to problematic healthcare systems (Melvin, 2012), identifying elements such as heavy work burden, constant prioritising, high acuity, lack of time, overtime/ having to work extra days and general lack of resources. Austin et al (2009) participants described feeling discouraged by management inactivity. Ultimately, system failings are contributory as a causative factor to stress. What is clear is that all these contributing factors are multidimensional with stress reactions being precipitated by different mechanisms and not only in isolation to each other.

While much research has concentrated on secondary traumatisation in oncology, psychiatric and emergency nursing, there has been no study of nurses involved in acute stroke care, who are subject to similarly intense patient’s traumas. The aim of this study was to investigate the context and cause by which stroke specialist nurses may experience the development of feelings of STS in the hyper acute setting.

Methodology.

This qualitative study uses a narrative approach. Expressions of interest were sought from stroke specialist nurses who had experienced what they felt to be traumatic/ stressful or upsetting events during the course of hyper acute care delivery. The participants were registered nurses all of which worked in hyper acute stroke services and needed to be involved in the assessment, diagnosis and delivery of emergency interventions to stroke patients. No limit was applied to the nurses’ length of experience in undertaking these roles. The potential participants were contacted through their affiliation to regional and national stroke related agencies. Participants were asked to contact the researcher directly (by email) with their expressions of interest to be involved in the study. Individuals who expressed an interest in participation were provided with the study information sheet and consent forms. The method of data collection was through a mixture of written texts and semi structured interviews. At interview the participants were specifically asked, ‘please can you tell me in as much detail as possible of any events related to your specialist hyper acute practice that have made you feel traumatised or distressed’. This question was also asked of the participants providing their data electronically. The data were collected in 2016 and 2017. Data collection was made using audiotaped semi- structured interviews at an agreed date and location. Alternatively, participants were asked to contribute their stories of traumatic/ stressful events related to hyper acute stroke care electronically via email. The data collected electronically was in the form of a one-off response rather than a series of conversations. Electronically collected data and consent forms were returned to a secure email address.

This study had the potential to cause disquiet for the participants and the researcher. Participants could find themselves re traumatized by recounting or reliving distressing episodes related to their practice. Alternatively, the researcher was exposed to others trauma material. Approval to undertake the study was obtained from the researchers' university ethics board. The university distress protocol for qualitative data collection was adhered to throughout the data collection phase. Interviewed participants were informed they could stop at any point during their conversation. The researcher also stated that they would stop the interview if they felt the participant was becoming uncomfortable. Those who participated electronically were also informed that should they be distressed that they could stop writing their accounts and were under no obligation to submit any data. All of the participants were aware that they could withdraw from the study at any point without need of an explanation. The researcher was given every opportunity to discuss their feelings related to the data collection, transcription and analysis at their bimonthly doctoral supervisory meetings. The participant's responses including names and places were anonymised.

The approach to the narrative analysis used in this study was guided by the work of Polkinghorne (1995). All of the electronic data was received in typed format with the exception of one handwritten response. This, along with all of the audiotaped interviews were initially transcribed by hand and then using a word processor. As the collected data existed as fully formed stories and text suggestive of experiences, both the paradigmatic and narrative approaches were employed. Paradigmatic analysis of narratives was applied as the analytical method where the data was collected as fully formed stories. The data was then analysed to identify common elements or themes inherent in the text. This was done by both deductively applying the theory to data and inductively by allowing themes to emerge and concepts to develop from the stories. From this approach general concepts evolved that illuminated categories and elaborated the relationship between them. The narrative analysis approach was apposite where the data did not present itself in storied form. Where the data did not present as a fully formed story, the actions and events described within it were configured to that of a plot. The plot is the thematic line of the narrative, with different events contributing to the analytical development of a narrative. In this case the plot being that of a presentation of hyper acute stroke, the characters involved (patient, relatives, SSN, doctors, nurses) and the traumatic event. The resulting narrative must not only fit the data but give a significance to that which was not readily apparent in the data (how the events, characters and environment conspired to produce a situation capable of provoking feelings of STS). The overall result is a series of constructions that offer a new understanding of this particular situation- the cause and context by which STS could develop in SSNs engaged in hyper acute stroke care.

Results.

The chosen methods of data analysis and the subsequent results were debated and verified by the lead author with their doctoral supervisory team who have experience in undertaking qualitative research using narrative approaches. The data was collected from 22 participants (12 interviewed, 10 emailed). 20 respondents were female. Ages ranged from 31 to 56 years. No limit was placed on the amount of time spent working within the specialty- the length of stroke related experience ranged from six to twenty years. All of the nurses participating in this study were employed in the sphere of hyper acute stroke care and were involved in the practice of stroke assessment, diagnosis and emergency interventions. The results of this study reported 4 areas describing stroke specialist nurses' experiences of hyper acute stroke care in which lay the cause and context for the potential of STS development: exposure to acute suffering and death- young presentations, moral distress, interaction with relatives and problematic healthcare systems.

Theme 1: Exposure to Acute Suffering- Young Presentations

Many of the experiences referred to within these data refer to vivid memories of what each specialist nurse had referred to as traumatic or upsetting. While a number of stories included elderly patients, by far the majority, reported as traumatic, concerned young patients presenting with major strokes. The outcomes in these patients were generally not favourable and ranged from major disability to death. A number of the responses refer to rapid deterioration and death in previously fit and well young patients, which was difficult for those involved to comprehend. As one nurse stated of a woman of 28 years old admitted with an extensive intracerebral bleed,

'I felt utter sadness that a young person in the prime of her life was going to die…. I could not stop thinking about her. How her body looked so perfect on the outside' (P2).

One nurse reported a source of distress on thinking about what the future might be for a young man admitted with a severe acute stroke,

‘Oh gosh, he’s very young, he’s gonna be spending all of his life in a nursing home. You know and he’s young, what is the chance of him being happy?’ (P4).

There is recognition of sorrow for those that survive but have their lives wrecked by these events. The data illuminate’s nurses’ responses to these ‘fractured futures’ which can be ascribed to any age of stroke patient. However, the feeling appears particularly poignant and perhaps more strongly felt when discussing younger patients.

Furthermore, it has been suggested that empathetic engagement is a fundamental consideration in the development of STS (Pearlman and Saakvitne, 1995). Arguably, the nurses involved in this study may identify or feel more empathy with younger patients due to the perceived similarities within their personal lives. Several stories referred to similar ages of the patient, their personal lives and children, as illustrated by one nurses’ experience,

‘She was 34 years old. In my mind I thought she could be my sister. My heart sank when I heard she had a 8 months old baby. My sister had a daughter too. When her husband repeated her name I asked her where was she from. We were both from the same country. I will forever remember this patient and her family because of the similarities with my personal life’ (P15).

Distress was often expressed by the participants involved in this study with reference to complications of interventions with thrombolysis and thrombectomy; one nurse described this as a further source of distress,

‘Treating patients with thrombolysis is particularly stressful because although you know the outcome could be good you also know harm can be done and it takes all your strength to hold the faith that this is the right thing for that patient and hope that they will be ok. I have seen a couple of young men who have had very large strokes who are so ill with large clots in the MCA (Middle Cerebral Artery) and your gut feeling is that this isn’t going to go well but no clinical reason – one then fits, is rescanned has bled and dies the next day, the other has MCA syndrome and is rushed for cranial decompression surgery and ends up with severe stroke brain damage’ (P3).

Theme 2: The Influence of Moral Distress.

Moral distress is the situation whereby practitioners are unable to operate according to their individual standards and is analogous to conflicts between team members as to the direction of care. The respondents in this study also reported on their experiences referring to this and in particular the decision to treat (thrombolyse/ thrombectomy) or not. A number of nurses commented on decisions made by medical colleagues that left them perturbed,

‘I have a particular problem with ED Consultants who are looking for a reason not thrombolyse rather than give active treatment – They are almost waiting for it to improve or for time to run out and I am in no doubt that this patient should have treatment and am ready to go and the decision is slow or they decide not to – I find this extremely stressful’ (P10).

It is suggested that where nurses are not involved in the decision-making process, are not heard or their views discounted, that this can lead to inter-professional and interpersonal conflict. It is possible to contend that the distress recalled in these stories reflects inter-professional discord resulting in situations which was contrary to these nurses' sense of patient advocacy, as illustrated by the following story referring one nurses' feelings regarding an older person's treatment,

'There was discussion amongst the team around thrombolysis. There was much debate about his age, previous ability and the fact that he was in a care home. The discussion was around whether it 'was worth doing ', the need to meet targets, good to get experience and other things along these lines that did not sit comfortably with me and I did say so at the time but it was fair to say that I was probably intimidated by the level of staff around me and felt like I was a lone voice' (P3).

Theme 3: Interaction with Family Members.

It was recognized that interacting with relatives of acute stroke patients could be emotionally draining. Recognition was made to the difficulties of trying to meet relatives' needs when working against time constraints and having to prioritize other patient assessments. Several nurses commented on how they were confronted by multiple anxious relatives while trying to invest all their efforts into giving emergency care, as suggested by the following,

'You know trying to deal with lots of relatives banging questions at you but at the same time trying to care for someone' (P1).

Furthermore, it would appear that relative's inability to comprehend the acute illness and the presumption that treatment will be curative, is crucial to their own and the nurses' subsequent stress. For example,

'They sent her for thrombectomy and unfortunately it didn't work and she bled horrendously afterwards and passed away. And it wasn't about her, you know, it was more about the family that was, afterwards that really couldn't come to terms with it and how many times I did have to sit down and say she's not going to recover, they kept saying well she's had all this, thrombolysed, she's then been taken to (regional neurosurgical centre), surely, they must have been able to sort things out. Only when she died did they actually come to terms with it' (P6).

Theme 4: Problematic Healthcare Systems.

These data revealed several areas where stroke specialist nurses felt that healthcare systems contributed as STS triggers. Many stroke specialist nurses also have coordinating roles revolving around clinical throughput which sees them act as custodians for the acute stroke unit beds. The stroke specialist nurses raised concerns that managing beds as part of their role takes them away from what they see as the fundamental aspects of their role-assessment, diagnosis and intervention, as in the following,

'Often feel stressed at situations where there are insufficient beds available for the demand from ED, very busy HASU (hyper acute stroke unit) and demand-can become anxious when patients suitable for thrombolysis need to be seen quickly but there is difficulty getting this achieved when up against a time constraint and when other patients still need assessing' (P17).

Many of the responses reported feeling stressed by the often unrelenting volume of patients that presented as possible strokes and in need of review by stroke specialist nurses, as the following exemplifies,

'…the volume of patients is incredibly stressful. You use the word trauma and sometimes I can't think of a better word. Sometimes I do feel physically, you know, traumatized after coming off a shift' (P9).

Another nurse offered this consideration of their predicament regarding dealing with a high workload,

'the times when its stressful for me is when you don't get a chance to eat, you don't get a chance to stop, you're constantly on your feet from the moment you arrive at 7.30 (am) and you're in A&E then wait till someone turns up for the nightshift' (P1).

The data found that a number of specialist nurses viewed their role as something different from the established view of nursing. The stroke specialist nursing role with its blurred boundary between nursing and medicine accords well to a situation of ambiguity. Increased patient acuity, multiple comorbidities and enhanced use of new technology are all viewed as increasing uncertainty in healthcare settings. These elements are omnipresent within stroke specialist nursing practice. Stroke specialist nurses are often found working autonomously. The level of responsibility, particularly when contemplating decision making, was an intense source of stress for several nurses,

'I always go home and think have I made the right decision? Especially when I'm quite autonomous. I'm in A+E and I can go up to two or three patients a day and say no it's not a stroke but I still kind of you know, worry about that. At my level it’s all about decision making. The hyper acute point of view you’re making these snap decisions’ (P4).

The following story reveals how the combination of acuity, services constraint, unpredictability and family involvement resulted in a terrible situation that resounds with the powerlessness of being forced to bear witness to another’s trauma,

‘We had a patient come in for thrombolysis, but we’ve got nowhere on the ward to put this patient. We’ve got a trolley now in our treatment room so what we had to do was put the patient on the trolley in our clinic room which is obviously not ideal, obviously took the patient down to be scanned and back continued obviously the thrombolysis stuff and then all of a sudden the patient started vomiting but then started bleeding literally from everywhere out of their nose, mouth, everywhere, went completely unresponsive, ended up going into cardiac arrest and literally in the treatment room it was like a bloodbath. I’ve never ever seen it look that way before and that is the one thing that will always stick with me cos it was just awful and obviously her family were there and it wasn’t very nice. It just looked horrendous. It was just a horrendous situation’ (P22).

Discussion.

This study’s lead author has been involved in stroke care for over 25 years- much of this was being spent as an ANP and a clinical manager for a team of SSNs working in the hyper acute arena. The lead writer has bourn witness to many clinical situations that have been traumatic or distressing such that it has resulted in their own experience of feelings of STS. These experiences have both provoked and informed this enquiry. The findings of this study have been resonant with that of the lead author. Furthermore, this study’s findings share resonance with the literature of the nursing experience of STS in the areas of oncology, ITU and emergency settings. The findings have particular similarity with those reported in the ED where the impact of high acuity, emergency interventions and clinical unpredictability are reciprocated.

The accusation could be made that these nurses have simply referred to what has saddened them rather than what has been an event resulting of the feelings commensurate with STS. However, these nurses contributed their experiences of what they found traumatic and this should be appreciated not trivialised. This report constitutes one chapter of a doctoral thesis on this topic. All of the SSNs who contributed data to this study went on to describe their actual experience of STS (insomnia, anxiety, depression, apprehension, dissonance, and hypervigilance) related to the events described. It is envisaged that this will also be reported in further papers.

Trauma reactions have previously been identified among stroke patients (Favrole et al, 2013). What is paramount is that stroke patients have been observed as being traumatized by what has happened to them. Conceptually, STS is the response resulting from exposure to a traumatized individual, rather than the traumatic event itself (Komachi et al, 2012). The stroke specialist nurses' responses offer a unique and insightful perspective of bearing witness to patients' traumatic experiences. However, it is possible to suggest that they are being traumatized directly by their immediate involvement. Regardless of whether the mechanism of trauma is direct or secondary, SSNs appear to be exposed to these perils on a regular basis.

Traumatic reactions occur principally in response to witnessing other peoples (patients/ relatives) trauma, which is, suffering a stroke. However, the contexts in which these events occur are highly influential. Many nurses described catastrophic events. Although people of varying ages were affected, the specialist nurses felt particularly saddened by younger patients. Empathetic engagement, a key determinant of STS development (Figley, 1995), was linked to the specialist nurses' responses to these younger patients.

Uncertainty has previously been discussed in the setting of stroke with regards to communication and prognosis (Payne et al, 2010), survivors (O'Connell and Baker, 2004) and carers (Greenwood et al, 2009). There are no papers available that discuss stroke specialist nurses' feelings of uncertainty. Stroke specialist nurses are often confronted by scenarios of acute deterioration and fluctuations in patient's conditions. Although some of the stories referred to visions which were truly horrific, the sense of trauma was no less realized by the acute and often unpredictable nature of stroke. Many of the respondent's data discusses intense experiences of different clinical trajectories that often couldn't be legislated for. It is these unforeseen and often unpredictable events that have colluded to produce stress reactions in the specialist nurses.

Advances in treatment and technology (thrombolysis/ thrombectomy/ telemedicine) have demanded SSNs role evolution. There exists some variability in the roles of SSNs in the UK. However, for those SSNs working in the hyper acute field, many see themselves involved in emergency assessment, investigation, diagnosis and the selection for intervention (Hamilton et al, 2018). The SSN role can be viewed as having a proximity to medicine, while also embodying elements of the traditional and specialist roles and taking on those of advanced practice (Sanders and Ashman, 2018). However, the blurring of roles and responsibilities can also serve to increase uncertainty, not only for the nurses themselves but also of the expectations demanded of them.

Crippen (2016) refers to moral distress in the context of individual's standards being compromised by others. Many of the stroke specialist nurses made expressions of passion for their deeply held set of values. However, they also discussed feelings of their values and beliefs being violated by decisions either being removed or imposed upon them. The data suggests that these deeply held values that form these nurses' moral fabric have been at best ignored and at worst have been violated. The data does not state the nurses as being silent, but their opinions were marginalized and one went so far as to say they felt intimidated.

The families of people that present with acute strokes need to seek information and knowledge related to the clinical condition (Hafsteinsdottir et al, 2011). However, this demand is not always met, with staff reported as having little insight into relatives' information needs (Morris et al, 2007). Families may feel traumatized themselves on seeing their loved ones in distress. This, along with possible problems of insight can be projected onto the specialist nurses and so increasing their sense of tension.

The atmosphere of conflict and constraint has also been denoted as elements conspiring to produce stress reactions. There were several areas of the service which were described as demanding. The nature and complexity of hyper acute stroke care places the specialist nurses under added duress. The atmosphere of constraint is perpetuated by the need to make appropriate clinical decisions and prioritize patient care while managing different role demands and trying to meet nationally set targets.

Stroke specialist nurses are impacted on by heavy workload, high acuity and the need for prioritization. Burns et al (2013) have argued that organizational and service failures can lead to institutional abuse. The stroke specialist nurses' data does not indicate abuse as such; there is service and organizational inadequacies that hinder these nurses' practice. It is possible to contend that these service and organizational deficiencies, such as time and space, lay outside of the specialist nurses' direct influence. It is therefore creditable that highly specialized acute care is maintained under such duress.

What also becomes familiar is that often these specialist nurses, often working in isolation for long shifts, take the brunt of these emergency referrals. This solitary means of working left some nurses feeling deserted. Specialized roles impart greater responsibilities previously situated in the domain of medicine. As each of these participants had offered up stories of their traumatic experiences, their worries in regards to decision making could be seen as sustaining their traumatization.

In summary, the context of stroke specialist nurses stress is multifactorial. The themes permeating the data were consistent among the SSN responses collected at interview and electronically. Constancy was also apparent in what the nurses described as traumatic was the same whether the events occurred in centralised (hub) hyper acute centres or local hospital stroke units. Furthermore, none of the participants referred to events where traumatic reactions might have occurred but did not. Lavoie et al (2010) have referred to the evolution of trauma reactions in the circumstances of being a victim, being a witness and the influence of the conditions in which the event occurs. Much of the data has offered thick descriptions of traumatic events positioned in the sphere of hyper acute stroke specialist nursing. However, not all of the data presented here concerns itself with the elemental characteristic of STS, that is, being witness to someone else's' trauma/ suffering. There is a combination of additional influences referred to - acute illness in varying age groups plus/

minus intervention, increased mortality, ethical considerations, and inter-collegial disputes, interaction with relatives and service demands and expectations. All potentiate the risk of adverse stress reactions and increase the possibility of STS among stroke specialist nurses.

STS has been cited as having a negative impact on staff wellbeing and retention and increased absenteeism. It can furthermore result in compromised care and be detrimental to the quality-of-care provision (Meadors and Lamson, 2008). Specialist stroke nurses and their managers need to have an appreciation of the causes and the context in which they can become subject to STS development. Hyper acute stroke practice calls for its specialist nurses and their managers to develop strategies to recognize and negate STS at individual and organizational levels (Duffy et al, 2015).

This study has several limitations. These data were collected from a purposive sample over a prolonged period of two years and by one researcher. The data was collected in the years 2016 and 2017. As hyper acute services have evolved in the preceding years it may be of interest to see if the areas described still resonate with SSNs. Collecting data electronically allowed the researcher to access participants over a wide geographical space. However, it is not possible to know with certainty if the participants were distressed by recounting their experiences. While participants who contributed their data electronically were safeguarded from the researcher's influence, non- verbal data such as facial expressions, body language, voice tones and tears, were lost to the interpretation.

Conclusion.

The aim of this study was to describe and discuss the cause and context of STS occurring within stroke specialist nurses. The causes appear to be multifactorial and can occur either in isolation or in combination. Stroke specialist nurses dealing with hyper acute presentations are exposed to these elements by the very nature of their work and are at risk of developing STS.

Key points for policy, practice and/ or research

- The causes and context of secondary traumatic stress in stroke specialist nurses is complex and multifactorial.
- Findings support the need for greater recognition of the emotional burden of specialist stroke nursing.
- Findings call for stroke specialist nurses and their managers to develop strategies to recognize and negate secondary traumatic stress at individual and organizational levels.

Declaration of conflicting interests

No conflict of interest to declare.

Ethical considerations

This research obtained ethics approval from the Board of Ethics, Manchester Metropolitan University.

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