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Mental health and subjective wellbeing in UK mental health nurses.

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Thesis submitted for PhD

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City University London

July 2016

Volume 2 of 2

Volume 2

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8.3 Interview findings on subjective wellbeing

A purposive sample of mental health nurses with high SWB and subjective experience of mental illness were interviewed about their SWB and what SWB meant to them. The thematic analysis of their interviews identified four core descriptive themes: what they did to consciously improve or maintain their SWB ('Activities to aid my SWB'), how other people impacted positively on their SWB ('Other people and my SWB'), how certain attitudes were associated with high SWB ('Attitudes for SWB') and how high SWB was linked to their relationship with work (SWB and my relationship with work'). Across the four core descriptive themes, three underlying interpretive themes emerged, manifested in an underlying common language used to describe exactly how other people, work, attitudes and experiences positively impacted on SWB. The underlying themes emerged across all three sections of the qualitative data. They are revisited in Chapters 9, 10 and 11 as well as in this chapter. These themes were: choice and control, distancing and connecting, nurturing myself. Figure 8.4 represents the thematic findings on mental health nurses' SWB in pictorial form.

Figure 8.4: MHNs' subjective wellbeing (SWB)
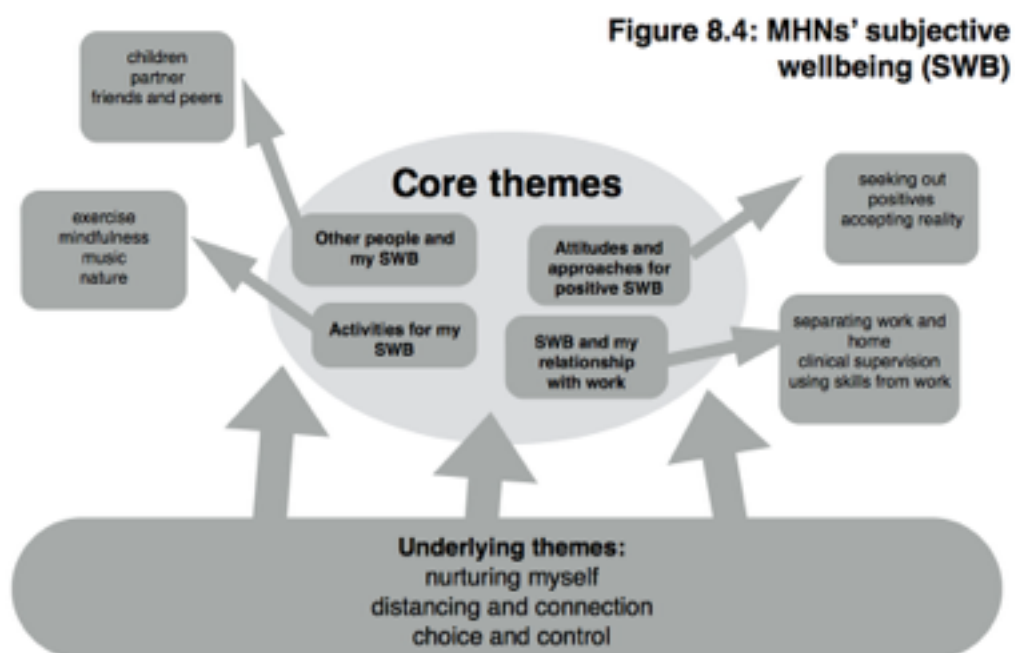
8.3.1 Activities to aid my subjective wellbeing

Four linked activities emerged as central to good SWB: exercise, practicing mindfulness, being in nature and listening to music. The participants talked about how the activities aided SWB by giving them time and space for themselves. The activities created a distance between themselves and their work or between themselves and other difficult situations. These activities were also ways of self nurturing.

8.3.1.1 Exercise.

> *'I cycle to work, so, from that perspective, I'm 20 minutes if I cycle from work, so, by the time I get home, it's drifted off my shoulders'* (Lucy)

> '*It's about having a bit of space where I'm just doing something for me*' (Rose).

Exercise was associated with SWB for a number of participants. Yvonne did triathlon activities, and trained for competitions. She said sport helped her to feel *'healthy and balanced'*. Jackie was a regular runner, who also took part in competitions. Other participants took zumba or yoga classes, attended gym sessions or went for walks. Norman cycled, and played badminton with a work colleague. Exercise helped them feel good physically. It was also associated with the other ways of enhancing wellbeing: being in nature, music, mindfulness. The benefits of exercise for SWB included '*clearing the head*' (Yvonne), controlling thoughts, and distancing from difficult situations. Yvonne said exercise helped her by:

> *'Feeling happy and content and that things are going as you want them to. Feeling healthy and balanced.'*

For many, physical activity was associated with being outside: '*swimming outside in the lakes and the rivers and the seas*' (Yvonne) or dog walking in woods and by the sea. For Fiona physical activity was associated with not thinking too much, with taking a break from thinking. For Rob walking was about

focusing on sounds and nature. Yoga and martial arts were also described as good for '*slowing the mind down*' (Zoe) and having '*focus*' (Neil). Some participants (Jean, Ryan, Lucy and Ruth), however, were not taking part in regular exercise but they still acknowledged its benefits for wellbeing.

8.3.1.2 Mindfulness

Participants used mindfulness techniques as means of dealing with difficult emotional responses to situations and '*bringing things into perspective*' (Zoe). Zoe described mindfulness as a means of '*distress tolerance*'. They talked about learning the techniques through partners, books or courses associated with their nursing work, and then continuing to do this practice under their own steam. Participants talked about sharing mindfulness practice techniques with others: learning in a group, learning it from a partner, teaching mindfulness to their partner or teaching it to service users. Mindfulness was promoted by them to partners and to patients, as explained by Ryan and Christine:

> '*I've started doing some mindfulness meditation which is something that I became interested in during my training. I'd never really done it myself, and then since starting this new job they're setting up a new group for patients where they're delivering mindfulness and they're training groups of staff as well so that they can learn how to deliver it.*' (Ryan)

> '*Because of my clients it's one of the skills in DBT so, yes, I learnt it through there. And actually I find it beneficial now too… That is lived experience and I find it beneficial now to be able to say to them, I use it and these are the times I use it and actually it's really, really helpful for me so it could be helpful for you. Give it a go, don't just dismiss it. And that's actually been helpful in getting my clients to understand mindfulness a bit better and what the purpose of it is.*' (Christine)

Mindfulness was associated with having control and choice about how the participants felt, about having perspective and awareness. Through mindfulness they could manage their internal responses to a situation, choosing to control a response. Christine used a 'descriptive' technique to '*bring me back into the*

moment, bring me back into myself'. There seemed to be a social aspect to mindfulness also, in terms of learning from others or sharing learning with others, either at home or work. When participants talked about mindfulness the underlying themes of self nurturance and creating both distance and connection to others emerged:

> *'It's about putting the upsetting things into perspective. Because what I tend to do when I get upset is go, well, I did this wrong, so that means that that's going wrong, so that means that I'm a horrible person, and start joining the dots in a really bad way. And what he'd* (her partner) *say at that point is, you're not horrible, you're just upset, and just encouraged me to step back and just look at the situation for what it is, and not let it take over. Which is…really helpful. So being aware of the thoughts before it being distressing'* (Lucy)

Lucy's description shows how learning mindfulness with others was a point of connection with other people, however it gave her some distance or 'perspective' on difficult situations. Practising mindfulness was a way of looking after the self through changing a response to distress. Whilst this could be learned, it could also be something more innate. For Christine, for example, mindfulness training at work had led her to identify some of her pre existing mental approaches as being '*mindful'*. In this cases '*mindfulness*' was a disposition, or trait that she could now give name to and consciously use rather than a new skill.

> *'It is a really good technique. It's just a good technique. I mean, I've only used mindfulness for the last three years and I've had… If you'd asked me three years ago what my wellbeing was I probably would have said the same, that I've got a good wellbeing, but I wouldn't have been able to probably say why. But I think probably my wellbeing is partly due to the fact that from a young age I think I've always known that I can only control me because I haven't fought anybody else.'* (Christine)

8.3.1.3 Being in nature

Participants described how 'being in nature' made them happy. This was often associated with the theme of taking exercise, when participants talked about running, cycling or walking by the sea or in woods. For Rob, Chloe and Fiona the sounds in nature were particularly beneficial. Being in nature was about connecting with something beyond human that could bring about a change in their mental state. Chloe described the profound impact that being in nature has on her view on life:

> 'So, what I'm saying is, is that, me stood by a beach, I'm the microcosm and it just reminds me that everything that I come across, everything that I'm experiencing at the minute is really small, and it's just, like, its nothing, it is a blip in time and, you know, it, kind of, gives me some perspective.'

Being in nature enabled both a sense of connection and distance, and was a means by which participants could nurture themselves. Participants connected with the macrocosm and the '*natural*' world. 'Being in nature' created a distance between the self and the environment of the home, hospital or office.

8.3.1.4 Listening to music

Music was frequently associated with SWB, whether participants were making it or playing it. Rob and Ryan described being in bands and playing music with other people as bringing them pleasure. Music helped them to connect with people. Fiona, on a more solitary note, described sitting at home playing the harp as therapeutic. Listening to music was also associated with exercise and movement, whether being played while running or being 't*urned up loud*' (Monica) when driving away from a difficult day at work. Music was a means of changing and controlling mood. Jean said she found her hobby of life modelling beneficial as it was an opportunity for her to be still and listen to music. Ryan referred to his experience of mindfulness classes at work to articulate the power of music on his psyche:

'I think the sort of state of mind that you're aiming to get into when you're doing mindfulness meditation of sort of focussing on the present and try not to think about things you've got to do or the past or the future, and that sort of focus on the here and now. I get a similar thing when I listen to music, sort of almost escapism I suppose, clearing your mind and just focussing on what you're listening to or what you're doing at that moment.'

8.3.2 Other people and my subjective wellbeing

Partners, children, friends and peers contributed to participants' SWB in a variety of ways, either incidentally or intentionally. In the survey those nurses who lived alone had lower SWB than their counterparts. Living with one other person was associated with relatively higher SWB, whereas the effect of additional people in the household on SWB, the number of children in most cases, was less clear cut. For the interview participants the contribution that significant others made to their happiness was clear and justifiable.

8.3.2.1 Children

Parenting was associated with SWB, having both an immediate and long term effect. In the long term, participants said that becoming a parent had enabled them to make what they saw as positive life choices. Participants who were parents talked about making positive decisions to scale down their work in order to focus on family life and doing activities with their children. Yvonne's busy family life, ferrying teenage sons to band practice, meant that there was a separation between her home life and her work stress. It also appears that parenting could be a protective and motivating factor in keeping some participants well. For Joanna, getting herself well after depression was about being better able to look after her son. For Neil, parenting two small children when his wife was ill required him to manage difficult emotions.

Parenting was seen as having an immediate as well as long term positive effect on SWB. It was associated with being able to better experience positive emotions. Eleanor cited giving birth to 'two beautiful twins' as a cause of her

increased wellbeing and cessation of depression. This was linked for her to the experience of getting and giving love, and having family responsibilities. Jackie described how the act of being with children had an immediate positive effect:

> *'I think sometimes, you can just, if you're a bit, sort of preoccupied by stuff that's going on, if you can just put it away for a little bit, and really get yourself playing, and absorbed, in the sort of, I suppose in the now, really. And get yourself enjoying your little one, and laughing, and stuff like that.'*

8.3.2.2 Help from my partner

Whilst caring for and being with children enabled participants to make some long term positive life choices and to experience immediate positive emotions, help from partners was more practical and focused on how partners enhanced their ability to cope with work and life stress. For some, partners offered specific help to address their personal mental health problems. For others partners were a source of support to deal with periodic difficulties and stresses at work. They described going home and talking to partners, to (as three respondents described) '*vent their feelings*.' On the other hand, Jackie described the support from her partner as being about his respecting her wish to not talk when she was stressed, and allowing her to '*decompress'* in her own way after a difficult day at work. Heather's partner limited the amount of time she was allowed to talk about work. He set a clock on how long she could off load about work each day, and she found this helpful:

> *'I don't talk about work all that much but if I'm coming in and I've had a bad day he'll know and he'll hand me a beer and say 'you've got 10 minutes then go' and next time I feel if I feel angry upset or irritated then I have space to vent'* (Heather)

Some participants had partners in the same or similar fields of work and said that this shared knowledge and experience was of benefit. More commonly though, participants said that their partners were not in health care and said that

this contrast was good. Some found partners helped them to distance from work-related problems.

> '*He is a designer – it's worlds apart. He is very supportive. It's good to have the difference as at work sometimes it is a bit like a little village where everyone knows everyone's business. I have seen it when relationships break up both parties are in mental health in the organisation it gets messy and slightly unprofessional at times.*' (Zoe)

> '*My wife is a doctor and a few of my friends are doctors, so there's a lot of common ground there and a lot of, sort of, ways that we can vent... that I can vent, talking about work. But other friends, there's a really wide range of different types of jobs, really, so sometimes it's about talking about work, but, you know, there's a real variety in our group of friends, so it's not always just talking about work or work problems, it's, you know, all the other things that are going on in life.*' (Ryan)

8.3.2.3 Friends and peers

Friends and peers influenced SWB in a number of ways. They gave participants an opportunity to talk and let off steam, to feel cared for and included. They also served to distract participants from their own problems and to bring perspective on work stresses. Being a friend could also be a source of self worth, with Ryan and Patty both talking about the benefits of what they gave as friends rather than what they got from friends.

> '*I've got a friend, a work colleague, she's just retired and she went through a very similar thing and we tend to... she's come back part-time and we tend to, because we understand the system and everything else, is be very kind of supportive of each other and we can usually see when the other one is starting to get a bit stressed or... and kind of up the support, if you like, at those times.*' (Rose)

> '*I have some very close friends and I have quite a lot of wider friends as well. I have people that include me in things which I find really nice. So*

I've got a very close friend who's got another friend and often I'll be included and we'll all have a giggle together. I see my friends relatively often.' (Christine)

Organised social activity at church and through sport was seen to support wellbeing. It made participants feeling included and connected. For Sylvia, Monica and Norman their social life at church helped them cope with difficulties.

Friendships that had developed at work were a source of support and also could be motivating factors for staying with a particular team or service. The participants described how their team looked after one another, whether through gifts and monthly nights out, or through helping with challenging case or work loads. Participants described team cohesion as developing over a number of years, and how team support could withstand organisational pressures.

'*We've got a very close, very supportive team. We have loads of supervision and the team are quite open, so, if there's dynamics going on, or difficulties, then people are quite honest, which is unusual, I think, because, generally, in teams, you, kind of, just have to just knuckle down and get on with it.* '(Joanna)

'*And I think we rally round quite well if someone is visibly stressed. And it's little things, from just making someone a cup of tea to saying, look, what do you need to do? Do you need to go and have five minutes? And they're just really good, we're really good at looking after each other and I've never worked in an environment where there's always been that immediate peer support. And I think, you know, we talk about it quite often, how lucky we are. Which is why a lot of us don't want to move on.'* (Carrie)

'*it's very supportive environment. If anyone comes back and says I am not happy or I am worried about that person they are supported and people rally round. The basic premise seems to be' we're all here, we're*

all good at our jobs, we like each other'. It is a good starting

point.' (Chloe on her home treatment team)

Whilst most participants described work friendships as a source of workplace wellbeing, there were some outliers here though. Sylvia and Norman described past conflict with their managers in teams that they had subsequently left. For them, SWB was associated with leaving work situations that did not support their SWB. Fiona, also, was less than positive about her current work environment, saying '*don't mix work colleagues and friends.*' She had taken the decision to work nights in order to avoid the politics on her ward. All of the descriptions here supported the underlying notion that being around supportive colleagues, with shared views and shared humour could support nurses' SWB, as could creating distance between oneself and colleagues who did not offer that support.

8.3.3 Attitudes for subjective wellbeing

The interviews demonstrated that SWB was maintained by attitudes as well as by activities. These attitudes typify the various aspects of global SWB as defined in Chapters 2 and 3, and measured by the three SWB scales. The nurses described how they sought out positive experiences, typifying a hedonic or pleasure seeking approach to happiness. At the same time they said that their high SWB was due to an attitude of 'reality acceptance.' This reflects the evaluative aspect of SWB, whereby a happy person is satisfied with their lot in life. Finally, SWB was associated with valuing the self, in particular relation to nursing work and being a nurse. This can be related to the eudaemonic notion of SWB, where it is about deriving meaning or purpose in life. This valuing the self, or self esteem, is linked to self nurturance, as discussed in Chapter 2, because the individual must see themselves as of value in order to invest in self care.

8.3.3.1 Seeking out positive experiences

'*…spending a lot of quiet time watching TV, escaping, watching my*

favourite DVDs, you know, sort of romantic stories, listening to music

definitely, oil burner with lavender in, I go and have a shoulder/back massage every three weeks to get rid of the tension in my shoulders; I do nice things for myself.' (Sylvia)

SWB was, understandably, associated with doing pleasurable things, be they arts and crafts (Ellen, Patty, Rose) or watching movies or reading books (Trevor, Rob, Norman) or participating in sporting activities (Rob, Neil, Norman). That these pleasurable experiences could be sought out or actively undertaken are exemplified by Ellen's comment that:

'I think there's lots of things that I can do to make myself feel better.,'

and Heather's view that:

'I do a lot of work to keep myself positive.'(Heather)

Participants described deliberate actions to improve how they felt day by day. Sylvia talked about the ways she made time to '*do nice things for myself*' and Rose talked about how '*I do more things for me now.*' For Yvonne this was described as *'just making space for yourself*.' Where there were the four core activities (exercise, mindfulness practice, being in nature and music appreciation) that the nurses did, they also described a more general pleasure-seeking approach to life, reflecting the underlying theme of 'nurturing myself'.

8.3.3.2 Accepting reality

'…radical acceptance. Things are as they are. You cannot change them and you have to accept it, you have to fully accept it; not, oh, God, I'll have to accept that then I suppose. It's about really fully accepting things. This is just how they are and I think that actually that's something that's in me naturally.' (Christine)

When asked about why they had high SWB, even given past or present experience of mental health problems, the mental health nurses talked about their attitude to change and adversity. Many had been affected by changes at

home and restructuring at work and saw a coming to terms with and acceptance of change as vital to their SWB. Alison described how her wellbeing improved through accepting the reality of her family life and home situation, rather than wanting it to change. Reality acceptance was also a position adopted by Christine (above) and Ruth, who saw her personal characteristics of *'not hankering for things'* and *'not comparing myself'* as being the source of current good SWB*.* For Ruth, who had been through difficult personal times, and had a strong socialist political leaning, this acceptance had been hard won through previous challenging life circumstances:

> '*I think that's maybe one of the keys to it is I don't compare myself to other people. I think I just compare myself to myself and what I've wanted and how I feel really, you know, whereas I do know lots of people who are aggrieved that they haven't got the things other people have got the kind of things other people have got kind of thing.'*

Christine talked about using the approach of '*radical acceptance',* which she had learned as part of her dialectical behavioural therapy (DBT) training at work. Like the mindfulness techniques that she Ryan and Zoe had learned through their nursing practice, clinical practice had given her tools to enhance her own SWB as well as that of her patients. Similarly, Carrie described keeping a gratitude log, which served as a daily reminder of the positive things in her life. This was a practice borne from her cognitive behavioural therapy training. In taking up these work-learned practices the nurses exerted choice and control over their own SWB*.*

8.3.3.3 Valuing myself

> '*I value myself, I know that I'm a very good person, I know that I'm a good nurse, I'm extremely supportive of my colleagues, and I care passionately about the service-users.'*(Sylvia)

Respondents talked about how their SWB had changed over time, partly through changes in their work and home lives, and partly through learning new ways of influencing wellbeing, such as the mindfulness techniques described

earlier. It must be borne in mind that the participants had all been chosen for interview because they had subjective experience of mental illness as well as high current SWB, so had known difficult times in life as well. The participants were asked if they were surprised by the survey finding that they had relatively high wellbeing. The majority said this did not come as a surprise, because they felt good.

> *'I think it's because underneath all of that you've got to have a good solid level of self-respect and belief in your own abilities really.'* (Patti)

Respondents talked about increasing self worth over time, and how this linked to their SWB. For Sylvia, Lucy and Eleanor, this valuing of the self was linked to their identity as a nurse, and knowing '*that I'm a good nurse.*'

> *'I'm very, sort of, self aware, and I think being at university as well has helped, the fact that, you know, you need to be very self-aware, you need to be very aware of your limitations, on a work level and a home level and, so, after a couple of near meltdowns at work, due to too many hours and not eating and not sleeping, I think I've, kind of, knocked myself to say, hang on a minute, you can only do so much.'* (Lucy)

Rose described increasing self confidence in her community nurse role, and associated this with accepting that she could not control all situations and minimise all possible risks for her service users. The valuing of the self was linked to both the activities undertaken to support SWB and the seeking out of positive experiences. Participants said that self awareness and self esteem had grown organically as they had got older, but also that it had developed through their activities such as yoga and mindfulness practice.

8.3.4 Subjective wellbeing and my relationship with nursing work

> *'I'm quite a positive person and quite open, so, take a step back from things, you know, and let things not get to me as much, which I can personally offer support for. You know, student nurses and newly qualifieds,'* (Lucy)

Participants' overall SWB was linked strongly to how they managed their experience at work. As mental health nurses all of the respondents were working with people in crisis and distress. They commonly also described working in teams and organisations where there were tensions and challenges. This theme is explored further in Chapter 10. Whether participants felt positive about life in general was associated with what resources they considered that they had to address their responses to work.

8.3.4.1 Separating work and home life

> *'I think one of the things I would say don't live on top of your work, as far as possible have clear boundaries about when you work and even if you're working at home have clear boundaries'* (Fiona)

The nurses described how they separated their home and work life as a way of maintaining their SWB. For some this was through conscious actions, protecting family life and family time, for others it was incidental to being at home. Analogies were used - of physical distancing and compartmentalisation. This active distancing was counterpointed by their confidence in their own judgement and being sensitive to their own feelings. Some respondents talked about the use of self awareness to notice how work was making them feel:

> *'Yes, because I noticed myself getting very tense and awareness of how my muscles feel, that sort of thing and so I'm able to let go and not sort of be gripping onto the chair or whatever.'*(Norman)

For some, being able to distance from work was associated with having self worth and valuing one's own views:

> *'I suppose, over 20 years, that's what I've learned. Work is work and you do it then, and home time is home time and you do that then, and, you know, if I don't well... I've got quite good now at switching off.'*(Yvonne)

For many there was a work self and a home self. Interestingly, even when participants were experiencing mental health problems, they felt capable of managing other people's problems at work, for example, Jackie talked about suffering with depression but being able to put on a '*work face*' nonetheless. The nurses set limits on how much of their self they revealed at work, both with service users and colleagues. This is a theme explored further in Chapter 10. Joanne said:

> *'I think, being able to have time for me and do the things that I love, because I love my job and I could very easily throw myself into doing lots of studying and courses, and all that kind of stuff, but, actually, that wouldn't be very healthy for me because I've got an eight year old son and I've got other interests, and all that kind of stuff, so it's about balancing.'*

Diana worked with children who were abused and had a young family herself. She described using a visualisation technique to put her work concerns *'in a box'* at the end of each working day.

8.3.4.2 Using clinical supervision

Clinical supervision was commonly seen as vital to SWB at work. It was the opportunity that the nurses had to reflect on their practice and seek guidance from peers or seniors, part of how mental health nurses' self nurture. It was seen to impact positively on SWB by providing a safe space to explore difficult cases and to seek reassurance and connectedness with others. Joanna and Neil, both working with young people with very traumatic family histories, relied on supervision to contain and contextualise their work. Joanne said;

> *'I am very much aware of vicarious trauma and because I've got that I learned quite early on in my career I've always ensured that that doesn't happen to me. I'm always the one to use supervision at work. There have been times when I have had two supervisors. I've had a nurse and clinical supervision with a psychotherapist.'*

Not all participants were involved in regular supervision. Those who were not saw this as a failing of their service or organisation. Like exercise, clinical supervision was described as an activity that promoted nurses' SWB even by those nurses for whom it was not regularly undertaken. Where the employer did not provide supervision, Diana and Norman, for example, arranged their own clinical supervision. Zoe also talked about a lack of formal clinical supervision as a problem in her service. Some participants were supervisors themselves, and saw this as a significant responsibility of their more senior roles. They enjoyed this aspect of nursing practice, both in terms of being able to support others but also because it allowed them to connect with their colleagues. In summary, clinical supervision was seen as positively impacting on SWB by both distancing the nurses from challenging situations and connecting the nurses to colleagues. Making sure that supervision arrangements were in place was a form of self nurture.

8.3.4.3 Using skills gained in work to look after my own subjective wellbeing

> *'I am reasonably good at being a practitioner that applies the theory out there to me. I am someone who lives more as a CBTer* [sic] *rather than it just being work or a job and I've learned from that; that was tremendous.'* (Patty)

Being a mental health nurse gave the participants particular access to opportunities to learn ways to boost their SWB. As identified above, a common aspect of the nurses' comments on SWB was that the skills they used to look after their SWB had been learned from or formalised through their work. Respondents brought their distinct professional perspectives to bear, for example, Patty, a CBT therapist, said she used CBT based relaxation techniques to manage her anxiety. She also used CBT techniques to '*challenge negative thoughts.*' Carrie was also a CBT practitioner. She described her improvement in wellbeing in CBT terms, talking about behavioural activation, through going for walks and through keeping a 'positive log' every day, akin to a gratitude journal.

Ellen talked about her personal 'WRAP ('Wellness Recovery Action Plan') plan' (Copeland,1997), using current mental health terminology to describe her own approach to her SWB. Christine, and other respondents who worked with people with personality disorders, described using work- learned techniques to manage their own mental health, such as mindfulness. This use of therapeutic techniques also helped Christine to connect better with her service users:

> *'Because of my clients it's one of the skills in DBT (Dialectical Behaviour Therapy) so, yes, I learnt it through there. And actually I find it beneficial now too. That is lived experience and I find it beneficial now to be able to say to them, I use it and these are the times I use it and actually it's really, really helpful for me so it could be helpful for you. Give it a go, don't just dismiss it. And that's actually been helpful in getting my clients to understand mindfulness a bit better and what the purpose of it is.'*

8.4 Discussion

The findings on SWB of both phases of the study are discussed here in the context of previous studies, in the broader field of SWB research and specifically in the study of nurses. The findings of the survey are considered first, then the thread of the findings is followed through to the interviews. Where the survey findings provide insight into the state of mental health nurses' SWB, the interviews pick up the thread of SWB from the perspective of those mental health nurses who demonstrated high SWB through their survey responses. By focusing on this particular group, this study takes the study of UK mental health nurses' mental health in a new direction, away from stress and burnout, aligning it more with the 'wellbeing' approach advocated by Black (2009) and Boorman (2009).

8.4.1 Survey findings

This study found that mental health nurses have relatively low SWB, compared to general population norms using all three SWB measures (although comparison must be tempered by the fact that this survey data is crude and

reflective of a population with particular demographic makeup, as discussed at 5.4.5.2).

As has been discussed in the presentation of findings, there was limited evidence of the impact of demographic factors on SWB scores, although age and gender had significant correlations with some aspects of SWB. Comparisons of means between findings of this study and those of the much larger population based studies (such as the ONS Wellbeing results (ONS, 2012) or the general population normative data for the WEMWBS (Taggart, Stuart-Brown and Parkinson, 2015) have used the one sample t-test, which allows for comparison of results from differently sized samples.

Whilst one measure, the SWLS has some history of use with nurses there has been no previous published study using these measures with UK mental health nurses. A unique insight into the SWB of this population has been gained through using measures specifically designed for SWB rather than measuring the absence of symptoms of mental illness or mental distress. At the time the survey was conducted, there had been no previous studies of nurses using the WEMWBS or the ONS questions. McManus et al (2012) also use both the ONS questions as well as Short WEMWBS in their time lag study of members of the UK population applying for Job Seeker's Allowance. The nurses in the present study had lower means on all four items on the ONS measures than the 2021 job seekers interviewed in that study. This finding suggests that mental health nurses are a unique group, whose experience of SWB is not typical of the general UK population.

In Chapter 3 it was shown that there is a paucity of research evidence regarding mental health nurses' SWB and there has been limited use of SWB measures in studies of UK nurses. As such there is little normative data for the population to compare these results against. The literature search described in Chapter 3 did not find any studies that measured mental health nurses' SWB specifically, apart from Chakraborty et al's (2013) cross sectional survey, although Sahebalzamani et al's (2013) survey of hospital nurses in Tehran did include psychiatric nurses. Where the SWLS scale has been used to measure SWB in the wider nursing population, mean scores have ranged from 20.15 in Turkish

nursing students (Akhunlar et al, 2010) to 28.9 in evening shift nurses in Iran (Vanaki and Vagharseyyedin, 2009). In a recent study of healthcare professionals, including nurses (n 38), Shapiro et al (2005) reported SWLS scores for pre and post intervention and control groups as part of their study on the impact of mindfulness based stress reduction. Scores were 20.80 pre intervention, 24.80 post intervention and 23.83 for the control group. At 21.62, the mental health nurses in the present study had SWB slightly higher than that of the baseline score in Shapiro et al's (2005) study and in Akhunlar et al's (2010) study.

8.4.1.1 Demographic factors and subjective wellbeing

The present study found limited evidence to suggest that demographic and workplace factors correlate with high SWB. The impact of age and gender have been considered in various general and specific population studies, as has household composition (Chanfreau et al, 2013; Dolan, Peasegood and White, 2008). It must be noted, however, that there are no existing studies looking at global SWB for mental health nurses in relation to these factors. Graham and Shier (2012), in their study of the SWB of social workers, looked at age and gender, along with other specific workplace variables, but did not find them to be strongly predictive of outcomes.

The survey findings suggest that other factors may correlate more strongly with mental health nurses' SWB than demographic and workplace factors. The profession may have a set of correlates to SWB that should be measured in future studies. As discussed in the SWB literature review in Chapter 3, previous surveys have found high SWB in nurses to be correlated with the individual qualities of hardiness (Abdollahi et al, 2014), spiritual intelligence (Faribors, Fetemeh and Hamidreza, 2010; Sahebalzamani et al, 2013), emotional intelligence (Por et al, 2011), good self esteem (An et al, 2014) and low levels of depression (Jacobs, 2013; Ratanasiripong and Wang, 2011) and anxiety (Lan et al, 2004), as well as with self reported healthy living, including self nurturance (Nemcek, 2007) and taking exercise (Jacobs, 2013). High SWB has been correlated with high job satisfaction (An et al, 2014; Gurková et al, 2011; Gurková et al, 2013), career satisfaction (Nemcek, 2007; Nemcek and James,

2007b), good support from supervisors (Yildirim & Aycan, 2008), flexible working arrangements (Skinner et al, 2011; Ward. 2011) and a 50/50 work life balance (Makabe et al, 2014). A number of these characteristics were identified by the interview participants in phase two of the present study as being associated with their SWB. This suggests that further survey research on mental health nurses' SWB should include survey questions that have been derived from the interview findings of the present study in adjunct to or rather than the demographic and workplace questions used in this first instance.

8.4.1.1.1 Gender

Whilst women had higher scores than men across all six SWB measures, this difference only met the threshold for statistical significance in the 'life worthwhile' ONS questions.

Based on research on SWB in the general population it might be expected that men would have higher SWB than women on the WEMWBS (Tennant et al, 2007; Bartram, Yadegarfar and Baldwin, 2009), with women scoring higher than men on the ONS questions (Office for National Statistics, 2012) as well as having higher scores on the ONS 'anxiety' question. Women might be expected to have slightly higher scores than men on the SWLS (Maltby and Day, 2004; Pavot and Diener, 2008). Many other studies of nurses' SWB found no gender specific effects (Ostermann et al, 2010; Sparks et al, 2005).

8.4.1.1.2 Age

There was a u shaped curve to SWB, with those in the older and younger age groups having significantly higher SWB than those nurses between 40 and 49. In previous research age has positively affected WEMWBS scores (Bartram, Yadegarfar and Baldwin, 2009). SWB has been higher at the lower and higher ends of the age spectrum for the WEMWBS (Tennant et al, 2007) and ONS scores (Office for National Statistics, 2012) and for the SWLS (Siedlecki et al, 2008). Baby boomer nurses in Australia (born between 1946 and 1965) have been found to have higher SWB than their younger colleagues (Brunetto Farr-Wharton and Shacklock, 2012). Other studies have found no association

between age and nurses' SWB (Appel et al, 2013; Faribors, Fatemeh and Hamidreza, 2010; Nemcek, 2007; Nelson et al, 2014) whilst Gurková et al (2014) found increasing age to negatively correlate with life satisfaction in Czech nurses. The relationship between age and SWB in nurses is therefore different in different studies.

8.4.1.1.3 Household size

As shown in Table 8.10 those mental health nurses who lived alone scored lowest on all of the SWB measures apart from the ONS 'happy yesterday' question. ANOVAs did not find a significant relationship between gender, SWB and household size, however both men and women living with one other person had higher mean scores than their counterparts. Research on the general adult population of the UK has found a relationship between SWB and household size, which differs between men and women (Chanfreau et al, 2013). According to the 2009-2010 Understanding Society survey of 40,000 UK households using the Short WEMWBS (SWEMWBS), women's SWB is not affected by the number of children in a household, whereas men's SWB decreases as the number of children increases (Chanfreau et al, 2013). Living alone is associated with relatively low SWB for men but not for women, with male SWB being at its best when living with one or two people (Chanfreau et al 2013). In the Health Survey for England study living alone was shown to adversely affect scores on the 'life satisfaction', 'worthwhile' and 'SWB yesterday' questions of the ONS, but not the 'anxious yesterday' question (ONS, 2012). Within the research on nurses' SWB gathered for the present study, reviewed in Chapter 6, household size was not commonly measured and so its impact is not known. There is a lack of research on mental health nurses lives outside the workplace and how they influence SWB. There is sufficient evidence in the present study to suggest that further research on mental health nurses living alone compared to those living with partners and those living with families should be pursued.

8.4.1.2 Workplace factors and subjective wellbeing

8.4.1.2.1 Work status

The present study found a slight but not statistically significant difference between full and part time working and SWB, with part time workers scoring higher on the WEMWBS and the SWLS. It also found that the three unemployed nurses had relatively low SWB. In general population studies unemployment has consistently been shown to correlate with low SWB (Dolan et al, 2007; 2008). It has been shown to reduce life satisfaction over the life course (Fujita and Diener, 2005) and to impact on the unemployed person's vulnerability to mental illness (McManus et al, 2012).

There is some qualitative research evidence that flexible working arrangements for nurses, such as part time working, can positively affect self-assessed work-life balance (Skinner et al, 2011; Harris et al, 2010) and professional fulfilment (Edwards et al, 2003). Whilst most of the studies reviewed in Chapter 3 included demographic data on proportions of full and part time nurses, few have presented analyses of findings according to work status. A two phase mixed methods study of Australian nurses found that part time nurses had lower anxiety (Hegney et al, 2014) but that at the same time they found it difficult to keep up with their professional development and training (Drury et al, 2013). Yoder et al (2010), in the qualitative part of their study on professional quality of life and compassion fatigue in US Magnet hospital nurses, found that going part time was one of a number of strategies that nurses used to manage compassion fatigue. This quantitative finding is corroborated by the interview findings in phase two of the present study, where nurses talked about going part time as a positive choice to support their SWB.

8.4.1.2.2 Years in the nursing profession and years in role

No significant correlations were found between years in the nursing profession or years in current role and SWB. Years in profession and years in role do link to nurses' ages because in most cases years of age increase at the same rate as years in role and in profession (this is further explored in section .6). As with work status, information on years in the profession is available in the reports of some of the reviewed studies, but had not been commonly analysed in relation to SWB. Increasing years of experience of mental health nursing have been associated with lower burnout (Johnson et al, 2011, 2012), as well as higher

work engagement (Vanaki and Vagharseyyedin, 2009). Johnson et al found that distress (also described by Johnson et al as 'emotional strain'), for example, was less prevalent in older staff. Strain tended to be higher in staff who had been working for a longer time in their present post and in mental health overall. Johnson et al (2011, 2012) also found that being in a current post for over a year and having a long time of service in mental health care tended to associate with lower positive engagement. UK mental health employees five to nine years into their career were most likely to be burnt out in Johnson et al's study, whilst Vanaki and Vagharseyyedin (2009) found that nurses with two to 10 years' experience were experiencing more stress and less managerial support. The relationship between years in post, role, age and SWB should be further explored in the UK, as it has been in Australia and the US (Letvak, Ruhm and Gupta, 2013; Brunetto, Farr-Wharton and Shacklock, 2012), particularly given the immanent staffing crisis caused in part by the early retirement of many mental health nurses (RCN, 2014b).

8.4.2 Discussion of the interview findings on subjective wellbeing

Whilst the survey found limited associations between demographic and workplace factors and SWB, the mental health nurses in the interviews made a number of connections between their SWB and certain activities, attitudes and aspects of their relationships with other people and with work. There was a common language used to describe how or why attitudes, experiences or relationships promoted SWB, which has been interpreted as three underlying themes: 'nurturing myself', 'distancing and connecting' and 'choice and control'. The interview findings are well supported by previous research on SWB in other populations and on aspects of positive mental health in nurses and their colleagues, particularly coping and resilience as discussed in Chapter 2. The supporting evidence is considered here.

One novel aspect of the findings of this study is how important activities, attitudes and relationships outside work were for nurses' SWB. Where previous research has focused on nurses wellbeing in work, there is little that is known about what mental health nurses do outside work to make them feel good, apart from in studies where 'coping' strategies as part of stress management have

been measured, for example in the all-Wales study (Coyle et al, 2000). The findings of the present study build on those of the all-Wales and other mental health nurse studies by asking mental health nurses to detail how their SWB is maintained, rather than just how they cope with stress. Where Coyle et al (2000) found that stable home life and a healthy life outside work were paramount in terms of coping, the present study encouraged nurses to say exactly how home life and outside interests aid wellbeing because of the use of semi structured interviews and because of the focus on positive mental health.

8.4.2.1 Activities to aid my subjective wellbeing

Four particular activities were associated with mental health nurses' SWB: engaging with music, exercise, being in nature and practicing mindfulness. Whilst four distinct activities were described by the participants, in some cases they were undertaken all at the same time, for example, going for a run by the sea whilst listening to music.

Study participants talked about the positive impact of music on their wellbeing, both playing it and listening to it. Music has previously been suggested as a source of stress relief for nurses (Lo, 2002; Kravits et al, 2010). It has also been identified as a source of 'self nurturance' in previous qualitative studies of nurses (Rose and Glass, 2006, 2010; Kidd and Finlayson, 2010) and of social workers (Graham and Shier, 2010). Music is known to have a positive impact on wellbeing on older adults (Adams, Leibbrandt and Moon, 2011; Creech, 2013), patients in various settings (Biley, 2000) and across the lifespan (MacDonald, 2013; Rickard and McFerran, 2012) It is a means of having peak experience (Rana, Tanveer and North, 2009) and experiencing 'flow' (Fritz and Avzec, 2013). Flow, according to Csikszentmihalyi (1990), is the state of absorption reached when engaged in an activity with the right balance between challenge and skill. According to Moneta (2004) it relates to both eudaimonic and hedonic wellbeing because it gives life meaning and a sense of pleasure. The more experience of flow a person has in daily life, the more happy and fulfilled they feel. Listening to music also stimulates oxytocin, a hormone which is associated with feelings of wellbeing and connectedness (Ishak et al, 2011) and, along with

other creative pursuits, has been found to reduce stress and promote healing (Leckey, 2011).

Interview respondents associated physical exercise with SWB. The evidence for the impact of exercise on SWB in nurses is mixed, with some studies showing no correlation in student nurses (Hawker, 2012) or in the general population (Chanfreau et al, 2013; Schuller et al, 2012). However, reviews of the literature have found moderate regular exercise to positively impact on depression, anxiety, self esteem and mood states (Fox, 1999; Dolan et al, 2008). Research on how physical activity might improve SWB suggests that it, like music, is a means of experiencing 'flow' (Csikszentmihalyi, 1991), it creates a sense of absorption and loss of self-consciousness (Jackson and Eklund, 2002). It also aids with a sense of detachment and recovery (Newman,Tay and Diener, 2013) and increases a sense of autonomy, especially in women(Newman,Tay and Diener, 2013, 2013). These findings support Lucy and Rose's comments that exercise was 'something for me' that separated them from the cares of work.

McCann et al (2013), in their systematic review on resilience factors in health professionals, found evidence that exercise enhanced coping and resilience in psychologists and doctors, but that no similar studies had been undertaken with nurses. Jacobs (2013) points out that those studies which have not found an association between physical exercise and SWB in nurses have been focused on short term outcomes and have not considered how particular patterns or types of exercise may impact on nurses or health workers SWB in the longer term. In her study, Jacobs found that those nurses taking more exercise during weeks of higher stress showed fewer symptoms of depression. Nurses in previous interview studies have cited physical activity as a means of maintaining their wellbeing, particularly in terms of '*removing myself from work*' (Rose and Glass, 2006, 2010) and as a means of '*looking after oneself*' (Edward, 2005). Again, these findings support the descriptions given in the present study of exercise as 'something for me' (self nurture) and as a way of 'distancing' from problems.

The positive impact of mindfulness practice on SWB was a common theme in the interviews. Kabat-Zinn (1991) describes mindfulness as nonjudgmental

paying attention to the present moment. Research on mindfulness has tended to look at two aspects: dispositional mindfulness (whereby a mindfulness tool is used to measure the extent to which research participants experience life in a mindful way), and mindfulness training (where the impact of learning specific mindfulness techniques, such as Mindfulness Based Stress Reduction(MBSR), is measured) (Brown and Ryan, 2003). Within the present study, nurses described having learned mindfulness techniques in the context of learning to teach them to their patients, which they were now using day-to-day as an approach to 'living more mindfully'. Christine, though, described an innate dispositional mindfulness and how learning mindfulness techniques had given her a way of describing her (preexisting) approach to challenging situations.

Mindfulness and meditation have become common tools within mental health, part of a recovery oriented approach which is very much influenced by positive psychology (Slade, 2010). MBSR has been found to positively impact on subjects' experience of stress and chronic health conditions (Grossman et al, 2004). The research literature on mindfulness for health professionals is 'promising' in terms of its results, according to Irving, Dobbin and Park (2009), however, the studies have tended to be small scale and methodologically limited. In both MacKenzie's (2006) and Lan et al's (2014) intervention studies, learning a mindfulness technique had a positive impact on nurses' SWB. Dispositional mindfulness has been found to associate particularly with eudaimonic well-being (Hanley et al, 2014). Richards, Campenni and Muse-burke (2010) found mindfulness to mediate self care in mental health professionals. High dispositional mindfulness has also been associated with positive affect and life satisfaction, as mediated by emotional intelligence (Schutte and Malouff, 2011). Whilst Christine's description of mindfulness suggests that she was of a 'mindful disposition' already before formally learning it, other nurses (Ryan and Lucy, for example) described mindfulness as a new set of techniques that they were putting into practice, perhaps not quite disposed to it just yet.

Nurses have been previously found to be well disposed to the use of mind-body practices, with Kemper (2010) finding that 99% of nurses surveyed were already using a mind-body technique such as mediation or prayer as means of

stress relief. Drury et al (2013) found that nurses in their interview study considered education on mindfulness and meditation to be a means of stress management. Ward's (2011) nurse interviewees also talked about how they has adopted mindfulness techniques into their work. McCann et al's (2013) meta-analysis found evidence of the positive effect of mindfulness practice on social workers and doctors. In Shier and Graham's (2011) study on SWB in social workers in Canada, mindfulness also was a strong theme. Their interviewees talked about being mindful as part of social workers' self-awareness and personal identity. It was essential for reflection and for balancing work and personal life. The parallels between the present study and similar studies are striking, not least because comments on mindfulness were not solicited, rather they emerged through general discussion about participants' SWB.

Another activity to aid SWB was 'being in nature'. The nurses described how spending time in natural surroundings positively affected their mental health. This is a finding that is well supported in the wider SWB literature. There is an established link between being in nature and SWB (Ambrose-Oji, 2013; Howell et al, 2013), in particular in terms of the opportunity for mindfulness, 'fascination' and 'directed attention' as means of restoration (Kaplan, 1995) and stress recovery (Ulrich et al, 1991). Connectedness to nature and feeling part of nature (biophilia, as coined by Wilson, 1984) have been associated with high SWB measure scores in a range of populations, with these concepts also being linked to eudaimonic 'meaning in life' (Howell et al, 2011) stress relief (Tyrväinen et al, 2014) and life satisfaction (Zhang et al, 2014). The positive effect of nature on SWB remains even when other mitigating factors, such as taking exercise or being a certain age, are accounted for (Korpela et al, 2014).

In the present study 'being in nature' was described as a solitary activity, rather than something done with other people, although previous research has found that 'beautiful nature' has been found to stimulate helping behaviour and sociability (Zhang et al, 2014). Getting out in nature was a positive move for the nurses in the present study, who were able to describe positive choices they could make to feel good, to the extent of not just experiencing positive emotions but also experiencing awe and a sense of the sublime(Keltner and Haidt, 2003), potentially associated with 'spiritual wellbeing'. This is particularly present in

Chloe's comments about 'the macrocosm.' Their actions, as a group with high SWB, match those of previous studies, wherein people who actively seek out spiritually nourishing leisure activity do so with the express purpose of increasing SWB rather than it being a byproduct (Heintzman and Mannell, 2003).

There is little research directly looking at the relationship between nature and nurses' SWB. Irvine's (2005) dissertation study measured the impact of nurses taking a work break in a natural environment. She found this intervention to cause nurses to feel refreshed and relaxed. The nurses in Rose and Glass' (2009) study linked wellbeing to spiritual enrichment in terms of seeking solitude and peace. Graham and Shier's (2010) social workers also conceptualised the physical environment as offering peacefulness as an aspect of SWB (Shier and Graham, 2011).

8.4.2.2 Other people and my subjective wellbeing

The nurses described the positive impact of close family, partners and friends on their SWB, whether this was through listening, distraction or setting limits on rumination about work-related problems. Friendships and partnerships were also associated with high self esteem and feeling valued. Being a parent, a partner or a friend was a connection that was seen as SWB-enhancing. These roles were also associated with making decisions that supported high SWB. These findings are well supported by the SWB literature. High levels of personal social support are generally associated with high SWB (Dolan, Peasegood and White, 2008; Slade, 2010). The degree to which friends and family support impacts on SWB differs between countries, as does the relative impact of friendship versus family (Brannan et al, 2013). Sociability is associated with SWB, as mediated by the personality trait of extraversion (Burke et al, 2006) although whether this is causal, meaning whether happy people socialise more or whether sociable people are more happy, is not clear (Strack. Argyle and Schwarz, 1991).

There is some previous research on nurses' SWB that supports these particular findings of this study. Student nurses in focus groups and interviews have

identified close relationships to be central to their wellbeing (Watkins, Roos and Vander Walt, 2011; Freeburn and Sinclair, 2009). Similarly spending time with friends and family was key to wellbeing for the nurse interviewees in the studies by Drury et al (2013) and Rose and Glass (2009). Conversely, low social support has been found to be a predictor of poor wellbeing and stress in psychiatric nurses (Leka et al, 2012).

Parenthood was seen to have both an immediate and long term positive effect on SWB. Participants talked about how being a parent affected their priorities and decision making in the long term, causing them to make lifestyle choices such as cutting down their hours of work. They also said that there was an immediate positive impact on mood of being with their children. Within the literature on nurses' wellbeing, parenting has been associated with 'stress' and has been seen as a cause of anxiety (Drury, 2013; Skinner, 2011, Simunić and Gregov, 2012). Becoming a parent has been deemed to be part of the 'reality shock' of early adulthood for newly qualified nurses (Daehlen, 2008). Conversely, in Makabe's (2014) study of work-life balance in nurses, those with a self reported 50/50 work-life balance tended to be nurses who were married with childcare responsibilities.

In the wider literature, the evidence for the impact of parenting on SWB is mixed, partly due to the range of ways in which it has been measured (Nelson et al, 2012; Nelson, Kushlev and Lyubomirsky, 2014). Evidence from cross sectional and longitudinal studies suggests that having children reduces wellbeing, despite 'folk theories' to the contrary (Hansen et al, 2014). Vanassche, Swicegood and Matthijs' (2014) analysis of international data found that the positive association between SWB and parenting depends on cultural factors, particularly the perceived status of fatherhood, marital status and family life. When large data sets on SWB and parenting have been analysed, with controls set for background factors such as marital status, education level, religiosity and health, little difference has been found in SWB between those with and without children (Deaton and Stone, 2014). Parental SWB also changes over time, peaking around the time of the first birth and declining when there are three or more children (Myrskylä and Margolis, 2014 looking at large data set longitudinal data on British and German households). Nelson, Kushlev

and Lyubomirsky (2014) theorise that parents' SWB can be viewed according to the 'broaden and build' theory of SWB (Fredrikson and Joiner, 2002), which posits that positive emotions beget positive emotions. This suggests that parents may increase their sense of SWB through perceiving parenting in terms of meaning in life, satisfaction of their basic needs, greater positive emotions, and enhanced social roles. At this point it is worth remembering that the interview subjects were identified because of their high SWB. Their perspective on parenting may differ from that of mental health nurse parents with lower SWB.

The parents in the present study offered a unique insight into the possible positive impact of parenting on their wellbeing, both in terms of work-life balance and the experience of positive emotions. As a group who were chosen based on their high SWB scores, their views support Nelson, Kushlev and Lyubomirsky's (2014) theoretical proposition that SWB and parenting are linked by their subjects' positive attitude to the experience. Having children was seen as an occasion for addressing work-life priorities. The advent of parenthood seems to be a moment where positive choices were made about the balance of work and family life, in line with the characteristics of this high SWB group, who viewed themselves as having some choice and control over the structure of their lives.

8.4.2.3 Attitudes and approaches for happiness

Nurses in this study talked about coping with change and challenge through an 'acceptance' approach. It makes sense that the study participants would associate 'reality acceptance' with their SWB because they had all scored highly on the Diener SWLS, meaning that they had made a positive evaluation of their life as a whole. It is logical that those nurses who had a positive evaluation of their life ('life satisfaction') would have an attitude to life that was at peace with their reality. Acceptance of reality is associated with resilience in nurses (Spence, Laschinger and Fida, 2014). It is an element of psychological capital, of which the other elements are hope, optimism and self efficacy (Luthans & Church, 2002). In Spence Laschinger and Fida's research, psychological capital is the vital intrapersonal resource protecting nurses from

burnout, meaning it is the internal resources the nurse has to cope with stress. Acceptance of reality is also a facet of a mindfulness based approach to working in health and social care (Mackenzie et al, 2006; Mandal et al, 2011; Schier and Graham, 2011; Bazarko et al, 2013) which can allow practitioners to engage with reality in a dispassionate and non-evaluative way (Grossman 2004). It is seen as a functional coping mechanism(Collins et al, 2006; McCann et al, 2013; Jacobs, 2013) and has been found to be a common attribute of the spiritual aspects of nursing practice (Sessana et al, 2011).

Another attitudinal association with SWB in this study was the nurses' sense of self worth and valuing of themselves. The nurses' comments here can be considered in the context of self esteem, self acceptance and self nurturance, which have all previously been studied in relation to nurses, as discussed in Chapter 2. Self acceptance is an aspect of eudaimonic wellbeing (Ryan and Deci, 2001; Ryff and Keyes, 1995) and has been found to correlate significantly with SWB in nurses (Montes, Berges and Augusto-Landa, 2014; Loukazedeh and Bafrooi, 2013). Acceptance of self and others has been described as an important facet of psychiatric nursing by veteran nurses in Humble and Cross' (2010) study. It is a core component of the Rogerian therapeutic relationship, which has long been deemed a central aspect of mental health nursing practice (Rogers, 1995; Ruddick, 2010).

Cross sectional surveys have found a positive correlation between high self esteem and high life satisfaction and a negative correlation between self esteem and depression and anger in nursing students (Ratanasiripong and Wang, 2011; Liu 2010; Hawker, 2012; Cha and Sok, 2014). Edwards et al (2003), in their systematic review, found high self esteem to be a moderator of stress in mental health nurses. It is also associated with resilience (Matos, 2008). Low self esteem is a mediator and component of SWB (Xu et al, 2014; Barry, 2009). It has been associated with compassion fatigue, an indicator of poor professional quality of life for nurses (Drury et al, 2013). Self esteem has also been associated with the individual characteristic of 'being positive' that enabled workers to have workplace wellbeing (Biggio and Cortese, 2013).

The participants described how they actively sought out positive experiences and took part in activities that made them feel good. As discussed above, commonly those experiences included exercise, music making or listening and being in nature. More broadly, participants were involved in a range of activities with the goal of 'self-nurturance', 'self nurturance' being a 'trait of happy people' (Nemcek, 2007) whereby happy people seek out and make time for activities and practices that they consider to be good for their own wellbeing. The finding here that mental health nurses actively seek out ways of feeling good can be compared with Nemcek's work on nurses' 'self nurturance' and SWB. Nemcek's (2007) descriptive survey found a correlation between self nurturance, life satisfaction and SWB in US registered nurses. Rose and Glass' (2010) nurses also described making 'self nurturing' lifestyle choices as means of creating a life balance.

8.4.2.4 Happiness and my relationship with work

The nurses talked about how they looked after their SWB by separating work life from home life, and setting limits on the impact of work on the home. This was in the context of creating some 'distance' from work, creating 'a balance' and having choices about their circumstances. There is a body of evidence to support the participants' views that work-life balance is key to SWB. In Ward's (2011) qualitative study nurses described very similar strategies for keeping boundaries between work and home. They used the journey home as an opportunity to refuel or unwind, just as the nurses in the present study did. Having a good work-life balance was also linked to having what Luthans and Jensen (2005) call 'positive psychological capital' in American nurses. It was a characteristic of what Beddoe, Davys and Adamson (2013) describe as 'resilient practitioners' of social care. Perceiving a balance between work and home life is associated with both the affective and evaluative aspects of SWB (Gröpel and Kuhl, 2009). In Simunic and Gregov's (2012) survey of Croatian nurses, work-family conflict impacted on their life satisfaction. Also, the nurses in Rose and Glass' (2009) study considered boundaries to be vital to work life balance.

The nurses had learned to balance work and home over their careers, and related their SWB to their skill at negotiating what Skinner et al (2011) have

described as a 'porous boundary' between work and home, where work experience can impact positively or negatively on the home. Skinner et al's (2011) participants described 'negative spillover' between work and non-work-life, not least because of a nurse's personal commitment and investment in work. In contrast to Skinner's participants, the mental health nurses in the present study described how they successfully maintained a boundary between work and home. This was hard won, in some cases. Being able to manage the work life boundary well has been seen as the mark of a mature mental health practitioner, with the subjects in Crawford et al's (2010) study of community personality disorder services identifying that maintaining work life balance and having a life outside work were an important attributes for prospective members of their team.

Whether they were currently involved in clinical supervision or not, the mental health nurses in the present study considered it to be an important means of maintaining SWB in relation to work. This was deemed to be an important aspect of nurses' self care. Where some mental health nurses did not have clinical supervision arrangements provided by work, they sought out supervisors themselves. This notion of the importance of clinical supervision is borne out in previous studies. Nurses value the emotional support that clinical supervision formalises (RCN, 2013a; Edwards et al, 2006). For the Australian psychiatric nurses in both Rose and Glass' (2006) study and Happell, Pinikahana and Martin's (2003) survey, clinical supervision was integral to nurses' sense of professional satisfaction and to the quality of care. Hyrkäs' (2005) survey of Finnish nurses found it to positively impact on job satisfaction and experience of stress. However, mental health nurses in other studies have said that they prefer informal approaches to accessing support from colleagues to formal clinical supervision (Burnard et al, 2000; Coffey, 1999; Dickinson and Wright, 2008).

Effective clinical supervision has been described as being vital to mental health nurses' wellbeing and safety (MacCulloch and Shattell, 2009) and their resilience (McCann et al, 2013). Nurses with 'efficient clinical supervision' have been found to have better wellbeing at work than their colleagues, and to be more motivated and committed (Koivu, Saarinen and Hyrkas, 2012a, 2012b).

However, mental health nurses who attend clinical supervision groups have been found to experience higher stress and to perceive their shortcomings more (Severinsson and Hummelvoll, 2001), with a hypothesis that this is linked to their developing a heightened moral sensitivity through supervision practice. Other intervention studies have found no impact of clinical supervision on mental health nurses' work satisfaction, job strain or sense of coherence (Berg and Hallberg, 1999). It seems that the perception of clinical supervision (like having children) is positive, even if the actual impact may be less so.

One unique finding of the present study was the way in which the interview participants described their own SWB through the lens of their professional perspective. Learning from work was applied by the mental health nurses to understanding and managing their own SWB. This is a phenomenon not discussed in any of the literature on mental health nurses reviewed for this study. When researchers have spoken with nurses about their coping skills and strategies this has not been explicitly linked to the coping skills and strategies that they may be teaching to patients and service users as part of their nursing work (Burnard et al, 2003; Yoder, 2010). There is some precedent for the finding, though, with Irving et al (2009), in their review of the evidence of the effect of MBSR on health professionals, citing some studies measuring the positive impact of mindfulness training and 'wellness practices' learned by both health care professionals and patients simultaneously.

Research on nurses' SWB has characterised them as 'lifelong learners' for whom training and development are vital to their commitment to their role (Brunetto et al, 2013). In Mackintosh's (2007) study, surgical nurses described the impact of their work experience on themselves, making them more able to cope with uncertainty and less likely to get distressed by challenging situations. They did not, however, go so far as to describe how skills learned in nursing practice were applied to their own situations. The nurses in Rose and Glass's (2010) study saw nursing as 'emotional work', where the nurses gave significantly of themselves, with SWB being interwoven with how much they could give of themselves in work. The present study shows that mental health nurses' SWB can be enhanced through their work as well as outside it. The positive impact of coping and wellbeing interventions directly aimed at nurses

has been measured in several studies (Irving et al, 2009; Appel et al, 2013; Bolier et al, 2014; Mackenzie et al, 2006; Ostermann et al, 2010). Nurses in the present study did not describe having wellbeing promotion interventions aimed at them, rather they had picked up such skills incidentally or else had learned a new language at work to describe what they used on themselves informally. This suggests that there is more that employing organisations can do to support the SWB of their nursing staff. There is potential for shared learning and using of wellbeing enhancing practices between both mental health nurses and their patients.

8.5 Conclusion

This is the first study looking specifically as SWB in UK mental health nurses. Novel findings for this study are that UK mental health nurses have lower SWB than general population norms, using three SWB measures. Being male and being aged between 40 and 49 were factors separately associated with having a lower sense of life being worthwhile. A convincing model for the impact of demographic and workplace factors on SWB could not be derived from the data, via ANOVAs or standard linear multiple regression.

Whereas the nurses in the survey as a whole had relatively low SWB, the mental health nurses interviewed in this study were an exceptional group with high SWB. They offer an original insight into SWB that has previously been lacking in research on healthcare professionals. Their views may be uncharacteristic of the wider mental health nursing population because of the purposively selected nature of the group. However, the strong commonality between the thematic concerns of these nurses and the findings of other studies on SWB in working age adults as well as the support for the findings that is evident in previous research on mental health nurses' resilience, self care, coping and self esteem, all support a claim for the relevance of this study

Demographic and workplace factors were shown to have limited correlation with high SWB. Whilst the present study did find some differences according to age and gender, only differences in the ONS life worthwhile question were statistically significant. This suggests that the 'eudaimonic' aspect of SWB (for

which factor the ONS question is the only one used that isolates it) operates differently to the hedonic and evaluative aspects of SWB. Future studies should be designed to account for this difference, which is further discussed at 9.2.1.5.

The research evidence on the impact of parenting on SWB presents a complex picture however, in this study several of the nurses with high SWB saw parenthood as positively impacting on SWB. Many of the findings from the interview analysis are well supported by previous research on the importance of workplace, family and social support on SWB for working age adults. They are also well supported by research on the analogues for SWB in mental health nurses that have been the subject of prior research. In the survey living alone was associated with lower SWB but those nurses living with just one other person has the highest SWB. Work-life balance and the opportunity to access clinical supervision were seen by interview participants as key to SWB. These findings are also backed up by previous research.

A unique finding of this study is that the interviewees translated learning and skills from work to their personal lives and to their active approach to understanding and supporting their own SWB, particularly with regard to mindfulness and reality acceptance. The influence of work on subjective experience as well as the influence of non-work subjective experience on mental health nursing is a thread across all three sets of findings from this study and is explored further in the next two chapters.

Chapter 9 Mental health nurses' subjective experience of mental health problems

9.1 Introduction

This second of three findings and discussion chapters presents the quantitative and then qualitative findings on mental health nurses' subjective experience of mental health problems. The findings address the following research questions:

What is the state of UK mental health nurses' mental health, in terms of experience of mental health problems and degree of SWB?

How do experience of mental health problems, SWB, demographic and work place factors interact for mental health nurses?

How have mental health nurses with subjective experience of mental health problems experienced mental health care and treatment?

The thread of subjective experience of mental ill health is followed from the online survey to the interviews, with selected survey participants with high SWB and experience of mental health problems describing their subjective experience of mental health care and treatment.

9.2 Survey participants' subjective experience of mental illness

Participants were asked about their experience of mental health problems in terms of: themselves now, and in the past; people they live with now and people they have lived with in the past. Some participants had both their own and family members' experiences on which to draw. As shown in Table 9.1, 24.9% of participants reported experiencing mental health problems at the time of the survey. 45.6% of participants reported having experienced mental health problems in the past. 36.5% of participants had lived with someone with mental health problems in the past. 9.5% were living with someone with mental health problems at the time of the survey.

Table 9.1: Percentages of RMNs with experience of mental health problems

	n	%
Group A: MHNs have MHP at the time of the survey.	55/221	24.9%
MHNs have had MHP in the past.	99/217	45.6%
MHNs living with someone with MHP at the time of the survey (also16% (36) lived alone)	21/221	9.5%
MHNs who have lived with someone with MHP in the past.	80/219	36.5%
Group B, MHNs in this survey had some personal or familial experience of MHP.	142/222	59.9%
Group C, MHNs have a personal experience of MHP, in the past or present.	112/215	52.1%
Group D, MHNs have past or present experience of living with someone with MHP?	94/221	42.5%

2% (n 5) of participants with some subjective experience of mental health problems had experience in all four categories: current, past, own and living with. 3% (n 8) of participants only had experience of their own current mental health problems. The majority of participants (55%, n 78) with subjective experience of mental health problems had experience from more than one category.

For the purpose of analysis the participants were divided into four groups:

Group A: MHNs with mental health problems at the time of the survey (24.9%, n 55).

Group B: MHNs with any form of subjective experience of mental health problems, either for themselves or for those with whom they had lived (59.9% of the total sample, n 142)

Group C: MHNs with subjective experience of their own mental health problems in the past or present (52.1%, n 112)

Group D: MHNS who had past or present experience of living with someone with mental health problems (42.5%, n 94).

The groupings are represented in Figures 9.1 and 9.2.

Figure 9.1: MHNs with subjective experience of mental health problems

Group A: MHNs with mental health problems currently 24.9% (n 55)

MHNs with mental health problems in the past 45.6% (n 99)

Group B: All MHNs with some subjective experience of mental health problems 59.9% (n142)

MHNs currently living with someone with a mental health problem 9.5% (n21)

MHNs who have lived with someone with a mental health problem 36.5% (n80)

Figure 9.2: Groups C and D

Group C: RMNs with subjective experience of their own mental illness 52.1% (n112)

RMNs reporting both current and past own MHP 17% (n40)

mental ill health in the past 45.6% (n 99)

mental ill health currently 24.9% (n 55)

Group D: RMNs with experience of living with someone with mental illness 42.5% (n94)

living with someone with a mental health problem 9.5% (n21)

have lived with someone with a mental health problem 36.5% (n80)

RMNs reporting both current and past living w/ MHP 2% (n5)

9.2.1 The relationship between experience of mental health problems and subjective wellbeing

The relationship between subjective experience of mental health problems and SWB was analysed through comparison of SWB measures scores between each group and the rest of the participants, using independent samples t-tests. The results of these comparisons are summarised in Table 9.2, Table 9.3,Table 9.4 and Table 9.5. Where results were significant at $p<0.05$ this is indicated in bold. Where results were highly significant at $p<0.01$ level this is indicated with an asterix.

Cohen's d effect sizes, with corresponding coefficient (r) values and confidence intervals (CI) are reported in the tables because these can offer a better insight into clinical significance than solely reporting p values (Baguley, 2009; Sainani, 2012; Coe, 2002; Gardner and Altman, 1986). Whilst describing SWB measure scores in terms of clinical or non clinical significance may be inappropriate given that they are not clinical measures, it is possible to describe the difference between groups in terms of minimal clinically meaningful difference (MCMD) (Hays and Wooley, 2000; Wyrwich et al, 2005). There are two ways of interpreting MCMD: distribution based and anchor based. According to the distribution based approach, the magnitude of the difference in means between two groups (as evidenced by the effect size) denotes that a difference may be clinically meaningful (Hays and Wooley, 2000). The anchor based approach entails comparison of scores against norms or grading parameters, in this instance the UK general population norms and the grading parameters of the SWB measures.

Cohen's d was calculated using two different used to measure effect size, using online effect size calculators. One was recommended by Pallant (2010) and included r calculations (http://www.uccs.edu/~lbecker/). The other was recommended by the Campbell collaboration (http://www.campbellcollaboration.org/resources/effect_size_input.php). This one included Confidence Intervals and took into account sample size, hence the slight variation in Cohen's d scores. Both have been reported in the tables in

order to acknowledge the differences, although in no case do the different calculations impact on the interpretation of the significance of the results.

A summary of the significant findings for each table is described below, however of greater interest is the story that emerges when looking at the four tables together, whereby the relationship between SWB and mental health nurses' own experience of mental health problems is different from the relationship between SWB and having experience of living with others with mental health problems. This is discussed in the summary at 9.2.1.5.

9.2.1.1 The association between subjective wellbeing and current experience of mental health problems in mental health nurses

Table 9.2 Comparison of mean scores for MHNs with mental health problems(MHP)(Group A) now v. rest of sample

	MHP now mean(SD) (95%CI)	Without MHP now mean(SD) (95%CI)	independent samples t test	Effect size: Cohen's d, r [†] Cohen's d, 95% CI [‡]
ONS 1 life satisfaction	4.85 (SD 2.256) (CI 4.25-5.43)	6.59(SD 2.15) (CI 6.25-6.89)	t(218) -5.194, p0.000*	d -0.789, r -0.367 d-0.809, CI-1.123 to -0.495
ONS 2 happiness	4.29 (SD 2.307) (CI 3.73 - 4.90)	6.39 (SD 2.448) (CI 6.00 - 6.76)	t(218) -5.579, p0.000*	d-0.883, r-0.404 d-0.87, CI-1.186 to -0.554
ONS 3 anxiety	4.85 (SD 2.628) (CI 4.18 - 5.56)	2.99 (SD 2.692) (CI 2.60 to 3.42)	t(217) 4.462, p0.000*	d 0.699, r0.330 d0.695, CI 0.383 to 1.007
ONS 4 worthwhile	5.98 (SD 2.407) (CI 5.33 - 6.59)	7.60 (SD 2.041) (CI 7.28 - 7.92)	t(217) -4.868, p0.000*	d-0.726, r-0.341 d-0.758, CI -1.071 to -0.444
SWLS	17.52 (SD 7.006) (CI 15.46 - 19.59)	23.02 (SD 7.031) (CI 21.81 - 24.16)	t(211) -4.913, p 0.000*	d-0.784, r-0.365, d-0.783 , CI-1.104 to -0.462
WEMWBS	41.08 (SD 7.098) (CI 39.10 - 43.12)	49.57 (SD 7.590) (CI 48.27 - 50.72)	t(209) -7.111, p0.000*	d-1.155, r-0.500 d-1.146, CI-1.477 to -0.814

[†] Using effect size calculator: http://www.uccs.edu/~lbecker/
[‡] Using effect size calculator: http://www.campbellcollaboration.org/resources/effect_size_input.php

There was a significant association between current mental health problems and low SWB. Table 9.2 shows that mental health nurses who reported experiencing mental health problems at the time of the survey had significantly lower scores across all three SWB measures than other participants (p<0.01). There was a large effect size (>0.8, using Cohen's (1988) criteria) for the

difference between ONS life satisfaction, ONS happiness and the WEMWBS scores. The effect sizes were above medium (0.5) across all measures. However, when the grading criteria and normative values for the SWB measures are applied they show that mental health nurses in either group in Table 9.2 had relatively low SWB. When mental health nurses with mental health problems at the time of the survey were removed from the sample mental health nurses' ONS life satisfaction (6.59 v. a norm of 7.4), ONS happiness (6.39 v. 7.3) and WEMWBS scores(49.57 v. 50.7) were still relatively low. Their ONS life worthwhile scores were almost on a par with normative scores (7.60 v. 7.7), the SWLS mean score was within the normal range of 23 to 27 and the ONS anxiety score reflected slightly less anxiety than the ONS norm (2.99 v. 3.1).

The differences between mean SWB scale scores were statistically significant. According to the distribution based approach to MCMD, the magnitude of the difference in means (as evidenced by the effect size) suggested clinically meaningful difference, because mental health nurses with current mental health problems had significantly lower SWB than their colleagues. According to the anchor based approach the outcome was similar but less clear cut. Using the cut off points for the ONS, participants with current mental health problems (Group A) had very low SWB in terms of their happiness and life satisfaction than other participants, who also had low happiness and life satisfaction. The mental health nurses in Group A had a low sense of life being worthwhile when compared to their fellow participants, who had a medium sense of life being worthwhile. Group A had high anxiety whereas those with no present mental health problems had medium anxiety. Group A were slightly dissatisfied according to the SWLS and their fellow participants were slightly satisfied. There is no scoring criteria for the WEMWBS, but the normative mean is 50.7 out of a possible total score of between 14 and 70 (Stewart-Brown and Janmohamed, 2008). The difference between Group A and the norm was significant (one sample t-test[1]: t -9.773, df 51, SE dif. 0.984, p <0.000) whereas the difference between those without mental health problems and the norm was not significant (one sample t test: t1.8773, df158, SE dif. 0.602, p0.0623).

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[1] http://www.graphpad.com/quickcalcs/OneSampleT1.cfm?Format=SD

9.2.1.2 The association between subjective wellbeing and any form of subjective experience of mental health problems in mental health nurses

Table 9.3 Comparison of mean scores for MHNs with/without subjective experience of MHP(Group B)

	With MHP mean(SD) (95%CI)	Without MHP mean(SD) (95%CI)	independent samples t test	Effect size: Cohen's d, r † Cohen's d, 95% CI
ONS 1 life satisfaction	5.78 (SD 2.479)(CI 5.36-6.20)	6.80 (SD 1.760)(CI 6.39-7.19)	t(208) -3.555. p 0.000*	d-0.454, CI 0.7317 to -0.1765
ONS 2 happiness	5.52(SD 2.696)(CI 5.08-5.95)	6.41(SD 2.254)(CI 5.90-6.89)	t(188)-2.638, p0.009*	d-0.358, r-0.176 d-0.3496, CI-0.6259 to -0.0734
ONS 3 anxiety	3.70(SD 2.797)(CI 3.26-4.13)	3.04(SD 2.726)(CI 2.45-3.61)	t(168) 1.718, p0.088	d0.239, r0.119 d0.238, CI-0.0375 to 0.5137
ONS 4 worthwhile	6.92(SD 2.379)(CI 6.54- 7.31)	7.68(SD 1.878)(CI 7.24-8.05)	t(218) -2.449, p0.015	d-0.355, r-0.175 d-0.344, CI -0.621 to -0.067
SWLS	20.63(SD 7.696)(CI 19.41-21.91)	23.55 (SD6.642)(CI 22.12-24.94)	t(212)-2.925 p0.004*	d-0.4062. r -0.1990 d-0.398, CI-0.679 to -0.117
WEMWBS	46.62(SD 8.893)(CI 45.14-48.09)	49.11(SD 7.074)(CI 47.49-50.74)	t(210)-2.234 p0.027	d-0.395, r-0.194 d-0.3004, CI-0.586 to -0.018

† Using effect size calculator: http://www.uccs.edu/~lbecker/
‡ Using effect size calculator: http://www.campbellcollaboration.org/resources/effect_size_input.php

Mental health nurses with any form of subjective experience of MHP(Group B) had lower mean SWB scores than those mental health nurses with no form of subjective experience of MHP. This is summarised in Table 9.3. Group B (with either past or present personal or living with experience of mental health problems) had consistently lower mean SWB scores than the other participants across all three measures. The difference between SWLS, ONS happiness and ONS life satisfaction scores was highly significant (p<0.01). The difference in their anxiety scores was not statistically significant. There was a small to medium effect size for the difference between the means of the two groups for all measures. This denotes a clinically meaningful difference between the two groups, although this was less stark than that between Group A and the rest of the participants, as discussed above. Using an anchor based approach to clinical significance, it must be acknowledged that both groups in Table 9.3 had mean scores lower than population norms across all measures, save the SWLS

score of the comparator group (23.55). The mental health nurses had low ONS life satisfaction, low ONS happiness, medium ONS anxiety and were slightly satisfied according to the SWLS. The only measure where a cut off point was crossed was with the ONS life worthwhile question. It can be surmised from these findings that that having some subjective experience of mental health problems is associated with lower SWB scores in mental health nurses. The difference between the WEMWBS score for mental health nurses in Group B and the population norm of 50.7 was significant (one sample t-test: 5.3503, df 135, SE 0.763, p<0.0001) whereas the difference between those without mental health problems and the norm was not significant (one sample t test: t 1.9595, df 75, SE 0.811, p 0.0538).

9.2.1.3 The association between subjective wellbeing and mental health nurses' subjective experience of their own mental health problems in the past or present

Table 9.4 Comparison of median and mean scores for MHNs with/without past or present subjective experience of MHP(Group C)

	With MHP mean(SD) (95%CI)	Without MHP mean(SD) (95%CI)	independent samples t test	Effect size: Cohen's d, r [†] Cohen's d, 95% CI [‡]
ONS 1 life satisfaction	5.85 (SD 2.472) (CI 5.39-6.31)	6.49(SD 2.053) (CI 6.10- 6.90)	t(209.5)-2.061, p0.041	d-0.282, r-0.139 d-0.281, CI-0.55 to -0.011
ONS 2 happiness	5.44(SD 2.672) (CI 4.93 - 5.93)	6.25 (SD 2.432) (CI 5.76 - 6.70)	t(212) -2.316 , p0.022	d-0.317, r-0.157, d-0.315, CI-0.585 to -0.045
ONS 3 anxiety	3.87(SD 2.835) (CI 3.35 - 4.41)	3.06 (SD 2.684) (CI 2.54- 3.59)	t(211) 2.150, p0.033	d 0.293, r0.145 d 0.293, CI 0.023 to 0.563
ONS 4 worthwhile	6.83 (SD 2.377) (CI 6.36 - 7.25)	7.55 9SD 2.061) (CI 7.17 -7.92)	t(2112) -2.374, p0.018	d-0.324, r-0.159 d-0.323, CI-0.593 to -0.053
SWLS	20.66 (SD 7.54 (CI 19.19 -22.01)	22.90(SD 7.109) (CI 21.44- 24.35)	t(205) -2.195, p0.029	d-0.306, r-0.151 d-0.305, CI-0.579 to -0.031
WEMWBS	45.77 (SD 8.538)(CI 44.12 - 47.40)	49.13(SD 7.972)(CI 47.52-50.75)	t(203) -2.927, p0.004*	d-0.407, r-0.199 d-0.408, CI -0.685 to -0.132

[†] Using effect size calculator: http://www.uccs.edu/~lbecker/
[‡] Using effect size calculator: http://www.campbellcollaboration.org/resources/effect_size_input.php

Table 9.4 shows that mental health nurses with past or present experience of their own mental health problems(Group C) had lower SWB than other survey

participants across all three measures. This difference was statistically significant (p<0.05) with small effect sizes across the ONS measures, and the SWLS. It was highly significant for the WEMWBS (p<0.01), with a medium effect size. Using the anchoring approach to clinical significance the results in Table 9.4 reflect the same pattern as in Table 9.3. Mental health nurses' SWB scores remain lower than population norms and they are in the lower categories for the ONS and the SWLS. The difference between the WEMWBS score for Group C and the population norm of 50.7 was statistically significant (one sample t-test: 5.9729, df 106, SE 0.825, p<0.0001) whereas the difference between those without mental health problems and the norm was not significant (one sample t test: t 1-9496, df 97, SE 0.805, p0.0541). The mean scores in Table 9.4 are very similar to those in Table 9.3, suggesting that scores for Group C influenced the scores for Group B (of which they are part): having one's own experience of mental health problems is influential on SWB, whether past or present.

9.2.1.4 The association between subjective wellbeing and mental health nurses' past or present experience of living with someone with mental health problems

Table 9.5 Comparison of median and mean scores for MHNs with/without experience of living with someone with MHP (Group D)

	With MHP mean(SD) (95%CI)	Without MHP mean(SD) (95%CI)	independent samples t test	Effect size: Cohen's d, r † Cohen's d, 95% CI ‡
ONS 1 life satisfaction	6.28 (SD 2.264) (CI 5.81- 6.72)	6.07(SD 2.323) (CI 5.64 - 6.47)	t(218) 0.655, p0.513	d 0.092, r0.0457 d 0.091, CI-0.176 to 0.359
ONS 2 happiness	6.03(SD 2.550) (CI -0.343 - 1.042)	5.68(SD 2.597) (CI 5.24-6.18)	t(218)0.995, p0.321	d0.136, r0.068 d 0.136, CI-0.132 to 0.403
ONS 3 anxiety	3.30 (SD 2.785) (CI 2.71 - 3.82)	3.57(SD 2.798) (CI 3.06 - 4.07)	t(217)-0.708, p0.480	d-0.097, r-0.048 d-0.097, CI-0.365 to 0.171
ONS 4 worthwhile	7.45(SD 2.113) (CI 7.01-7.85)	7.00(SD 2.324) (CI 6.60 - 7.40)	t(217) 1.463, p0.145	**d0.203, r0.101** **d0.203, CI-0.067 to 0.469**
SWLS	21.62(SD 7.160) (CI 20.08- 23.06)	21.76(SD 7.714) (CI 20.47- 23.19)	t(211)-0.142, p0.887	d-0.02, r-0.01 d-0.019, CI-0.290 to 0.253
WEMWBS	**48.87 (SD 9.017) (CI 46.95 - 50.73)**	**46.56(SD7.726)(CI 45.16-47.90)**	**t(209) 1.995, p0.047**	**d0.275, r0.136 d0.278, CI0.004 to 0.552**

† Using effect size calculator: http://www.uccs.edu/~lbecker/
‡ Using effect size calculator: http://www.campbellcollaboration.org/resources/effect_size_input.php

Table 9.5 presents the SWB scores for mental health nurses with experience of living with someone else with mental health problems (Group D) versus the rest of the sample. These data give a different account of the influence of mental health problems on SWB to the other three sets of analyses. Participants in Group D had higher mean ONS scores, including lower anxiety and higher WEMWBS scores than their counterparts. The difference in their mean SWLS score was 0.14. Only the difference in their WEMWBS scores was statistically significant (p<0.05) and only the difference in life worthwhile scores and WEMWBS scores had a meaningful effect size (>0.2). The ONS scores for both groups were still low, and the participants in both groups were still only slightly satisfied according to the SWLS. The difference between the WEMWBS score for mental health nurses without personal experience of living with someone with mental health problems (not in Group D) was significantly lower than the population norm of 50.7 (one sample t-test: 5.8944, df 120, SE 0.702, p<0.0001) whereas the difference between those in Group D and the norm was not significant (one sample t test: t 1.9254, df 89, SE 0.950, p0.0574). The results shown in Table 9.5 show that living with someone with mental health problems may elevate SWB rather than reduce it. This is in contrast to the data presented in Tables 9.2, 9.3 and 9.4, that subjective experience of mental health problems is associated with lower SWB in mental health nurses.

9.2.1.5 The relationship between experience of mental health problems and subjective wellbeing: a summary

In summary, having subjective experience of mental health problems was associated with relatively low SWB in mental health nurses. This was particularly the case for mental health nurses reporting their own current mental health problems at the time of the survey (Group A). This is not surprising. A link between current experience of mental health problems and feelings of dissatisfaction with life, anxiety and anhedonia has been found in previous studies discussed in Chapters 3 and 4 (Hawker, 2012; Jacobs, 2013; Rodwell and Munro, 2013; Bolier et al, 2014; Lan et al, 2014). Findings of the WEMWBS in particular have been correlated with findings of psychiatric caseness using

the GHQ12 (Tennant et al, 2007; Bohnke and Croudace, 2015). What is surprising though, is that experience of living with someone with mental health problems was not associated with lower SWB, in fact the direction of influence was opposite, suggesting higher SWB. This was significant for the ONS life worthwhile question and the WEMWBS. This finding suggests that being a carer, partner, child or parent of someone with mental health problems may have positive effects on mental health nurses' SWB.

Also of note is that mental health nurses' SWB was relatively low whether participants with subjective experience of mental health problems were separated out or not. Mental health nurses' WEMWBS scores were below the general population norm across all eight groups. Their SWLS scores only reflected slight satisfaction at best (23.55 out of a possible 35 for mental health nurses with no subjective experience of mental health problems in Table 9.3). Their ONS life satisfaction was either low or very low, as was their happiness yesterday. Whilst mental health nurses reporting mental health problems at the time of the survey had high anxiety yesterday, according to the ONS grading criteria, mental health nurses in all other groups still had medium levels of anxiety. Mental health nurses' scores on the ONS life worthwhile question were below the UK general population norm of 7.7 but were at least in the medium category. This finding suggests that whilst subjective experience of mental health problems may be a factor in mental health nurses' SWB it is not the only or defining factor.

The findings of each of the three measures support one another, as may be expected by their strong positive correlation (discussed at 8.2.1). The responses to the ONS 'life worthwhile' question for mental health nurses without experience of MHP (Groups A,B and C) were only slightly below the general population norm of 7.7 (ONS, 2012). Mental health nurses with experience of living with someone with mental health problems had a higher mean ONS 'life worthwhile' response than those without. This too was above the general population mean. This suggests that mental health nurses may experience the evaluative and hedonic aspects of SWB differently to the eudaemonic aspect. A hypothesis that may be drawn from these findings is that mental health nurses experience low amounts of pleasure and satisfaction, but that they do consider

their lives to have meaning. Differentiation between the three aspects of SWB in future studies of mental health nurses is called for, because happiness is clearly multifaceted for this professional group. The importance that mental health nurses place on embodying values, caring, and giving of the self (as discussed at 2.3.3) and yet the strain of mental health work, may be reflected in their differentiated response to questions about their happiness.

9.2.2 The relationship between demographic and workplace factors and experience of mental health problems

The relationship between experience of mental health problems and three demographic (gender, age and number in household) and three work factors (work status, years in the profession, years in current post[2]) was analysed using Pearson's chi square tests for independence with Yates' continuity correction for the categorical independent variables (gender, age, household size, years in the profession, years in post, work status, supervising others). See Table 9.6 for a summary of findings**. These factors were chosen because previous research on nurses and mental health nurses has also explored their association with presence of possible mental ill health (see section 5.4.4.1). Statistically significant results (p<0.05) are reported in bold in the text and highlighted in bold in the table. For this set of analyses the same four groups were compared to the rest of the sample as in 9.2.1:

> Group A - MHNs currently experiencing mental health problems at the time of the survey (n 55, 24.9%);
>
> Group B - MHNs with any form of subjective experience of mental health problems either themselves or as a family member(n 142, 59.9%);
>
> Group C - MHNs with their own past or present mental health problems (n112, 52.1%);

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[2] The 12 student nurses were included in these analyses in a composite variable of <2 years qualified (including them and recently qualified nurses)

Group D - MHNs with past or present experience of living with someone with mental health problems (n94, 42.5%).

Table 9.6 The relationship between demographic and workplace factors and personal experience of mental health problems (MHP)

		%(n) in the demographic and workforce categories			
		Group A	Group B - all subj experience of MHP	Group C - own past or present hx	Group D - have lived w or living w
	overall	24.9(55)	59.9(142)	52.1(112)	42.5(94)
gender	men	20.0 (12)	68.9 (42)	52.9(83)	40.9(65)
	women	26.9 (43)	61.9(99)	50.9(29)	45.9(28)
age	under 40	20.5(17)	63.1(53)	53.1(43)	45.8(38)
	40-49	31.6(24)	67.7(51)	56.6(43)	44.7(34)
	50 and over	23.3(14)	60.0(36)	46.4(26)	33.3(20)
household size †	living alone	27.8(10)	**88.6(31)**	68.6(24)	60%(21)
	living w 1 person	21.3(16)	**50(38)**	43.7(31)	36.8(28)
	living w 2 or 3 others	27.0(24)	**68.5(61)**	52.3(46)	40.9(36)
	living w 4 or more others	21.1(4)	**55.0(11)**	52.6(10)	45.0(9)
work status	full time	23.9(39)	65.2(107)	49.7(79)	43.9(72)
	part time	32.5(13)	61%(25)	64.1(25)	34.1(14)
years in profession	<2 years qualified	13.2%(5)	59%(23)	54.1%(20)	48.7%(19)
	3-5 years qualified	25%(6)	75%(18)	65.25(15)	54.2%(13)
	6-10 years qualified	30.3%(10)	62.5%(20)	51.65(16)	43.8%(14)
	>11 years qualified	27.6%(32)	65%(76)	49.1%(56)	37.6%(44)
years in current role †	<2 years	22.7%(22)	67%(65)	**62%(57)**	**52.6%(51)**
	3-5 years	25%(14)	64.3%(36)	**41.1%(23)**	**43.6%(24)**
	6-10 years	36.4%(12)	70.6%(24)	**56.3%(18)**	**26.5%(9)**
	>11-20 years	20%(6)	46.7%(14)	**40%(12)**	**26.7%(8)**

Significant results in bold, † Chi square test show sig. results p<0.05

9.2.2.1 The relationship between gender and mental health problems

More women than men reported mental health problems at the time of the survey (26.9% of women and 20.0% of men) (Group A), however a higher proportion of men reported their own past or present mental health problems(Group C) (52.9% v. 50.9%) and any form of subjective experience of mental health problems (Group B) (68.9% v. 61.9%).

The relationship between gender and subjective experience of mental health problems was not statistically significant.

9.2.2.2 The relationship between age and mental health problems

A higher proportion of mental health nurses between the ages of 40 and 49 had subjective experience of mental health problems than their younger and older colleagues, both at the time of the survey (Group A), with any form of subjective experience(Group B) and with their own past or present mental health problems (Group C). A higher proportion of nurses under 40 (45.8%) had past or present experience of living with someone with mental health problems than those aged between 40 and 49 (44.7%) or aged 50 and over (33.3%). This is an interesting finding because it confounds the expectation that subjective experience of mental heath problems would increase over a lifetime and that people who were older would be more likely to have experience of living with someone with mental health problems. When the findings on age are put together with findings on years in the profession and years in post a complex picture emerges (see 9.2.2.5).

The relationship between age and experience of mental health problems was not significant for any of the four categories.

9.2.2.3 The relationship between number in household and mental health problems

There was a significant association between being in Group B and household size but not for the other three groups:

Group B χ² (4, 220) = 17.293, p = 0.002, phi = 0.280

Across all four groups, there was a higher proportion of experience of mental health problems in those living alone compared with those living with others. There was a lower proportion of experience of mental health problems in those living with just one other person than in the other household categories. This finding supports the findings on SWB presented in Table 8.10 and discussed at 8.4.1.1.3, that those mental health nurse who lived alone had lower SWB across all three measures.

9.2.2.4 The relationship between work status and mental health problems

There was no significant relationship between work status and experience of mental health problems for any of the four categories.

These findings suggest that working full or part time is not associated with experience of mental health problems. It was not associated with SWB measure scores either.

9.2.2.5 The relationship between years in the profession and years in post and mental health problems

Mental health nurses' number of years in the profession and years in post were divided into four categories (Table 9.6). Higher proportions of mental health nurses who had been in the profession for three to five years reported an overall experience of mental health problems, their own experience of mental health problems and having lived with someone with mental health problems than in the other categories. The lowest proportion of mental health nurses reporting mental health problems at the time of the survey were those with less than two years' experience (13.2%). The lowest proportion of those reporting their own past or present experience (Group C) or experience of living with someone with mental health problems (Group D) were those with over 11 years since qualification. Whilst the findings on age, years in post, years in profession and SWB were unremarkable, the findings on subjective experience of mental health problems suggest that nurses who have been in the profession for the

least amount of time are more likely to have subjective experience of mental health problems.

Nurses with six to 10 years experience in their current post had the highest proportion of reported mental health problems at the time of the survey (36.4%) and in Group B (70.6%). Nurses with less than two years' experience reported the highest proportion of both past or present mental health problems (62%) and experience of living with someone else with mental health problems (52.6%). There was a significant correlation between years in post and both overall experience of mental health problems and experience of living with someone with mental health problems.

Years in profession

There was no significant association between experience of mental health problems and years in the profession as a categorical variable.

Years in post

There was a significant association between experience of mental health problems and years in the post as a categorical variable only for those in Group C and Group D:

Group C χ^2(3, 210) = 8.289 p = 0.040, phi = 0.199;
Group D χ^2(3, 216) = 10.706, p0.013, phi -0.223

9.2.2.5.1 Years in post and profession as continuous variables

Table 9.7 Comparison of mean years in profession and post for MHNs with/without experience of mental health problems

	Group A (n54)	no current MHP (n157)	Group B (n136)	v. rest of sample (n76)	Group C (n107)	v. rest of sample (n98)	Group D (n 89)	v. rest of sample (n121)
years in profession	15.65 (SD 10.09)	14.48 (SD11.22)	13.6 (SD 9.9)	16.76 (SD12.39)	13.94 (SD10.84)	15.79 (SD10.89)	**11.96 (SD9.62)**	**16.74 (SD 11.43)**
Years in post	5.36 (SD5.75)	5.56 (SD6.46)	**4.75 (SD5.52)**	**6.89 (SD7.26)**	4.99 (SD6.15)	6.29 (SD6.48)	**3.92 (SD4.78)**	**6.69 (SD6.95)**

Significant results in **bold** p<0.05

Continuous variable data on years in profession and years in post was available. A comparison of mean years in post and profession was made using all four groups. The results of this analysis are presented in Table 9.7.

Whilst the findings on the relationship between years in the profession and experience of mental health problems were not statistically significant using the chi-square test, independent samples t-tests using years in the profession as a continuous variable found a significant difference in mean number of years in the profession between nurses in Group D and the rest of the sample: 11.96 years (SD 9.62) versus 16.74 (SD 11.43) (independent samples t-test: t(210) = -3.29, p = 0.01, two tailed). The magnitude of difference between the means showed a small to moderate effect (Cohen's d -0.452, r -0.22)

The mean number of years in post for mental health nurses in Group B was also significantly different to the rest of the participants: 4.75 years (SD 5.519), versus 6.89 years (SD 7.260), p 0.029) (independent samples t-test t(122.2)= -2.215, p 0.029). The magnitude of difference between the means showed a small to moderate effect (Cohen's d -0.332, r -0.164). Also the mean number of years in post was significantly different for those with experience of living with someone with mental health problems(Group D) than other participants: 3.29years (SD 4.78) versus 6.69 years (SD 6.95) (independent samples t-test: t(207.13) = -3.415, p = 0.01, two tailed). The magnitude of difference between the means showed a small to moderate effect (Cohen's d -0.464, r -0.22).

Number of years in post was inversely correlated with overall experience of mental health problems, particularly in relation to living with someone else with mental health problems. Those with experience of living with someone with mental health problems had significantly fewer years of professional experience than those without. Put together with the findings on age, discussed at 9.2.2.2, the influence of time on experience of mental health problems seems to be complicated. Whilst the findings on age, years in post, years in profession and SWB were unremarkable save that being under 40 was associated with higher SWB and that there was a U-shaped age curve to SWB (see Table 8.10 and Section 8.2.6), the findings on subjective experience of mental health problems suggest that nurses who have been in the profession for the least amount of time are more likely to have subjective experience of mental health problems from which they draw.

Whilst it may be assumed that for individuals age, years in the profession and years in post are on the same trajectory, the findings of this study suggest that for the population of UK mental health nurses as a whole, the relationship may not always be so clearly defined. There are a number of possible explanations for this. The mental health nurse profession attracts mature students, so those with relatively few years in the profession may not be so youthful (49% of students in Pryjmachuk and Richards' 2007 study were over 25 at the start of their course). There may well be a relationship between experience of mental health problems and when nurses change posts or join the profession. The personal qualities of resilience and hardiness may be factors here, with the profession attracting and keeping those individuals who thrive on challenge. This explanation is proposed by Pryjmachuk and Richards(2007) in their discussion of why mental health nursing students presented with lower GHQ caseness than fellow students. There may also be a cohort effect, with an increasing number of UK mental health nurse coming into the profession with experience of mental health problems as a result of overt encouragement to do so in recent years and policies of inclusion for people with mental health problems. This warrants further research, where the confounding and contributory factors may be assessed and the impact of inclusive policies may be assessed.

9.2.3 The combined relationship between demographic and workplace factors and experience of mental illness

Direct logistic regression was performed to assess the impact of the demographic and workplace factors (independent variables) on mental health problems (the dependent variable) at the time of the survey (Group A), with any subjective experience of mental health problems (Group B), past and present own mental health problems (Group C) and past and present experience of living with someone with mental health problems (Group D). These are reported in tabular form in Appendix 9.1.

9.2.3.1 The combined relationship between demographic and workplace factors and current experience of mental health problems in mental health nurses (Group A)

The full model was not statistically significant, X^2(8, N = 213) =15.986, p = 0.314 and none of the independent variables made a unique statistical contribution to the model.

9.2.3.2 The combined relationship between demographic and workplace factors and any form of subjective experience of mental health problems in mental health nurses (Group B)

The full model was statistically significant, X^2(14, N = 204)=3.402, p 0.003 indicating that the model was able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 15.1% (Cox and Snell R Square) and 20.8% (Nagelkerke R Square) of the variance and correctly classified 68.5% of cases compared to 64.7% when none of the variables were entered into the SPSS predictive model. The independent variables that made a unique statistical contribution to the model were: being post for two years or less, being qualified for between three to five years and living alone increased likelihood of subjective experience of mental health problems; being in post for over 11 years, living with just one other person and living with four or more people reduced the likelihood of subjective experience of mental health problems.

9.2.3.3 The combined relationship between demographic and workplace factors and mental health nurses own past or present mental health problems (Group C)

The full model was statistically significant, X^2(14, N = 196) = 28.415, p 0.013 indicating that the model was able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 13.4% (Cox and Snell R Square) and 17.9% (Nagelkerke R Square) of the variance and correctly classified 68.5% of cases compared to 52.8% when none of the independent variables were added to the SPSS predictive model. The independent variables that made a unique statistical contribution to the model were: being in post for less than two years increased likelihood of reporting mental health problems as did being in the profession for three to five years; being in post for three to five or over 11 years and living with just one other person reduced the likelihood of mental health problems.

9.2.3.4 The combined relationship between demographic and workplace factors and experience of living with someone with mental health problems (Group D)

The full model was not statistically significant, X^2 (14, N= 204) = 21.626, p0.087 indicating that the model was not able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 10.1% (Cox and Snell R Square) and 13.5% (Nagelkerke R Square) of the variance and correctly classified 67.2 % of cases compared to 57.8& of cases identified in the SPSS predictive model without the addition of the independent variables. Some independent variables did make a unique statistical contribution to the model: being post for two or less years increased likelihood of having lived with someone with mental health problems; being in post for six to ten or over 11 years decreased likelihood of having lived with someone with mental health problems. Living with just one other person decreased likelihood of having lived with someone with mental health problems.

9.2.3.5 The relationship between demographic and workplace factors and personal experience of mental health problems: a summary

In summary, independent demographic and workplace variables had a significant combined effect on the likelihood that mental health nurses reported subjective experience of mental health problems, in particular the variables of household size and years in profession and post were the best predictors of mental health problems for groups B, C and D . However the relationship between years in profession and post and mental health problems was not progressive, with different years in post and profession being associated with reporting own and lived with mental health problems. The predictive models here were not convincing, as evidenced by the R Square all being under 20%. This suggests that household size and years of professional and post experience warrant further investigation, but that other stronger predictor of mental health nurses' mental health problems should be sought. The poor fit of this model calls for further exploratory research to be done, looking beyond the obvious factors.

9.3 How mental health nurses experience mental health problems: interview findings and a conceptual model

Figure 9.3: Conceptual model of RMNs' subjective experience of mental illness

The interview participants were all chosen because of their subjective experience of mental health problems as well as their high SWB. They were asked to describe their ownexperience of mental illness. This chapter presents an analysis of the interview data according to the perspective of the mental health nurse as patient, service user or carer. In the next chapter, the interview data is discussed according to the theme of the impact and influence of those experiences on work, however, as will be seen in this chapter, work and home experiences of mental health problems were interwoven. Coded transcript data of relevance to the core theme of subjective experience of mental health problems was described and summarised, in order to identify themes and trends within each node and across the data set. This led to the development of a conceptual model of mental health nurses' subjective experience of mental illness, as presented in Diagram 9.4**.** What emerged from these findings is the complexity and nuance of the nurses' experience. Mental health problems did not occur in a vacuum. The findings here are supported by the survey findings, which were that whilst almost 25% were experiencing mental health problems at the time of the survey, almost 50% had experienced them in the past.

The conceptual model represents the three themes that emerged within the core theme of subjective experience of mental health problems, described as 'Interwoven Histories.' In the interview accounts of personal and familial experience the emergent themes were: me and my family, my life at the time and drawing on the personal. Individual experience was interwoven with family life, the experience of mental illness was interwoven with the experience of other life events and being a nurse was interwoven with being a patient or carer. For many participants personal history was linked to family history, for example, in the way that their own subjective experience of mental health problems was woven with that of other family members. The interweaving of being a nurse and patient was demonstrated in the way that each role gave insight into the other. Similarly experiences of mental health problems at home were interwoven with those at work. It is worth noting here that several interviewees had more than one subjective experience of mental health problems from which to draw. This overlapping experience in the interviews mirrored the overlap identified in the survey. Accounts of experience were connected by the overlapping influence of their personal experience and their work experience.

Being a nurse and working in mental health influenced and was influenced by those personal and familial experiences. The findings presented in this chapter reflect the underlying theme of 'distancing and connecting' that was first discussed in the previous chapter. The underlying themes of 'choice and control' and 'self nurturance' were less present in participants' accounts of their experiences of mental illness, but 'distancing and connecting' were, particularly when they talked about how a shared experience of mental illness might bring them closer to or further from family members: the interweaving could be tight or loose knit.

9.3.1 Me and my family

> *'Yes my brother had depression. My mother was - I don't know what is wrong with her - there is something, I don't know what -and my gran has got Alzheimer's and she tried to take her own life when I was younger. There were a lot of things in my family.'* (Zoe)

For many participants mental illness was a long running thread in their family history. Family experience of mental illness was not an isolated incident. Participants looked at the past, whether from their childhood or more recently, and the role familial mental health problems had played was sometimes subtle, sometimes shocking. Not all of their stories were sad or regretful. Rob, a nurse who had qualified in later life, saw his childhood experiences with his uncle as having *'planted a seed subliminally that came to light at a later time'* in his becoming a nurse

Chloe's mother had bipolar disorder. Chloe described the influence of watching her mother's cyclical illness over '*15, 20 years'*. She describes her motivation to 'fight' with her own depression as coming from watching her mother. Lucy also had a mother with bipolar disorder, and said that 't*here's always been a fear*' of it presenting in her and her sister. As well as possibly instigating an interest in becoming a mental health nurse, family experiences had influenced her choice of work setting. Diana said that she avoided working with people with eating disorders because of her mother's anorexia and Tracy stayed away from working with '*alcoholic men*' because of her father. Ruth said she avoided going

into mental health work *'for a long time'* because of her mother's mental health problems but eventually he drifted into care work and then nurse training and found that *'it felt like it came naturally and it made sense.'* Not all participants had family mental health stories though. Eleanor, for example, had her own life history of anxiety and depression but did not know of any family background.

Participants' roles as mental health nurses influenced the family experience of mental health problems. When navigating the health system or working out how to manage illness they had their professional knowledge from which to draw, for example Yvonne, Joanna and Melissa had identified family members' dementia and instigated referrals and treatment. They took on an expert role within their families with regard to decision making about the condition. Norman recounted a contrasting story, in which he, as an experienced mental health nurse, had not taken account of the seriousness of his father's depression until he accompanied him to an assessment appointment:

> *'I think, for me, the thing that made me most aware of really*
> *how he was feeling was, he was off work, and they sent him*
> *for an occupational health assessment. And I went with him,*
> *and I sat in the room with the doctor and him. And, you know,*
> *when your dad's talking about thoughts about suicide, and*
> *that sort of thing, it's quite shocking. You know, you know of*
> *people who are depressed, feel that way, because you're*
> *working with it every day. It's different when it's your dad.'*

His professional expertise had not been called into play by his father, about whom Norman said he could not be *'detached and objective.'* Ruth also described a distance between her approach to mental illness at work and her approach to mental illness in the family:

> *'In a way more so with my cousin I think when he starts talking about*
> *mental health stuff actually I'm often a bit thrown because I just forget*
> *that it's an issue really, and I suppose because I go and visit and I'm so*
> *far away from work I'm in a completely different sort of mindset and it's*

difficult sometimes not to feel like you're working when someone starts talking about mental health.'

Others had tried to change the family dynamic around mental illness once they had taken on a nursing role. This was not always successful. Ryan said:

> *'Yes, certainly with my uncle, his mood. As long as I can remember, he goes through periods of just complete isolation, low mood, doesn't really do anything, doesn't communicate with anybody, and then that will change and he'll be the complete opposite and very outgoing, and he goes travelling around the world and parties. But, yes, he's not the sort of person who would ever go to the doctor, and I've talked to him about it before, and he will just, sort of, fob it off and say that he doesn't want to talk about it, he doesn't want tablets or medication to be thrown at him. He's just not interested in any of the, sort of, medical side of it.'*

and Jean said of her changed approach to her father's mental illness on starting her nursing course:

> *'I tried to approach him directly about it, I went, dad I've got some experience now with working with other people who take these meds, and I know about them, and I think, I don't think it's the right way to go about it when you're feeling on edge. And he just, kind of, shot me down, he just went, is that what you know about it?'*

Whilst Ryan and Jean, as younger family members, were attempting to change family conversations about mental health problems, Lucy described growing up with one parent with bipolar disorder and one parent who was already a mental health nurse. Her dad had begun training before her mum got diagnosed although they were no longer together. She described '*blame*' and '*paranoia*' from her mother towards her father, particularly in relation to her hospital admissions. She also described her current way of dealing with her mother as

> *'I think I just have to take a step back and let her deal with it.'*

9.3.2 What was going on in my life at the time

> *'Yes, I've had, on and off, since my teens I've had experiences of depression, with quite severe anxiety associated with it. It usually happens at times of stress, when things get too much and it, kind of, just builds up and then I crash'* (Eleanor)

As well as mental illness being an ongoing theme in many participants' family lives, the participants talked about the particular circumstances in which their mental health problems emerged. For some they were precipitated by a trauma, bereavement or significant life event. For others a period of depression was associated with relationship breakdowns or work pressures. These were all described though in the context of a complex history and life situation. Similarly to the notion of interwoven family histories whereby the nurse's own experience of mental health problems had to be contextualised by the experiences of other family members, it seemed important to put it in the context of '*what was happening at the time*' with work, home and family. Diana situated her recent depressive episode in '*a combination of life events*':

> *'I left my home and my relationship, still loving him, I knew I couldn't do any more. I think that is really hard when you leave someone you love but can't be with. So I had to leave my home I was gutted to leave, I'd put a lot into it. I bought my own home and that was stressful and I was nursing my nan with Alzheimer's disease and going in to see her every day. And my nana was like my mum so I was in the grieving process but still going there every day, and I was grieving for the end of my relationship and my nan, who was like my mum and so obviously I got depressed. Really quite depressed.'* (Diana)

This quote shows that Diana's depression was interwoven with her nan's Alzheimer's, a relationship break up and moving house. Rose also took sick time off work with depression. The 'last straw' was increasing pressure at work, but financial and family pressures were also 'overwhelming' her at that time:

'... I'd been divorced about three years at that point. And I think when I first separated and got divorced it had been sort of a relief, really; I saw it as quite a positive thing. And then I think sort of three years down the line things kind of settled down a little bit and then things got a bit... I don't know whether they got on top of me, my kids were getting older and I was just struggling a bit financially and just trying to fit everything in the day. I mean, you're a single parent trying to fit everything in, in one day and I think I just got quite overwhelmed with it all. I think work...there were some changes at work, actually at the time, I remember. Our team had been cut slightly and we were just under more and more pressure to do more and more with less and less.'

Like Rose, Joanna and Ellen described the crisis point of their mental health in terms of being *'overwhelmed':*

'I've had a couple of episodes of depression. So, the first was when I was living in Edinburgh, so, I was probably about 19, I think. I think, just being away far away from my family and not really knowing where I was going with my life, I felt a bit overwhelmed, and I was drinking quite a lot socially, which I don't think helped at all. So, yes, I felt quite low and I went to see my GP at the time, who wasn't very helpful, didn't really offer me anything. I'd started self-harming a little bit, so...but I, kind of, just- I think I got to the point, when I was living up there, that I thought, actually, this isn't right for me, and that's when I came back to Oxford. So, it had probably been rumbling on for about a year, with me just feeling a bit low, thinking, well, that's because of my situation and money and relationships, and all that kind of stuff. So, that was probably the first time' (Joanna)

'Yes. My dad died, just coming up to two years ago, and I had what we referred to with my friends and family as a meltdown- breakdown - So everything fell apart he'd been unwell for a period of time and it was very unexpected, so there was a period when he made a recovery, and it was unexpected, and then things took a downturn. So, and also work just got really complicated. A number of my patients also became really unwell

at the same time. So, I think I just became really overwhelmed. And had to take some time out of work, about four or six weeks. Just because I was very distressed and crying all the time, and really couldn't go and, well, couldn't really function to talk to other people about their mental health problems, so yeah, took some time out and re-gathered myself, shall we say.' (Ellen)

For several female nurses the period after child birth was a time of risk of mental illness. For Yvonne this was not textbook post-natal depression, rather severe anxiety when her children were small. Monica said that her first episode had been post-natal depression, but there had been subsequent ones. In contrast, it was Christine's husband who began suffering from severe depression soon after the birth of their second child. Christine's own experience of post-natal symptoms was overshadowed by her family responsibilities:

'It was hard. It was hard because the kids were really young as well and I was, like, you know, if (my son)[3] was asleep, the three-year old was asleep, the baby was awake, (my husband) was asleep, so I had to look after the baby. And if the baby was asleep and (my son) was awake, (my husband) was asleep so I was looking after (my son). I felt...That was quite a hard time for me just because it was just tiring, really, really tiring. But, you know, I couldn't have changed it. There wasn't anything I could do about that. It was just how it was. And I was a bit postnatally depressed with (my daughter) for just about, oh, literally, about...she was about six months old when I realised.'

For other participants having a baby and feeling well signified having moved on from their own and their families' mental health histories. Tracy said that giving birth to and caring for her twins was when 'life just changed.' Chloe talked about both her sister and herself being anxious about becoming ill like their mother, and the significance of avoiding post-natal depression. In the previous chapter, the associations that participants made between children and SWB were

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[3] (my son) (my husband) have replaced proper names used by the participant, in order to protect anonymity

discussed. Here, in contrast, it can be seen that childrearing was associated with poor mental health, particularly when children were very young.

In summary, subjective experience of mental illness did not happen in isolation. The nurses had complex family lives and family roles. They had their own mental health problems and may also have been supporting family members with theirs. Their experience of mental illness was interwoven with family life and life events. Relationships were not static, nor were experiences of mental health problems. The interweaving metaphor is useful because if reflects how different aspects of the person's history may arise or recede in different contexts.

9.3.3 Experience of healthcare: drawing on the personal

> *'I had to fight quite hard for my dad and it was quite...I was quite upset, really, because it was the trust that I worked for, and, actually, the care he got, I felt was, you know, not good enough.'* (Yvonne)

Participants' talked about their experience of mental health care. This usually encompassed encounters with their GP, experiences with psychotropic medication and referral to counselling and therapy services. For some it included visits to hospital or from community mental health teams. There were accounts of positive and negative experiences, with participants comparing and contrasting their experiences with different health professionals or of different medications. For some, subjective experience of mental illness preceded their nursing career, for others it had been part of their life whilst nursing, and was still being experienced at the time of our interview. There were some common themes emergent from participants' descriptions. These were about their being the expert patient; seeing things from the patient point of view and their motivation to nurse.

Participants' descriptions of their encounters with other health professionals showed that they did not switch off their critical nursing faculties when in the 'patient' or 'carer' role. Their expertise as mental health nurses could be a barrier to accessing care, or else could make them aware that what was on

offer was not going to help. Diana related her disappointment with primary care to a conscious decision to get better on her own terms:

> '*I went to my GP because I came out in skin problems for the first time in my life and he said I think you're depressed and I want you to take some antidepressants but I said no. he gave me a questionnaire, the Beck Depression Inventory and said come back in 2 weeks. And I just said 'I'm a mental health nurse, I know my own mind.' That was it, I went to a different GP and I asked for counselling and she said 'we haven't got a counsellor. If we had a counsellor then everybody would want one.' but I was too ill at the time to challenge it. Whereas now I could really let rip about that type of comment. So I said OK and she said 'all we've got is a gateway worker⁴ which is what you're like anyway' so I never saw her again. I saw another GP and he said 'you're depressed and I'd like you to try these antidepressants' and it was horrendous and I said no and I didn't want to but I started to get better. My friends stepped it up a bit more up to the mark and took me out more and came round more. I went for massages more, I went to the gym more. I just took care of myself , made sure I had the basics of care, consciously taking the decision that I'd got to get better*' (Diana)

Sylvia described herself in similar circumstances, wherein she did not consider the counselling offered in primary care (group therapy) to be suitable so she found a private counsellor. Patty also, describing how her 'breakdown' was dealt with, said that she got better through self reliance.

> '*Because people didn't inquire beyond the initial assessment of the psychiatrist that I saw, there was no follow up in that sense other than the GP saying how are you getting on? There was nothing else so it was self-resources, it went back to self-resources*'

Rose was prescribed an online Cognitive Behavioural Therapy (CBT) course by her GP

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⁴ Improving Access to Psychological Therapies mental health worker in the GP surgery

*'You know when...a little knowledge is a dangerous thing, really, isn't it?
What I found myself doing is being really critical of the actual course.
Quite rightly, it was for people who'd got absolutely no knowledge of
mental health or depression or anything like that. It was a very basic
CBT that you worked through week on week, say, if you identified some
issues that were very particular for you and examined them and
challenged them and it was all very much like that. But it was quite
cartoony and it was quite incredibly clichéd. I found myself on many
occasions shouting at the computer, saying oh, for God's sake, that's
just ridiculous'*

For some participants medication was temporarily helpful, others were taking
medication long term for 'maintenance' and others decided that medication was
not right for them. Ellen reflected on the contrast between what she said to
patients and the misgivings she had about medication:

*'Having spent ages encouraging people to take it, I think partly the
people that I see, you know, because they're older, older people, they've
had a longer history. I think that I struggled to take it because I was
worried about the side effects, and having spent all my time saying, well,
you know, the side effects will hopefully, you know, they're going to
outweigh the fact that you're going to have a better quality of life. And
even though I said all these things for other people, I was very worried
about them for myself. Also, I think it was admitting that I needed them.
It felt like I was somehow, faulty.'* (Ellen)

Similarly, Diana differentiated between what she said to patients about
medication and what she chose to do herself. Ellen also later went on to say:

*'So, I feel that's also something that I've learnt from taking the
medication, that it's not a sign of giving in, it's something that works.'*

This quote shows how her own experience of medication had informed her
nursing practice. Sylvia also had episodes of depression during her nursing life.

She saw that they had affected her nursing practice by making her '*a more understanding person*.' Monica also said her experience with antidepressants was something that informed her medication discussions with patients, whilst Jackie said CBT enabled her to learn about her '*underlying beliefs and assumptions about life,*'

When Monica's daughter was referred to child and adolescent mental health services (CAMHS) this caused Monica (who was in nurse training at the time) to question her abilities as both a nurse and a mother:

> '*She kind of went off the rails, got involved in the wrong people and suddenly in part I felt like a failure because I could deal with other teenagers but then I could leave them at home at the end, you know what I mean? I could leave them and come home. I thought how the hell do I deal with my own daughter, you know, you couldn't deal with her as a professional, obviously, and I knew what needed to be done. So I had to go to the GP and refer her, and we went through CAMHS and funnily enough she went through the family kind of intervention centre that I'd done my placement on and I was just finishing and I did explain to them that my daughter was going to be referred.*'

Heather had her own CMHN as a teenager. She associated her experiences with him to her motivation to work in mental health. Tracy tracked her motivation to become a nurse back to her observations of the hospital treatment of her father:

> '*I remember visiting my dad on the psychiatric units, because he was sectioned, and I remember meeting people, and I remember just thinking you should treat people with a bit of respect. Just because they're ill doesn't mean that we need to treat them like they're outcasts, and I know that mental health services have improved, but they always made me interested and always made me think this is what I could do. Then I just had other friends who ended up in hospital, and seeing them and just- not that I was badmouthing the nursing, but some of them, the*

care for them just wasn't acceptable and I just thought I could do better than this.'

Just as in the previous chapter, nurses talked about how they took learning from work and applied it to the management of their own SWB, the nurses' experience of mental health problems influenced and was influenced by their experience as nurses. Being a mental health nurse was intimately linked with having experience as a mental health service user or carer.

9.4 Discussion

The findings on MH nurses subjective experience of mental health problems in both phases of the study are discussed here in the context of previous studies, both within mental health nursing research and in the broader field of research on health and care professionals with mental health histories. The findings of the survey are considered first, then the findings of the interviews.

First, whilst the percentage of mental health nurses with mental health problems at the time of the survey is on a par with the population norm of one in four, overall personal experience of mental health problems, in the past and with family members was much higher. This is the first study looking at overall experience in nurses rather than just presence of symptoms at the time of a survey. In this first study to measure SWB in UK mental health nurses, an association was found between subjective experience of mental health problems and lower SWB. The qualitative element of the study offers a unique insight into the mental health experiences of mental health nurses. The participants described how being a nurse and being a patient or carer were interwoven, suggesting the importance of taking account of more than just current reporting of symptoms when considering how mental health nurse and colleagues encounter mental health problems beyond working with patients. Their own experiences of mental health problems were interwoven with other life experiences and with those of their family members. By taking a step out of the workplace and the focus on the mental health of nurses at work, this study has revealed aspects of nurses' expertise by experience that have rarely been identified or discussed.

9.4.1 Survey findings

9.4.1.1 Prevalence of mental health problems in mental health nurses

The survey found that 24.9% of mental health nurses were experiencing mental health problems at the time of the survey, with 45.6% reporting past or present mental health problems. It asked nurses to self-report their experience of mental health problems rather than identifying markers of mental ill health through psychometric measures such as the SF36 (Ware and Sherbourne, 1992) or the GHQ12 (Goldberg & Williams, 1988). The only study found in the systematic review of the literature on nurses' mental health (see Chapter 4) using a similar measure was Virtanen et al's (2012) study of health risk behaviours and morbidity in Finnish hospitals. Virtanen et al asked their survey participants to say whether a doctor had ever diagnosed them as 'suffering from a mental disorder' and 17% of 842 psychiatric hospital nurses met this criteria, lower than the percentage found in the present study. There is a lack of research on nurses' historical experience of mental illness. Whilst psychometric tests are useful in identifying possible cases of mental illness this is not the same as asking nurses to disclose current or past experience of mental health problems, care and treatment. There is also a dearth of evidence on mental health nurses' experience as carers or family members of people with mental health problems. The present study is therefore offering a novel insight into prevalence rates according to nurses' own reckoning rather than symptom checking. A move away from 'objective' symptom checking for caseness, as per the GHQ (Goldberg & Williams, 1988), is in keeping with attempts to gather self-determined 'expertise by experience'.

Whilst there is a lack of studies using the same measure of mental ill heath it is still worth comparing the current findings with those studies where measures of mental health 'caseness', in the absence of anything more similar. Studies looking at GHQ 'caseness' in UK mental health staff have found it to be between 42% and 27.9%. Caseness in the UK has been reported at 42% for early career mental health nurses (Kipping, 2000), 41% for CPNs (Fagin et al, 1995; 1996), 39% for CMHT staff (Johnson et al, 2011), 38% for CMHT staff

(Walsh et al, 2002); 35% (Edwards et al, 2000), 31% and 27.9% for WBPNs(Fagin et al, 1995;1996), 30% for CMHT staff (Wykes, Stevens & Everitt, 1997), 29% for mental health trust staff (Johnson et al, 2011), as shown in Table 4.5. The prevalence of mental health problems at the time of the present survey was therefore slightly lower, at 24.9%, than that found in similar populations using a different measure. It is more akin to the prevalence found in the largest reported study of NHS staff (n11637), regardless of specialty, reported by Wall et al (1997) as 26.8% using the GHQ12. More recently, Mark and Smith (2012) surveyed nurses accessed at random via the Royal College of Nursing (hence a similar target group to the one in the present study, albeit not mental health nurses), using the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983), and found 27.3% of nurses to meet the '*clinical cut-off for anxiety and depression*.' They compare this to Calnan et al's (2001) report of 23% GHQ12 caseness in general practice staff and 14-18% caseness in the general population.

According to national psychiatric morbidity data (McManus et al, 2009) prevalence of 'Common Mental Disorders' in the UK is commonly reported at one in four members of the population:

> *'in 2007 nearly one person in four (23.0 per cent) in England had at least one psychiatric disorder and 7.2 per cent had two or more disorders.'*(HSCIC, 2009)

However, reported prevalence differs depending on the measures used. Overall prevalence of common mental disorders in UK working adults, using the Clinical Interview Schedule (CIS) (Lewis et al, 1992) has been measured at 13%, with health professionals having a higher than average prevalence, at 19% (Stansfield et al, 2011). Katikireddi, Niedzweidz and Popham (2012) compare national UK Household Panel Survey GH12 scores over a number of years, and give it at 15.5% for 2010.

What can be said here about the present survey is that the percentage of mental health nurses disclosing mental health problems at the time of the survey is comparable to that reported by the ONS for the general population,

and to recent studies of NHS staff, with UK studies of mental health problems in the adult working population often showing health workers to have higher prevalence of mental health problems than other professions.

9.4.1.2 The relationship between mental health problems and subjective wellbeing

Having subjective experience of mental health problems was associated with lower SWB in the present study. As discussed in Section 6.2, there is little contemporary normative data on mental health in UK mental health nurses. What evidence there is on mental illness in this population has focused on associations between mental health caseness and work and personal factors, in relation to stress, coping and burnout. The present study therefore offers a unique insight into the interaction between SWB and experience of mental health problems. It shows that individual experience is the factor that correlates with low SWB in mental health nurses rather than living with other people with mental health problems. It also showed that mental health nurses have relatively low SWB even when those with subjective experience of MHP are excluded from the analysis.

There have been previous studies of nurses where a measure of SWB and measures of mental health have been used together, for example to measure the effectiveness of an internet health promotion intervention for nurses and allied health professionals (Bolier et al, 2014). The correlation between SWB and mental health was not directly measured in that study, rather the study found the intervention to impact positively on psychological wellbeing but not on SWB or psychiatric symptoms. Lan et al (2014) used the SWB measure of the Subjective Happiness Scale (SHS) (Lyubomirsky & Lepper, 1997) as well as the Depression Anxiety Stress Scale (DASS-21)(Lovibond, 1995) to measure the impact of mindfulness training on Malaysian nurses. Participants did report significant improvements in both anxiety, depression and happiness. Exact correlations between the two measures are not reported.

Hawker (2012) used both the SWLS (Diener et al, 1985) and the HADS (Zigmond and Snaith, 1983) in her cross sectional study on the associations

between physical activity and mental wellbeing in student nurses. The correlation between HADS and SWLS scores was not reported, save to say that neither life satisfaction, anxiety nor depression had a significant relationship to physical activity. Jacobs (2013) used the CES-D depression scale (Radloff, 1977) and the SWLS in her battery of measures in her study of work stressors and health behaviours in US nurses, describing both as measures of 'psychological wellbeing.' Jacobs(2013) found a negative correlation between SWLS and CES-D scores (-.51, p<0.001), meaning that lower SWB was associated with higher depression. Rodwell and Munro (2013) used the negative affect scale of the PANAS (Watson, Clark & Tellegen, 1988) as a measure of SWB alongside the GHQ12 and other measures in their Australian study of relationships between organisational resources, job demands and nurses' wellbeing. They found negative affect and wellbeing (measured by the GHQ12) to be correlated (-0.57 p<0.001) with higher levels of negative affect being associated with lower wellbeing. Kilfedder, Power and Wells(2001) use the PANAS and the GHQ12 (describing it as 'a measure of psychological strain') alongside stress and burnout measures in their study of 510 Scottish psychiatric nurses. They found GHQ12 outcomes to be correlated with positive affectivity (-0.4 p<0.001) and negative affectivity (0.6 p<0.001). These results support the findings of the present study, in that they establish an association between symptoms of mental illness and lower SWB. Whilst the present study has not measured symptoms, its findings on self reported experience are similar. This may support an argument for the use of a self reported experience of Mental health problems question rather than a symptom checker in future studies. This should be particularly considered when the population being studied are themselves experts in mental health.

9.4.1.3 Demographic factors and mental health nurses' personal experience of mental health problems

There have been no previous surveys looking specifically at the association between demographic and workplace factors and prevalence of mental health problems in UK mental health nurses, using a similar measure to the present study although demographic and workplace questions are commonly part of the survey used in studies of nurses' mental health using caseness measures.

9.4.1.3.1 Gender

Whilst more women than men reported current mental health problems in the survey, the relationship between gender and experience of mental health problems was not found to be significant. The ONS Psychiatric Morbidity Survey (McManus et al, 2009) found women to be more likely to have common mental disorders than men (19.7% v 12.5%). Women have had consistently higher GHQ12 caseness as measured in the Household Panel Survey (Katikireddi, Niedzwiedz and Popham, 2012). The relationship between gender and mental health problems is a complex one, where for example, women are consistently more frequently diagnosed with depression than men and men are more likely to be diagnosed with alcohol dependence or antisocial personality disorder (Singleton et al, 2000; Astbury, 2001). According to the WHO (Astbury, 2001), gender differentials in terms of diagnosis and treatment as well as self reported symptoms, should be seen in the context of social and cultural circumstances. As such difference in male and female reporting of mental health problems should be seen in the context of differences in how women report and experience mental ill health compared to men. Extrinsic (social) factors play a part, as well as intrinsic factors.

In many of the studies on the mental health of nurses there is a higher proportion of women than men taking part in the studies. For this reason few studies report findings according to gender, and several studies report only on the mental health of female nurses (Kawano, 2008; Suzuki et al, 2004; Lyonette and Yardley, 2006; Lin et al, 2012). In a study of Japanese mental health nurses (Yada et al, 2014) female nurses were found to experience more fatigue and anxiety than their male counterparts.

In Wall et al's (1997) analysis of the impact of gender and occupation on NHS staff GHQ12 scores, the difference in caseness between male and female nurses was negligible (30% and 29% respectively). However across the health professions overall, female managers and doctors exhibited particularly high GHQ caseness as well as depression, anxiety and fatigue. In the studies reviewed as part of the systematic review in Chapter 4 associations between

gender and mental health caseness were discussed as being of note in four studies. Abdi et al(2007) found an association between GHQ caseness, burnout and gender in their study of 200 Iranian nurses. Van Daalen et al's (2009) study of 1650 mental health workers in the Netherlands found that women in high patient interaction roles (ie frontline mental health nurses) were more likely to report psychiatric problems than men. This difference was not present for those in low patient interaction roles. Perry et al (2015) used the SF36 (Ware and Sherbourne, 1992) as part of a survey of 382 Australian hospital nurses (not mental health) and found being male was associated with higher vitality, a quality associated with good mental health, according to the SF36 subscale. In Christensson et al's (2011) survey of a national cohort of nursing students, 10.7% of female versus 5.7% male students self reported as depressed using the MDI. Christensson et al compare this finding to a UK survey of university students (Webb et al, 1996) that put depression at 12% for males and 15% for females. In conclusion, the gender differential in self reported mental ill health found in the present study is typical of reported differences between men and women in studies of the general population and of nurses.

9.4.3.1.2 Age

The present survey found 40-49 year olds to be most likely to report mental health problems at the time of the survey (31.6%) and 30-39 year olds to be most likely to report a lifetime experience of mental health problems (68.0%). There was a degree of variation in the prevalence of mental health problems between age groups, with the middle aged groups having higher prevalence overall and at the time of the survey. This finding is of interest though, as it might be assumed that lifetime prevalence would go up through the age categories. Rather, it peaked at ages 30-39, suggesting that perhaps nurses with subjective experience of mental illness may not stay in the profession beyond a certain age or that there is a cohort effect. It may also suggest that those nurses who stay in the profession are more hardy, and less likely to experience mental illness. It could also be reflective of the more overt encouragement of people with mental health problems to join the profession in recent years, leading to an increased prevalence in the younger cohort. The age breakdown of participants to the online survey was typical of the profession

(CFWI, 2012b). There is a large dip in UK mental health nurse numbers post 55 because of 'mental health officer status', which means all mental health nurses qualified before 1995 have the option to take a full pension at 55.

Age difference in prevalence of mental health problems has been found in a number of non UK studies. Prevalence of mental ill health has been found to be high in studies of younger nurses (43.4% in LaVoie-Tremblay et al, 2008; Ryan and Quayle, 1999). Older nurses (over 60) have been found to have better mental health but higher prevalence of health problems per se than younger nurses (Letvak, Ruhm and Gupta, 2013). Conversely, Musshauser et al (2006) found age to influence physical but not mental health scores in a survey of female hospital workers. Younger age has been associated with higher emotional exhaustion in Japanese mental health nurses (Leka, Hassard and Yanagida, 2012). In Christensson et al's (2011) study, younger (under 30) nursing students were more likely to report depressive symptoms than those over 30. Arafa et al (2003) found younger Egyptian nurses to be at higher risk of psychiatric morbidity than older nurses. However, Malinauskiene, Leisyte, and Malinauskas (2009) found nurses age 45-54 to be at higher risk of GHQ caseness than those in other age brackets. These findings of higher mental illness in younger nurses run counter to the expected dip in SWB at middle age and relatively good SWB to be expected in younger working age adults. The nurses surveyed in the present study who were aged 40 to 49 year had lower SWB than counterparts according to the SWLS measure.

In the UK, Prosser et al (1996) found older age to be a predictor of high job satisfaction, but not other variables, including the GHQ. Increasing age has been associated with lower depression in UK general and psychiatric nurse trainees (Dudley, Langeluddecke and Tennant, 1988). According to the British Household Panel Survey (Singleton et al, 2001), neurotic disorders (including anxiety an depression) are most common between 40 and 54. However, Singleton et al found that there was no striking correlation between psychiatric symptoms as identified by the CDI between age groups, save the trait of 'irritability' which declines in women with age.

Just as caution must be applied in the analysis of gender and mental ill health, these findings on age and mental health problems in UK mental health nurses must be treated with caution. When Brunetto et al (2012) looked at the wellbeing of Australian nurses they had done so in the context of generational shifts (from Baby Boomers to Generations X and Y). The studies discussed here which found age-related differences in psychiatric symptoms account for their findings in relation to both the points the nurses are in their careers and the social circumstances of younger versus older and middle aged people, for example the ages of their families and their general health. Without a longitudinal cohort element the present study cannot fully account for the impact of age. Nurse training and certainly access into the profession in the UK has changed over the years (RCN, 2014b), meaning that the characteristics and social circumstances of UK mental health nurses in different age brackets should be accounted for, particularly with almost half of UK nurses now being over the age of 45 (RCN, 2014a). The findings of this survey call for further work, mirroring the studies on generations in nursing that have been conducted in Australia and the US (Humble and Cross, 2010; Brunetto, Farr- Wharton and Shacklock, 2012; Letvak, Ruhm and Gupta, 2012). Cohort research on mental health nurses in the UK has focused on student nurses or those newly qualified (Kipping, 2000; Pryjmachuk and Richards, 2007; Rungapadiachy, Madathil and Gough 2006; McCrae, Askey-Jones and Laker, 2014). These groups are perhaps easier to access for research, becasue of recent or current associations with academia, but there is a lack of evidence on older and more established nurses.

9.4.3.1.3 Household size

There was a relationship between household size and overall lifetime personal and familial experience of mental health problems, with people who lived alone at the time of the survey being more likely to have current mental health problems (27.8%) and to have lifetime experience of living with or having mental health problems. In the present survey 16.2% of participants lived alone, similar to the UK population as a whole (from the UK 2011 census, ONS, 2015). As with the UK working age population, men and older people were more likely to live alone. Within the UK general population those who live alone are more

likely to report anxiety, depression, suicidal thoughts, use illicit drugs and to be in receipt of mental health services, even when age and gender are adjusted for (Singleton et al, 2000). When Meltzer et al (2002) conducted a focused analysis of the ONS Psychiatric Morbidity Survey data for 2000, looking at the social circumstances of people who reported having mental disorders, they found that 'Those with a disorder were more likely to be single, divorced or separated, and less likely to be married.' 155 of those with a neurotic disorder lived alone, while those with a psychotic disorder were 'far more likely' to live alone (38%). 30% of those with a neurotic disorder lived in households of 4 or more, whereas 32% of those with no mental disorder did.

The current research on the association between household make up and nurses' mental health is variable and limited, and the way different households are defined varies between studies. This makes comparison difficult. However, the findings of the present study are supported by the published evidence, in that living alone is associated with various markers of mental illness (Meltzer et al, 2002). The number of people in household has been correlated with physical health and workplace stressors but not mental ill health in Japanese and Thai hospital nurses (Lambert et al, 2004). The number of people in household was also not a significant predictor of mental health in US and South Korean nurses (Lambert et al, 2004). In the UK household make up as well as size is associated with nurses' mental ill health. Pryjmachuk and Richards (2007) found that having preschool age children in a household predicted GHQ caseness whereas having at least one child of school age increased likelihood of caseness in student nurses. Perry et al(2015), in their survey of Australian nurses, found that symptoms of common mental disorders were more prevalent in those nurses who lived alone compared to those who lived with a partner or spouse. Having children has been found to be a protective factor against burnout for Spanish nurses (Grau Martin et al, 2009), whilst perceived anxiety is higher in Turkish nurses without children (Boya et al, 2008). Not having children was associated with 'depersonaliation' in UK hospital and community nurses by Prosser et al (1996), GHQ12 caseness and fatigue in NHS staff (Wall et al, 1997, Hardy et al, 1997). Being 'single' was associated with higher risk of cynicism (Johnson et al, 2012) and depression (Christensson et al, 2011). It seems that household size and make up has some relationship with likelihood

of having mental health problems, but, similarly to its relationship with SWB, the influence and impact is dependent on a number of factors and can be perceived in numerous ways.

9.4.3.1.4 Work status full or part time

Whilst a higher proportion of nurses who worked part time had mental health problems at the time of the survey (32.5% versus 23.9%), a higher proportion of full time nurses had overall lifetime experience of mental health problems than those working part time (65.2% versus 61.5%). There is limited published information on the relationship between nurses' employment status and mental health, as was found for SWB in chapter 6.1.3. Many studies report employment status in their demographic variables but do not present analyses with employment status as a factor. There is limited published information on part time versus full time working and mental health problems, as the focus in population studies has been on comparing unemployed with employed adults (Singleton et al, 2001).

9.4.3.1.5 Years in the nursing profession and years in role

The present study found that the number of years a nurse had been in the profession did not correlate with experience of mental health problems. Years in current post did significantly correlate with having personal experience of mental health problems, with those with personal experience having typically been in post for fewer years than those without experience. Years in the profession was, however, a significant factor in likelihood of living with someone with a mental health problems, past or present, when logistic regression was applied.

In some reviewed studies data on the variable of years in nursing was gathered but excluded from final analyses due to its strong correlation with age (for example, Kawano, 2008). In others the variables of years in the profession and years in current post or setting were reported just as descriptive means rather than reporting of possible correlations (Edwards et al, 2001; Sorgaard et al, 2007). Both years in profession and age were retained for analysis in the

present study and revealed that the relationship between age and mental health problems and years in post and profession and mental health problems were not the same.

Prosser et al's (1999) modellling of mental ill health and burnout in UK acute and community mental health nurses found correlations between tenure in the profession and burnout factors but not GHQ caseness. The all-Wales study also found evidence of lower burnout in nurses who had been longer in the profession (Hannigan et al, 2000). However, Ryan and Quayle (1999) found age (being under 30) but not years of practice to relate to GHQ60 caseness or work stress indicators in Irish psychiatric nurses. Neither years as a nurse nor years working on current unit were correlated with mental ill health in Chinese nurses (Lambert et al, 2007). Similarly years in the profession were not a significant factor in the mental health of US, Japanese, Thai or Korean nurses (Lambert et al, 2004) or Jamaican nurses (Lindo et al, 2006). Years in the profession has been negatively correlated with depressive symptoms in US nurses (Welsh, 2009).Conversely, having more than 20 years of experience in nursing has been associated with poorer mental health in Thai nurses (Kaewboonchoo et al, 2009) and with incidence of PTSD in Swedish forensic nurses (Lauvrud, Nonstad and Palmstierna, 2009).

In summary, the findings of the present study are supported by previous research on gender, age, household size and work status. There is a lack of comparative data on full time versus part time work and mental health problems in mental health nurses. Research also suggests that younger nurses are more likely to have mental health problems than their older colleagues. The effect of mental health nurses' gender and experience of mental illness is hard to ascertain, due to the gendered nature of the profession, where 'being male' may also bring other factors into play, such as being in a minority and experiencing stigma and stereotyping. Longitudinal and cohort studies are needed in order to determine the impact of these factors. As discussed in Chapter 8 in relation to SWB, the relationship between years in post, role, age and mental health problems should be further explored in the UK, as it has been in Australia and the US (Letvak, Ruhm and Gupta, 2013; Brunetto, Farr-Wharton and Shacklock, 2012). The UK faces an ageing mental health nursing workforce,

with 29% of English mental health nurses being over 50 and with the option to retire at 55 (RCN, 2014b). Longitudinal research on mental health nurses mental health and SWB could tease out the relationship between age and years in the profession. Cohort studies, with a focus on nurses later in their careers, would identify those factors in the mental health nurse experience that are different between nursing generations.

9.4.2 Interview findings

9.4.2.1 Interwoven histories within the family

Following the thread of subjective experience of mental illness from the survey, in the interviews nurses were asked to talk about their personal experiences of being a mental health service user or carer. Participants described their experiences, within the context of their family lives and family members' experiences. Mental illness was not isolated for one person in the family, their histories were interwoven and influencing each other. Of the previous research on nurses with Mental health problems the focus has very much been on their experience at work and also on their individual experiences. This is the first study that sets nurses' own illness experience of mental into a wider family context.

There is research on mental health nurses' identities and motivations which is of relevance here. In Majomi, Brown and Crawford (2003)'s interviews with UK community mental health nurses, participants talked about how 'difficult and demanding family situations were integrated with professional career.' Their participants viewed as 'work-family conflict' with nurses having to balance two interconnected roles.' Family experience of mental health problems is one reason for nurses to choose their profession (Sercu, Ayala and Bracke, 2015) and informed therapists' approaches and attitudes to their work (Telepak, 2010). In Kidd's (2008) narrative accounts from nurses with mental health problems, family and personal mental health history was a pervasive influence on life and work. Mental health nursing students have been found to be hardier and to be less concerned with home-work interface problems than nursing students from other branches (Pryjmachuk and Richards, 2007). In Humble and Cross's

(2010) analysis of interviews with veteran mental health nurses, 'being different' from other professions was the central theme. The 'difference' was located in the mental health nurse's attitude to the self and lived experience, wherein 'the participants saw meaning in the lived experiences of those with a mental health problems, and also meaning in the lived experience that they shared with them.' (2010, p133). If lived experience and life history was appreciated as central to understanding and engaging with those in their mental health care, it makes sense that the nurses' sense of their own lived experience was a rich and complex one that influenced how they understood and engaged with their patients.

9.4.2.2 Interaction between home and work

Participants talked about the interplay between their family and professional roles, and how their subjective experiences with mental health problems at work and home influenced each other. For some the nurse took on an expert role at home, for others their professional expertise was rejected or called into question when not at work. Skinner et al (2011) have written about the interaction between work and home life for nurses and midwives, finding tensions here to be exacerbated by shift work and lack of work support, however they do not focus on mental health nurses, nor on nurses with mental health problems. Work-home balance has been a theme in the nursing literature and of the participants in this study. The boundaries between family experiences, personal experiences and work experiences are 'porous' (Skinner et al, 2011). Also, Joyce, Hazleton and Macmillan (2007; 2009), in their interview study of nurses with mental illness, conceptualise the move from nurse to patient as 'crossing a boundary'. This study also found the boundary to be porous, or to use the chosen metaphor, nurse and patient/ carer roles were interwoven. What the present study adds to an appreciation of how nurses negotiate this 'porous boundary', however, is a historical sense of family mental health problems. What that illness means can change over time, and for this group of participants the influence of family or personal mental illness was not always a negative one. What has also not been explored in previous work is how the nurse's 'expert' role in the family, because of their mental health professional's knowledge, can affect their relationships and roles within the family.

9.4.2.3 What was going on in my life at the time

When participants talked about the circumstances in which their own experience of mental health problems emerged, they typically described a combination of life events that had brought them to a crisis point. There was not usually one single precipitating factor or 'stressor'. In Kidd's (2010) work, nurses with mental health histories were categorised as either having mental health problems before joining the profession, developing mental health problems during their adult life independent of work and those who develop mental health problems as a consequence of work. In the present study the distinctions were not as clear, with the influence of home and work and past and present being more fluid. A particular event at home or work may be a crisis or high point in an experience of mental distress but not an isolated one. This is supported by Majomi, Brown and Crawford's (2003) findings about community mental health nurses balancing work and home roles, that work stress (a subject exhaustively studied in mental health nurses) must be seen in the context of ' whole experience of multiple roles and life events.

9.4.2.4 Experience of healthcare: drawing on the personal and the professional

For participants subjective experience had been a developmental or learning experience and had influenced their clinical practice. It had led to them reflecting on their practice or else had motivated them to work in a certain way, whether their experience was before or during their nursing career. Whilst no one spoke specifically about the 'wounded healer' concept, the participants acknowledged the influence of their experience on their motivations to nurse. This reflected core elements of the 'wounded healer' archetype - that wounds act as motivation and as a source of power (Conchar and Repper, 2014; Rippere and Williams, 1985). Whilst the nurses could articulate that their personal experiences shaped their therapeutic approach there was a lack of association between what they did and the theoretical perspective, suggesting that the 'wounded healer' concept was not in their vocabulary. As previous scholars on this topic have said, the research and theoretical literature on

'wounded healers' is limited and contentious (Conchar and Repper, 2014; Zerubaval and Wright, 2012). While Zerubavel and Wright (2012) argue that it should be distinguished from the concept of 'the impaired professional', Conchar and Repper (2014) situate being a 'wounded healer' with 'peer support' work. In Moll et al's (2013) study, situating mental health workers' personal experiences in an institutional ethnography, talk of personal mental illness was 'silenced' despite an explicitly promoted workplace culture of openness and talking about mental health problems. The perceived positive influence that personal experience had on the nursing practice of the participants in this study is in contrast to the 'largely negative' experience of the nurses in Joyce, Hazelton and Macmillan's study (2007). Their participants saw becoming mentally ill as 'the antithesis of being a nurse' (2007, p375).

Personal experience has been associated with increased understanding and empathy by nursing and social work students (Gilbert and Stickley, 2014) and in Kidd's autoethnographical study, prior experience of mental illness individually and in the family was a motivating factor to join the profession. For her subjects, and for Moll's (2013), disclosure of mental illness was associated with vulnerability and bullying, and with concern that professional competence would be called into question. It seems therefore that in previous empirical studies nurses have cited personal experience as a motivator but it has not always been associated with enhancing their expertise. In the present study the participants made that explicit association. This was also true in the reverse, with the nurses' experience in mental health care having an influence on their experience as patients or users of services. This aspect of nursing with mental health problems has not previously been explored.

Participants had varying degrees of satisfaction with the care they received. Their experiences as users of mental health services were filtered through their experience as nurses, and vice versa. Their professional expertise influenced how they viewed the quality of care, with some participants deciding to 'take matters in their own hands' rather than accepting what was offered by the GP. Nursing 'expertise' influenced how the experience of treatment for mental health problems. Again, the wounded healer concept is a useful one here, in that

'finding their own cure' has been described as a motivator for people joining the helping professions (MacCulloch and Shattell, 2009; Tillet, 2003; Barnett, 2007).

Joyce, Hazelton and MacMillan (2007; 2009) characterise the experience of mental health nurses becoming patients as 'crossing the boundary'. Some participants in their study found development of a mental illness equated with 'losing control', which they saw as 'the antithesis of being a nurse.' Some of their interviewees had been hospitalised for mental health problems and experienced the 'control' as well as the 'care' aspect of nursing from the other side. Like the participants in the present study, some of Joyce, Hazelton and Macmillan's nurses took decisions about their treatment in to their own hands, which they describe as 'some degree of resistance to the domination of medicine'. The 'expert' attitude of the nurses in this study was not be viewed as definitively anti-medical. It was more about the participants as nurses recognising and using the mental health knowledge and skills they had for their own benefit, in the face of being treated by GPs and other health professionals with less experience and knowledge

9.5 Conclusion

The findings of this chapter provide a unique insight into the experience of mental health problems in UK mental health nurses. First, by asking directly about past, present, personal and familial experience the survey allowed for an estimate of self reported prevalence rather than presence of symptoms. The prevalence of mental health problems is comparable to that found in studies using symptom focused measures. This study also finds some associations between demographic and workplace factors and experience of mental health problems. It finds an association between presence of mental health problems and SWB. Conclusions that can be drawn regarding the strength of association and the generalisability are limited due to the sample size and response rate, and so further larger scale studies using the same measures should be done. As the first UK study using these particular measures, the findings should be viewed as a vital starting point for future research.

The findings from the interviews are supported by some of the existing research and theoretical literature on nurses and healthcare workers' experiences as patients. There are novel findings here, perhaps because the interviewees were encouraged to talk generally about their experience of mental health problems rather than just about mental health problems and work. The broad context of nurses' experiences was a key factor: their histories, their families, the complexities of their lives. Also, some of the nurses in this study talked about the influence of their nursing expertise on their patient experience. Thus far the 'expert by experience' literature has focused on what 'patients' can bring to the healthcare worker role and not the other way round. Clearly the 'porous boundary' can work both ways, with nurses critiquing and adapting their approach to mental health care based on experiences as both a nurse and a patient or carer. This finding compliments the finding discussed in Chapter 8, that nurses take SWB skills learned from work and apply them in their non-working lives, because it gives a further example of how mental health nurses' lives inside and outside of work inform one another. It suggests that individual and organisational strategies to enhance and maintain nurses' wellbeing should take account of what happens outwith as well as within working hours. The findings of this chapter also suggest that mental health nurses, as mental health experts, require care and treatment for their own mental health problems that is commensurate with their expertise.

Chapter 10 Subjective experience of mental health problems and mental health nursing work

10.1 Introduction

This chapter addresses the central research question of:

> How do UK mental health nurses negotiate, use and manage their own mental health and wellbeing in relation to their work?

The first part of the chapter addresses the ways in which mental health nurses negotiate and manage their mental health problems in the social environment at work, particularly in their relationships with their managers, colleagues and employing organisations' responses to mental health problems. The second part of the chapter addresses the ways in which mental health nurse use their subjective experience of mental health problems in their mental health nursing work with patients and service users. In each section the survey findings are discussed, then the interview findings. The chapter ends with a discussion of the findings.

In the survey mental health nurses were asked about disclosure of mental health problems at work and the impact of mental health problems on their work with colleagues, work with service users and their work load. In the interviews participants were asked to say how mental health problems were dealt with at work, both by colleagues, and managers. They described the organisational response to mental health problems, which included their experience of occupational health services.

10.2 Working in mental health: how mental ill health is negotiated in working relationships

The survey showed the extent to which the mental health nurses perceived the impact of mental health problems on work. Following this thread the interviewees were asked to describe how mental ill health was dealt with at work and what managers' and colleagues' responses had been. The

management of workload and capability to perform nursing duties was a source of concern. Organisational responses to mental health problems were discussed in terms of the mental health nurses' experience of occupation health services.

10.2.1 Effect of mental health problems on work - survey findings

Tables 10.1 and 10.2 present the survey responses on the impact of experience of mental health problems on work, according to their current personal, past personal, current living with, having previously lived with experience. The summary findings (Table 10.2) reflect the same trends as the answers to individual questions (Table 10.1). The most frequent responses are highlighted in bold.

According to Tables 10.1 and 10.2 the majority of mental health nurses sometimes saw their subjective experience of mental health problems had a positive impact on their work with service users and colleagues, with 25% saying that it *always* impacted positively on their work with service users (see Table 10.1 and Table 10.2) . The type of experience with the least positive impact was 'currently living with' someone with mental health problems. Overall, 48%(n 120) of mental health nurses said that their experience never impacted on work with service users in a negative way. As shown in Table 10.1, past personal and living with experience was seen as *never* negatively impacting on work with service users by 53.8% (n 49), 65% (n 13) and 71.2% (n 42) of respondents respectively. Only current personal experience of mental health problems drew a more evenly spread response (never 29.6%(n16), occasionally 38.9%(n 21), sometimes 29.6%(n 16), always 2%(n 1)). Across all four types of subjective experience, only 3 people (0.1%) said that they thought their experiences *always* negatively impacted on service users.

Table 10.1: Effect of mental health problems on work - survey responses

		n	never	occasionally	sometimes	always
Does your experience of mental health problems affect how you work with the users of your service?	**in a positive way**	55	1.8%(1)	16.4%(9)	**54.5%(30)**	27.3%(15)
	in a negative way	54	29.6%(16)	**38.9%(21)**	29.6%(16)	2%(1)
Does your experience of mental health problems affect how you work with colleagues?	**in a positive way**	55	7.3%(40	34.5%(19)	**50.9%(28)**	7.3%(4)
	in a negative way	54	15%(8)	**40.7%(22)**	38.9%(21)	5.6%(3)
Does your experience of mental health problems affect how you manage your workload?	**in a positive way**	55	27.3%(15)	29.2(16)	**38.2%(21)**	5.5%(3)
	in a negative way	54	14.8%(8)	24.1%(13)	**48.1%(26)**	13%(7)
Has your experience of mental health problems affected how you work with the users of your service?	**in a positive way**	97	1%(1)	14.4%(14)	**48.5%(47)**	36.1%(35)
	in a negative way	91	**53.8%(49)**	25.3%(23)	20.9%(19)	0%
Has your experience of mental health problems affected how you work with colleagues?	**in a positive way**	95	11.6%(11)	25.3%(24)	**47.4%(45)**	15.8%(15)
	in a negative way	91	**44%(40)**	30.8%(28)	22%(20)	3.3%(3)
Has your experience of mental health problems affected how you manage your workload?	**in a positive way**	92	21.7%(20)	30.4%(28)	**37%(34)**	10.9%(10)
	in a negative way	88	27.3%(24)	22.7%(20)	**44.3%(39)**	5.7%(5)
Is your experience of living with this person affecting how you work with the users of your service?	**in a positive way**	19	26.3%(5)	**31.6%(6)**	**31.6%(6)**	10.5%(2)
	in a negative way	20	**65%(13)**	5%(1)	30%(30)	0%
Is your experience of living with this person affecting how you work with colleagues?	**in a positive way**	19	26.3%(5)	26.3%(5)	**42.1%(8)**	5.3%(1)
	in a negative way	19	**47.4%(9)**	10.5%(2)	36.8%(7)	5.3%(1)
Is your experience of living with this person affecting how you manage your workload?	**in a positive way**	20	**45%(9)**	20%(4)	30%(6)	5%(1)
	in a negative way	19	31.6%(60	26.3%(5)	**42.1%(8)**	0%
Has your experience of living with this person affected how you work with the users of your service?	**in a positive way**	69	8.7%(60	17.4%(12)	**43.5%(30)**	30.4%(21)
	in a negative way	59	**71.2%(42)**	11.9%(7)	13.65(8)	3.4%(2)
Has your experience of living with this person affected how you work with colleagues?	**in a positive way**	69	34.8%(24)	11.65(8)	**42%(29)**	11.65(8)
	in a negative way	65	**67.7%(44)**	13.8%(9)	16.9%(11)	1.5%(1)
Has your experience of living with this person affected how you manage your workload?	**in a positive way**	68	**66.2%(45)**	14.7%(10)	14.7%(10)	4.4%(3)
	in a negative way	65	**64.6%(42)**	9.2%(6)	21.5%(14)	4.6%(3)

The majority of respondents (35%) said that the impact of their experience of mental health problems on working with colleagues was positive, although 32% said it *never* had a positive impact with 44% saying that it *never* had a negative impact. Of note in the individual question responses, 67.7% of respondent who had lived with someone with mental health problems in the past said that it *never* had a negative impact. As with the impact on service users, only a small percentage (3%) of respondents said that their experience *always* had a negative impact on work with colleagues.

Table 10.2: Effect of mental health problems on work - summary results

Experience of mental health problems affects:		never	occasionally	sometimes	always
work with service users	in a positive way	23%(67)	14%(41)	**38%(113)**	25%(73)
	in a negative way	**48%(120)**	21%(52)	30%(73)	0.1%(3)
work with colleagues	in a positive way	32%(80)	22%(56)	**35%(89)**	11%(28)
	in a negative way	**44%(101)**	27(61)	26%(59)	3%(8)
managing work load	in a positive way	**38%(89)**	25%(58)	30%(71)	7%(17)
	in a negative way	**43%(112)**	17%(44)	34%(87)	6%(15)

The majority of respondents said that mental health problems never impacted on their workload management, either positively or negatively. However, as shown in Table 10.1, there was a difference between mental health nurses who had their own experience and those who had lived with someone with mental health problems.

The majority of those currently experiencing mental health problems said that it impacted on workload management sometimes both positively (38.2% (n 21) and negatively (48.1% (n 26) sometimes. Past experience of living with someone with mental health problems *never* impacted on workload management negatively (64.6%) or positively (66.2%) in the majority of cases. For those currently living with someone with mental health problems, there was less reported impact on workload management, with 45% saying it *never* impacted on a positive way and 42.1% saying it *sometimes* impacted on a negative way.

The survey findings suggest that mental health nurses find some positive impact of their subjective experience of mental health problems on their work and that in many cases there was no perceived negative impact. This is a novel and useful finding. Mental health nurses can see their subjective experience of mental health problems as having a positive effect on their work. Mental ill health at work does not have to equate to distress and impairment.

Interviewee responses to the survey questions were drawn out from the data set. The interview participants were chosen because of their high SWB as well as their experience of mental health problems, it might have been the case that their responses were at odds with the majority of survey respondents. Table 10.3 summarises their responses with the most frequent responses in bold. The same pattern of responses is reflected by the interviewees as in the whole survey.

Like the survey respondents as a whole, the majority of interviewees saw experience of mental health problems having a positive impact on work with service users and colleagues *sometimes*, but less so on workload management. The majority saw these experiences as *never* having a negative impact. Monica, for example, saw her experience as always positive, *never* negative, and mental health nurses such as Heather and Rob presented more variation in their responses. Regarding the experience of living with someone with mental health problems, the majority of responses said it *never* affected work*, in terms of both positive and negative impact, only Rob and Melissa considered the living with experience as *always* positive for service users and colleagues.

Table 10.3: Effect of mental health problems on work - summary of interviewees' survey results

Experience of Mental health problems affects		never	occasionally	some times	always	n
work with service users	in a positive way	2	4	**18**	16	40
	in a negative way	**27**	8	3	0	38
work with colleagues	in a positive way	5	8	**19**	7	39
	in a negative way	**22**	11	5	0	38
managing work load	in a positive way	**16**	11	9	3	39
	in a negative way	**19**	9	9	0	37

10.2.2 Colleagues' attitudes to mental health problems in the team

The thread of perceived impact of mental health problems in work is pulled from the surveys into the interviews with three strands: the collegiate response, the management response and the organisation's response in the form of through occupational health provision. Within the theme of colleagues' responses to mental health problems, three related sub themes emerged: openness, support and stigma. Many participants knew of colleagues who also had mental health histories, and reflected on their observations of others' experience as well as their own. There was a common view among respondents that mental health teams should be skilled at managing mental health problems because of their professional expertise, but this was not always the case:

> *'Because it was one thing to say we're trying to reduce stigma among people that we're working with but in terms of within our own team and the wider our mental health service, I think we're really poor. I think that we don't want to admit because, you know, the sick clients that I see coming in will say all sorts of things and yet when you're talking to the person on the phone if they're phoning in sick or whatever, they're clearly saying I'm stressed, I'm depressed, I'm anxious, whatever, you know, but they'll not openly admit to that. '* (Norman)

> *'…we're good at giving advice but not taking it as mental health nurses. We've also got this view that it wouldn't happen to us. Because we've got*

this view that it won't touch us. I suppose I'm meant to know about this stuff and prevent it and when it did happen to me I was embarrassed about it.' (Diana)

Diana's comment describes an attitude whereby having a mental health problem may be viewed as a source of professional embarrassment, in that professionals '*should be able to manage our own mental health'* (Joanna). For Norman. Having a mental health problem within a team may be known but not openly discussed. In contrast, for Ellen '*everyone in the team knows*' about her and other colleagues' mental health histories, which to her was due to their professional awareness of mental health problems. Heather also described a team environment in which people were open regarding diagnoses of mental health problems and personal histories:

> *' I think because we're working in the area, mental health is not that uncommon, and maybe we are open and able to talk about it more.'*

On the other hand, Zoe and Alison worked in teams where people knew there were mental health histories but they were not openly discussed. Norman said that people's mental health problems were known but not discussed in his team, and that this was in contrast to the team's attitude to clients. He said:

> '*I think that's wrong, somehow because of what we're doing and that what we say we're supposed to be doing for the patients.'*

Collegiate openness with regard to mental health problems was seen as a marker of professional integrity for Fiona, who took a conscious decision to be open:

> *'I decided this time around I wouldn't make any bones about it, I would talk about having been depressed, I would talk about how it was for me and I would use that to every single advantage that I possibly could for the benefit of whoever really because we can't expect...you've got to walk the walk, there's no point talking the talk.'* (Fiona)

Regarding stigma, there was a wide range of views, with Tracy, for example, saying that she did not consider there to be any stigma of mental health problems within the profession. Patty's first personal experience of mental health problems had been thirty years ago and she considered there to have been a definite shift since then away from stigma, both in society in general and within the health professions.

Yvonne differentiated between '*anxiety and depression*', as not stigmatised compared to '*proper psychiatric illness, like schizophrenia...manic depression*'.. For some participants, the stigma around mental health problems was not in relation to the mental health problems per se, but rather about taking time off sick and team and managerial attitudes to sickness absence. Time off was stigmatised because it had an impact on the whole team in terms of workload and case load so any time off was '*under the microscope*'(Jackie). Joanna also reflected on previous team attitudes to long term sickness as lacking in compassion. Her witnessing of others' attitudes to a colleague with mental health problems and the way some colleagues spoke about their mental health service users and colleagues and this had affected her approach:

> '*Sometimes it can be the way in which you hear your colleagues talking about patients. Makes you… makes me wonder… I wonder what they would say if it was me who was feeling anxious, or, if somebody's… I don't know… off on a long term sick… I'm just thinking, actually, there was a chap in my previous job who was off on a long term sick for most of the time that I worked there, which was nearly two years, due to mental health problems. And he was very much, kind of… initially, it was, kind of… people were angry about the fact that he wasn't there to be able to do his job. There wasn't very much compassion for him in his situation. And then he was just, kind of, forgotten. But I think, whether part of us think, well, we're trained professionals, we should be able to manage our own mental health; I don't know. And I think quite a few professionals aren't very, kind of, sympathetic or empathic towards each other, particularly if it impacts on their case load or if it impacts on their work load*'

As well as the impact of sickness on team workloads, colleagues' deteriorating mental health was seen as potentially risky for patients. Team management of that risk could be uncomfortable, particularly in a small, well established team, according to Ellen, describing a colleague with bipolar disorder:

> *'And the difficulty is, when you're working you can see when she's becoming very unwell, and how things start to deteriorate, and then you do start to worry about patient care, and how things are being managed, especially when you have less and less staff. So I can understand why things are done to intervene, as such. But, sometimes I think it's difficult, because you work in such a small team, things are said that shouldn't necessarily be shared. And it's partly because a lot of us have known each other for a very long time.'* (Ellen)

Giving another example, Ellen said that she and a particular colleague supported each others' mental health through taking time out together and improving the office environment. Monica also described offering support to colleagues who were having difficult times:

> *'I've got colleagues at work that are struggling with life basically, things that are happening in their life, but I don't think they've got actual mental health problems. I think it's just a case of trying to fit in their work life with whatever's going on at home and I think, you know, you try to support them as well. You know that they're going through stuff and you know that ultimately you can't do anything to change what's going on outside.'*

Melissa talked about using the same skills she used with patients to support a colleague in her small team who had mental health problems:

> *'So, I mean, it's the same as when you're working alongside the people we support. It's spending time with people and offering any... you know, thinking out of the box. You know, it's not just straightforward so I think that was it.''*

Team attitudes to mental health problems depended on the work setting, as well as on team closeness and culture. Diana contrasted the ward and the community setting, saying of a ward based colleague:

> *'...at times we thought what can we do to support her but other times she needed to go off sick. The manager would send her home. But I think on the ward you are more tightly bound together, you do build relationships. You're watching each other's back a lot of the time.'*

Eleanor also described her previous ward versus current community team as 'close knit'. Joanna and Neil both held roles where they co-facilitated group therapy. For them and their teams, being aware of colleagues' current mental health was integral to them being able to do their job. When Neil was going through his divorce the team was sensitive to what work he should take on, similarly in Joanna's team, awareness of a colleague's current family issues meant they could support her well in group. Joanna said:

> *'I think we do, probably, a much better job at that than many other teams that I've worked in would do. I think, because we're more...we're quite understanding that we have lives and we're human beings. We're not just there to do our jobs; we...we've all got baggage and stuff that comes with us. So, I think that we do manage it fairly well.'*

Figure 10.1: Colleagues responses to mental health problems

Stigma

Degrees of openness

Team 'closeness'
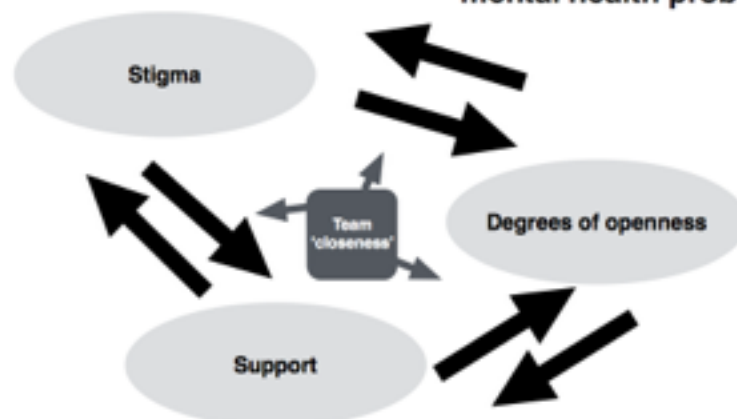
Support

In summary, the participants described a range of ways in which their colleagues and teams dealt with mental health problems. The three aspects of this (sub themes) were openness, stigma and support. As shown in Figure 10.1 there was interaction between these three aspects of colleague's responses and their impact on the mental health nurse with subjective experience. Degrees of openness, stigma and support all influenced each other. Their effect on each other was influenced by 'team closeness', which was a central, pivotal force.

In order to access support from colleagues the mental health nurse had to be 'open' about their experiences and their needs. The degree to which the mental health nurse or colleagues were open regarding mental health problems depended on the stigma that mental health problems had within their workplace. Whilst mental health problems per se may not be stigmatised, taking time out and the effect this had on others' workloads was stigmatised. The findings suggest that a way in which stigma may be addressed is through mental health nurses being more open about their mental health problems, however this willingness to be open is affected by perceived stigma. The stigma associated with mental health problems or time out could affect the amount of support available from colleagues. At the same time, the amount of support a person might need or get could also be stigmatising, when those team members who were being supported and managed by the whole team, through team management of their workload and their risks. Stigma, degrees of openness and support were mediated by 'team closeness', the extent to which teams had a collective sense of wellbeing and shared identity.

The findings here relate to the underlying theme of 'distancing and connecting', whereby team 'closeness', how distant or close the mental health nurse was to colleagues, impacted on how open they were, how accessible collegiate support was and how stigmatised the mental health nurse with mental health problems felt. Support, openness and stigma were interlinked, influencing each other, with team closeness.

10.2.3 Management responses to mental health problems

Figure 10.2: Continuum of managerial responses to mental illness
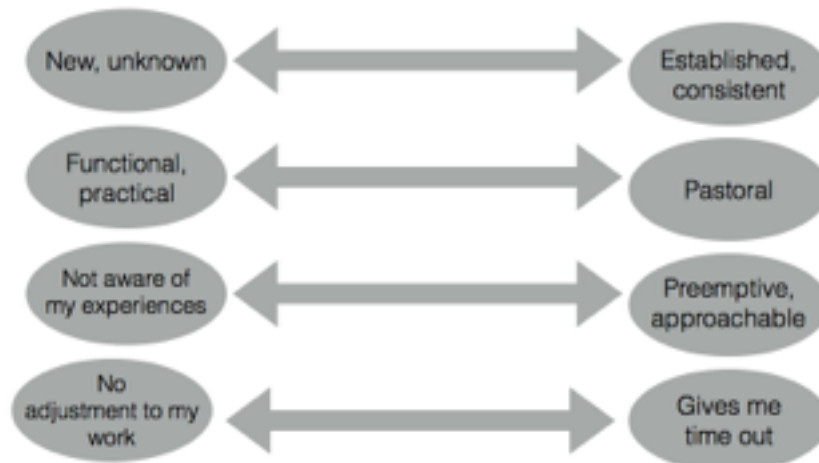
> '…he doesn't just say, what are you doing with this person, what are you doing with that person? He says, how are you doing? How are you coping? He's brilliant.' (Christine)

Within the interviews, a sub theme within 'mental health problems and work' was 'management responses.' This followed the thread of those survey questions on the impact of experience of mental health problems at work. According to the interview participants, managers set the tone for how the team dealt with colleagues' mental health problems. They were also the representative of the employer and organisation for the mental health nurse. As with their descriptions of colleagues, there was a range of experiences, ranging from positive to negative.

Whilst it was possible to conceptualise what the participants said about colleagues' responses according to a consistent model of influence and effect, what the mental health nurses said about their managers was more varied, reflecting a range of experiences that was best represented according to a set of continuums in Figure 10.2. The validity of qualitative research is in part

reflected in how deviant or outlier cases are addressed (Seale, 2012; Ritchie et al, 2013). Representing this theme as continuums means that the diversity of cases has been encapsulated in the model. Managers ranged from new and unknown to established and consistent. MNHs' relationships with managers ranged from being purely functional and practical to being more pastoral. Some managers were not aware of the mental health nurses' mental health. Others took the mental health nurse's mental health problems into account, even preempting their needs. Some managers encouraged the mental health nurse to take time out when not mentally well. Others made no workplace adjustment in light of the mental health nurse's mental health.

Many participants were generally positive regarding the way their managers had responded to their mental health needs. A positive management approach was about being approachable and preemptive, with the manager fostering a working environment where staff could reflect on and respond to their estimation of their mental health and where they were encouraged to speak out:

> *'She's really understanding. So, I will sometimes say, say if I'm getting a little bit sort of, not great. And I've done that before, is just took a few days off, just to try and get my sleep sorted or something. To see if that's, that I get things on track again.'* (Jackie)

> *'I had a word with that manager and he, kind of, says, do you feel able to sit, you know, to put your hands up when you're feeling ill, and I'm, like, yes, fair enough and, you know, I'm that kind of person and I do wear my heart on my sleeve, so, you can tell when I'm not well'* (Chloe)

When participants talked about their work and their team they frequently described how organisational changes and restructures had impacted on their and colleagues' wellbeing, and how that was being dealt with by both themselves, their managers and their wider team. There was a wider context in which subjective experience of mental health problems took place. Several participants talked about the impact of management changes and moves, with successful managers being redeployed to failing areas within their organisation or else new managers being forced on their team, with good and ill effects:

> *'So as soon as we can get new people started I think it will be better. But as far as the team goes the manager moved on a couple of weeks ago and we've got a new manager in from another ward. The staff felt about the old manager they didn't quite have that connection with him. The new manager has only been there three weeks but we believe that she is more ... bureaucratic really and more really centred I suppose but time will tell. I think there was a bit of conflict between the old manager and the staff but we'll see where it goes from there.'*(Rob)

The participants spoke of the importance of consistency and of the manager having a connection with the team. When managers were being moved around this was impacting on team wellbeing as well as the wellbeing of individuals. An established, known manager was preferable to one who was new and unknown.

Sylvia was one participant who voiced general discontent with the management hierarchy at her work and with being told by her line manager to '*play the game*.' However, her description of her manager's approach to her mental health was a sympathetic one on both counts:

> *'My ward manager, so the Band 7, well, he knows that I get up and down a little bit. I sort of, sometimes I stick my head into his office on the way out of a shift, and say, sorry if I was a bit snappy, I was hormonal, and we just have a joke about it.'*

The manager was approachable and knew her well. There were some participants whose experience of the management response were not so positive. Lucy worked as a bank nurse, meaning that she did not have a permanent line manager. Her relationship with managers was functional, with no pastoral, supportive aspect:

> *'With managers as well, you're not in that kind of relationship, it's, kind of, like, book shifts, how you getting on and that's that really, from my*

point of view. I think if I was on a permanent contract and I spent a bit more time.'

Ellen reflected on her experience of depression and did not consider there to be a managerial response or acknowledgement of her situation. She, like Yvonne and Rose, described getting to breaking point and 'crashing' before her mental ill health was noticed or responded to.

> *'Nothing really changed, or there was no, sort of, support from management as such to say, you know, or it didn't feel like there was. There probably was to a degree, but I wasn't aware of it. Because what I really wanted someone to say was, just go away, you know, you don't have to come in, you don't have to deal with anybody else's problems. But that didn't happen.'*

This was in contrast to Diana, whose manager recognised and responded to her mental health needs:

> *' I did have a very good manager who said I'm giving you a few days off carer's leave. I was horrified I said ˜no no I don't need them. You don't want people telling you, you need carer's leave. I know it was her way of saying I know you're not alright.'*

and Ruth, who appreciated her manager's '*light touch*' approach:

> *'...really supportive. I had the same manager both times and the first time round the nice thing was that she didn't contact me for about a month or so which some people sort of said, oh, I would have thought, you know, but I just, work was the last thing on my mind. The only thing was the situation, you know, and that was it and I think I would have felt pressure if she'd have been calling me even to see how I was, and so it was about a month and by then it was just nice like how are you doing, don't come back until you're ready...'*

Whilst the mental health nurses described a range of experiences of managers, their comments were in consensus regarding what a 'good' or desired managerial response to mental health nurses' own mental health problems or problems at home would be. This was towards the right side of the continuum in figure 10.2, where the manager was a consistent presence in the mental health nurse's working life, who offered staff pastoral support rather than just meting out tasks and who was proactive in addressing team members' mental wellbeing. In discussions of both managerial and collegiate responses to mental health nurses' mental health problems the underlying themes of 'distance and connection' and 'choice and control' emerged. Connection, in this case what may more aptly be described as 'closeness' within teams influenced openness from the mental health nurse and the support that mental health nurses with mental health problems could access. The mental health nurses were concerned with having 'choice and control' over their circumstances, both of disclosure but also of how their mental health problems were handled. Interestingly, the mental health nurses appreciated a manager who exerted some control and told them what to do, insisting that they take time off, for example.

10.2.4 Experience of occupational health services

Participants were asked about how their employer had responded to their mental health problems via their occupational health service. As with their experiences of colleagues and managers, their experience was mixed, ranging from '*absolutely wonderful*' (Fiona) to '*they weren't very helpful at all*' (Ellen). Within this theme, three sub themes emerged, reflecting the unique position held by these mental health nurses with mental health problems. First, several mental health nurses were concerned by the relative lack of expertise in mental health of the occupational health nurses to whom they had been referred. Second, they were concerned about being 'treated' in the same services and by the same professionals as the people they had nursed. A third common concern was the return to work, with participants having mixed experiences of how the return was broached and managed.

Rose's and Ellen's occupational health nurses acknowledged their relative lack of expertise:

> *'Well, the woman whom I saw had no experience in mental health at all. She was a general nurse. And so she just had no idea, really, you know. I mean, to be fair, she did say I have no idea.'* (Rose)

> *'It was somebody that has done occupational health for our trust for quite some time, and it was more, kind of, well you know, you're mental health, and I'm a general nurse, and you know, everything's, kind of, okay. You know, you're a nurse..There wasn't any constructive support.'*(Ellen)

Rather than having a bad face-to-face experience, Diana avoided accessing occupational health services due to a fear of what the other mental health nurses described:

> *'I'm not sure I've never been there and I'd probably be a bit 'I know more than you' I might be wrong thinking like that but I'd go there with that in my mind and I'd want to know they were more experienced than me in mental health to deal with my mental health. I don't want to go to someone who has done a module on mental health in their occ (sic.) health training to know about my mental health.'*

This denotes both a confidence in her own abilities and how her unique position may have made accessing mainstream services difficult. Similarly Sylvia, who worked in a specialist forensic setting, had not gone to occupational health because she did not consider the practitioners had sufficient understanding of her work. Occupational health for her organisation had been contracted out to a generic non NHS occupational health service. She said":

> *'Because they don't tend to understand forensic nursing. I mean, for example, ****(the occupational health service provider) give return-to-work interviews and don't even know what control and restraint is, or, you know, if somebody has an injury, and they go for an interview, they*

say, well, you know, do you think I'm fit to respond, and they don't even know what control and restraint is.'

These quotes show that when mental health nurses needed mental health support at work, both they and their service had to negotiate the boundary between their roles. Ellen said:

'...just because I'm a mental health nurse, at that point I wasn't a nurse, I was the patient.'

As described above, participants were unable to access occupational mental health services uncritically. Their mental health nursing role also means that they felt at risk of exposure and broken confidentiality. For Monica this was due to her overhearing a colleague talk about a friend who worked in the occupational health service. She asked to be referred by her trust to services outside of the NHS and this was declined. In contrast, Trevor described a positive experiences of occupational health because his counsellor was someone employed by and known within his trust.

Fiona's account of a positive occupational health experience conveyed that the occupational health practitioner had some authority and took charge whilst she was in a difficult situation. She said:

''…she just arranged for people in the place not to contact me and that did mean that I didn't hear from the people I perhaps did want to hear from but I just felt like that would be fine if I didn't hear from anybody for a while, that would be absolutely fine. At the same time she made clear that I could go and talk to her whenever I wanted to and she was a bit more directive about it than that, she actually gave me appointments. It's fine any time you find you don't think you can make it in here but we need to keep in contact, we need to do this to keep the organization happy.'

Heather, undertaking an occupational health assessment as part of the application process for nurse training, had submitted to a request from the

occupational health practitioner that she described as '*mortifying*.' Because of a self declared past history of self harm, declared on her application, she was asked to remove her tights and show her legs, in order to prove she had no recent self harm wounds. She said:

> '*I was only 17 when he was doing it. I didn't want my chances to be affected by me as a stupid wee girl at the time. And I thought maybe I was unwell at that time but before that I just thought I was an idiot.*'

For some participants occupational health contact had been limited to negotiations on returning to work, with a focus on the sickness absence monitoring and graded returns. Jackie and Jean described taking the business of getting better into their own hands, with the relationship with occupational health being functional and procedural. In Ruth's case, the limited interest and input from occupational health was welcome, and reflected for her an acknowledgement that her sickness absence was being resolved.

Figure 10.3: Mental health nurses' views on occupational health management of their mental health problems
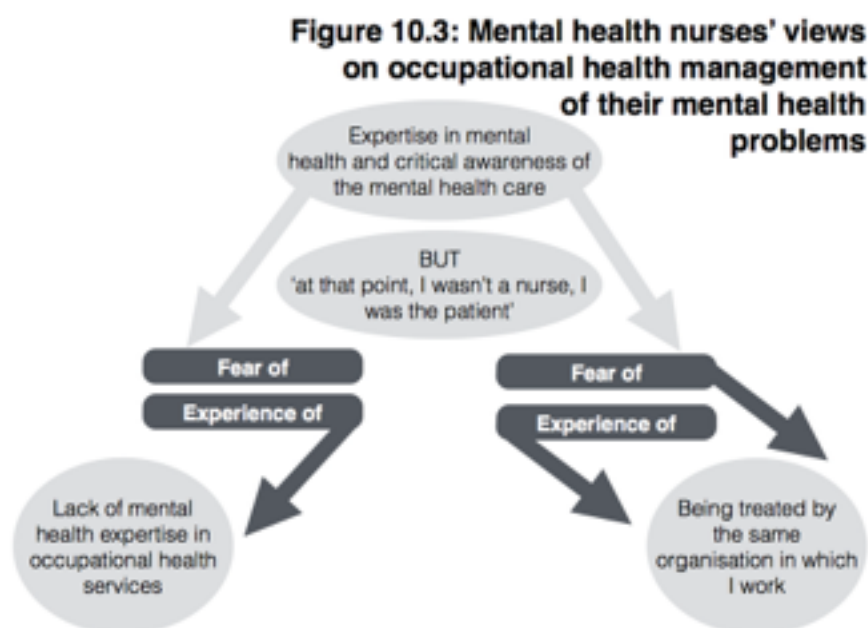
In summary, it was evident from the interviews that the mental health nurses critically appraised occupational health from their expert standpoint. There was no real consensus as to what the best approach should be, save that occupational health services should acknowledge and offer services appropriate to the participants' level of mental health expertise. The participants' unique

mental health nursing perspective was also reflected in their view that mental health care should comprise more than the negotiation of practical assistance. This is figuratively represented in Figure 10.3. Whilst there was a range of experience described, with some mental health nurses describing excellent organisational responses to their mental health needs, the common thread through this theme was the way that mental health nurses critically appraised their experience of occupational health services based on their expertise as mental health workers. This was similar to their critical appraisal of their experiences as patients and carers, as discussed in the previous chapter. The mental health nurses' views on occupational health provision reflect The underlying themes of 'choice and control' and 'self nurturance'. Several mental health nurses chose to self care rather than to rely on occupational health services, either because they found the services to be lacking or because they feared this would be the case. Where 'choice and control' was an important element of maintenance of SWB, as discussed in Chapter 8, the mental health nurses wanted some choice and control over their treatment and the handling of their mental health. This stemmed from their expertise in the field.

10.3 Being a mental health nurse: using experience of mental health problems in mental health nursing work

In this next section the ways in which mental health nurse with mental health problems use or reveal their experience in their work are discussed. First the survey results on disclosure of mental health problems are presented, followed by an interpretation of the interviewees' comments on disclosure.

10.3.1 Disclosure of mental health problems - survey results

Disclosure of mental health problems was a thread running from the survey to the interviews. Table 10.4 summarises the survey results on disclosure to clients, colleagues and managers, giving overall percentages of response. Table 10.5 presents the results for each disclosure question, with the most frequent responses in **bold**. The summary findings reflect similar trends to the individual questions with the exception of the question on experience of currently living with someone with mental health problems, where respondents

to this question were most likely to *never* disclose their experience to clients(74%, n14), colleagues(50% (n10) or managers (50%, n 10).

Table 10.4: Disclosure of mental health problems- summary of survey results

Disclosure of Mental health problems to:	n	never	occasionally	sometimes	always
my clients	258	**62%(161)**	29%(76)	8%(21)	0
my colleagues	241	27%(64)	**41%(98)**	29%(69)	4%(10)
my manager	241	**36%(86)**	20%(47)	25%(60)	20%(48)

Table 10.5: Disclosure of mental health problems- survey results

		n	never	occasionally	sometimes	always
Do you disclose your personal experience of mental health problems	**to clients**	55	**75%(41)**	22%(12)	4%(2)	0%
	to colleagues	55	13%(7)	**56%(31)**	27%(15)	4%(2)
	to your manager	54	24%(13)	20%(11)	**28%(15)**	**28%(15)**
Have you disclosed your personal experience of mental health problems	**to clients**	97	**58%(56)**	30%(29)	12%(12)	0%
	to colleagues	97	27%(26)	**35%(34)**	**35%(34)**	3.1%(3)
	to your manager	97	**31%(30)**	14%(14)	29%(28)	25.8%) 25
Do you disclose your home experience of living with mental health problems	**to clients**	19	**74%(14)**	11%(2)	16%(3)	0%
	to colleagues	20	**50%(10)**	30%(6)	20%(4)	0%
	to your manager	20	**50%(10)**	15%(3)	30%(6)	5%(1)
Do you disclose your previous experience of living with someone with mental health problems	**to clients**	69	**73%(50)**	22%(15)	6%(4)	0%
	to colleagues	69	30%(21)	**39%(27)**	23%(16)	7%(5)
	to your manager	70	**47%(33)**	27%(19)	16%(11)	10%(7)

Table 10.6: Interviewees' disclosure of mental health problems- summary of survey

Disclosure of mental health problems to	n	never	occasionally	sometimes	always
my clients	40	**26**	8	6	0
my colleagues	39	8	**18**	12	1
my manager	40	**16**	10	8	6

The results show that mental health nurses were most likely to *never* disclose the various types of mental health problems experience to their service users. Nobody said that they *always* did so. Between 11 and 30 % of respondents might *occasionally* disclose their experience. Between 4 and 12% of respondents might *sometimes* disclose their experience. This suggests that disclosure to service users is not the norm, and for the majority of mental health nurses it would be an unusual practice. In the interviews, following a thread from the survey, the topic of disclosure was discussed in detail, with mental health nurses giving some examples of times when disclosure had occurred and also some of the ways that personal experience might influence their work without explicit disclosure (see 10.2.3.1).

Regarding colleagues, the majority of respondents reported occasional disclosure: 4% of mental health nurses said that they *always* disclosed, whilst 27% said they never disclosed. Occasional disclosure was most common for current personal mental health problems and past experience of living with someone with mental health problems. Respondents were most likely to *never* disclose to colleagues that they were living with someone with mental health problems. This suggests that mental health nurses had no definitive rules regarding disclosure to colleagues. This finding is backed up by the interview findings, where disclosure to colleagues was dependent on the different types of relationships mental health nurses might have with different people, being more likely to disclose to fellow mental health problems experiencers or to people who had become friends. Also the interviewees described varying degrees of closeness and openness within their teams, where talking about mental health problems might be more or less common in the work environment.

According to this survey, disclosure to managers was not the norm. The results show that mental health nurses are most likely to *never* disclose their experience of mental health problems to their manager. The results in Table 10.5 shows that 47%, 50% and 31% of respondents never disclosed to their manager their personal past or living with someone with mental health problems in the present or future. 28% of mental health nurses with current mental health problems did disclose their current mental health problems *always* or *sometimes.* The findings here suggest that being open about mental health problems is not the norm in the mental health nursing workplace, and that management culture is not such that mental health nurses either want to or feel able to always tell managers their mental health problems. As with colleagues, the interviewees talked about a range of experiences of managers dealing with their mental health problems. Some mental health nurses had a business like, purely practical relationship with their managers. For others their manager was a confidante or ally.

The interviewees' responses to these survey questions were explored further in order to see whether they reflected the survey population as a whole. Table 10.6 summarises their responses. As with 'impact on work', the pattern of disclosure for interviewees mirrored that of the survey respondents, of whom they were a subset. This gives credibility to the interview responses being reflective of a wider group, because their tendencies to disclose or not were similar. Like the survey respondents overall, most interviewees did not disclose to clients or managers their experience of mental health problems. Disclosure to colleagues was more evenly spread, and more likely to happen *occasionally* or *sometimes*.

Fiona was the only person who said that she *always* disclosed her *past experience* to colleagues, although she also said that she never disclosed her *currently living with* someone with mental health problems to her manager. Ellen was the only person who said she *always* disclosed her current mental health problems to her manager. The comparative patterns of disclosure between *personal experience* and *living with experience* show a more disparate picture of disclosure when talking about oneself, in that that only Rose, Trevor, Zoe and Allison gave the same response regarding disclosure to all three categories of

possible confidantes. This suggests that the mental health nurses had different ways of presenting themselves and their experiences to different audiences. Disclosure of *living* or *having lived with* someone with mental health problems was more likely to happen only *occasionally* or *never*. This suggests that mental health nurses tend to have reason to disclose about themselves more often than regarding their home situations. This finding is echoed in interview findings about differentiation between work and home life and distancing between the two.

10.3.2 Bringing experiences into work - interview findings

> *'I spent six or seven years as a clinical nurse specialist in the therapeutic community and I found that you were your own tool in a sense, your experiences were your tools both for empathizing with people and for helping people to learn in that situation. I wouldn't just tell clients about something to do with me unless I had a point that referred to them. I certainly wouldn't land clients with a load from me but I would use my experiences to tell them how I could understand them and maybe to put some suggestions their way about how they could go about doing whatever they want to do and I think that's where the boundaries are for me. They are very clear to me. You make yourself vulnerable to clients of the not dementia type and you have to make yourself somewhat vulnerable in order for them to see a person as opposed to a nurse, not a professional but an actual real person.'* (Fiona)

As well as describing their experiences of healthcare and how their mental health problems were dealt with at work, the mental health nurses talked about how their experiences were brought into their work. At the heart of this were the instances when they had disclosed their experiences to service users and colleagues. The mental health nurses also talked more broadly about how their experiences influenced and were used in their work, in a less explicit way. Linked to this were comments made by the mental health nurses about their identity as a nurse and what being a nurse meant to them. 'Being a nurse' was associated with who they were as people, as individuals. 'Being a nurse' was

**Figure10.4: Bringing experiences to work
- a conceptual model**

Identity as a nurse with
a mental health history

Use of my self and
experiences in my work

Disclosure and
crossing boundaries
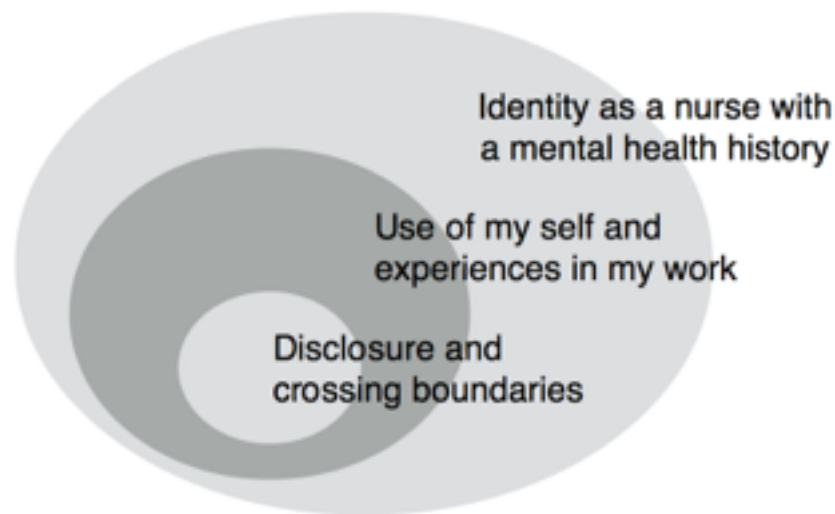
about using the self, being oneself. All three of these ways of bringing experiences into work are exemplified in the quote from Fiona above.

A conceptual model for **'**Bringing experiences to work' is shown in Figure 10.4, with 'Disclosure and crossing boundaries' at the centre, encompassed within a more subtle way in which mental ill health experiences were brought to work, through a conscious or deliberate 'use of self and experiences'. This was encompassed by a broader way in which subjective experiences were brought to work, through the mental health nurses' identity as a nurse with a mental health history. For Fiona, (who said *'your experiences were your tools'* her life experiences were part of her nursing identity, ever present in her work, she used her experiences with clients ('*to tell them how I could understand them*') often but not always, whereas full disclosure was a rare occurrence of crossing a boundary where 'you make yourself vulnerable.'

10.3.2.1 Disclosure and boundaries

When the mental health nurses were asked to describe how their own mental health experiences interacted with their work practice, they talked about disclosure and boundaries. Several participants relayed cautionary tales, from

their own past and from colleagues on the risks of oversharing and crossing boundaries. Working out boundaries seemed to be something that came with years of mental health nursing experience. Over time mental health nurses may become more relaxed and comfortable to negotiate boundaries rather than being rigid, as explained by Trevor

> *'…more early in my career I might have been less open as my training would have said do not tell people. But working with older people who openly ask you things out of friendship and kindness and they only want to be normal- asking have you any family and that sort of thing. I don't have any problem with that…'* (Trevor)

When disclosure of mental health problems to colleagues was discussed, a range of views were given. Disclosure of mental health history seemed to occur when there was a point of commonality between the mental health nurse and colleagues, such as Heather talking with a colleague about her father's alcohol use because they had a shared history. Sharing with colleagues and managers was understandably linked to closeness and friendship. It also depended very much on work setting, with participants contrasting the different mental health settings in which they had worked. For example, self disclosure was deemed 'you can't go there' in forensics by Diana. She began her career in that setting and had learned to be more open in other settings:

> *'I think it's working in forensics. Because I worked there to start with, working with peadophiles where you don't tell them anything about you, that when I moved on to that it took me ages to give a little bit. It took a long time to realise I don't have to be so guarded.'*

In her present role, Diana remained wary of boundaries between herself and her service users, because of their diagnoses:

> *'Yes I'll tell them I've got a baby or that I have children. But working with kids with Aspergers the social boundaries are not there. They will just ask - Have you got a husband? Have you got a baby? They don't have the cognitive judgement to work out what is appropriate. So if I told them*

that I'd had depression they might want to speak about that every single session. Cos the social cues are not there.'

Other mental health nurses working in forensics had similar views, with Rob, for example, recounting his experience of 'relational security' training following an incident of inappropriate sexual relationships between a psychologist and a patient in his forensic unit. Similarly, Alison talked of avoiding disclosure with her Asperger's patients, who might 'latch onto' the information. Those mental health nurses who had worked or were working with older people said that talking about home and family was part of being 'normal' with their client group, as described by Trevor above. Ruth had chosen to talk more about herself when working in a group setting as a co facilitator with a peer support worker:

> *'Yes, I think it depends on the situation because it's not like, I mean me and the peer support worker that I worked with we did a group together that was like a kind of recovery group and in those circumstances there was, we would have warm up, you know, bits of the group and we would take part in the group as much as the clients in those circumstances it felt right and it felt, you know, comfortable to share some things'*

'Being clear about boundaries' was about being careful when talking about oneself when talking with patients and service users. Boundaries may be negotiated or crossed, but it was important to know that they were there. This was important to a number of participants, for example, Rob and Ryan talked of keeping and knowing '*a line*'. For Diana, not talking about herself was a means of '*self protection*'. For Ryan it was about putting the patient's best interests first:

> *'You know, you need to be careful how much information you're giving to patients about your own experiences, and you need to make sure that you're doing that in a way that's in the best interest of the patient and it doesn't just become a sort of... a type of extra therapy for the staff member.'*

For Ellen it was about recognising that everyone's experience is different. For Sylvia, not disclosing details of her depression was a means of containing information about herself, as

> '*you don't know who they're going to talk to, and you don't know what they're going to do with that information, so, you know, that can always come back to bite you.*'

Patty made a similar point. Ruth said that she had got a good idea about how and when to disclose from her experience of supporting and supervising the peer support worker in her team. Alison, on the other hand, gave a different rationale for non-disclosure to colleagues and patients. She said that she had left her mental health problems behind, and so they were not part of who she was now.

Some participants set specific rules around their self disclosure. Rob said anything referring to his own life would only be relayed in the 'third person.'

> '*I've not talked to any colleagues about it no because I don't think the situations require that. I will try to help patients reflect on things by using my experiences but not in a direct way like in a third person type of way say I knew somebody who suffered too. Do you know what I mean? If I wanted to have a conversation with the patient about something that happened in my life I would put it in a third person.*'(Rob)

Norman differentiated between conversation and disclosure saying:

> '*You can be friendly and you can have social chit-chat when you're out with somebody but it's always a conversation with a purpose rather than just conversation and enjoying somebody's company and that's one of the things that's different between family and friends, and patients.*'

The notion of '*a conversation with a purpose*' was similar to Fiona's approach to disclosure when she '*had a point that referred to them*' and Heather's idea that:

'I think sometimes just to give people a wee snippet about your life and your upbringing can give help to explaining things.'

Some mental health nurses (Joanna, Fiona, Christine) had worked in therapeutic communities or with borderline personality disorder clients where the mental health nurse's personality was very much part of the therapeutic approach.

There were some accounts of self disclosure that were not by choice, however, Lucy talked about '*the self project*' she was forced to undertake as part of her nurse training, when a presentation by a service user triggered strong feelings in her regarding her own past. Joanna also had a strong reaction when she encountered 'psychodrama' on a placement

'I'd never seen psychodrama before and didn't know anything about it, and it was so powerful that I literally could not contain the distress that I felt for her and her situation. And it wasn't, like, I wasn't bawling my eyes out but I said to her afterwards, cor, that was really… I could really feel your pain, I could really connect with that and understand that. And I think that, if we're able to show our patients how their story or their background, or their interactions, make us feel, then they're getting a bit of real feedback about…'

Joanna had had mental health problems whilst working in a personality disorder service. Because her own problems had manifested in her behaviour and appearance, it had been obvious to the service users when she was unwell and when she started to get better. When periods of mental ill health had occurred during their career, participants may have had to justify and acknowledge the reasons for taking time out to colleagues and service users.

10.3.2.1.1 Judicious disclosure

Participants talked about times when they might disclose their experiences. This seemed to be about developing rapport, validating experiences and progressing the nurse-patient relationship. Tracy said that she used it to '*turn the*

conversation around' to where she wanted it to go. It may include letting the patient know that certain treatments or practices had helped them. Ellen said:

> *'I definitely feel that, for my working qualities, and the experiences that I have, it's been very beneficial to be able to talk to patients and their families about some of the difficulties that people may have. So I do share the fact that I have had depression and a period of great difficulty, just because I think I have a little bit more understanding than I did, whereas before I was all, kind of, like, let's do it, you know, let's set some goals.'*

Also whilst Trevor said '*I don't talk with clients. Occasionally might be a bit of self disclosure but it is not the norm really'*, he also said that he might self disclose

> *'if people are reluctant to talk about things because they feel embarrassed then I might say that it's alright to not be fine all the time. I have tried antidepressant myself and they do help.'*

Judicious disclosure was in order to convey understanding rather to give advice:

> *'I think you can disclose personal information to show empathy, and support, and an understanding of where that person might be, but you don't ever know what somebody else is feeling, you can know what it's like to be depressed, but my depression will be different from somebody else's. But you can know what it's like to feel at the bottom of a dark hole.'* (Sylvia)

Carrie had a technique for sharing her experiences as a means of relationship building, which contrasted with Rob's only disclosing in the third person. She used 'we' rather than 'I' or 'you' or 'they':

> *'I use we, and us, and I'll always use the plural. I don't like to say, you know, when you're feeling like that. I'll always say, when we're feeling like this…'*

For Rose, disclosure to colleagues about her experiences had to be selective and limited, because

'you don't want to come across as someone who just can't manage.'

10.3.2.2 Using one's own experience to inform work with service users

'Engagement is the most important thing, the most important thing. In fact it doesn't matter if the therapy's no good; it's about whether or not they engage with you and they trust you and they want to tell you things and they get a… I think they get a sense of wellbeing from that, a sense of self-esteem as well that here's somebody who, yes, I know she's paid to care for me but we laugh together and we talk about things and I feel safe. And that helps them to start thinking, how can I move on from just feeling safe with this person to feeling safe with other people.' (Christine)

In the survey mental health nurses had been asked whether their experiences of mental health problems affected their work with colleagues, service users and their workload. This was followed up in the interviews with questions on how exactly the experience had impacted on their work. A theme emerged: 'the use of self in work' (Fiona's idea of yourself as a '*tool*') It was the mental health nurses' whole range of life experiences that influenced their work, not just their mental health experiences. Being aware of the self in work seems to be an essential element of nursing people who were mentally ill. For some mental health nurses the experience of mental health problems had changed their outlook on the work. For others it had motivated them to nurse in the first place.

10.3.2.2.1 Being 'real' is part of mental health nursing

'…one of the important things about nursing is that you are using your personality and you're using your experiences. At the same time I do feel like, you know, I have to have a role. I have to be professional. I have to be boundaried and I find it much easier to be like that.'(Ruth)

Like Fiona (above) and Ruth, others saw use of self as an important part of their work. Life experience and 'being real' (Joanna) meant being credible to patients but also being able to understand and empathise with them. Having some shared experience (of mental health problems) was a point of connection. Several mental health nurses described the importance of wider 'life experience' to mental health nursing. They talked about how it gave mental health nurses credibility and insight. Neil said that his life experiences as a carer of someone with mental health problems and his life experiences of working in manual labour gave him both credibility with service users and insights that some of his younger colleagues who had gone into mental health straight from school lacked. Patty said:

> *'I think life experience is more valuable than anything. If you do it too much by book learning, a, it's false anyway and one of the things when I first started my RMN training was that I would be reading case notes and I actually said to one of the sisters why is it… I've been through this, I've had to deal with that, why is it they are the patient and I'm not? Her answer always stuck with me is that what you went through at the time you went through for that and who was there for you and you may find that simply because there are people around doesn't mean to say you can tap into them, you can't always use them because of the way you view yourself. Of course that rings true in the sense that was exactly what was happening to me.'*

In these instances use of experience was not necessarily a disclosure of personal mental health problems, rather it was an element of relationship building and making connections. The mental health nurses did not necessarily share their insights with colleagues or patients, however they did reflect on the way that life experience influenced their approach to patients.

In contrast to these views, though, Christine said that her difference from the patients brought 'balance'. She said:

'I think they need me for the… actually for my point of view not having the lived experience. They need me to give another view, a balanced view that's not about having been through it.'

10.3.2.2.2 Experiences aid empathy and understanding

Mental health nurses who had had mental health problems during their career described how their subjective experiences had affect their empathy with and understanding of the people in their care. Heather said:

'I think with the self harm I think it have a lot more empathy for them than a lot of people. I can understand the release of it. I can understand suicidal tendencies, even though mine might not have been so severe, as we see severe cases, but still my skills are there for that person.'

Yvonne said of her experience of mental health problems during her nursing career:

'…it shocked me and it made me realise how, you know, how mental health is, really; how, kind of, mental health illness can affect you. Because I really did break down and really did have no control over it and I just cried and was in a terrible state, so it made me more… I had some more empathy after that, I suppose, because I realised how it can get you.'

Subjective experience of mental health problems enabled the mental health nurses to look at things from the patient perspective. The experience 'changed' Ruth's professional outlook:

'I think I do see things differently. I mean I think you, I think having experienced care and being unwell you do have a differently outlook anyway because I think you think how would I want them to be treated kind of thing but, you know, now when someone talks about anxiety I really know although I could have empathised, you know, and had an idea I now know really how that is. So yes, I think differently.'

As well as increasing empathy the experience enabled the mental health nurses to have 'hope' and to see their patients more fully. Having 'recovered' or managed with mental health problems themselves, the mental health nurses could see the possibility of recovery for others. Ellen said:

> '*I think some of the things that I thought would be helpful to people, now make me cringe. You know, things that came up in books, or groups that we would do, and the way that we would talk to people about, you know, wow, you know, you should be doing this, this would be really helpful. And when they would say, but I can't do that, and we was like, oh, maybe they're just not trying. And now just really appreciating that it's just, they're here, they're doing so much just by being here, and just, I don't know, yes. I think I'm such a better practitioner for having experienced it.*'

In contrast, two participants said that being in the thick of their mental health problems made them less able to work well with service users and less able to access their emotions, as well as being less able to manage their workload. Monica said:

> '*when mum, when I lost my mum I remember for, oh gosh, for about two, three years after I was emotionally blunted and I don't know how much of that was the shock or how much of it was, it could have been antidepressant medication as well the blunts it made, but I think a lot of it was the shock. I just had no kind of, you know, normally I'm one of these people if you're upset about something I could give you a hug and I could really feel it for you, but I felt like I was talking to somebody but I got nothing. I was like there, there, okay, you'll get over it in a minute and that wasn't me it wasn't me at all.*'

Patty said:

> '*… I was very hard on myself, I was frustrated and angry with myself because there were so many blocks to me I couldn't deal with but I'm in*

a position of authority and a position of responsibility, I've just got to manage them. Of course I was a manager, I was sort of constantly… there were too many balls in the air really and I just wasn't controlling any of them.'

Many participants described the boundary between the work and home self. Maintaining that boundary was part of feeling subjectively well (as discussed in Chapter 8) They had 'the work face' and the work identity, whereby they could keep caring and giving at work but would 'crash' at home. It seems that past history of mental health problems has a perceived positive effect on being a good mental health nurse, but that at the time of experiencing it, it adversely affected the ability to do the job well, although home life may suffer before work life.

'I've been clinically depressed for quite a few years, was able to function at work okay, but then coming home, I would be completely burnt out, I wouldn't be doing the cooking, the housework, I'd be completely exhausted. I'd be shouting at the telephone, using all sorts of swear words, it was a stress response, because at work the phone never stops ringing, you can't have a conversation, you're constantly interrupted, so when I got home, and all I wanted to be was peaceful, and the phone rang' (Sylvia)

10.3.2.3 Being and becoming a nurse

'I always say to people, look, this is me; I'm being genuine. Yes, I have a professional qualification but what you see with me isn't my nurse role; this is me, this is …, and I'm interacting with you in a very genuine way.' (Joanna)

Broadening out from the circles of disclosure and use of self, the mental health nurses' subjective experiences were also described in the context of their identity as nurses and their motivation to nurse. Nursing was seen as being '*part of my personality*' (Sylvia) and a vocation.

10.3.2.3.1 Nursing identity

Nursing identity, what it means to be a nurse, is a fluid and contested concept (see Section 2.3.3). Participants talked about nursing identity changing over time, for them as individual nurses, but also for the profession as whole. Some participants' subjective experience of mental health problems called into question their nursing role. It certainly impacted on how their mental health problems was managed. Diana talked about how she had '*put up with a lot or behaviour*' from a boyfriend with mental health problems because '*in your role as a mental health nurse one of the things you do is you stick in there.*' When Diana herself had depression she was professionally '*embarassed*' by the experience, as though she should know how to stay mentally well:

> *'Yes I was embarrassed. I went home once and I was in tears and I needed to just say yes its depression,.. In the group I've always been the one people come to. I remember feeling embarrassed about it. At the time I was battling through but you don't put the pieces together until further down the line.'*

For Sylvia her personal values (of compassion and authenticity) were aligned with nursing values. For Ruth, working as a nurse in the NHS was aligned with her political views. She had a sense, though, that these values were being eroded and that nursing in the NHS held a different meaning to some years ago. She said:

> *'I think when I was doing my degree I used to go on a lot of demos and there were a lot of nurses and I thought how cool that was and I thought how cool nurses must be and working at the NHS must be because they were all, you know, quite political and all the rest of it, and I think up until a couple of years ago it felt like we were being paid better for what we were doing. It felt like you could say there was pride in being a nurse and it's definitely been eroded definitely feels like that.*'

For other participants the job had changed in terms of increased paperwork and administration, less patient contact time and less job security. Some participants

had the experience of their service being moved out of the NHS and into the social and charity sector (Ruth, Yvonne, Joanna). Being a nurse was a less secure profession than in the past and its public standing.

10.3.2.3.2 Motivation and career choices

> *'People are drawn to mental health because of our personalities and our experiences and things we've experienced in our childhoods. The maddest people I have known are mental health nurses - people you think they need serious therapy.'* (Diana)

> *'It goes back to then because I think it created empathy within myself for people who have suffered mental health. If no one wanted to talk about my uncle who was a family member, you know, I just felt an empathy that a lot of people could be being overlooked and missed out, missing opportunities and missing out on life just because they've got something wrong with them which isn't their fault. I suppose that's just the way I am really.'* (Rob)

When subjective experience of mental health problems had happened prior to going into nursing it was commonly cited as a motivating factor for joining the profession. Experiences affected the choice of practice area also. For Tracy, personal experience dictated areas she did not want to work:

> *'I find it really difficult to work with alcoholic men, it's just something that I find hard. It makes me feel like a scared little eight-year-old, so I try and acknowledge that.'*

Neil moved from adult to child mental health work partly due to his personal experiences. He said:

> *'...there is that innate aspect of me that wants to help people - it's always been there - I used to mend people's cars and things like that - the thing that drives me - I think the more I worked in adult mental health the more I wanted to make a difference at that earlier level - I suppose*

now I've got all of that experience that makes me a more effective practitioner and I think that is what drives me - that I've seen that I can make a difference'.

Trevor had moved from adult to older peoples mental health services following his stress related depression. In contrast Alison and Eleanor had chosen to work in settings with higher stress and crisis demands because of a pleasure in 'being a little bit stressed.' (Eleanor). Nursing was seen as a vocation, with not all people being able to have empathy in the same way as they, the nurses could. One motivation to nurse was 'being nosy' (Chloe, Alison), wanting to understand people.

Not everyone started out wanting to be a mental health nurse though. For some, when choosing a career in health and social care, nursing offered the biggest financial incentive to train. Others had different aspirations. Ellen wanted to teach. Some (Patty, Monica) had originally trained as general nurses then gone into mental health at a later date. Despite comments regarding the challenges and changes in their services and roles, the mental health nurses talked about 'loving' their job. This love of the work was very much linked to their interest in other people and desire to connect and to play a part in changing their lives for the better:

> *'I like to sit down and spend time with people and I like to, sort of, you know, get to know people, along with mental health you have to find, you know, their background, their lifestyle and, I don't know, I find it more interesting and more challenging.'*(Lucy).

The mental health nurses liked connecting with people living outside of the main stream or at difficult points in their lives.

> *'I like working with people- I understand mental health problems on an intuitive basis and more formally what I like is working with people that need our help and you have got to see through the thing that most people would turn away from, whether that is a psychotic person reciting the Bible in the street or being quite dangerous or the other hairy bloke*

*who used to disappear for three days after he came in and had a shower and come out looking totally different, all shaved. Those people in society who you would cross the street, you wouldn't want to sit next to them on a bus. I like working with those people in their acute phase, you know, seeing an improvement in that situat*on.' (Alison)

Ryan said:

'I find it fascinating. It's a real... it's a real privilege to be able... you know, you get... you get to learn so much about the ins and outs of people's lives, and it's a real privilege to be, sort of... to be given the opportunity to be a part of... you know, if someone's having problems, to be a part of their situation, and I find it fascinating and, yes, really interesting and really satisfying. If you're able to make a difference, it's great and it's really satisfying, but I just think it's such an interesting job, and I think there are not many jobs where you get to sit down and talk to people about the sorts of things that we do talk to people about.'

This motivation to nurse and love of the job contrasted with a lack of enthusiasm for the paperwork and administration that was an increasing part of the nursing role. Carrie said:

'But I think most of my stuff comes from the fact that I really enjoy my job. I don't necessarily enjoy the service stuff at the moment, but trying to leave that to the people that need to worry about it. But I really love my job.'

In summary part of nursing work is about being clear about boundaries and choosing what and when to disclose. This observation applies to other personal information, not just information regarding subjective experience of mental health problems. The subjective experience of mental health problems, along with other life experiences, can be drawn on in nursing work to enhance authenticity and empathy. In accordance with the 'wounded healer' archetype, subjective experience of mental health problems forms part of the identity of the mental health nurse, in many instances motivating them to choose the

profession and informing their choice of mental health specialism. The skilled mental health nurse, working in a close team, with good occupational health and managerial support that enable or enhance 'self nurturance', can use their self and draw on their experiences to be a good nurse, to undertake good 'emotional work.'

10.4. Discussion

10.4.1 Working in mental health

In the survey mental health nurses said that the impact of mental health problems on work was generally but not always positive and generally never or only occasionally negative, reflecting a range of experiences and views. Following this thread, the interview participants were asked about how mental health problems were dealt with by their colleagues, their manager and by occupational health services. They described a range of experiences, from positive to negative. The quality of their experiences depended on the closeness there was within their team, the managerial approach of their boss and on whether their occupational health service was equipped to cope with the mental health of mental health staff.

10.4.1.1 Experiences with colleagues

In this study participants' experiences of mental health problems at work were affected by the 'closeness' of their teams. This closeness affected their degree of openness, it affected the amount of stigma that was felt and the amount of support that was available. The importance and value of team working is a recurrent theme in the wider literature on mental health nursing and the experience of mental health nurses (Cleary, 2012; Delaney and Johnson, 2014). When Edward (2005) explored 'resilience' in crisis care mental health nurses, a key theme was the protective nature of the team. Informal support from colleagues has been described as the most oft cited way that mental health workers cope with their work (Reid et al, 1999; Burnard et al, 2000).

The findings of this study mirror those of Joyce, Macmillan and Hazelton (2009), who interviewed 29 nurses with mental health histories. Their nurses also talked about why and when they might disclose their experiences at work and about the range of managerial and collegiate responses to that disclosure. Colleagues' support and their attitudes, whether stigmatising or supportive, were vital to the nurses' disclosure and management of mental health problems at work. Degrees of collegial support depended upon how long nurses had worked together before the illness and also on individual personalities and attributes. This was similar to the effect of 'team closeness' in the present study. Further work by Joyce has explored colleagues' attitudes to fellow nurses mental health problems in depth, using survey methods (Joyce et al, 2012). This found that 'textbook knowledge' of mental health problems was often disregarded when faced with colleagues' problems. It also found that informal and formal support, and changes to work patterns may aid the nurse with mental health problems but that if the nurse's experience of mental health problems was associated with 'underperforming' in the nursing role then sympathy and support could be lacking. Joyce et al (2012) linked their findings to Glozier's (2006) UK findings that nursing with mental health problems experience stigma from colleagues.

Research on nurses with mental health problems has previously focused on the experience of workplace stigma (Glozier, 2006; Smith, 2013; Joyce et al, 2012: Moll; Sercu, Ayala and Bracke, 2015). Glozier et al (2006) found that returning to work following mental health problems was much more stigmatised than returning from time out with another condition, diabetes, however return to work following alcohol problems was viewed even more negatively than returning from mental health problems. This finding is borne out in Tei-Tominaga, Asakura and Asakura (2014)'s survey on mental health stigma in nurses and nurse managers in Japan, which also found that nurses hold more stigmatising beliefs about other nurses with mental health problems compared to colleagues with physical health problems.

In their literature review on stigma of mental health problems and nursing, Ross and Goldner (2009) found there to be limited research on the experience of nurses with mental health problems, although they did find research on nurses

as stigmatisers and on the stigmatised status of mental health nursing within the wider nursing profession. Ross and Goldner (2009) concluded that nurses can act as perpetuators of stigma and that nurses with mental health problems may be shunned by colleagues. This is borne out by the findings of Brohan's (2010) systematic review of 48 studies of disclosure of mental health problems to employers, whereby people with mental health problems often do not disclose their mental health problems because they expect to be discriminated against. The Brohan review encompasses research on disclosure to employers across employment settings rather than just within healthcare, but it provides a context for the present study. Brohan et al (2010) found that people do not disclose because they do not want to be unfairly treated or lose credibility in the workplace. Some studies report genuine experiences of stigmatisation and some studies report that decisions to disclose are influenced by expectations that doing so will lead to discrimination. Stigmatising attitudes are therefore both present and anticipated in the workplace both for nurses and for other employees with mental health histories.

In the present study, the participants described a range of experiences, and in general the survey responses on the impact of subjective experience of mental health problems on working with colleagues were positive. There was a distinction made though, between certain settings and certain types of mental health problems, with anxiety and depression being less problematic than bipolar disorder for example. This reflects the findings of Ross and Goldner's (2009) review. The present study adds to our understanding of stigma within the nursing profession because it offers insight into what is being stigmatised. The participants said that colleagues stigmatised colleagues' mental health problems if they meant that their own workload would increase and if they may put service users at risk. The stigma from others, or self stigma and embarrassment also stemmed from a notion that mental health nurses should know how to look after their own mental health. Being mentally ill called into question personal and professional integrity. These insights into the beliefs underlying stigma are invaluable to those tasked with addressing stigma within a mental health employer. The impact on workload and on service user safety must be addressed as well as the perceived impact on professional status and confidence.

10.4.1.2 Experiences with managers

According to the mental health nurses interviewed in this study, managers set the tone regarding attitudes towards mental health problems within their teams. Whilst there is wealth of survey research looking at workplace factors and nurses' mental health, much less has been written from a qualitative point of view. The present study is of unique interest because of the point in time in which it has been conducted. Without exception, the nurses in this study referred to organisational and managerial changes in line with wider changes to the NHS (see Chapter 2 for a discussion of the policy context for mental health nursing). They offer an insight into what it is like to work in a mental health team at a particular point in history. Some mental health nurses, for example Patty, contrasted attitudes to mental health problems now and in the past. Some contrasted experiences from setting to setting. Their descriptions of managers and workplaces reflected the interplay of occupational and social factors that are measured in the Demand-Control-Support model (Karacek, 1979) of job strain or the Effort-Reward model (Siegrist et al, 2004), however, what is novel and powerful in this study's findings is the range, the continuum of management responses and the variety of team dynamics described.

The mental health nurses in the present study had experienced management changes and organisational restructures as having negative effects on staff wellbeing. They also described nursing as having less job security than in the past. This is borne out in the literature, with Bourbonnais et al (2005) finding that psychological wellbeing in Canadian nurses was adversely impacted by high demand and low decision latitude but also by increased workloads and decreased social support as a result of restructuring. Also with Canadian nurses, using the Demand-Control-Support model, Enns et al(2014) found depression and absenteeism in nurses to be associated with low autonomy, high job strain and working in non-hospital environments. In a study of Turkish nurses Boya et al (2008) found anxiety and depression to be associated with perceived job insecurity. In the UK, multivariate analysis of factors associated with CPN stress in the all-Wales study included the negative influence of perceived job insecurity on CPNs' wellbeing. Using Karacek's model, Shen et al

(2005) found psychological distress in Taiwanese nurses to be associated with low control, high demand and low workplace support. In Lambert's work, good mental health in Japanese hospital nurses was associated with workplace social support. Escriba-aguir and Perez Hoyos (2007) found low support from supervisors and high psychological demands were associated with poor psychological wellbeing in nurses. Kikuchi et al (2013) measured the relationship between depressive and anxious temperament and effort-reward in female Japanese nurses. They found depressive temperament to be associated with all aspects of effort and reward, whilst anxious temperament was only associated with 'over commitment.' This suggests that the experience of the workplace is influenced by the mental state and traits of the nurses as well as vice versa. Demand-control and support were measured in Johnson et al's morale study of UK mental health workers, as reported in Wood et al(2011). As per Karacek's model, low job demand, high job control and high social support at work were associated with high wellbeing.

In their study of Japanese nurses, Tei-Tominaga, Asakura and Asakura (2014) found that those managers who had worked previously with nurses with a mental health problems were less likely to have stigmatising attitudes to them. Exposure seemed to positively affect attitudes. They, like Glozier (2006), recommend exposure as a means of altering managerial and collegial attitudes. Anto et al's (2010) large scale pan European study of mental health nurses' attitudes to mental health problems (2010) found mental health nurse attitudes to mental health problems to be broadly positive and non stigmatising. They cite a broad range of literature, both empirical and theoretical, that exposure and experience are what positively influence attitudes of nursing staff. This broad positivity may be contrasted with Moll's (2013) findings from ethnographic research in one particular organisation, on the 'silencing' practices that she saw as taking place regarding workers' mental health problems.

For Moll 'silencing' was a major barrier to addressing health care workers' mental health problems in one Canadian hospital setting. She described it as an active process, whereby not only were colleagues secretive and disclosures strategic, there were messages from the organisation to keep quiet. Moll's work is based on mental health services in one location not in the UK so may not be

totally applicable to this UK study. She also used an institutional ethnography approach which specifically looked at relationships and dynamics, rather than individual subjective experiences, as in this study. In the present study, mental health nurses described a range of experiences of colleagues, managers and the organisation. They certainly were making choices in relation to disclosure and management of mental health problems, however a range of approaches were appreciated.

10.4.1.3 Experience of occupational health services

The interview participants described their experiences of occupational health services. As mental health professionals, several mental health nurses had been disappointed with their occupational health provider, which was not equipped to meet their needs as experts in mental health. Whilst the wider literature that has looked at nurses experiences of mental health problems at work may have touched on back to work plans and attitudes of colleagues (Glozier, 2006; Tei-Tominaga, Asakura and Asakura, 2014; Moll, 2013) the role of occupational health services for mental health nurses has not previously been explored in depth, save for a study by Gibb et al (2010) which surveyed mental health nurses' views on a Scottish occupational health service. They found that whilst mental health nurses were aware of the occupational health service they preferred to self care or to get informal support from colleagues. Similarly, in the present study 'self care' was often a preferred option, due to a lack of confidence in the occupational health provider.

In recent years the focus on employee wellbeing in the NHS has called for health employers to have staff wellbeing strategies and to offer access to counselling and mental health support (Boorman, 2009; Harvey et al, 2009). The mental health nurses in the present study had mixed experiences of accessing that support and mixed attitudes to accessing it. What they brought to their contacts with occupational health was a critical approach based on their expertise within the field. They were not passive recipients of the service. As described by Black (2008) and discussed in Chapter 2, the development of occupational health services has not been in step with the development of mainstream (NHS) health, particularly in relation to mental health and wellbeing.

The Boorman review (2009) of the state of mental health and wellbeing of NHS staff called for a more preventive than reactive approach within NHS occupational health provision. Whilst the well evaluated (Brooks, Gerada and Chalder, 2013) Practitioner Health Programme (PHP) has been praised for its expert provision of mental health care for doctors and dentists, no such service exists for mental health nurses. In their review of the literature on the mental health of doctors, making the case for a PHP, Brooks, Gerada and Chalder (2011) cite similar reasons for setting up the service as those fears and experiences described by the interview participants. Doctors may not seek help for mental health problems because of concerns regarding confidentiality and the implications of their ill health for their professional standing. Mental health nurses in this study either feared or had experienced either a lack of skill from their occupational health service or were not comfortable receiving treatment from the same organisation for which they worked. The findings of this study make a strong case for a nurses' PHP.

10.4.2 Being a mental health nurse

10.4.2.1 Disclosure and boundaries

In the survey mental health nurses showed themselves to be limited and selective in their disclosure of mental health problems. Disclosure to managers was not usual and disclosure to patients happened infrequently. Disclosure to colleagues was variable. These findings were supported by those of the interviews wherein disclosure was described as happening in certain circumstances with certain people, for specific reasons only. Some participants' attitudes to disclosure had changed over time, following personal experiences or after hearing of disclosures that had not gone.

Research on disclosure in mental health nursing has not encompassed disclosure to patients of mental health problems. The recent research on boundaries and disclosure within mental health nurse-patient relationships has focused on either sexual boundary crossing (Peternelj-Taylor and Yonge, 2005) or nurses' self disclosure regarding their home lives. Ashmore and Banks (2001, 2002, 2003a,2003b) surveyed adult and mental health nursing students

regarding self disclosure, not of mental ill health but of personal information of any sort. They found that mental health nursing students were more likely to self disclose than general nursing students, but that they were less likely to disclose to patients than to colleagues. Self disclosure was often justified as a means of progressing the therapeutic relationship and also because of finding they had a shared experience. Both of these were rationales given for self disclosure during the present study. Similarly, for Moll's participants disclosure happened in the context of work performance and addressing stigma. In Stanley et al's (2007) qualitative study of student and practitioner nurses and social workers with disabilities, disclosure of disability was seen as a stepped and negotiated process, meaning that disclosure happened incrementally and circumstantially. Their participants with mental health problems had more mixed experiences of disclosure than those with physical disabilities, and found the 'disability label' complex, with different terminology being used in different contexts and the relative benefits and disadvantages of its use depending on setting, for example it may be useful to disclose when negotiating for 'reasonable adjustments'.

Brohan et al's (2010) systematic review of the literature on 'beliefs, behaviour and influencing factors' for disclosures of mental health problems to employers found disclosure to have four dimensions: selective (meaning disclosure can be done with certain people as part of a strategic approach) , partial (meaning that only certain aspects of a condition may be disclosed), inadvertent (meaning that sometimes disclosure may be unplanned, for example when symptoms emerge) and strategically timed (meaning that disclosure may be put off until the person is secure in their job role or has got established within their team). The pattern of disclosure reported by the survey participants in the present study was certainly selective, most commonly it happened 'sometimes' or 'occasionally.' Interview participants were 'judicious', or 'strategic' regarding disclosures to service users..

The main reasons given for disclosure to service users were to further the therapeutic relationship or to demonstrate understanding and insight. This contrasts with the reasons for disclosure to managers and colleagues that Brohan et al (2010) identified: to gain adjustments; because of previous positive experience of disclosure; to obtain support; to explain behaviour; and because

concealing was stressful. Two of Brohan et al's (2010) reasons for disclosure are of relevance here: to be honest and to act as a role model. Whilst the study participants did not explicitly talk about role modelling, some, for example those involved in group work, used disclosure to validate others' experiences and be 'real' as a means of supporting service users to talk about themselves (see 10.3.2.2.1). The nurses role modelled that it was ok to talk about one's own experiences in certain settings.

Joyce, Macmillan and Hazelton (2009) identified disclosure as a theme in their interviews with nurses with mental health problems. Like the interviewees in this study, disclosure to colleagues was a judicious, strategic move, based on estimations of the benefit of its impact. It was not 'a given' and not the norm. Moll (2013) described 'strategic disclosure' not just to whom, but also what was said and when. She talked about disclosure as reputation management and 'testing the waters' where past experiences may be disclosed but not current ones. Like the participants in this study, Moll's subjects' disclosure to service users was 'exceptional'. They considered it to be against the nursing professional code of practice.

Self disclosure and giving of the self have been seen as tools at the mental health nurse's disposal for progressing therapeutic relationships. Welch (2005) interviewed six experienced mental health nurses regarding 'pivotal moments' in their therapeutic relationships with service users. For his interviewees, self disclosure, for example of the suicide of one of the nurse's relatives, was an unusual occurrence, which took place in the context of developing trust and rapport. Gardner (2010) explored professional boundaries in the context of developing therapeutic relationships in a study of 15 mental health nurses. He conceptualised the nurse patient relationship in terms of 'levels of engagement' from 'therapeutic friendliness' to 'therapeutic alliance.' For his participants, the role of the nurse was to manage the relationship whilst being 'emotionally tidy'. It is up to the mental health nurse to artfully lever the relationship and rapport from stage to stage, navigating across boundaries. Similarly, in O'Brien's (1999) focus group study, mental health nurses saw their expertise in mental health practice as being founded on how they managed that nurse- patient relationship. Whilst 'disclosure' was not mentioned specifically, the mental

health nurses talked about individualised care which may incorporate 'bending the rules' and 'minimising the visibility' (of the therapeutic nurse-patient element) of the relationship, which entails 'being natural' with the person. When mental health nurses see the relationship as the tool for their work, and also see their self as a tool in that relationship, which is highly individualised, self disclosure becomes one means of doing mental health nursing work.

10.4.2.2 Using one's own experience to inform work with service users

Whilst O'Brien's (1999) mental health nurses use the phrase 'being natural' and McAllister, Happell and Bradshaw's mental health nurse leaders (2013) made 'authentic connections', the Mental health nurses in this study talked about 'being real'. Life experience, not just of mental health problems, was seen as something that gave the mental health nurses credibility and insight. Authenticity or 'use of self' is a common theme in studies looking at mental health nurses' perceptions of their role (Hurley, 2009; Holm and Severinsson, 2011). It also links to the notions of 'the wounded healer', whereby personal insight is viewed as giving the 'healer' stronger powers to cure fellow sufferers. Whilst the present study is concerned with mental health nurses' self perceptions, the real impact of those experiences cannot be measured. None of the mental health nurses interviewed here declared themselves 'a wounded healer', although some notion that experience informed 'good' mental health practice was implied.

The mental health nurses in the interview phase of the study, who were a purposively sampled group with high SWB, were positive about their contribution and their role. This is in contrast to other studies of UK mental health nurses, where their identity has been associated with doubt and lack of status (Crawford, Brown and Majomi, 2008). The same authors (Majomi, Brown and Crawford, 2003) studied work-home role conflict in UK community mental health nurses, and found that 'the personal' was often sacrificed for 'the professional', with mental health nurses engaged in 'active negotiation' between the two. The findings of the present study do not refute those of the 2003 study. Indeed, work- home balance was a preoccupation of the participants in this

study, however these mental health nurses conceptualised their home and personal experiences as contributing positively to what they could offer at work.

Personal experience of common mental health problems has been shown to negatively impact on nurses' work performance (Gartner et al, 2010), professional commitment (Kanten and Ulker, 2014) professional job satisfaction(Karanikola and Kaite, 2014). The association between presence of psychiatric symptoms (as per GHQ measures, for example) and burnout has been established in a number of studies of mental health nurses (Edwards et al, 2000; Johnson et al, 2011), where burnout is characterised by emotional exhaustion, depersonalisation and a low sense of professional accomplishment (Maslach, Jackson and Leiter, 1996). Whilst 'compassion satisfaction' has been identified as a counterweight to compassion fatigue and burnout, whereby nurses enjoy and benefit from their emotional labours, it has been associated with lower not higher incidence of anxiety and depression (Hegney et al, 2014). The interview participants in the present study were therefore an unusual group in that they had personal mental health histories and high SWB. They derived satisfaction from their work, in particular the emotional labour, the 'compassionate' element of mental health nursing practice. This aligns with Wilson and Crowe's(2008) findings, that Mental health nurses say that the most satisfying elements of their work is the therapeutic relationship (specifically 'being therapeutic, knowing oneself and knowing how').

10.4.2.3 Being and becoming a nurse

The mental health nurses described ways in which subjective experience of mental health problems had influenced the formation and development of their nursing identities. Mental health nurse identity has been the subject of research and discourse for as long as the profession has existed (Clarke, 2006; Happell, 2006; Happell, 2014). Mental health nurse identity is often defined in relation to others: not just patients or service users but also in relation to other mental health professionals (White and Kudless, 2008) and other nurses (Humble and Cross, 2010). It is not static, changing as the student mental health nurse becomes the mental health nurse (Rungipadiachy, Madatil and Gough, 2006) and as the mental health nurse takes on new educational roles and duties

(Hurley and Lakeman, 2011; McCrae, Askey-Jones and Laker, 2014). Mental health nurse identity is seen as troubled, because of mental health nurses' somewhat troubled relationship with the medical model and the coercion and control aspect of psychiatric care (Schulze, 2007) (as discussed in section 2.3.2). Another aspect of mental health nursing is the non-therapeutic, coercive element. In the UK mental health nurses are responsible for care and treatment of people detained under the Mental Health Act in hospital or under the restriction of Compulsory Treatment Orders (CTOs) in the community. Coercion and control are elements of mental health nursing practice that come to light when service user and nurse accounts of the mental health setting are called for(Rose et al, 2013; Hercelinskyj, 2010; Kipping, 2000).

Notions of nursing identity in this study were similar to those in previous studies, in that the participants valued team work and relationships (Wilson and Crowe, 2008; Cleary et al (2012). They also placed importance on mental health nursing's alignment with their personal values and curiosity about people. A previous study of UK mental health nurses (Haque et al, 2002; Nolan et al, 2004) found that nurses most valued client contact and least valued the administrative elements of their work. Certainly a dislike of administrative, non-client work was shared by mental health nurses in the present study.

When cohorts of nurses have been studied at different career points, motivation and values are seen to alter, with newly qualified nurses espousing the values and ideals associated with their professional education which are altered over time (Maben, Latter and Clark, 2007). At the same time, veteran mental health nurses, and those nurses across the profession who have 'survived' have been shown to have resilience, commitment and enthusiasm (Humble and Cross, 2010; Harrison, Hauck and Hoffman, 2014). In the present study, several nurses described their particular skills and training in terms of certain therapeutic approaches and were enthused about working in mental health. In McCrae, Askey-Jones and Laker's (2014) recent study of UK postgraduate diploma students, participants identified more with the mental health field than with the profession of nursing, and saw their practice in terms more of values than of skills.

The nurses with whom the participants of the present study have something in common are the 10 veteran Australian mental health nurses interviewed in Humble and Cross' (2010) interpretive phenomenological study. The major theme of their encounters was 'being different', in that their mental health nurses saw themselves as different from society and from nurses as a whole. Their 'difference' was because of their unique 'attitudes and attributes': their preparedness to be with and advocate for their psychiatric patients and their acceptance and use of self. Where the mental health nurses in the present study did not describe themselves as being 'different' from colleagues, they did consider use of self, acceptance of self and willingness to 'be with' patients as essential to their work. Harrison, Hauck and Hoffman (2014) asked 192 Australian mental health nurses why they went into and stayed in the profession. Mental health nurses' motivation in their study came from 'wanting to make a difference'. This was in part related to personal and familial experience of mental health problems, as in the present study. Their participants were drawn to the profession through encounters with inspirational mental health nurses and through 'intrigue' and 'interest' piqued by stories of mental health problems. This was similar to the participants in the present study, who were 'fascinated' by people. Another motivation to be an mental health nurse was a desire to address the stigma of mental health problems, partly linked to an identification with mental health service users as a stigmatised group (Sercu, Ayala and Bracke, 2015), with mental health nurses also being seen as a stigmatised group within nursing and healthcare (Ross and Goldner, 2009).

In Sercu, Ayala and Bracke's (2015) comparative study of mental health nurses in two different hospitals a range of notions of nursing identity were evident, linked to different notions of stigma and nurses' relation to it. Some mental health nurses saw their work as addressing stigma arising from the psychiatric medical model. Some other mental health nurses saw their work in a diagnostic and therapeutic framework and were less focused on combating stigma. In the present study, motivation, identity and relationship with mental health problems were interlinked, but by degrees, with some mental health nurses coming to the profession with a strong desire to effect change and others falling into it and having personal experiences later.

10.5 Conclusion

In summary, mental health nurses who took part in the survey and interviews reported that personal and familial experience of mental health problems tended to have a positive effect on work with service users, colleagues and their workload. Few mental health nurses reported a negative impact on their work. The interviewees' described a range of experiences of team, managerial and occupational health responses to their and others' mental health problems. Stigma was a factor in some of their stories, so was support and shared understanding. For some, their relationship with managers and occupational health was functional. Others described managers, colleagues and occupational health practitioners who handled them with sensitivity. The mental health nurses experienced people's responses to their mental health needs from the critical standpoint of being 'experts' in mental health. This influenced how they viewed the treatment they received.

Direct disclosure of personal and familial experiences was not common. It was reportedly rare with service users, but also was not the norm with colleagues and managers. This suggests that there is not a culture of openness regarding mental health problems within mental health workplaces. According to the interviewees, disclosure was usually a planned action on the mental health nurse's part, as a means of connecting with another person through shared experience. Disclosure was used as a means of furthering the therapeutic relationship. The participants in this study, like those in other studies, described the use of self and drawing on personal experience as vital to their mental health work. Mental health experience motivated and contextualised their nursing practice.

The findings of this study are supported by the findings of previous studies, regarding how mental health nurses see their role. However, this study provides a unique insight into the positive aspects of mental health experience, as seen by mental health nurses. When they described their experiences of being mental health service users or carers, the participants in this study cast a critical eye on their mental health practice and the practice of others, based on

personal insights and reflections. 'Expertise by experience' worked both ways. Similarly, when the mental health nurses described their experiences at work and how mental ill health was managed within their organisation and team, their 'expertise by experience' informed their views. They were expert mental health nurses as well as having personal experience on which to draw. Expertise, and deft use of self were in evidence when the nurses talked about the influence of their experiences on their work. Deliberate disclosure of experience was just one way in which the nurses drew on their subjective experience in their work.

Chapter 11 Discussion

11.1 Introduction

A summary and discussion of key findings are presented in this chapter. First, a conceptual model derived from the findings is discussed. Second, the thesis research questions are addressed.

11.2 A conceptual model: answering the research question

The aim of this study was:

> To explore the mental health and subjective wellbeing of a sample of UK mental health nurses.

The central research question was:

> How do UK mental health nurses negotiate, use and manage their own mental health and wellbeing?

The conceptual model presented in Figure11.1 is drawn from the findings presented in Chapters 8, 9 and 10. This conceptual model shows that mental health nurses SWB and experience of mental health problems is affected by them being mental health nurses, just as their mental health nursing work is informed by their subjective experience of mental health problems and their SWB. The participants described certain ways in which nursing practice and subjective experience informed one another, with underlying themes of choice and control, distance and connection and self nurturance. These were the ways in which SWB and mental health problems were used, negotiated and managed by the mental health nurses in this study.

A key finding of this study is that mental health nursing work - being a mental health nurse- informed nurses experience of having mental health problems . It informed nurses' views on and expectations of their own care and treatment. It informed their decisions about how to look after their mental health, for example

their choice of treatment and help. It also informed their SWB practices, with the nurses applying learning from work to themselves (for example, mindfulness techniques). This is a unique finding of the study and has not been described in previous research.

Figure 11.1: conceptual model of the interaction of MHNs' SWB, mental health and work
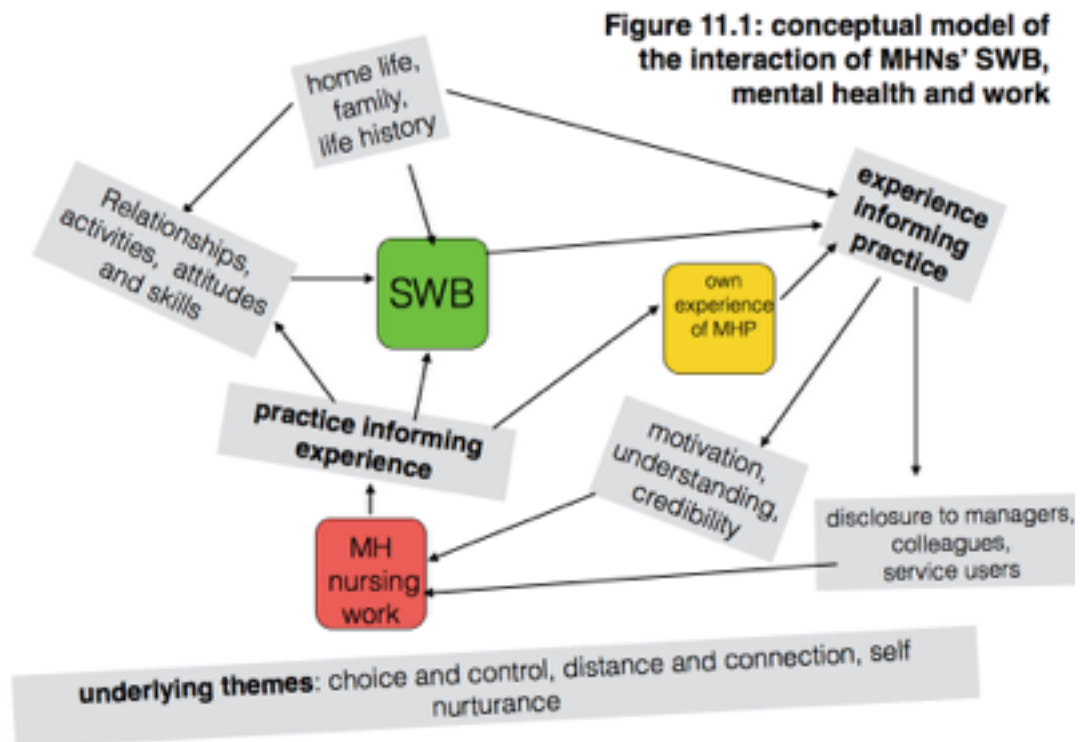
Another key finding of this study is the extent to which mental health nurse's experiences outside work informed their nursing practice in numerous ways. It motivated them to practice as mental health nurses. It created understanding and empathy for the mental health service users in their care and, in certain circumstances the mental health nurses saw it as giving them credibility when talking to patients. It was also evident that subjective experience was explicitly used to inform practice when mental health nurses talked about their own experiences to managers, colleagues and service users. This notion of experience informing therapeutic contacts within mental health nursing practice should be contextualised within the broader picture of nurses using themselves and their experiences in their work. Subjective experience of mental health problems was one aspect of their life which may be used in mental health nurses' work, just as other aspects of family, home or life history may also be used. Perhaps surprisingly, the 'wounded healer' image that was discussed in

Chapter 2 was not brought up by the participants, although they did say that their subjective experiences had motivated them to nurse and gave them understanding and credibility. This suggests that the wounded healer image is not one that is in common use among mental health nurses. Whilst the image has stayed pertinent in the theoretical and autobiographical literature on the helping professions, as evidenced by Conchar and Repper's (2014) review, it did not appear to be used by mental health nurses about themselves.

Whilst this study offers a novel perspective on how the experience of mental health problems informs mental health nursing work, the findings are supported by previous work on the use of self in nursing and on nurses' identities, whereby making connections and forming relationships are seen as the bedrock of mental health nursing practice, with the use of the self fundamental to 'emotional labour'(Hochschild, 1983; Smith,1992), the 'being' a mental health nurse rather than 'doing' mental health nursing work, as discussed at 2.3.3. Where the nurses described the subtle and pervasive ways in which their practice was shaped by their personal experience, disclosure of the specifics of their mental health problems was not common. Self disclosure was selective and circumstantial. Whilst other researchers, such as Moll (2013) have conceptualised the lack of open discussion of mental health problems in mental health organisations as 'silencing', it is evident that the nurses in this study made conscious decisions about disclosure on a relationship by relationship basis, whether with managers, colleagues or service users.

11.3 Underlying themes

Three underlying themes emerged across the three bodies of qualitative findings. These were: choice and control, distancing and connecting and self nurturance. The organisation of the findings in Chapters 8,9 and 10 has been dictated by the sequential design of the study and the major descriptive themes dictated by the research aim and research question: subjective wellbeing, subjective experience of mental health problems and mental health nursing work. These 'interpretive' themes have been drawn from a close reading of the data, providing an insight into the mechanisms by which experience and

practice inform each other: the how rather than the what or why.

11.3.1 Choice and control

The underlying theme of choice and control had several aspects. First, in relation to SWB the nurses described how they had made healthy living choices to improve their SWB, such as cutting down their working hours following their becoming a parent, for example. Secondly, attitudes associated with high SWB were 'seeking out positive experiences', another was 'accepting reality' . The nurses chose to approach life in a positive way and exerted some control over their reactions to life events. In particular, mindfulness techniques were cited as enabling some participants to exert control over their responses to difficult situations.

The theme of choice and control emerged strongly in relation to mental health problems at work. An example is when the nurses described less favourable experiences with occupational health services or with managers, lack of choice and control were markers of failed encounters. Some nurses opted out of treatment and support on offer, choosing to either self care or to find their own treatment providers. When the nurses described their own experience of mental health problems, they described how career choices had been made in light of their own experience, and also that their nursing experience influenced the treatment choices they made. In work, disclosure and use of self was done judiciously. The choice to disclose personal experience was another example under this theme, which was undertaken in certain circumstances that were determined by their skill and expertise.

Where choice and control have previously been considered in relation to mental health nurse this has been either in association with workplace wellbeing (lack of control over work is associated with burnout, Maslach et al, 2001; Freeney and Tiernan, 2009); demand-control and support, according to the Karacek (2009) model were associated with low morale in UK mental health workers (Johnson et al, 2010) or in relation to the historical tension between care and coercion in mental health care (Coffey and Jenkins, 2002; Holyoake, 2014). There is limited previous research considering 'choice and control' in relation to

self disclosure and self care, although 'autonomy' has been discussed as a characteristic of personal wellbeing for nursing students (Watkins, Roos, and Van der Walt, 2011) and 'assertion' was one of the self caring strategies used by the nurses in Rose and Glass' (2010) study on emotional wellbeing. Perhaps the most apt parallel to draw here is with the concept of hardiness, as described in section 2.4.4,where the hardy person responds to challenges with commitment and a belief in their ability to control outcomes. Hardiness has been shown to mediate happiness and mental health in nurses (Abdollahi et al, 2014; Lambert et al, 2007). The social workers in Graham and Shier's study also talked about choice and control in relation to their work and personal lives. They characterised this as a 'dynamic of control and openness', and like the participants in the present study, they associated this with mindfulness and intentional use of self within their work (Shier and Graham, 2011).

11.3.2 Distancing and connecting

The underlying theme of 'distancing and connecting' emerged across all three major topic areas of SWB, subjective experience of mental health problems and mental health nursing work . The nurses managed their own SWB by creating distance between themselves and other people and their work though spending time in nature, or exercising. Other activities to maintain SWB brought them into closer connection with other people, such as learning mindfulness practices in a group at work. Clinical supervision at work was also described as a beneficial by some participants because it connected the nurses to their colleagues.

When talking about how subjective experience was brought into their work, nurses described how self disclosure could enhance connection with patients, with 'connecting with people' being an explicit aim of mental health nursing work. A sense of 'connection' or closeness was a requirement if nurses were to disclose their own mental health problems and seek collegiate support. The metaphor of 'interwoven histories' describes how the nurses' accounts of their own mental health experiences were interwoven with their work experiences, with family members' experiences and with other aspects of their lives. Having mental health problems had brought some nurses closer to family members. For others the experience had a distancing effect. For some, becoming a nurse

had brought them closer to family members, for others it had a distancing effect. In these ways subjective experience of mental health problems was used in nursing work, and the presence of that experience was negotiated and managed.

'Distancing and connecting' is related to the notion of boundaries. Being a mental health nurse with a mental health problems has been described as 'crossing a boundary' (Joyce, Hazleton and Macmillan, 2007) or as a 'hyphenated' existence (Kidd, 2010). Awareness of boundaries between nurse and patient is a fundamental aspect of mental health nursing practice (Gardner, 2010; Peternelj-Taylor and Yonge, 2003). There is also a concern in the literature with the boundary between work and home life for nurses, which must be negotiated or protected in order to maintain their SWB (Skinner et al, 2011; Mackintosh, 2007). For the purpose of maintaining SWB the nurses in this study also described the establishment and maintenance of boundaries between work and home. However, experience of mental health problems at work and at home were clearly interconnected, as were nurses own lives and those of their families.

For the subjects of Graham and Shier's (2011) study, high SWB was associated with a strong connection between work and personal life, whereby what happens in one affects the other. This point is also made by Kipping (2000), who argues that traditional work-stress models do not account for the effect of nurses' home lives. Again, Graham and Shier's study provides strong supporting evidence for the present one, not least because of the shared interest in mindfulness of the two groups, which was totally unexpected and unprompted in the present study. Identification of 'distancing and connecting' as the way in which mindfulness practices and supervision are seen by nurses as aiding their SWB, suggests that this may be the mechanism by which these practices work, rather that just that it does work.

11.3.3 Self nurturance

Self nurturance was identified as an important element in nurses' SWB in the early stages of this study, as discussed in Chapter 2, where it was also

described as 'self care' and was associated with nurses' 'self esteem.' When asked to say how they looked after their high SWB, the nurses could describe self caring activities they did to maintain and boost their SWB. What is of interest here is that these activities were undertaken with the express purpose of enhancing SWB or looking after mental health, rather than it being a by product, thus subjective wellbeing was actively pursued rather than happening incidentally.

Self care and self nurturance of course emerge when nurses talk about how they look after themselves. In the Australian study, community nurses have described numerous self care strategies for emotional wellbeing which, similarly to in this study, combined attitudes, actions, work and non work aspects(Rose and Glass, 2009, 2010). There is less of a precedent for nurses to talk about 'self care' in relation to managing their own mental health problems. To date, only Gibb et al's (2010) Scottish survey has addressed mental health nurses occupational health service experiences, finding that mental health nurses may prefer to self care than to access occupational health assistance. In the present study, choosing to self care was associated with a critical appraisal of the services on offer, based on the nurse's expertise in mental health care. When casting the critical gaze on mental health provision outside work some nurses described how they sought out services to suit them because what was on offer was not satisfactory. the interview participants described a range of experiences, with some stating that their occupational heath or their GP or counselling had been effective, although this judgement was being made from their expert standpoint as a nurse as well as a patient. However, They did not appreciate being treated by someone with less mental health awareness and expertise than themselves.

In Nemcek and James' (2007) US research on self nurturance, high self nurturance was associated with life satisfaction and with a supportive work environment. Where nurses focused on nurturing patients but neglected their own wellbeing then their life satisfaction was lower. The findings of the present study also suggest that there is value in addressing how mental health nurses can look after their own SWB but also how mental health services for them may be designed to address their specific expert needs. There is a difference

between self nurture as proactive, preemptive measures for maintaining and enhancing SWB and self care as a reaction to unsatisfactory services that do not meet mental health nurses' expectations or needs. Where self care is chosen over what is on offer this is not mental health nurses negotiating for their mental health needs, it is them losing a negotiation or else having no other choice.

11.4 Answering the research questions

As well as having exploratory aims, this study had six specific research questions, derived from the literature reviews presented in Chapters 3 and 4.

11.4.1 What is the state of mental health of UK mental health nurses, in terms of experience of mental health problems and degree of SWB?

In this study mental health nurses were found to have relatively low SWB compared to participants in general population studies. They were 'slightly satisfied' with life according to the SWLS. As this was the first study using these measures with this population, the results should be regarded as a baseline or starting point for further research.

Over half of the nurses surveyed had experience of mental illness, in the past and present, either of their own and those close to them. The percentage of respondents who were experiencing mental health problems at the time of the survey (24.9%) was similar to that of the general population and within the range of findings from previous studies using different measures. The lack of a definitive response rate for the survey limits the claim to generaliseability that can be made, although the demographic composition of the sample was similar to that of the UK mental health nurse population as a whole.

11.4.2 How do experience of mental health problems, subjective wellbeing and demographic and work related factors interact for mental health nurses?

For the sample of UK mental health nurses surveyed in this study there was limited evidence of an association between certain demographic and workplace factors and having high SWB or having subjective experience of mental health

problems. Some demographic and work related differences were found but the findings must be caveated by the small effect size, risk of bias and risk of type 2 errors due to the study being underpowered (Christley, 2010).

This study found women consistently had a higher SWB compared to men across three measures yet more women were experiencing their own mental health problems at the time of completing the survey. Those participants aged between 40 and 49 consistently scored worse across the SWB measure than younger and older participants. There was a statistically significant correlation (p<0.05) between being under 40 and having a higher score on the 'life worthwhile' than those age 40 to 49. No statistically significant correlation between household size and SWB was found, although those living alone had lower mean scores across the SWB measures, including having lower anxiety. The present study found a slight but not statistically significant difference between full and part time working and SWB, with part time workers scoring higher on the WEMWBS and the SWLS. The demographic and workplace data gathered in this study and their association with experience of mental illness and SWB warrant further investigation. There are indications that gender, age, household size, work patterns and points in nursing career are associated with and potentially affect the nurses experience of mental health problems and their SWB. The direction and extent of influence cannot be inferred from the story told by the results of this one online survey. In this instance the use of online survey methods and access via a third party has failed to achieve the ambition to describe the state of UK mental health nurses' mental health. Any further study aiming to explore the associations identified here must firstly address the challenge of gathering enough evidence from a representative and quantifiable sample to produce confident results.

11.4.3 Is there a subgroup of mental health nurses with subjective experience of mental health problems who also have high SWB?

Within the group of survey participants who reported subjective experience of mental health problems, there was a cohort who scored higher than general population norms on both the WEMWBS and the SWLS. Being a mental health nurse and, importantly, being someone with personal experience of mental illness does not have to equate to having low SWB. Mental health nurses with

Mental health problems can be satisfied with their lives, feel happy and can see their lives as meaningful and worthwhile. This is an important finding. Evidence of the mental ill health of mental health nurses should support calls for increased resources to meet their needs, however listening to those mental health nurses who are happy and coping should assist policy makers in determining how to use those resources. Their insights should inform employers' 'health and wellbeing' policies, as called for by Black (2008) and Boorman (2009). Like Graham and Shier's (2010) study of subjectively well social workers, the present study has been undertaken in reaction to the attention paid to the detrimental aspects of the profession and the struggles that mental health nurses may face. The group identified in the survey in phase one that were interviewed in phase two, should offer the profession hope and inspiration as they continue their careers.

11.4.4 How do mental health nurses with subjective experience of mental health problems and high SWB look after their own mental health?

This research has found that mental health nurses look after their own mental health and wellbeing in a number of ways. There was clear evidence that the nurses took active steps to improve their wellbeing: exercise, being in nature, listening to or making music and practicing mindfulness. The activities they undertook to maintain SWB are supported by a comprehensive evidence base, as discussed at 8.4.2.1. The nurses also described attitudes that helped them to feel good: accepting reality, and nurturing and valuing themselves. Reality acceptance is an attitude that has been previously associated with high psychological capital and resilience in nurses (Spence Laschinger and Fida, 2014; Luthans and Church, 2002). Valuing the self and self nurturance through the pursuit of positive experiences have also previously been associated with nurses' life balance and life satisfaction (Nemcek, 2007; Nemcek and James, 2007; Rose and Glass, 2010). As well as what the nurses could do themselves to promote happiness and SWB, there were other external factors that were perceived to have an impact. Family members, children and partners, friends and peers could also enhance wellbeing in a number of ways. Being a parent was seen to enhance wellbeing particularly because of the immediate requirement for a parent to switch off from work and focus on their children and because parenting led to a shift in work life balance. Friends and family could

act as distractions and sources of support. The friend, parent or partner role was also a perceived source of self worth and value for the interviewees.

There are ways in which mental health nursing work can contribute to SWB also, for example the nurses in this study valued clinical supervision as a means of both stepping back from the challenges of mental health work and connecting with colleagues. Finally, the nurses talked about using skills that they had learned in their mental health nursing work to enhance their own wellbeing. They practiced what they preached, whether this was mindfulness or cognitive behavioural techniques. A novel finding of this study was that being a mental health nurse could be a way into learning about how to look after one's own mental health.

When describing how SWB was enhanced or maintained, all three aspects of SWB, were referenced: it the hedonic, evaluative and eudaimonic (Ryan and Deci, 2001; Waldron, 2010). Pleasure seeking was evident in their activities and attitudes. The attitudes of valuing the self and accepting reality related to the life satisfaction or evaluative aspect of SWB. The happiness drawn from parenting and from partners and friends related to the eudaimonic or meaning-seeking aspect of SWB. This was also in evidence when mental health nurses spoke about the self worth they drew from their identity of being mental health nurse.

11.4.5 How have mental health nurses experienced mental health care and treatment?

It is important to state here that the nurses interviewed in this study described a range of experiences of mental health care. Some nurses had positive, inspiring experiences of being a mental health service user or carer. Others did not. A task of qualitative and mixed methods research is to identify themes and patterns, but also to account for variation and difference. Whilst there were undoubted similarities and commonalities between the personal accounts of mental illness from the nurses interviewed, their stories were also unique and subjective. The nurses worked in teams with unique dynamics and lived in a range of home and family circumstances, from one nurse living in armed service accommodation for most of her life to others who had chosen to live in remote parts of the country.

The broad theme which emerged here was 'interwoven histories.' The experience of mental health problems did not happen in isolation. Personal experience was often interwoven with the experiences of family members. Where nurses or family members had period of mental illness, this was often in the context of other major life events, or a combination of work and home factors which left them 'overwhelmed.' The nurses' experience of mental health care was interwoven with their mental health nursing work. They drew on their work-based knowledge to address the mental health of themselves and family members. They approached mental health care from the service user or carer perspective with a critical awareness of what good mental health practice should be like. Their subjective experiences of mental illness informed and altered their practice, for example changing their approach to medication or therapy. Earlier life experiences of mental health nurses and psychiatric treatment had clearly informed their practice, as 'wounded healers', motivating them to become mental health nurses.

This study adds to the understanding of what it means to be a mental health nurse with a mental health history because it demonstrates that a full account of that experience must include both home and work life, both the past and present and the 'expertise by experience' of being a mental health nurse as well as a service user or carer. Where previous studies (Moll et al, 2013; Joyce, Hazleton and MacMillan, 2007) have explored the experiences of health care workers with mental health problems in the workplace, the broader canvas of this study as well as the focus on the 'subjective' has meant that workplace experiences have been set in a wider context. The mental health nurse does not switch off 'being a mental health nurse' once they step out of the hospital doors, it seems.

11.4.6 Does personal experience of mental health problems inform mental health work and vice versa? In what ways?

Survey respondents were asked about the impact of personal or familial experience of mental health problems on work and about the extent to which those experiences were disclosed to service users, colleagues or managers. The thread of impact and influence on work was picked up and explored further during the interviews. Whilst a range of responses were gathered, survey

responses showed that this impact on work was more positive than negative. A range of experiences were described by the interview participants, with the 'closeness' of their team, the social environment created with their colleagues and this created by their manager and the degree of skills and expertise of the occupational health team all being factors in the quality of the mental health nurse's experience of having mental health problems and being at work.

According to the survey, disclosure of the nurse's own experiences was not usual, including to managers, service users or colleagues. The interviewees could give examples of circumstances in which they or others had disclosed about their mental health problems, however this was unusual. Some interviewees had strategies for bringing their own experiences into therapeutic work with service users, by using 'we' not 'I' for example, or making judicious disclosures in order to take their therapeutic work in a particular direction. 'Use of self' was seen as part of the mental health nurse's role. Being and becoming a nurse was part of their identity, and identifying with and connecting with people with mental health problems had motivated them to choose a nursing career. Just as 'being a mental health nurse' informed how the nurses critically appraised their experiences as service users and carers, and just as the nurses took skills and knowledge gained through work and applied them to their own maintenance of wellbeing, so did they bring their life experience and subjectivity into work. Looking at the survey responses and the interview transcripts, this bringing of 'expertise by experience' into work was not necessarily done in an overt, explicit way. Moll(2010) has talked about 'silencing' being the all encompassing mode in which health care staff's mental health experience has been dealt with at work. This study has told a different story, where subjective experience of mental illness pervades various aspects of the nurse's work life, because the nurse draws on aspects of his or her life experience, history and personality in order to do the job of mental health nursing, to be a mental health nurse.

11.5 Conclusion

In conclusion, this mixed methods study has considered how UK mental health nurses negotiate, use and managed their own mental health, both inside and outside of work. Its unique contribution to knowledge had been its focus on

SWB and mental health and its highlighting of the expertise by experience within the mental health nursing profession. It has found that within the mental health nurse population there are some nurses whose subjective experience informs their practice but for whom their nursing practice has also influenced their experience of mental health problems. Nurses' experience of mental health care and treatment was interwoven with that of their families and other life experiences. It was also interwoven with their mental health nursing work, which meant that they critically appraised their subjective experience through the lens of their being a mental health nurse, just as their mental health nursing work was viewed through the lens of their experience of mental health problems.

Chapter 12 Conclusion

12.1 Summary of novel findings

This thesis has made an original contribution to knowledge in the following ways:

This study has moved the discussion of mental health nurses own mental health on from the focus on stress and burnout towards 'a more holistic assessment of the many overlapping factors that contribute to well-being' (Shier and Graham, 2013, p31). Such an approach is in keeping with the recovery and wellbeing focus of contemporary mental health care (Slade, 2010; Perkins et al, 2012). It brings the discussion of mental health nurses' mental health in step with discussions of population health and wellbeing, including that of mental health service users.

The findings of this study add to the existing body of evidence showing that mental health professionals, in this case nurses, have lower than average SWB and that many of them bring expertise by experience into their work. There has been limited previous research on UK mental health nurses' SWB and on their subjective experience of mental illness. This is also the first study to use the WEMWBS with a mental health nurse sample and one of a limited number of studies using the SWLS whereas previous UK studies measuring mental health nurses' experience of mental illness have used psychometric measures to identify potential caseness.

A further unique contribution of this mixed methods study has been its account of how interwoven mental health nurses' experience of being a nurse and being someone with a subjective experience of mental illness and someone looking after their own SWB are. Mental health nurses do not just exist in their mental health nurse role when at work. Work and life may be balanced and negotiated but they impact on and inform one another. Future research should take account of the complexity of nurses' lives. A focus just on work or just on work related stress or morale does not reflect the multitude of factors at play affecting nurses' mental health and wellbeing. More mixed methods research as well as more intervention and longitudinal research is called for, if policy makers' goals

of improving healthcare workers' mental health and wellbeing are to be achieved.

12.2 Reflection on the mixed methods design

A strength of this study has been its mixed methods approach. A classic explanatory sequential design has been used, with a participant selection variant (Cresswell and Plano-Clark, 2009). Use of qualitative and quantitative data has allowed for a rich picture of mental health nurses' SWB and mental health to emerge. Whilst findings have been discussed sequentially, this has been done thematically using the 'following a thread' approach (Moran-Ellis et al, 2006). This approach 'grounds' qualitative finding in the survey findings and is reflective of mixed methods epistemology. Both the qualitative and quantitative aspects of the study have been conducted according to standards of practice within those domains (Bryman, 2012; Ritchie et al, 2013). The initial research aim and question were derived from both personal interest and from identified gaps in nursing academic awareness of how mental health nurses with mental health problems and high SWB look after their own mental health. The research questions were refined and the study was designed following a review of the literature on both mental health nurses' SWB and their experience of mental ill health.

A limitation of the study has been the low survey response rate and not achieving the desired sample size, which was not calculable. The means of accessing survey participants, via third parties (the RCN and the MHNA) via an online survey meant that the researcher did not have direct access to potential participants and that access was mediated via group emails and newsletters. The sampling limitations affect the claims to generaliseability of the study that can be made, although the final sample was demographically representative of the UK mental health nurse population. This enhances its generaliseability. The number of response was not dissimilar to previous studies of the mental health of mental health nurses, although they have tended to focus on one geographical area or employer. Of significance, this was the first study to have measured UK mental health nurses' SWB using the WEMWBS and the ONS4. It is also one of a small number of studies using the SWLS. Finally, this is the first study to measure UK mental health nurses' own subjective experience of

mental illness through directly asking them about their experience rather than eliciting symptoms and determining caseness.

The qualitative phase of the study followed a robust thematic analysis approach. The sample size for the interviews was 71% (27 of 38 mental health nurses approached). Accessing this group of participants would not have been possible without the phase one survey. For this reason the survey has merit and value within the mixed methods design. Interviews with this purposive sample of mental health nurses with high SWB and experience of mental health problems offered a unique insight into the subjective experience of mental health nurses' nursing practice, interaction with colleagues and patients and use of self.

12.3 Recommendations for practice, policy and future research

This study makes a unique contribution to the understanding of the mental health and SWB of UK mental health nurses. The findings can be used to address how mental health nurses might better care for themselves and better be served by their employers and by mental health services. They should be used to address how the expertise of mental health nurses might best be used to shape the provision of occupational mental health services.

12.3.1 Recommendations for policy makers.

- **When mental health nurses present either to occupational health services or to their general practitioner with mental health problems there should be a route to treatment that is commensurate with their expertise.**

The health and wellbeing of the healthcare workforce is vital to the capacity of the UK healthcare system to support the heath of the nation. Preliminary findings of the task force for the forthcoming national mental health strategy have made reference to the importance of staff morale and the psychosocial work environment (Mental Health Taskforce, September 2015). The recommendations of the Boorman Review are also yet to be fully implemented (Chartered Society of Physiotherapy, 2015).The insights provided by the participants in this study show that the relationship mental health nurses have with their work and their own mental health is multifaceted. Mental health

nurses' critical awareness of mental illness and mental health care and treatment does not switch off when they become patients or carers. They deserve care that reflects their expertise and experience. Mental health nurses with mental health problems should be able to benefit from the same degree of specialist support as that offered to doctors via the Practitioner Health Programme.

12.3.2 Recommendations for employers and managers.

- **Employers and managers should review the extent to which their team environments enable nurses to disclose their mental health problems.**

- **Employers should take into account the effect that changes in management and team membership may have on team connectedness, and therefore on openness, support and stigma of mental illness.**

The survey revealed that whilst nurses with subjective experience of mental illness generally viewed that experience as having a positive impact on their work, disclosure of these experiences to managers was not usual. This suggests that employers and managers may have people with undisclosed experience within their teams, but that the climate does not engender disclosure as previously argued by Moll's (2013) 'institutional practices of silence'. Lack of disclosure means that staff are missing out on opportunities to access help and support. As Stanley et al (2011) have described, disclosure to employers can be a transaction undertaken as a means to getting reasonable adjustments. It can also be part of a more subtle process of coming to terms with and negotiating one's identity. Employers must be sensitive to the reasons why staff might prefer to keep their experiences to themselves. The interviews found that managers set the tone for discussions of personal mental health within teams. They also showed that the individual's experience of stigma and support, and their willingness to be open, depended on the connectedness of their team. Employers should consider the impact that management and team changes have on nurses' willingness to be open about their mental health.

- **Employers' staff well-being strategies should reflect the importance of choice and control in supporting well-being and mental health. They**

should enable nurses to develop the attitudes, relationships, working and home environments that engender SWB.

This survey found that mental health nurses' SWB in general was below the national average and was particularly low in those nurses with subjective experience of mental illness. However, the group of nurses interviewed in this study described various ways in which their SWB could be positively maintained. Of relevance to employers are work/life balance, clinical supervision and the ways in which nurses took what they learned at work and practiced it on themselves. Employers should have policies that enable nurses to manage the 'porous boundary' between nursing work and home life. They should ensure that clinical supervision is available. They should also consider how therapeutic techniques and practices learned by nurses can benefit them as individuals not just as practitioners. 'Recovery Colleges' which have been set up in various parts of the UK have a philosophy that is supported by this research, in that service users and staff can attend together and learn together (Alois Zucchelli and Skinner, 2013; Perkins et al, 2012).

- **Occupational mental health services within organisations employing mental health nurses must be reflective of the specialised nature of mental health nursing work.**

Nurses in this study were critical of the care and treatment they and family members had received in various settings, but of particular interest to employers is the common view that occupational mental health services were not well equipped to offer these dual 'experts by experience' mental health advice or treatment. Where employers may be commissioning occupational health services or where employee health and wellbeing strategies in mental health service providers are being written by human resources departments, employers should take account of the knowledge and skills of their employees. Their expertise should be used in both the design of services and the development and implementation of policies. It is unacceptable for a mental health expert's mental health to be assessed by someone with limited training in mental health. Again, these arguments have been well rehearsed for doctors (Brooks, Gerada and Chalder, 2011; 2013) but not for other mental health professionals.

12.3.3 Recommendations for individual nurses.

- **Mental health nurses should compare their own subjective wellbeing practices with those of the nurses in this study. They should experiment with the activities and attitudes described in Chapter 8.**

This study offers an insight into the mindset of nurses who are coping well and provides a positive message that some nurses feel great about their work and about themselves. Other nurses can take inspiration from the interviewees, who actively looked after their own wellbeing through their actions at work and home. Nurses should use the findings of this study to argue for better provision of clinical supervision and for discussions within their teams about how mental health and wellbeing may be promoted.

- **Mental health nurses should be more open about disclosure. Talking about this difficult subject should allow for consensus to be drawn about when and how to do it.**

The nurses in this study were conscious of 'disclosure' as a difficult subject and yet most had examples of when it had been used. There is very little that has been written about how and when to talk about yourself in your nursing work. It is to be hoped that reading part of this study might stimulate a discussion of disclosure within the profession

12.3.4 Recommendations for future research.

- **A longitudinal cohort study, of mental health nurses measuring their SWB and mental health would address questions of causation that follow from the associations identified in this study.**

- **Intervention studies measuring the impact of mindfulness practices, exercise, music making and being in nature on the SWB of mental health nurses.**

The findings of this study suggest possible interventions to be developed and tested in order to improve nurses' SWB: mindfulness, exercise, music making or being in nature, as well as the workplace strategies of clinical supervision, addressing work life balance and offering nurses the opportunity to learn

wellbeing skills that benefit both them and patients. There have been too few intervention studies in this field, although there are three large scale trials underway at the moment (Watanabe et al,2015; Bolier et al, 2014; Moll et al, 2015). Whilst we might learn from these studies, there is a lack of UK-based intervention studies. There is also a lack of UK research on the lived experience of nurses with mental health histories. This study has identified that the 'expertise by experience 'is within our mental health nurses population. There is much more that this group could tell researchers about what works and does not work in mental health care, from their uniquely informed standpoint.

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Appendices

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Appendix 7 Standard multiple regression of demographic and workplace factors with subjective wellbeing measures.

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Appendix X.1 Journal article: Oates, J. (2015). Use of Skype in interviews: the impact of the medium in a study of mental health nurses. Nurse Researcher, 22(4), 13–17. http://doi.org/10.7748/nr.22.4.13.e1318

Appendix 1 Review protocol: the subjective wellbeing of nurses 2004-2014

(*This review protocol has been devised in accordance with the PRISMA protocol (Liberati et al, 2009) and the guidance from the Centre for Reviews and Dissemination (2009)*)

Review question

How has nurses' subjective wellbeing (SWB) been measured in the past 10 years? What is the state of nurses SWB?

Review objective

The objective of this review is to assess the current state of nurses subjective wellbeing, with a particular focus on mental health nurses by asking:

> How has the SWB of mental health nurses been measured?
>
> What is the state of mental health nurses' SWB?
>
> What personal, demographic and workplace factors are associated with SWB in mental health nurses?
>
> What is the impact and influence of SWB on being a mental health nurse?

Participants

Studies of registered nurses where subjective wellbeing (SWB) has been measured.

Interventions

Any intervention or combination of interventions where subjective wellbeing has been measured as part of the intervention or as an outcome measure for an intervention.

Control

No restrictions on control groups

Outcomes

Any outcome, including all measured used by researchers who describe their outcome measure as one measuring subjective wellbeing.

Study design

All study designs, including qualitative study designs.

Inclusion criteria

Included papers will be published between 2004 and 2014, in English, describing primary research explicitly described as measuring on the subjective wellbeing (SWB) of nurses.

Exclusion criteria

Pre- 2004 papers, not looking at nurses SWB; papers where SWB is not explicitly described (for example the vast literature on stress and burnout may relate to SWB, but such studies are only to be included if wellbeing is measured or discussed); opinion pieces, reviews, service descriptions.

Search strategy

To identify relevant papers through a search by the study author of the commonly used databases listing nursing research literature: *Cinahl, Medline, PubMed, EBSCO Academic Search Complete, Science Direct, Web of Science, Web of Knowledge, Social Science Citation Index, PsychINFO, PsychARTICLES*

The following search terms will be used in an initial title, keyword and abstract search:

nurs* AND 'subjective wellbeing',

nurs* AND 'satisfaction with life', and

nurs* AND mental wellbeing'

nurs* AND 'happ*' (for happiness, happy)

nurs* AND 'wellbeing'

Selected papers for full review will be those that describe primary research that meets the inclusion/exclusion criteria.

Data extraction

Full copies of all potentially relevant papers will be downloaded and reviewed, with information recorded on a data extraction sheet.

Data extraction criteria will be:

1. date reviewed
2. article titles
3. source
4. country of origin
5. relevance (1 meets incl criteria, 0 does not meet incl criteria)
6. quality
7. study design
8. study aims
9. study participants
10. SWB measures used
11. other interventions used
12. outcome/ results

References

Centre for Reviews and Dissemination (2009) **Systematic reviews: CRD's guidance for undertaking reviews in health care.** York: University of York, 2009.

Liberati, A. et al., (2009) The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions : explanation and elaboration. **BMJ, 339(b2700)**, p.doi: 10.1136/bmj.b2700.

Appendix 2 Sample data extraction record

Appendix 3.2: Sample data extraction record

date reviewed	article titles	source	country of origin	rel ev an ce	qu alit y	study design	study aims	study participants	SWB meas ures used	Mean SWLS Score	other measures/ interventions used	outcome/ results	notes
24 Dec 2014	Abdollahi, A	JPMHN	Tehran	1	1	cross section	role of hardin	252 nurses	Oxford Happiness In		Personal Vie	This study showed hardin	
24 Dec 2014	Akhunlar, Mł	Procedia SB	Turkey	1	1	cross section	link LS and loneliness		SWLS				
24 Dec 2014	An, J, Cha, S	JTN	US	1	1	cross section	factors affec	105 korean k	SWLS	M 4.81 SD 1	JSI, Acoultur	In the regression model, lil	
24 Dec 2014	Appel, Linda	MSN	US	1	1	intervention	impact of a ł	91 medico s	Happiness Scale, Gratitude Scale			no sig change post interve	
24 Dec 2014	Boiler, Linda	II	Netherlands	1	1	intervention	workplace m	1140 nurses	WHO 5 WB index		(Mental Heal	t the intervention was cap	
24 Dec 2014	Brunetto, Y, I	APJHR	Australia	1	1	cross section	comp private	1138 nurses	4 items designed for		supervisor sat, training sat, affect		
24 Dec 2014	Brunetto, Y, I	NO	Australia	1	1	cross section	gen comp of	900 nurses t	4 items designed for		supervisor s	dif results per generation	
24 Dec 2014	Brunetto, Y, I	JAN	Australia/ UE	1	1	cross section	Comp US an	1218 nurses	4 items designed for		supervisor sat, training sat, affect		
24 Dec 2014	Burke, R, Ko	EJoP	Turkey/ Can	1	1	cross sectional survey		224 staff nur	pos affect, life sat, neg aff			hosp culture aspects link	
25 Dec 2014	Chakraborty, R., Chatterje	India	1	1	cross section	To determine	101 nurses	PGI Gen WB measu		locus of con	various facto they identify		
25 Dec 2014	Drury, V, Crai	JNM	Australia	1	1	mm study - interviews		10 nurses	qual		nterviews	same study	
30 Dec 2014	Elkonin, D, &	HSAG	South Africa	1	1	cross section	comp sat, fa	30 ICU nurse	ProQOL		Professional	a high risk for compassion	
30 Dec 2014	Escribà-Agüi	S&H	Spain	2	1	cross section	to determine	945 drs and	SF36		MB	The prevalence of low vita	
30 Dec 2014	Faribors, B.,	PBS&H	Iran	1	1	cross section	to assess aj	125 nurses	OHI		spiritual intel	Results show that there is	
30 Dec 2014	Freeney, Y.M	UNS	Ireland	1	1	focus group	To explore n	20 nurses	qual			Facilitators of and barriers	
30 Dec 2014	French, H, d	HSAG	South Africa	1	1	semi structu	to explore ar	10 nurses	qual			nurses have positive as w	
30 Dec 2014	Gurková, E, I	UNS	Cz/SI	1	1	cross section	to investigat	499 nurses	McCloskey/Mueller		Satisfaction S	low association between j	
30 Dec 2014	Gurková, E.,	UNS	Cz/SI	1	1	cross section	to investigat	104 nurses	Schwartz			Findings of this study con	
25 Dec 2014	Hegney, D.G	JNM	Australia	1	1	mm study survey		132 nurses	proqol		POOQOL and DASS	same study	
30 Dec 2014	Jacobs, LM :	dissertation	US	1	1	cross section	to link well b	144 nurses t	SWLS	25.24			
30 Dec 2014	Karimi, L, Le	JAN	Australia	2	1	cross section	To investigat	312 nurses	GWBQ		emotional labour, job stress		
30 Dec 2014	KDIVU, A, Sa	JNM	Finland	2	1	quasi experiment		156 nurses	GHQ12		MBI, MCSS	Improvement in job resou	
30 Dec 2014	Koivu, A, Sa	JCN	Finland	2	1	intervention study		156 nurses	GHQ12		MBI, MCSS	The nurses who received	
31 Dec 2014	Leka, S, Has	JPMHN	Japan	1	1	cross section	to examine what stressors	378 psych n	GWBQ		job sat,		really from a
31 Dec 2014	Lindo, J, Mc	WIMJ	Jamaica	2	1	cross section	to assess the	212 drs and	GHQ30				
31 Dec 2014	Loukzadeh, :	JCS	Iran	1	1	cross sectional survey		88 nurses	Ryff's Psychological		emotion foo	The results showed EFCS	

**Appendix 3 Review protocol: the mental health of mental health nurses
1999-2014**

(*This review protocol has been devised in accordance with the PRISMA protocol
(Liberati et al, 2009) and the guidance from the Centre for Reviews and Dissemination
(2009)*)

Review question

How has UK mental health nurses' mental health been measured in the past 15 years?
What is the state of UK mental health nurses' mental health?

Review objective

The objective of this review is to assess the current state of UK nurses' mental health,
with a particular focus on mental health nurses by asking:

> How has the mental health of mental health nurses been measured?
> What is the state of mental health nurses' mental health?
> What personal, demographic and workplace characteristics are associated with
> mental health problems in mental health nurses?
> What is the impact and influence of mental health problems on being a mental
> health nurse?

Participants

Studies of registered nurses where mental ill health(SWB) has been measured.

Interventions

Any intervention or combination of interventions where mental ill health has been
measured as part of the intervention or as an outcome measure for an intervention.

Control

No restrictions on control groups

Outcomes

Any outcome, including all measured used by researchers who describe their outcome
measure as one measuring mental ill health.

Study design

All study designs, including qualitative study designs.

Inclusion criteria

Included papers will be published between 1999 and 2014, in English, describing
primary research explicitly described as measuring on the subjective wellbeing (SWB)
of nurses.

Exclusion criteria

Pre- 2004 papers, not looking at nurses' mental ill health; papers where mental ill
health is not explicitly described (for example the vast literature on stress and burnout
may relate to mental ill health, but such studies are only to be included if wellbeing is
measured or discussed); opinion pieces, reviews, service descriptions.

Search strategy

To identify relevant papers through a search by the study author of the commonly used databases listing nursing research literature: *Cinahl, Medline, PubMed, EBSCO Academic Search Complete, Science Direct, Web of Science, Web of Knowledge, Social Science Citation Index, PsychINFO, PsychARTICLES*

The following search terms will be used in an initial title, keyword and abstract search:

> *nurs* AND 'mental illness',*
>
> *nurs* AND 'common mental disorder'*
>
> *nurs* AND 'depression'*
>
> *nurs* AND 'anxiety'*
>
> *nurs* AND 'mental health problem'*

Selected papers for full review will be those that describe primary research that meets the inclusion/exclusion criteria.

Data extraction

Full copies of all potentially relevant papers will be downloaded and reviewed, with information recorded on a data extraction sheet.

Data extraction criteria will be:

1. date reviewed
2. article titles
3. source
4. country of origin
5. relevance (1 meets incl criteria, 0 does not meet incl criteria)
6. quality (1 primary research, 2 research review, 0 not primary research)
7. study design
8. study aims
9. study participants
10. mental health measures used
11. other interventions used
12. outcome/ results

References

Centre for Reviews and Dissemination (2009) **Systematic reviews: CRD's guidance for undertaking reviews in health care.** York: University of York, 2009.

Liberati, A. et al., (2009) The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions : explanation and elaboration. **BMJ, 339(b2700)**, p.doi: 10.1136/bmj.b2700.

Appendix 4 Copy of the online survey

About this survey

1. Please tick this box to confirm that you have read the Information for participants page

○ Tick here

2. Please confirm that you consent to take part in this survey

○ Tick here

3. How did you find out about this survey?

☐ email from my professional body

☐ email from my manager

☐ email from a colleague

☐ other

Other (please specify)

```
[                                                              ]
```

About you

4. In what country do you live?

Scotland

5. Which category below includes your age?

○ 17 or younger
○ 18-20
◉ 21-29
○ 30-39
○ 40-49
○ 50-59
○ 60 or older

6. What is your gender?

◉ Female
○ Male

7. What is your ethnicity?

☑ White - British
☐ White - Irish
☐ Any other White background
☐ Mixed White and Black Caribbean
☐ Mixed White and Black African
☐ Mixed White and Asian
☐ Any other mixed background
☐ Asian or Asian British
☐ Black or Black British - Caribbean*
☐ Black or Black British – African*
☐ Any other Black/Black British background

Other (please specify)

8. How many people currently live in your household?

- [ ] 1 I live alone
- [x] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] more than 8

9. What relationship to you are the people in your household (for example, parent, partner, child)

n/a I live alone	
person 1	partner
person 2	
person 3	
person 4	
person 5	
person 6	
person 7	
person 8	

10. Please state your job title or describe your job

Specialised dementia unit staff nurse

11. Do you work

- [ ] full time
- [x] part time

12. How many years since you qualified in your profession?

3

13. How many years have you been in your current job?

6 months

14. In your job do you have formal responsibility for supervising the work of other employees?

- [ ] yes
- [x] no

15. Taking everything into account, do you think paid work is generally good or bad for physical health?

Very good	Good	Bad	Very bad
◯	◉	◯	◯

16. Taking everything into account, do you think paid work is generally good or bad for mental health?

Very good	Good	Bad	Very bad
◯	◉	◯	◯

17. In general, how satisfied are you with: (please tick one box in each row)

	Very dissatisfied	Quite dissatisfied	Neither satisfied or dissatisfied	Quite satisfied	Very satisfied
a. your job	☐	✔	☐	☐	☐
b. the social environment at work	☐	☐	☐	✔	☐
c. the physical environment at work	☐	☐	☐	☐	✔

About your well being

18. Overall, how satisfied are you with life nowadays? (on a scale of 0-10 where 0 is not at all satisfied and 10 is completely satisfied)

Not at all satisfied   Completely satisfied

O   O   O   O   O   O   O   O   O   O   O

19. Overall, how happy did you feel yesterday? (on a scale of 0-10, where 0 is not at all happy and 10 is completely happy)

Not at all happy   Completely happy

O   O   O   O   O   O   O   O   O   O   O

20. Overall, how anxious did you feel yesterday? (on a scale of 0-10, where 0 is not at all anxious and 10 is completely anxious)

Not at all anxious   Completely anxious

O   O   O   O   O   O   O   O   O   O   O

21. Overall, to what extent do you feel the things you do in your life are worthwhile (on a scale of 0-10, where 0 is not at all worthwhile and 10 is completely worthwhile)

Not at all worthwhile   Completely worthwhile

O   O   O   O   O   O   O   O   O   O   O

22. The Satisfaction With Life Scale (Diener et al, 1985)
Below are 5 statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by ticking the appropriate box following that item. Please be open and honest in your responding.

	1 = strongly disagree	2= disagree	3 = slightly disagree	4 = neither agree or disagree	5 = slightly agree	6 = agree	7 = strongly agree
In most ways my life is close to my ideal.	☐	☐	☐	☐	☐	✔	☐
The conditions of my life are excellent.	☐	☐	☐	☐	☐	✔	☐
I am satisfied with life.	☐	☐	☐	☐	☐	✔	☐
So far I have gotten the important things I want in life.	☐	✔	☐	☐	☐	☐	☐
If I could live my life over, I would change almost nothing.	☐	☐	☐	☐	✔	☐	☐

About your well being

Warwick Edinburgh Mental Well-Being Scale (WEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

23. I've been feeling optimistic about my future

None of the time	Rarely	Some of the time	Often	All of the time
○	○	◉	○	○

24. I've been feeling useful

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	◉	○

25. I've been feeling relaxed

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

26. I've been feeling interested in people

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

27. I've had energy to spare

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	◉	○

28. I've been dealing with problems well

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

29. i've been thinking clearly

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	◉	○

30. I've been feeling good about myself

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	◉	○

31. I've been feeling close to other people

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

32. I've been feeling confident

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	◉	○

33. I've been able to make up my own mind about things

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

34. I've been feeling loved

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

35. I've been interested in new things

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	○	◉

36. I've been feeling cheerful

None of the time	Rarely	Some of the time	Often	All of the time
○	○	○	◉	○

About your mental health now

37. Are you presently experiencing or being treated for mental health problems

☐ Yes

☑ No

38. If you answered NO to the previous question please move onto the next page - About your mental health history.

If you answered YES to the previous question please tick the following answers that apply to you:

☐ I am experiencing mental health problems but not receiving any formal support or treatment

☐ I am currently care of a psychiatrist for my mental health problems

☐ I am currently care of my GP for my mental health problems

☐ I currently see a non medical practitioner about my mental health problems (for example a therapist, acupuncturist, counsellor)

39. Are you currently taking medication for your mental health problems?

☐ yes

☐ no

☐ If yes, please tell us what medication you are taking

40. What do you understand your diagnosis to be?

41. Does your experience of mental health problems affect how you work with the users of your service?

	always	sometimes	occasionally	never
in a positive way	☐	☐	☐	☐
in a negative way	☐	☐	☐	☐

42. Does your experience of mental health problems affect how you work with colleagues?

	always	sometimes	occasionally	never
in a positive way	☐	☐	☐	☐
in a negative way	☐	☐	☐	☐

43. Does your experience of mental health problems affect how you manage your workload?

	always	sometimes	occasionally	never
in a positive way	☐	☐	☐	☐
in a negative way	☐	☐	☐	☐

44. Do you disclose your personal experience of mental health problems

	always	sometimes	occasionally	never
To clients	☐	☐	☐	☐
To colleagues	☐	☐	☐	☐
To your manager	☐	☐	☐	☐

About your mental health in the past

45. Have you experienced or been treated for mental health problems in the past?

☑ Yes

☐ No

46. If you answered YES to the previous question please tick the following answers that apply to you:

☐ I experienced mental health problems but not receiving any formal support or treatment

☐ I was care of a psychiatrist for my mental health problems

☐ I was care of my GP for my mental health problems

☐ I saw a non medical practitioner about my mental health problems (for example a therapist, acupuncturist, counsellor)

47. Did you take medication for your mental health problems?

☐ yes

☑ no

☐ If yes, please tell us what medication you have taken

48. What did you understand your diagnosis to be?

depression

49. Has your experience of mental health problems affected how you work with the users of your service?

	always	sometimes	occasionally	never
In a positive way	☑	☐	☐	☐
In a negative way	☐	☐	☐	☑

50. Has your experience of mental health problems affected how you work with colleagues?

	always	sometimes	occasionally	never
In a positive way	☑	☐	☐	☐
In a negative way	☐	☐	☑	☐

51. Has your experience of mental health problems affected how you manage your workload?

	always	sometimes	occasionally	never
In a positive way	☐	☐	☑	☐
In a negative way	☐	☐	☐	☑

52. Have you disclosed your personal experience of mental health problems

	always	sometimes	occasionally	never
To clients	☐	☐	☐	☑
To colleagues	☐	☐	☐	☑
To your manager	☐	☐	☑	☐

About the people you live with

53. Do any of the people you currently live with experience or undergo treatment for mental health problems?

☐ N/a I live alone

☐ Yes

☑ No

54. If you answered YES to the previous question please answer the following questions:

Do you live with more than one person with mental health problems?

☐ yes

☐ no

☐ If more than 1 please answer the following questions about the person you spend most time with

55. What is your relationship to this person (for example parent, partner, child)?

[   ]

56. Please tick the following answers that apply to them:

☐ They experience mental health problems but not receiving any formal support or treatment

☐ They are currently care of a psychiatrist for my mental health problems

☐ They are currently care of their GP for their mental health problems

☐ They currently see a non medical practitioner about my mental health problems (for example a therapist, acupuncturist, counsellor)

57. Are they currently taking medication for their mental health problems?

☐ yes

☐ no

☐ If yes, please tell us what medication you believe they are taking

[   ]

58. What do you understand their diagnosis to be?

[   ]

59. Is your experience of living with this person affecting how you work with the users of your service?

	always	sometimes	occasionally	never
in a positive way	☐	☐	☐	☐
in a negative way	☐	☐	☐	☐

60. Is your experience of living with this person affecting how you work with colleagues?

	always	sometimes	occasionally	never
in a positive way	☐	☐	☐	☐
in a negative way	☐	☐	☐	☐

61. Is your experience of living with this person affecting how you manage your workload?

	always	sometimes	occasionally	never
In a positive way	☐	☐	☐	☐
In a negative way	☐	☐	☐	☐

62. Do you disclose your home experience of living with mental health problems

	always	sometimes	occasionally	never
To clients	☐	☐	☐	☐
To colleagues	☐	☐	☐	☐
To your manager	☐	☐	☐	☐

64. If you answered YES to the previous question please answer the following questions:

Have you lived with more than 1 person with mental health problems?

☐ yes

☐ no

65. Please give details of their relationship to you.

parent

66. Please answer the following questions about the person you spent most time with, if you lived with more than 1 person with mental health problems. please state your relationship to this person.

67. Please tick the following answers that apply to them:

☐ They experienced mental health problems but not receiving any formal support or treatment

☐ They were care of a psychiatrist for my mental health problems

☐ They were care of a GP for their mental health problems

☑ They saw a non medical practitioner about my mental health problems (for example a therapist, acupuncturist, counsellor)

68. Was this person taking medication for mental health problems?

☑ yes

☐ no

☐ If yes, please tell us what medication you believe they are taking

She cannot remember

69. What do you understand their diagnosis to have been?

depression

70. Has your experience of living with this person affected how you work with the users of your service?

	always	sometimes	occasionally	never
In a positive way	☐	☐	☑	☐
In a negative way	☐	☐	☐	☑

71. Has your experience of living with this person affected how you work with colleagues?

	always	sometimes	occasionally	never
in a positive way	☐	☐	✔	☐
in a negative way	☐	☐	☐	✔

72. Has your experience of living with this person affected how you manage your workload?
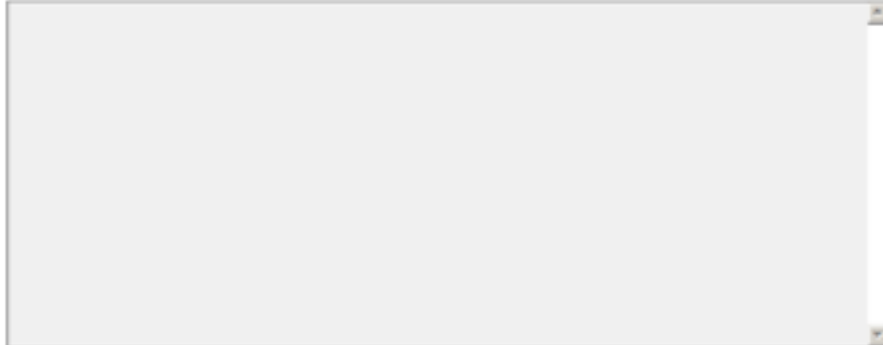
	always	sometimes	occasionally	never
in a positive way	☐	☐	☐	✔
in a negative way	☐	☐	☐	✔

73. Do you disclose your previous experience of living with someone with mental health problems

	always	sometimes	occasionally	never
To clients	☐	☐	✔	☐
To colleagues	☐	☐	✔	☐
To your manager	☐	☐	☐	✔

Final page

74. Thank you for completing this survey. Please use the space below for any additional comments you have about the survey and the topic

75. In phase 2 of this study we will be asking some of the people who have taken part in this survey to take part in an interview about their work, well being and mental health histories.
Interviews will take place between June and December 2013 at a time and place convenient to you.
You are under no obligation to take part in the study if you volunteer now and then change your mind at a later date.
Would you be willing to take part in an interview?
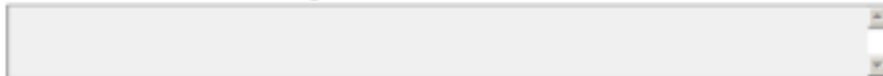
☑ yes

☐ no

76. If you would like to take part in an interview, at what email address would you like to be contacted to make arrangements?

Appendix 5 Interview topic guide

This topic guide covers the broad subjects to be spoken about.

Thank you for taking part in this study. You have already completed an online questionnaire. Before we start the interview I'd like to just check with you that you give **consent** to taking part in this interview and for the results to be analysed and reported back as part of a research dissertation and other publications. Any reference to anything you say will be anonymised. Today's interview should take about an hour. If at any point you want to stop the interview, ask questions or withdraw consent then please feel free to do so.

2. Demographics

Each interviewee has already undertaken an online survey. This gathered information about their age, gender, occupation, home set up. This information will be briefly reviewed at the start of the interview. Each interviewee also completed two surveys that measure subjective wellbeing. The results of this survey will be discussed.

3. Mental health history

- personal mental health history.
- contact with people with mental health problems prior to becoming a nurse.
- family and friend experience of mental ill health since becoming a nurse.
- opinions on the genesis of mental illness - in general and in relation to self, family and friends.

4. Mental health experiences and work

- impact of mental health experiences and work - in general and personally
- impact on work with service users
- impact on work with colleagues
- impact on managing work
- positive and negative impact

5. Subjective wellbeing

- personal understanding of subjective wellbeing?
- how do you support or manage your subjective wellbeing?
- what helps at work/ outside of work?

6. It has proved difficult accessing sufficient numbers of mental health nurses to conduct a truly generalisable study. It would be useful to know your views on why nurses might not take part in such a piece of research, and how to engage them in future studies.

7. do you have any further comments or questions.

Appendix 6 A 15-Point Checklist of Criteria for Good Thematic Analysis

**A 15-Point Checklist of Criteria for Good Thematic Analysis
from Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology.
Qualitative Research in Psychology, 3(2), 77–101.**

Process	No	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for „accuracy".
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described. Analysis
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process; themes do not just „emerge"

Appendix 7 Standard linear multiple regression of demographic and workplace factors with subjective wellbeing measures.

Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity and homoscedacticity. As would be expected, given the results of the analyses undertaken for each individual variable discussed at 8.2.6, the combined demographic and workplace factors only accounted for small amounts of variance in SWB scores. Tables 8.11 to 8.22 summarise the findings of the standard linear multiple regression analyses. The only independent variable found to have a significant contribution to the model across all six analyses was gender, on results of the ONS life worthwhile question (p 0.018) (see Table 8.18)

> For the ONS 'life satisfaction' question the model of six variables accounted for just 3% of the variance.
>
> For the ONS 'happiness yesterday' question the model of six variables accounted for 2.3% of the variance.
>
> For the ONS 'anxious yesterday' question the model of six variables accounted for 1.5% of the variance.
>
> For the ONS 'life worthwhile…' question the model of six variables accounted for 4% of the variance.
>
> For the SWLS the model of six variables (years in post, years in profession, age, gender, work status and number in household) accounted for 3.5% of the variance.
>
> For the WEMWBS the model of the six variables (years in post, years in profession, age, gender, work status and number in household) accounted for 0.5% of the variance.

These findings show that the factors that have been measured here did not influence SWB to a great extent. There may be other factors that do influence mental health nurses' SWB. Where the age and gender patterns identified within these data are similar to norms (see 8.4.1.1), their influence was not statistically significant. Further research should aim to find determinant factors for mental health nurses SWB. The qualitative part of this study offers some insight into factors that could be measured in future surveys as correlations of SWB.

Table A7.1: Model summary for the standard linear multiple regression analysis for ONS life satisfaction

R	R^2(%explained)	Adjusted R^2	Standard error of the estimate
0.174	0.03 (3%)	0.002	2.285

Table A7.2: Summary of coefficients for the standard linear multiple regression of the combined relationship between demographic and workplace factors and ONS life satisfaction

	Unstandardised Coefficients		Standardised coefficients		
	B	Standard Error	Beta (β)	t	sig.
(Constant)	6.436	0.773		8.322	0.000
Gender	-0.652	0.348	-0.129	-1.874	0.062
Years in profession	0.166	0.140	0.114	1.188	0.236
Years in post	-0.044	0.162	-0.024	-0.271	0.787
Number in household	0.073	0.182	0.028	0.400	0.689
Age	-0.098	0.223	-0.035	-0.440	0.660
Full or part time	-0.006	0.008	-0.058	-0.806	0.421

Dependent variable is ONS life satisfaction *p<0.05, **p<0.001

Table A7.3: Model summary for the standard linear multiple regression analysis for ONS happiness yesterday

R	R^2(%explained)	Adjusted R^2	Standard error of the estimate
0.153	0.023(2.3%)	-0.005	2.625

Table A7.4: Summary of coefficients for the standard linear multiple regression of the combined relationship between demographic and workplace factors and ONS happiness yesterday

	Unstandardised Coefficients		Standardised coefficients		
	B	Standard Error	Beta (β)	t	sig.
(Constant)	6.388	0.888		7.191	0.000
Gender	-0.512	0.399	-0.088	-1.282	0.201
Years in profession	0.241	0.161	0.144	1.501	0.135
Years in post	-0.056	0.186	-0.027	-0.302	0.763
Number in household	-0.064	0.209	-0.021	-0.305	0.760
Age	-0.318	0.256	-0.098	-1.242	0.216
Full or part time	-0.001	0.009	-0.007	-0.095	0.924

Dependent variable is ONS happiness yesterday *p<0.05, **p<0.001

R	R²(%explained)	Adjusted R²	Standard error of the estimate
0.123	0.015(1.5%)	0.013	2.813

Table A7.6: Summary of coefficients for the standard linear multiple regression of the combined relationship between demographic and workplace factors and ONS anxiety yesterday

	Unstandardised Coefficients		Standardised coefficients		
	B	Standard Error	Beta (β)	t	sig.
(Constant)	3.634	0.954		3.808	0.000
Gender	-0.400	0.429	-0.065	-0.932	0.352
Years in profession	-0.085	0.173	-0.048	-0.492	0.623
Years in post	0.071	0.200	0.032	0.356	0.722
Number in household	0.227	0.224	0.070	1.010	0.314
Age	-0.051	0.275	-0.015	-0.186	0.853
Full or part time	0.007	0.009	0.052	0.718	0.473

Dependent variable is ONS anxiety yesterday *p<0.05, **p<0.001

Table A7.7: Model summary for the standard linear multiple regression analysis for ONS happiness yesterday

R	R²(%explained)	Adjusted R²	Standard error of the estimate
0.209	0.044 (4%)	0.016	2.217

Table A7.8: Summary of coefficients for the standard linear multiple regression of the combined relationship between demographic and workplace factors and ONS life worthwhile

	Unstandardised Coefficients		Standardised coefficients		
	B	Standard Error	Beta (β)	t	sig.
(Constant)	7.823	0.752		10.401	0.000
Gender	-0.806	0.338	-0.163	-2.383	**0.018***
Years in profession	0.210	0.136	0.147	1.543	0.124
Years in post	-0.096	0.158	-0.053	-0.607	0.544
Number in household	0.104	0.177	0.040	0.589	0.557
Age	-0.250	0.217	-0.090	-1.154	0.250
Full or part time	0.003	0.007	0.025	0.347	0.729

Dependent variable is ONS life worthwhile *p<0.05, **p<0.001

Table A7.9: Model summary for the standard linear multiple regression analysis for ONS happiness yesterday

R	R²(%explained)	Adjusted R²	Standard error of the estimate
0.187	0.035 (3.5%)	0.006	7.396

Table A7.10: Summary of coefficients for the standard linear multiple regression of the combined relationship between demographic and workplace factors and SWLS score

	Unstandardised Coefficients		Standardised coefficients		
	B	Standard Error	Beta (β)	t	sig.
(Constant)	22.730	2.551		8.911	0.000
Gender	-1.792	1.147	-0.109	-1.563	0.120
Years in profession	0.115	0.462	0.024	0.250	0.803
Years in post	0.129	0.535	0.022	0.241	0.810
Number in household	0.922	0.600	0.108	1.537	0.126
Age	-0.939	0.735	-0.102	-1.278	0.203
Full or part time	-0.021	0.025	-0.059	-0.816	0.416

Dependent variable is SWLS score *p<0.05, **p<0.001

Table A7.11: Model summary for the standard linear multiple regression analysis for ONS happiness yesterday

R	R²(%explained)	Adjusted R²	Standard error of the estimate
0.073	0.005 (0.5%)	-0.025	8.476

Table A7.12: Summary of coefficients for the standard linear multiple regression of the combined relationship between demographic and workplace factors and WEMWBS score

	Unstandardised Coefficients		Standardised coefficients		
	B	Standard Error	Beta (β)	t	sig.
(Constant)	49.249	2.952		16.684	0.000
Gender	-0.731	1.327	-0.039	-0.551	0.582
Years in profession	0.128	0.534	0.024	0.240	0.811
Years in post	-0.062	0.619	-0.009	-0.100	0.920
Number in household	-0.181	0.694	-0.019	-0.260	0.795
Age	-0.335	0.850	-0.032	-0.393	0.694
Full or part time	-0.019	0.029	-0.049	-0.654	0.514

Dependent variable is WEMWBS score*p<0.05, **p<0.001

Appendix 8: direct logistic regression of the combined relationship between demographic and workplace factors and current experience of mental health problems in mental health nurses

Direct logistic regression was performed to assess the impact of the demographic and workplace factors (independent variables) on mental health problems (the dependent variable) at the time of the survey (Group A), with any subjective experience of mental health problems (Group B), past and present own mental health problems (Group C) and past and present experience of living with someone with mental health problems (Group D). These are reported in Tables 9.8, 9.9, 9.10 ad 9.11, as advised by Pallant(2010), with reference to Tabachnick and Fidell, 2014), giving Wald and B values and Odds Ratios for each variable. In each table the statistically significant variables (p<0.05) are highlighted in bold.

The combined relationship between demographic and workplace factors and current experience of mental health problems in mental health nurses (Group A)

Direct logistic regression was performed to assess the impact of seven independent demographic and work related factors on the likelihood that participants would report experiencing mental health problems at the time of the survey. The full model was not statistically significant, X^2(8, N = 213) =15.986, p = 0.314 indicating that the model was not able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 7.2% (Cox and Snell R Square) and 10.8%(Nagelkerke R Square) of the variance and correctly classified no more cases than the null model (75.6% of cases). None of the independent variables made a unique statistical contribution to the model, as shown in Table 9 8.

Table A8.1: Logistic regression predicting likelihood of current MHP (Group A)

		B	SE	Wald	df	p	Odds Ratio	95% CI for OR lower	95% CI for OR upper
gender	**m/f**	-0.737	0.421	3.065	1	0.080	0.479	0.210	1.092
years in post	**<2 years**			2.821	3	0.420			
	3-5 years	-0.554	0.469	1.394	1	0.238	0.574	0.229	1.442
	6-10 years	-0.051	0.497	0.010	1	0.918	0.950	0.358	2.520
	>11 years	-0.766	0.595	1.656	1	0.198	0.465	0.145	1.493
years in profession	**<2 years qualified**			3.868	3	0.276			
	3-5 years qualified	1.144	0.725	2.489	1	0.115	3.140	0.758	13.013
	6-10 years qualified	1.305	0.698	3.495	1	0.062	3.688	0.939	14.492
	>11 years qualified	0.952	0.615	2.395	1	0.122	2.590	0.776	8.645
age	**under 40**			2.464	2	0.292			
	40-49	0.640	0.443	2.088	1	0.148	1.897	0.796	4.522
	50 and over	0.188	0.528	0.127	1	0.722	1.207	0.429	3.393
no in household	**living alone**	0.528	0.127	1	0.722	1.207	0.429	3.393	0.528
	living w 1 person	-0.658		2.514	3	0.473			
	living w 2 or 3 others	-0.196	0.506	1.691	1	0.193	0.518	0.192	1.396
	living w 4 or more others	-0.735	0.476	0.169	1	0.681	0.822	0.323	2.090
supervision	**y/n**	0.217	0.373	0.338	1	0.561	1.242	0.598	2.579
ft/pt	**y/n**	0.428	0.424	1.018	1	0.313	1.534	0.668	3.521
Constant		-1.679	0.656	6.555	1	0.010	0.187		

a Variable(s) entered on step 1: gender, postcatv2, tprofcat, fourage, hse3, supervi, ftpt.

The combined relationship between demographic and workplace factors and any form of subjective experience of mental health problems in mental health nurses (Group B)

Direct logistic regression was performed to assess the impact of seven independent demographic and work related factors on the likelihood that participants would report experiencing their own past or present mental health problems. The full model was statistically significant, X^2(14, N = 204)=3.402, p 0.003 indicating that the model was able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 15.1% (Cox and Snell R Square) and 20.8%(Nagelkerke R Square) of the variance and correctly classified 68.5% of cases compared to 64.7% when none of the variables were entered into the SPSS predictive model. The independent variables that made a unique statistical contribution to the model, as shown in Table 9.9 were: being post for two years or less, being qualified for between three to five years and living alone increased likelihood of subjective experience of mental health problems; being in post for over 11 years, living with just one other person and living with four or more people reduced the likelihood of subjective experience of mental health problems.

Table A8.2: Logistic regression predicting likelihood of MHNs reporting any form of subjective experience of mental health problems (Group B)

		B	SE	Wald	df	p	Odds Ratio	95% CI for OR lower	95% CI for OR upper
gender	**m/f**	0.080	0.377	0.045	1	0.832	1.083	0.517	2.268
years in post	**<2 years**			9.342	3	**0.025**	9.342	3	0.025
	3-5 years	0.941	0.487	3.732	1	0.053	0.390	0.150	1.014
	6-10 years	-0.317	0.549	0.334	1	0.563	0.728	0.248	2.135
	>11 years	-1.624	0.583	7.766	1	**0.005**	0.197	0.063	0.618
years in profession	**<2 years qualified**			5.908	3	0.116			
	3-5 years qualified	1.672	0.709	5.563	1	**0.018**	5.324	1.327	21.364
	6-10 years qualified	0.708	0.621	1.299	1	0.254	2.031	0.601	6.864
	>11 years qualified	0.908	0.562	2.607	1	0.106	2.479	0.824	7.462
age	**under 40**			0.402	2	0.818			
	40-49	0.275	0.434	0.402	1	0.526	1.317	0.562	3.084
	50 and over	0.186	0.503	0.136	1	0.712	1.204	0.449	3.227
no in household	**living alone**			16.428	3	**0.001**			
	living w 1 person	-2.203	0.612	12.950	1	**0.000**	0.111	0.033	0.367
	living w 2 or 3 others	-1.125	0.612	3.378	1	0.066	0.324	0.098	1.078
	living w 4 or more others	-1.838	0.731	6.331	1	**0.012**	0.159	0.038	0.666
supervision	**y/n**	0.440	0.371	1.406	1	0.236	1.553	0.750	3.214
ft/pt	**y/n**	-0.309	0.424	0.532	1	0.466	0.734	0.320	1.685
Constant		1.626	0.673	5.834	1	**0.016**	5.083		

a Variable(s) entered on step 1: gender, postcatv2, tprofcat, fourage, hse3, supervi, ftpt.

The combined relationship between demographic and workplace factors and mental health nurses own past or present mental health problems (Group C)

Direct logistic regression was performed to assess the impact of seven independent demographic and work related factors on the likelihood that participants would report experiencing their own past or present mental health problems. The full model was statistically significant, X^2(14, N = 196)= 28.415, p 0.013 indicating that the model was able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 13.4% (Cox and Snell R Square) and 17.9%(Nagelkerke R Square) of the variance and correctly classified 68.5% of cases compared to 52.8% when none of the independent variables were added to the SPSS predictive model. The independent variables that made a unique statistical contribution to the model, as shown in Table 9.10 were: being in post for less than two years increased likelihood of reporting mental health problems as did being in the profession for three to five years; being in post for three to five or over 11 years and living with just one other person reduced the likelihood of mental health problems.

**Table A 8.3: Logistic regression predicting likelihood of MHNs' past
or present own mental health problems (Group C)**

		B	SE	Wald	df	p	Odds Ratio	95% CI for OR lower	95% CI for OR upper
gender	m/f	-0.082	0.364	0.050	1	0.822	0.922	0.452	1.880
years in post	<2 years			14.174	3	**0.003**			
	3-5 years	-1.634	0.466	12.311	1	**0.000**	0.195	0.078	0.486
	6-10 years	-0.748	0.516	2.100	1	0.147	0.474	0.172	1.302
	>11 years	-1.475	0.557	7.014	1	**0.008**	0.229	0.077	0.682
years in profession	<2 years qualified			4.999	3	0.172			
	3-5 years qualified	1.502	0.693	4.693	1	**0.030**	4.493	1.154	17.490
	6-10 years qualified	0.752	0.607	1.537	1	0.215	2.121	0.646	6.965
	>11 years qualified	0.418	0.538	0.602	1	0.438	1.519	0.529	4.363
age	under 40			2.364	2	0.307			
	40-49	0.628	0.419	2.253	1	0.133	1.874	0.825	4.257
	50 and over	0.306	0.502	0.372	1	0.542	1.358	0.508	3.631
no in household	living alone			6.733	3	0.081			
	living w 1 person	-1.217	0.482	6.375	1	**0.012**	0.296	0.115	0.762
	living w 2 or 3 others	-0.589	0.465	1.607	1	0.205	0.555	0.223	1.379
	living w 4 or more others	-0.609	0.638	0.910	1	0.340	0.544	0.156	1.900
supervision	y/n	-0.064	0.346	0.034	1	0.853	0.938	0.476	1.849
ft/pt	y/n	0.673	0.426	2.495	1	0.114	1.960	0.850	4.519
Constant		0.704	0.560	1.583	1	0.208	2.022		

a Variable(s) entered on step 1: gender, postcatv2, tprofcat, fourage, hse3, supervi, ftpt.

The combined relationship between demographic and workplace factors and experience of living with someone with mental health problems (Group D)

Direct logistic regression was performed to assess the impact of seven independent demographic and work related factors on the likelihood that participants would report experience of living with someone with mental health problems. The full model was not statistically significant, X^2 (14, N= 204) = 21.626, p0.087 indicating that the model was not able to distinguish between participants who did or did not report current mental health problems. The model as a whole explained between 10.1% (Cox and Snell R Square) and 13.5%(Nagelkerke R Square) of the variance and correctly classified 67.2 % of cases compared to 57.8& of cases identified in the SPSS predictive model without the addition of the independent variables. Some independent variables did make a unique statistical contribution to the model, as shown in Table 9.11. They were: being post for for two or less years increased likelihood of having lived with someone with mental health problems; being in post for six to ten or over 11 years decreased likelihood of having lived with someone with mental health problems. Living with just one other person decreased likelihood of having lived with someone with mental health problems.

Table A8.4: Logistic regression predicting likelihood of MHNs reporting experience of living with someone with mental health problems (Group D)

		B	SE	Wald	df	p	Odds Ratio	95% CI for OR lower	95% CI for OR upper
gender	**m/f**	0.060	0.344	0.030	1	0.862	1.062	0.541	2.085
years in post	**<2 years**			10.260	3	**0.016**			
	3-5 years	-0.834	0.427	3.810	1	0.051	0.434	0.188	1.003
	6-10 years	-1.424	0.518	7.565	1	**0.006**	0.241	0.087	0.664
	>11 years	-1.375	0.552	6.198	1	**0.013**	0.253	0.086	0.746
years in profession	**<2 years qualified**			1.809	3	0.613			
	3-5 years qualified	0.756	0.607	1.550	1	0.213	2.130	0.648	7.006
	6-10 years qualified	0.403	0.575	0.492	1	0.483	1.497	0.485	4.621
	>11 years qualified	0.147	0.502	0.085	1	0.770	1.158	0.433	3.098
age	**under 40**			1.076	2	0.584			
	40-49	0.414	0.403	1.052	1	0.305	1.512	0.686	3.334
	50 and over	0.344	0.479	0.516	1	0.473	1.411	0.552	3.609
no in household	**living alone**			6.827	3	0.078			
	living w 1 person	-1.189	0.464	6.561	1	**0.010**	0.305	0.123	0.756
	living w 2 or 3 others	-0.846	0.450	3.531	1	0.060	0.429	0.178	1.037
	living w 4 or more others	-0.553	0.603	0.841	1	0.359	0.575	0.176	1.876
supervision	**y/n**	-0.207	0.340	0.369	1	0.543	0.813	0.417	1.585
ft/pt	**y/n**	-0.341	0.410	0.691	1	0.406	0.711	0.318	1.589
Constant		0.740	0.540	1.882	1	0.170	2.097		

a Variable(s) entered on step 1: gender, postcatv2, tprofcat, fourage, hse3, supervi, ftpt.