**Mental health nurses' self-care at work, *searching for equilibrium*: An Interpretative Phenomenological Analysis**


## ABSTRACT

The nursing workforce plays a central role in quality health care delivery. Nursing work is associated with high levels of stress due to often unmanageable workloads. The associated attrition poses a serious challenge for recruitment and retention strategies. Self-care is recognised as a tactic for addressing workplace stressors, shaping a sense of cohesion where the world is viewed as comprehensible, meaningful, and manageable, thereby mitigating the risk of burnout. Yet research suggests it is not widely utilised by nurses. The aim of this study was to understand mental health nurses' lived experience of self-care at work. The research was undertaken using an Interpretative Phenomenological Analysis methodology. In-depth individual interviews explored nurses' attitudes to self-care and how they did or did not adopt self-care practices in the workplace. Data were analysed thematically. *The Search for Equilibrium*, was identified as the superordinate theme, developed from three subordinate themes, *The past self: "tormented and spent"*, *the intricacy of self-care,* and *the trusted inner circle: "safe and supported"*. These findings highlight the complexity of self-care and the importance of considering it as much broader than purely an intra-personal phenomenon, emphasising the importance of relationships and interpersonal connections. Time past, present, and future influenced how participants

made sense of their workplace experiences. These findings provide a deeper understanding of self-care in response to workplace stress and could assist in developing strategies to promote self-care for nurses, and ultimately positively enhance recruitment.

**Keywords**

Acute care

Burnout

Crisis team

Mental health nurses

Retention

Self-care

Stress

Workplace

## Introduction:

Nurses have a critical role in healthcare delivery priorities (World Health Organization, 2020). As health burden and complexity increase globally, recruitment and retention of nurses is a priority and presents a significant challenge due to unmanageable workloads, stress, and burnout (Buchen et al., 2018; Foster et al., 2020; Happell et al., 2013; Renwick et al., 2019). Nurses' self-care can mitigate risks associated with work stressors (Blackburn et al., 2020; Lamb & Cogan, 2016), yet the evidence suggests self-care is not routinely practiced by nurses (Halm, 2017; Melnyk, 2020).

## Background

Interest in nurses' self-care emerged as a strategy to address stress levels of nurses and ultimately influence better care of clients (Bowden et al., 2015; Mangoulia et al., 2015). Self-care may be defined as a "multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (Dorociak et al., 2017, p. 326) including social, spiritual, psychological, physical, and professional aspects. Self-care is essential for nurses well-being, enabling them to "work from a caring-healing paradigm" (Watson, 2012, p. 49). Nurses also need time to reflect on and consider their emotions and needs, minimising personal depletion and building the foundations of a healing presence through self-kindness and self-care (Helming et al., 2020).

The Self-Tuning Model of Self-Care (Vinje & Mittelmark, 2008) addresses the processes involved for nurses to maintain their vitality as they engage with their work. Whilst predominantly concerned with job engagement, the model offers insights into self-discoveries made by nurses' relating to their self-care (Vinje & Mittelmark, 2008). An ability to engage in introspection, or self-observation, becomes the cornerstone of self-care. This introspection ideally leads to self-sensibility and reflection. Originally, sensibility was constructed as the nurses' awareness, receptiveness and understanding of their clients' needs and situations, assisting the nurse to empathise with their experience (Vinje & Mittelmark, 2008). Self-sensibility is simply turning this sensitivity and awareness towards the self (Vinje & Mittelmark, 2008). These three processes (introspection, sensibility, reflection) create an internal adjustment in response to experiences such as work overload, stress, or achievement, that shape the sense of coherence (comprehensibility, manageability, meaningfulness) (Mittelmark et al., 2022). Sense of coherence will either promote or threaten health and well-being (Bauer et al., 2020). Self-care strategies facilitate positive adjustment, shaping the health-promoting sense of coherence.

Self-care, including cognitive, behavioural, and emotional strategies, provides nurses with psychological protection from the stresses and strains of work (Bjarnadottir & Vik, 2015; Blackburn et al., 2020; Bowden et al., 2015; O'Malley et al., 2022; Sinclair et al., 2017; Van Sant & Patterson, 2013). The available empirical literature details self-care through a variety of coping strategies including self-observation, adjustment, reflection, and cognitive reframing

(Bakibinga et al., 2014; Bowden et al., 2015; Gerace et al., 2018). When overwhelmed or distressed, nurses avoid, divert attention, walk away, take time out or experience resigned acceptance and emotional dysregulation, as they attempt to self-care (Antoniolli et al., 2018; Bowden et al., 2015; McTiernan & McDonald, 2015). Some nurses will feel less compassion towards others as they distance themselves, protecting the self as a form of self-care (Sinclair et al., 2017). To manage the disparity between desired care and the reality of work, nurses may lower expectations, suppress unwanted feelings, or overcompensate with clients (Nilsson et al., 2016). In the absence of self-care, disturbance in mood, physical health, outlook, and work disengagement are commonly experienced (Lachowska & Minda, 2020; Renwick et al., 2019; Scott et al., 2014).

There are challenges evident in nurses' engagement with self-care including perceived time/workload restraints (Bowden et al., 2015), the prioritisation of others above self (Halm, 2017), loss of purpose (Nilsson et al., 2016). Given the emphasis placed on nurse wellbeing, as it influences quality of care (Department of Health, 2020; Perlo et al., 2017), an understanding of self-care in practice is essential. Whilst self-care has been explored as part of resilience building (Delgado et al., 2022; Foster et al., 2020), there are gaps in our understanding of nurses' experiences of self-care at work, the significance of their relational and spatial world, as they attempt to cope with stress and challenges. Focusing on the individual nurses' self-care practices may assist in understanding why they remain stressed and at risk of burnout, with a

compromised sense of cohesion (where the world is comprehensible, manageable, and meaningful). This is despite organisational commitments to address work-related issues (Department of Health, 2020; Perlo et al., 2017). To our knowledge there are no previous studies exploring mental health nurses' self-care and sense of coherence.

The aim of this study was to understand mental health nurses' lived experience of self-care at work. *The Search for Equilibrium,* was a major theme and is presented in this paper.

## Methods

### Design

A qualitative approach, using Interpretative Phenomenological Analysis (IPA) (Larkin et al., 2021) was adopted. IPA aims to keep the individual central, to examine in detail the participants lived experience, personal meaning, and sense-making of experience (Larkin et al., 2021). With its groundings in Phenomenology (concerned with individual lived experience), Hermeneutics (the theory of interpretation) and Idiography (focused on the particular, the uniqueness of the individual) (Smith & Nizza, 2022), IPA was a useful approach, enabling the interpretation of findings where relatedness and connectedness, temporality, mood, selfhood, and embodiment (the understanding of and relationship to the body) became prominent.

The COnsolidated Criteria for REporting Qualitative Research (COREQ) checklist, to ensure explicit and comprehensive reporting, was utilised (Tong et al., 2007).

## Setting and participants

The sample was sought from mental health nurses working within home-based crisis teams (HBCT) in Ireland. HBCTs aim to support service users during acute mental health crisis, without admission to hospital, if possible, through intensive support (Department of Health, 2020). The work environment described by participants in this study was one of pressure and unpredictability, with a sense of urgency and intensity. There was insufficient space to reflect on practice and relationships with colleagues were at times strained. Connecting with service users or clients was at times both rewarding and stressful.

The sample was purposive and homogenous to allow meaningful perspectives from a position of shared expertise. To deeply understand the experiential claims of participants in particular contexts and to ensure the principles of Idiography and homogeneity are respected, small sample sizes are recommended (Smith & Nizza, 2022). The inclusion criteria were registered mental health nurses currently working in crisis teams in acute mental health care, with a minimum of six months experience in the setting. The Area Nurse Manager circulated information to potential participants. All nurses who met

the inclusion criteria were invited to participate in the study. Eight individuals expressed an interest in doing so, and ultimately participated.

## Procedure

The research team consisted of a Doctoral student (primary researcher) supervised by two academics with expertise in IPA. Semi-structured interviews of between 40 and 70 minutes were completed (Table 1). Participants chose the interview location, all occurred in their workplace, with participant and primary researcher only present. Each interview was audio recorded and transcribed, facilitating a deep immersion in the participants experience (Larkin et al., 2021). Rigour and quality of the study was addressed throughout, guided by markers of high-quality IPA studies (Nizza et al., 2021; Smith, 2011).

**Insert Table 1 about here**

## Ethics

Ethical approval for the study was granted from the relevant Clinical Research Ethics Committee. All participants received an information leaflet outlining study aims, potential risks, benefits, and researcher purpose. Written consent was obtained prior to the interviews and potential participants informed that involvement was voluntary, and they could withdraw from the study. None did so.

## Data Analysis

Data analysis was idiographic, inductive, and interrogative to meet the expectations of an IPA study (Larkin et al., 2021). Data analysis comprised of reading, re-reading, and listening to each interview individually, recording strongest recollections and taking initial notes, guided by description, linguistics, and emerging concepts (Larkin et al., 2021). Using participants own words and researcher interpretations, concise statements of what was important to the participant were developed. A search for patterns or connections was sought to map themes, and how they fit together, before moving to the next interview. Each interview analysis had its own theme map. When all interviews were analysed individually patterns were sought across all interviews before developing one master table of super-ordinate themes, guided by abstraction, polarisation, subsumption, context, metaphor, and hermeneutics. Table two illustrates the super-ordinate theme, *the search for equilibrium,* and the process of development. Generally, within larger IPA studies, group level themes need to be illustrated, with recurrence of a theme present in at least one third, or most stringently, all participant interviews (Larkin et al., 2021). Recurrence of group level themes was evident in all super-ordinate and subordinate themes developed.

Methodologically, IPA studies include a detailed and intensive analysis of the accounts produced by a comparatively small number of participants. The rationale for this relates to IPA's commitment to detailed, interpretative

accounts that do not sacrifice depth for breadth. The researcher is asked to engage deeply in each individual story followed by a detailed examination of similarities, differences, convergence, and divergence.

**Insert Table 2 about here**

Reflexivity

Trustworthiness, transparency, and attention to the IPA process are essential to monitor quality (Nizza et al., 2021). Reflexivity was ongoing, involving deliberate team reflections and discussion, which supported analysis in searching out convergence and divergence within the individual narratives. The study's rigor and quality were continuously reviewed, guided by Yardley's (2015) principles of validity and Smith's (2011) quality in IPA studies. Strategies adopted to ensure experiential focus, depth and complexity included careful participant selection and adopting a continuous questioning stance throughout the process of data collection and analysis. Each interview was analysed individually before developing group experiential themes, to ensure representativeness and variability of experience was illuminated. An audit of the process was completed to enhance confidence in the validity of the study, establishing if an external reviewer would recognise the process undertaken (Smith & Nizza, 2022).

Pseudonyms have been used to ensure participant anonymity with all identifying information altered.

**Findings**

The super-ordinate theme, *The Search for Equilibrium*, emerged from three subordinate themes, *The past self: "tormented and spent", the intricacy of self-care,* and *the trusted inner circle: "safe and supported"*. This theme was developed through the researchers' interpretations of participants reflections on their self-care (the double hermeneutic of IPA, whereby researchers attempt to make sense of participants sense-making) (Smith & Nizza, 2022). Time, past, present, and future, was significant in how participants made sense of their experience. An awareness of mood and body, and a consideration of relationships and interpersonal connections also emerged.

*The past self – "tormented and spent".*

Participants looked back on time when they were considering how they used to feel or be at work. Their experiences emerged through embodiment and mood. In the past, participants were unsure of their ability to remain in crisis work, questioning their nursing career choice, because of the physical and psychological impact. There was a struggle to separate the self from work, staying late in work or bringing worry home.

*"I suppose I would have gotten into the thing of staying behind and catching up and stuff… when I started first, I definitely brought stuff home and it was probably being unsure myself in the job… "* (Heather)

*"… took me two years to get on top of this job, because I used to go home on a Friday evening and I used to wake up at 4 on a Saturday morning tormented, did I do this, did I do that? That sense of dread, have I forgotten something, or should I have referred that person for the weekend… I used to think maybe I shouldn't do this job anymore…"* (Faye)

Participants described a sense of being so immersed in work they neglected themselves, not taking breaks, keeping work phones on out of hours or becoming "quite unsociable" at work. One participant described getting to a point where she had become physically unwell. Eve had not realised how consumed she was with work until a physical illness necessitated extended leave, quite simply, her body shut down.

*"I know the difference myself when I've had those kind of days rather than a day when I've had a proper break and sit down, The difference is just stress really and the tension and the rushing, the driving and pelting up the road, trying to get*

*somewhere and then you're trying to get somewhere else, just that leaving work, and I get all tensed up in my shoulders and my back…"* (Heather)

*"… the time off work, it was a massive learning period for me, I needed to take a step back from it because it had started to consume my personal life…"* (Eve)

The result of these unwanted feelings, stress, torment, and self-doubt, culminated in a struggle to perform at work. Participants withdrew because of the degree of distress experienced, or became unmotivated or avoidant, unable to complete work in a therapeutic or safe manner.

*"God I can't, I can't, I physically can't even go into the room. I can't listen to this…"* (Faye)

*"It led me to not want to go to work, it led me to question was I in the right role at all, was this the right job for me? … demotivate you as well so you want to do less, you realise that your stress levels are so high that if you do less then maybe you won't be as stressed. Though when I did less, I still was stressed…"* (Anne)

Participants lacked confidence to assert themselves or place limitations on what could be achieved. They accepted referrals without capacity to do so, working extra shifts, starting early, or staying late, as they attempted to meet the demands of work, feeling "*pulled in all directions*", unable to say "no", worried this would have negative consequences for them (Heather). Participants were so immersed in their experience that their work and wellbeing was affected. They described times where they were so intent on reviewing all service users that they spent little time or became overwhelmed by the intensity of the work.

"*… when I started here first, I remember one Friday seeing nine clients in the one day, I mean I definitely popped my head in each door, I did nothing therapeutic with any of them*"

(Chloe)

"*I remember working with a very difficult case going to the clinical lead and asking, no crying for supervision, before supervision was made available to me*" (Debra)

The language used by participants – "*sense of dread*" (Faye), "*tormented*" (Anne), "*consumed*" (Eve) – elucidated the distress experienced as participants reflected on their past self. This distress resulted in a struggle to perform. The participants' relationship with time was a significant finding as it

irradiated learning and the drive for change, looking back to their past self has informed decisions for the future self in work.

*The intricacy of self-care*

Participants were asked to consider their self-care at work and how they made sense of their experience. What emerged were the intricacies involved relating to purpose and ability to self-care. Participants had learnt from their past self, adjusting behaviour and attitudes as they attempted to manage their experience of work. They recognised that the care of clients necessitated a degree of wellness themselves without which the "*the service user is at risk*" (Eve). Participants agreed that the purpose of caring for the self was to enable care for clients and self-care – a need to protect themselves from the strain of work allowing them to continue in their role. Taking time outside work "to *mess around for half a morning*", to have fun, was considered a way to avoid life becoming about "*work, work, work*" (Chloe).

"*How are you going to look after someone who is unwell if you're not well yourself?*" (Beth)

"*I would like to continue, I love the job, but I think you have to protect yourself*". (Heather)

The manner that participants practiced self-care emerged in an embodied and spatially aware sense. Participants identified practices or behaviours they used to support their self-care. Participants spoke of meeting their physiological needs such as making sure they ate or changing the physical space they occupied for a short time. For Anne, meeting her physiological needs reminded her that she was "*worthy*" of care, she was "*treating*" herself, stating "*it's a soothing thing…*" (Anne). Through deliberate action, participants altered their space by moving away from their desk, prompting them to "*switch off*", to take care as they have learnt from the past and become more self-aware.

> "*… going to have a cup of tea, and to have something to eat it's almost like feeding your soul in a way, because you're feeling stressed, you're under pressure, and equally when you're feeling stressed or under pressure, often you neglect yourself.*" (Anne)

> "*… move away from the desk, it just helps you switch off… all your work is on the desk, so you think looking at your work, you're still working, you're not switching off so yeah there's a need to separate yourself from work for that length of time*".
>
> (Debra)

Garnering skills and knowledge through training and education, and applying these to the self, emerged as a component of self-care for participants to manage frustration or distress. Participant spoke of skills developed including mindfulness and distress tolerance that they put into practice at work to mitigate feelings of frustration or being overwhelmed when faced with challenges in their relationships with colleagues or service users, impacting their sense of worth or treatment goals.

*"I would use my mindfulness skills a lot, I would also use a lot of my DBT [dialectic behaviour therapy] skills particularly my distress tolerance…"* (Anne)

*I've started being more mindful, just going through everyone and discussing them with whoever I am working with, yeh, they're ok and we've this done, rather than racing from one thing to the next, not finishing tasks"* (Faye)

Other participants emphasised the importance of undertaking appropriate training as self-care. This supported their sense of skill to "*do the job*", reducing anxiety or worry. Being educated, having requisite knowledge and organisational skills enhanced participants confidence and coping ability.

*"I have to look at the medication, how is it working, is it working, are there side-effects, is it the best option, if not then we have to offer something else"* (Debra)

*"It's very hard to do a job you don't feel competent to do, that causes stress and burnout as well; you know that you have to have the appropriate training and skills to do it."* (Chloe)

Clinical supervision was available to most participants. One participant expressing concern that the external supervisor did not understand the complexities of crisis work and was therefore of limited help. Other participants found supervision helpful, offering space to develop self-awareness of "*areas that you need to be mindful of*" (Faye), to seek guidance and support, to practice skills and enhance performance.

*"… attend clinical supervision and em I know I can ring my clinical supervision at any stage and either talk to her over the phone or meet her for a coffee you know, em, and I have got a lot of benefit out of that."* (Eve)

"*Supervision is a place to talk where no-one is distracted by something else, so we're all listening to each other, you're listening to others…"* (Grace)

As participants learnt from their past self, they adjusted behaviour and attitudes to manage their experiences at work. Participants spoke of introducing boundaries and discipline towards colleagues and clients to mitigate the risk of stress or distress previously experienced. This is reflected in Eve's considerations of herself as evolving, she emphasised the need to recognise limitations, to have boundaries with herself and people around her. This evolution has occurred because of her reflections on how she was in the past and her desire to remain well.

"*… with maturity and a few blips along the way you know I had to make the decision that no I had to become more boundaried, I had to become more disciplined with myself, and with colleagues"* (Eve)

*"self-care from that perspective would probably be not getting overly involved with somebody, as in maintaining your professional boundaries."* (Heather)

As participants attempted to protect themselves from the intensity of work, they withdrew psychologically, standing back or becoming "*hardened*" to clients' stories. Participants were trying to protect their home lives and their mental health. Clinical experience was identified as the catalyst for this psychological withdrawal. Having gained experience, participants were able to tolerate others' distress, hardening to stories though not to the person, describing themselves as "*passionate*" and "*compassionate*" in their interactions. Beth put "*everything in boxes*" in her head allowing her to focus on the person rather than the story. It also protected her as she emphasised that if she thought back on stories, she would be an "*emotional wreck*".

> "*peoples' trauma and things like that can be very affecting so it' about distancing yourself from that… having a strong ability to stand back from situations.*" (Chloe)

> "*… the more experience you get the hardened you become… you have to protect yourself, in that way and that's what I've sort of done so even though like I'm quite passionate and I care a hell of a lot about the people, the stories are sort of put to one side…*" (Beth)

There was a consideration by participants that the nature of crisis work protected them from distress, where interventions were time limited, thus

reducing exposure to clients' pain. Participants spoke of maintaining distance, not getting "*bogged down*" in every detail of a persons' life. The purpose of the work was to undertake a specific intervention before referring onward, maintaining objectivity, and not getting caught up in or distracted by small details.

*"I don't mean then that I am uncaring because I'm not, but I just feel that I'm kind of more like right what's the actual problem? And what can we do? Rather than getting caught up in the ins and the outs and the little details of peoples' lives…"* (Heather)

*"So, I realised that I liked the crisis work, that type of work is more suited to my personality, I can go in and do something specific before the person moves on."* (Anne)

Certain client presentations or behaviours were challenging for participants. To manage their feelings, participants withdrew by avoiding training in a specific area. Debra acknowledged "*steering away*" from courses that addressed particular diagnoses. Whilst she admitted this was a "*weakness*" of hers, she was not inclined to alter this as she believed such presentations made unreasonable demands on her time and at the expense of other clients. Participants soothed themselves through self-talk, reminding the self that

service users must voluntarily engage with mental health services, at this stage. This enabled them to disengage from clients who were not open to team involvement. The client must "*lead their own recovery*", yet a sense of frustration did emerge when clients were unwilling to engage. Withdrawing through rationalisation offered some protection from unwanted feelings.

*"…we're a voluntary service and you have to remind yourself of that, as nurses we can be very paternalistic in our care, it's to get into that mindset if the person wants to engage with you, they'll engage"* (Chloe)

*"I'd set my own boundaries ok stop now, you know, and I'd be quite like that, I'd be quite a boundaried person anyway, so you would have to you know, say … if you're not willing to work with me then there's nothing I can do, I'm here like, this is inappropriate… I think sometimes, not an ultimatum now, I wouldn't say that but just ok you've had your chance, you know you've had many chances, where do we go from here?"* (Beth)

Taking better care included balancing work and personal time, not working extra shifts or extra hours routinely. Participants made definite decisions to manage their workload during work hours. Eve stated, "*whereas now in the last*

*few years if I have an appointment after work, I'll try make that appointment*" (Eve). Heather is adamant that she would not work late "*unless I really, really have to because I don't think I should have to*". Chloe has become assertive in expressing her limitations, "*five days a week is enough* (to work)". Leaving work at work enabled participants to keep aspects of themselves apart, separating their work and home lives. For Faye this was essential so she could focus on other priorities when work was finished. Eve succinctly highlighted the necessity for separation, the purpose being to avoid reaching a "*breaking point*", she emphasised "*thresholds*" to what is achievable and reminded herself of the purpose of work, thus avoiding becoming consumed by her job as she had been in the past. Heather's reflections offer further insight to the purpose of creating distance "*if I've all my jobs done, I can go home and forget about it, I couldn't do this job otherwise*". This perspective resonated with other participants, who had questioned their ability to remain in the role of crisis nurse. The psychological withdrawal found was to protect the home and work self thus avoiding bombardment, ultimately to be healthy, enabling them to continue in their role.

*"… so now I have to balance, I have to be respectful to my husband and daughter, I have to be home for a particular time and be OK." (Debra)*

*"… I can't go home stressed or my mind elsewhere, I have to be able to just leave it, like I said I go through it, close the diary, that's it, I have to be able to shut it off…" (Faye)*

All participants valued the potential of self-care to enhance their well-being and performance. Nonetheless, challenges emerged in the translation of self-care knowledge into practice, *"knowing what to do and the reality of it then is the problem"* (Heather). Participants were unaware of their need to self-care until their body messaged them through injury or stress, *"I would have kept going and going"* (Eve), *"I don't think about it (self-care) every day, but I do know when I need to take some time off or I do, you know you do obviously get stressed…"* (Chloe). The intensity of work influenced behaviour, despite the "*best of intentions*" self-care was put aside because of the nature of the work.

*"… it's quite hard because our jobs are so unpredictable, so you don't always get offloaded it's like come on we've got another assessment, it's like the A&E I think [accident and emergency] of mental nursing and sometimes you have to put your own self-care aside to move forward…" (Beth)*

*"I would feel guilty (laughs) if I didn't have the phone with me… there's like something at the back of my head, no, I need the phone there…"* (Grace)

Participants advised clients around their self-care, "*great to tell people what to do*" (Heather), yet they do not follow their own advice. The pressures of work explained some of this, however, participants also acknowledged that they could incorporate more self-care into their workday. Participants were critical of the choices they had made where they did not prioritise or balance demands, lacking confidence to express needs or being encultured to care for others first.

"*… yeah, it's my own fault, I could make time for that, I should make time, I don't prioritise it…*" (Faye)

"*… it's a case of prioritising caseload over self and I suppose it's very hard to go into a team meeting and say I don't have time to see this person because I need to take this time, if that makes sense, for myself…*" (Debra)

Participants doubted their value when compared to other disciplines, where others seemed to have clearer roles and established professional identities. There was a sense that other disciplines worked differently and were treated differently, which undermined participants' sense of value and worth, interfering with the ability to self-care.

*"So, I think then you typically want to do more cos [sic] you want to be seen to be good enough, to be able to do as much as everybody else."* (Anne)

*"… just assume that you can see somebody. We've often had the situation from doctors now sending a referral from the hospital and saying oh yeah, the crisis team will see you tomorrow when we're not in a position to do that. And it's been said a million times and it'll be said a million more…"* (Heather)

There was a cost associated with self-neglect that participants were able to identify. Most participants spoke of burnout, in themselves and colleagues. All associated the concept of being burnt out with the lack of self-care where nurses have not taken responsibility for their well-being "don't have the right things in place" (Heather). Participants perceived that that whilst the workplace does have a role to play, individual nurses need to be responsible for themselves and the choices they make regarding self-care and recognising when they are not performing. A degree of self confidence is required to enable self-disclosure and seek support.

*"Nurses become very burnt out, they've obviously got everything else going on in their own life, and they've not*

*sorted it out or they've not accepted it or sought the help or support they need.*" (Beth)

"*… everyone who works in our office is quite a strong personality and we're able to, we feel that we're able to go and talk to our colleagues whereas another person if they were quite shy or reserved mightn't have, mightn't feel they have that ability…*" (Chloe)

Whilst participants recognised their responsibility regarding their self-care, they believed that management had a role in facilitating self-care at work. They considered management teams lacked empathy regarding workloads and work environments and noted an absence of structured input.

"*… there'll always be a push for you to do more work until you get to the point where you say I'm not coping so em, so yeah I think it's the work…*" (Debra)

"*It's very easy to go home and pour the glass of wine at night after a bad day but like I think there should be a more focused thing at work…*" (Faye)

Other participants, however, believed a culture shift has occurred over time, allowing nurses to separate their work and family life, reducing the risk of harm. This divergence emerged from observations that management supported education and training, recognising the need for manageable workloads.

> "*Management are better to protect us and send us off on service days… there's a cultural shift towards nurses as a profession, we're not expected to work to the bone…*" (Chloe)

The findings illuminated the participants' understanding of their self-care. Attempts to reduce distress and manage unwanted feelings, through varied actions, behaviours and cognitive processes were evident, as were internally and externally created challenges to engage in self-care. Participants also spoke of the importance of their relationship with certain colleagues, the trusted inner circle, in their search for equilibrium.

*The trusted inner circle – "safe and supported."*

All participants worked as part of crisis response within a larger multi-disciplinary team. The majority made clear distinctions between the relationships forged with the crisis team (the team within the team) and the wider team. The crisis team emerged as the trusted inner circle, the group of colleagues that were available to listen, advise and support in a non-judgmental and safe manner,

ultimately augmenting the participants' self-care. These relationships created a sense of intimacy and friendship, participants received validation in their search for equilibrium, where vulnerability and uncertainty were acceptable.

"*[team is] quite intimate, so I suppose I'd be more open to speak to my team than maybe across the board, maybe in front of the whole MDT, maybe to say this is how that made me feel, I'd be able to offload to my team or even sometimes to ask questions*" (Beth)

"*… to literally say I'm feeling a bit blah, blah, blah and for them to say, it's OK, to reassure me, just reassurance…*"

*(Grace)*

A sense of safety emerged where participants would "*not be judged*", "*ridiculed*" or found "*lacking as a nurse or a person*". This sense of the identity of the trusted inner circle emerged from friendships forged at work. Chloe described the inevitability of forming friendships with colleagues who shared similar experiences (stressful working environments) and spent extended periods of time together. She concluded that friendships "*definitely help with coping or self-care*". Because Heather had strong relationships with her colleagues, she felt supported during times of stress, she was able to use

humour to defuse situations. She also labelled the relationships with her inner circle as friendships, these friendships facilitated good team workings.

*"…[the] team I work in is very good and we get along quite well, we can kind of make light of situations, you know when things are stressful… we've such a good team in that we all get on well, as kind of friends as well as work colleagues…"*

(Heather)

*"…it's important who you vent to, you wouldn't vent to everyone, only certain people I think you can vent to, only certain people you would trust in terms of not judging you, not ridiculing you, not maybe looking down on you"* (Anne)

A sense of caring arose, where participants supported each other by undertaking small things that eased pressure for a short time, such as managing calls or sharing complex caseloads where a colleague would offer to co-work a case, or if needed keywork, allowing the person some time away from the strain of a complex presentation.

*"… lunchbreak you want to do something or you've an appointment I'll say divert your phone to me so they can have*

*that head space… just little things like that but they're big things for head space"* (Faye)

*"There have been times when someone says I feel I'm not managing this well then someone might co-keywork that person with you or you know they might say I'll see them for the next few days…"* (Chloe)

Having trusted colleagues allowed participants to offload, to unburden themselves. Anne's use of language, ("*getting things off my shoulders", "not carrying"* issues) was powerful in that a sense of her embodied experience emerged where venting removed the weight from her body, she stated "*… once you get something off your chest you feel lighter and it's almost like you've parked that*". Other participants' experiences also emerged in an embodied way when they spoke of "*offloading*". Participants identified the importance of their relationships with their trusted circle that enabled this.

"*… offloading, at times as well, I suppose that's what I do, that helps because there are cases that are, you feel that you're, you just don't know what to do next, and you can discuss it… you're not carrying the burden then as much"* (Debra)

*"…we are great to bounce things; you know if we're struggling, off each other, you know not all of us have the answers but just, we're able to just blurt things out to each other… I have to get something off my chest"* (Grace)

All participants sought more than unburdening. They were actively seeking solutions or suggestions to improve their performance through probing, questioning, reflecting on their practice. They spoke of their desire to overcome challenges and find different ways of working if they had *"hit a wall"* or were *"a bit stuck"*. Beth gave an example of how the trusted inner circle supported enhanced practice where an issue was discussed, and potential solutions or alternatives offered, reflections mirrored by other participants.

"*Sometimes someone might have a really good idea have you tried this, or have you tried that…*" (Beth)

*"… struggling with a case or you feel you've just hit a wall, and you're not quite sure where to go it's good to be able to discuss it with your colleagues, they can come up with different ideas, you maybe you just haven't thought of…"*

(Eve)

Access to the trusted inner circle offered participants a sense that they were not alone in their practice or decisions. Generating solutions, easing burdens, creating a sense of comradery emerged in the findings. Seeking others' perspectives ensured participants felt they were "*not alone with someone*" (Heather) while other participants were reassured in their practice when able to debrief, ask questions and feel validated. Teasing out issues, exploring, and reflecting was enhanced by the presence of trusted colleagues.

"*… there's loads of different people from different backgrounds to debrief to and go to for advice I suppose we'd be quite close in that way…* " (Chloe)

"*…we meet to provide I suppose peer support and supervision and practice skills, look at if there is any difficulties we had in the week with the group or an individual client and how we might work around that*". (Anne)

The findings established that potential threats to the participants' well-being are mitigated through the trusted inner circle. The trusted inner circle offered protection against threats, threats that emerged in an embodied manner with visual language and metaphor ("*offload, things off chest/shoulders, being stuck, hit a wall*"). In the search for equilibrium, the trusted inner circle became fundamental to both coping and overcoming struggles or challenges.

## Discussion

Findings from this study relate to how self-care was understood by participants in their search for equilibrium as they attempt to manage the sense of bombardment experienced at work.

*How self-care was understood*

Participants noted the past self as stressed, tormented, and self-doubting, which culminated in a struggle to perform at work. The findings support previous research from a variety of settings, examining nurses' experiences and struggles in the face of excessive work demands and nurses' distress (Bowden et al., 2015; Foster et al., 2018; Ross et al., 2019; Sinclair et al., 2017). Connecting with clients has been scrutinised through the lens of compassion fatigue and moral distress across different nursing specialties including mental health, palliative, and critical care. Examples of questioning interventions, decision regret and choosing to leave the nursing profession have been presented (Austin, 2012; Christodoulou-Fella et al., 2017; Scott et al., 2014).

To overcome concerns with the past self, participants described their self-care through self-soothing, distinguishing home from work life, altering their space, accessing appropriate training, and the need for boundaries. Self-regulation of mood, behaviour and thoughts was evident through the processes of self-awareness, self-monitoring and reflection, findings previously noted in the

literature (Bowden et al., 2015; Gerace et al., 2018; Gregory, 2021; Kurebayashi, 2021; Van Sant & Patterson, 2013; Vinje & Mittelmark, 2008). Regulating responses through this self-monitoring and adjusting reflects participants attempts to make sense of their experience and manage their work, thereby influencing their sense of coherence (Pachi et al., 2022). The importance of team relationships and a safe space to offload or explore feelings and solutions were evident in this research. These findings are consistent with previous research emphasising the unique opportunities for nurses to cope with challenging experiences, building on key elements of Salutogenesis including resource strengthening and promoting coherent life experiences. This is achieved through peer support, unburdening to colleagues, clinical supervision, and teamwork (Bjarnadottir & Vik, 2015; Bowden et al., 2015; Crane & Ward, 2016; Dimunová et al., 2021; Fahy & Moran, 2018; West et al., 2020).

Participants in this study described psychologically withdrawing, stepping back, or becoming hardened to stories as they attempted to protect themselves and manage feelings of frustration. This is reflected in other research where participants experienced irritability, anger, and negativity when clients did not recover as hoped, withdrew physically and psychologically, or blamed themselves for outcomes (McTiernan & McDonald, 2015; Mikkola et al., 2017; Nilsson et al., 2016).

The findings from this study differ from previous research by suggesting that the stepping back or withdrawal described did not equate with non-engagement

with clients. Participants adopted a way of being that protected them from emotional distress, focusing on the individual rather than the story or past experience. They spoke of their enduring compassion and an awareness of the significance of the therapeutic relationship, considerations supported in the literature (Foster et al., 2020; Gerace et al., 2018). Participants were describing cornerstones of crisis work that emphasise the importance of comprehensive assessment and measured involvement with clients and their family (Duarte et al., 2016; Greenstone & Leviton, 2010). A novel understanding has emerged from this study where crisis work was identified as a protective factor against strain, allowing participants to enhance their sense of coherence, reducing the potential for moral distress; work is manageable and comprehensible (Ando & Kawano, 2018; Bauer et al., 2020). Interventions were time limited, thus reducing exposure to clients' pain and over-involvement.

*How barriers to self-care were understood*

There were challenges identified by participants' ability to self-care, including recognising they do not prioritise their self-care, or felt unable to express their needs. Earlier research has offered insights into nurses' socialisation towards caring for others first (Blum, 2014; Halm, 2017) which can explain some off the findings. However, the absence of nurses' self-care is detrimental to the individual nurse, the client, and the organisation where quality is negatively impacted, and retention threatened (Foster et al., 2020; Renwick et al., 2019; Sinclair et al., 2017).

As discussed in previous research, collegiality (Lake et al., 2019) and Social Identity Theory (Willetts & Clarke, 2014) may be significant when exploring nurses' reticence to self-care. In this study participants elucidated the benefits of the trusted inner circle where participants cared for each other and themselves through small acts of kindness and creating space to openly discuss issues or uncertainties. These self-care or team care acts occurred predominantly within small nursing teams, suggesting the need for ongoing organisational consideration of how collegiality and nursing identity can be further developed to ensure well-being and quality of care (Fahy & Moran, 2018; Hercelinskyj et al., 2014; Konttila et al., 2021; Lake et al., 2019).

Collegiality involves finding commonalities to build empathy and compassion, whilst recognising that individual actions can impact significantly on the organisational culture (Burr et al., 2017; DeSteno, 2018). Examples include flattening organisational structures, reducing hierarchies, seeking staff preferences (through staff surveys), encouraging or facilitating staff led committees or task forces, allowing staff to work together on various projects or issues (Deal & Peterson, 2016; Hoerr, 2005; Nohria et al., 2003; Violato et al., 2003).

When nurses can internalise and reflect on core values of their profession, engage in personal and professional development, and gain clinical experience, they are more likely to attain a professional identity, which in turn can influence well-being and resilience (National Academy of Medicine et al.,

2019; National League of Nursing, 2019). Codes of conduct and ethics support this attainment, and nurses themselves can employ numerous strategies to develop a professional identity including active involvement in professional organisations, obtaining advanced degrees, and seeking leadership opportunities (Kearney-Nunnery, 2019). Targeted postgraduate training within the clinical setting for newly qualified nurses, supported by organisational leadership, may offer further opportunities for these nurses to build professional identity and expertise (Walsh, 2018). Similarly, educational institutions, through the conceptualisation and definition of nursing identity with their students, may foster better care as they encourage student nurses to consider and plan how they will respond to challenges and demands in their future practice (Goodolf & Godfrey, 2021).

Being able to articulate the rationale for self-care may support nurses to express their needs more confidently. Nursing theories emphasise the centrality of self-care as a medium to ensure the goals of nursing can be achieved (Helming et al., 2020; Nightingale, 1992; Watson, 2012). Considering self-care within the concept of Salutogenesis and sense of cohesion highlights the significance of nurses' interpretations of experiences at work and the impact their responses to these experiences have on their sense of what is comprehensible, manageable, and meaningful. When nurses in this study engaged in self-care (self-regulation of mood, behaviour, thoughts; measured involvement; connecting with colleagues) their health promoting sense of cohesion was evident. Nurses also need organisational support to appreciate

self-care, its impact, and how it can be incorporated into their working lives (Lake et al., 2019; Perlo et al., 2017). The recruitment and retention of nurses may be positively influenced, essential considerations when one is reminded of the centrality of nurses in delivering health service priorities (World Health Organization, 2020), and the persistent concerns with recruitment and retention of nurses globally (Bowles et al., 2019; Buerhaus et al., 2017).

When nurses are well and present, quality of care and service user satisfaction are enhanced (Perlo et al., 2017). Building sense of cohesion, where work is meaningful, comprehensible, and manageable, can begin at pre-registration through guidance towards reflective practice that develops the ability to self-regulate and positively adjust to challenges. Likewise, professional identity can be conceptualised prior to registration and continuously developed. Reflective groups, such as Intervision (Roy et al., 2014; Staempfli & Fairtlough, 2019) should be considered, particularly in light of the known barriers to nurses' engagement with clinical supervision (White & Winstanley, 2021). Collegiality, whilst not extensively examined within nursing (Foster et al., 2021), can be addressed with organisational support whereby hierarchies are minimised, decisional and progress ownership is with staff, and they are encouraged to actively work together.

## Limitations

As an IPA study, staying true to the idiographic and phenomenological value was essential, this necessitated a small, homogenous sample. The study findings may be transferable to any environment with high work pressure and the inherent unpredictability of unscheduled care, though the approach limits the extent findings can be generalised.

## Conclusions

The aim of this study was to add to the current body of literature on what influences nurses' self-care at work. It has been argued that nurses fully appreciate the value of self-care, yet this knowledge is not translated into their self-care practices. The intrapersonal self-care strategies utilised by participants are similar to those noted in the literature as mental health nurses attempt to cope with the intensity of their work and connections with others. New understandings of the complex interplay of processes involved in nurses' self-care became apparent in the current study. Viewing self-care as an intrapersonal process only may limit our understanding of the intricacies at play. Given the centrality of nurses to the delivery of healthcare services and the challenges in relation to recruitment and retention of nurses, organisational commitment to the well-being and performance of nurses is essential.

Table 1: Indicative Interview Guide

I am interested in hearing about your experiences in your job. Can you tell me…?

- What's a typical day at work like for you?
    - Are there highs and lows? Things that go well? Times/activities you enjoy?
- Can you describe a little about how you cope with things that may happen in work?
    - Prompts: What is your understanding and interpretation of coping? How do you make sense of your coping style? What do you do, or maybe not do? In your experience do these strategies work for you?
- What do you think about the idea of nurses' self-caring?
    - Prompts: What is your understanding and experiences of self-care?
- Do you feel you care for yourself?
    - Prompt: What comes to mind for you? How? Always? Sometimes? What gets in the way of self-care?

Table 2: Super-ordinate Theme, The Search for Equilibrium

| ***The Search for Equilibrium*** |
| --- |
| ***ŧThe past self: "tormented and spent".***<br>*"I used to go home before on a Friday evening, and I used to wake up at 4 on a Saturday morning tormented"* (Faye: 97) |
| ***ŧThe intricacy of self-care: "you have to protect yourself".***<br>Purpose of self-care: "*…if they're not there 100% in body and mind the service user is at risk"* (Eve: 258)<br>Withdrawing to protect: "*…the more experience you get the hardened you become… you have to protect yourself…* (Beth: 184)<br>Challenges to self-care: "*… you just don't get that [time] because you just keep going but I suppose it's a choice you make sometimes as well you know"* (Heather: 149) |
| ***ŧThe trusted inner circle: "safe and supported".***<br>A certain connectedness: "*…they're not going to be judging me oh I'm not a bad person or a bad nurse or that maybe you can be a little more honest with them."* (Chloe: 416)<br>"*(Venting) can be very therapeutic… get things off your shoulders…"* (Anne: 146) |

**ŧ - Super-ordinate theme, ŧ - Subordinate theme, § - transcript line number**

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