DIFFERING LEVELS OF SELF-REPORTED DISPOSITIONAL MINDFULNESS IN RELATION TO THE REPORTED WELL-BEING OF PROFESSIONALS WORKING WITHIN ONCOLOGY

A thesis submitted to the University of Manchester for the degree of Professional Doctorate in Counselling Psychology (DCounsPsych) in the Faculty of Humanities

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Abstract

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Professional Doctorate in Counselling Psychology

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In recent years, mindfulness has become popularised due to its perceived effectiveness in different areas of life. Most of the recent literature in regards to mindfulness however, has been after training programmes to cultivate it as a skill, while assessment of its effectiveness in different life domains has been completed using quantitative measures. The purpose of this research was to approach the area of mindfulness from a humanistic stance, and to not teach or do anything to the person but rather research the person for whom they already are, focusing on a dispositional personal strength; mindfulness. Professionals working within oncology were chosen as a population, because even though the experiences of cancer sufferers has been extensively researched, the experience of their carers has been somewhat neglected. I wanted to listen to their perceived well-being, based on their own constructs and experiences, in relation to different perspectives of self-reported mindfulness. Self reported levels of mindfulness were assessed in staff working within a private cancer hospital using the Mindful Attention Awareness Scale. Maximum variation sampling was used to obtain both the higher and lower perspective levels of mindfulness. Due to a relatively low response rate, six individuals were asked to attend an interview - the three highest and three lowest scorers. Using a semi-structured interview in a qualitative methodology, questions were asked to generate experiences of well-being from individuals. Five themes were found after analysing the corpus of data using Thematic Analysis. The main themes that were identified in relation to well-being at work were; 'individual impact of working within oncology', 'patient relationships', 'staff relationships', 'transition from home to work', and 'environmental responses'. In presenting these themes it emerged that there were a wide range of views in regards to well-being. Different participants reported both positive and negative affects at work, particularly in relation to the impact of the deterioration of patients. Potentially, those participants who reported higher levels of perceived mindfulness experienced well-being more positively. Potentially, stronger relationships with both patients and colleagues were also had by those same participants, who interestingly, were less affected by work in their home life. They also potentially showed more resilience at work in being able to cope more effectively within the busy environment that was described. However, all participants described job enjoyment. Conclusions were drawn: Relationships are important with both patients and members of staff. A healthy work-life balance is also important. Mindfulness may aid the experience of well-being when working within oncology. Implications were presented in relation to mindfulness, Oncology and Counselling Psychology, with the potential for this research showing the effectiveness of mindfulness in its un-fabricated form in a naturalistic setting.
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1.

Introduction

1.1. The Position of a Counselling Psychologist within the Research

Counselling psychology is traditionally aligned to the humanistic values of personal growth and the promotion of well-being\(^1\) (Strawbridge & Woolfe, 2010). According to Packard (2009) there are nine core values within Counselling Psychology that are adhered to:

1. Altruism is our foundation as we strive to enhance the welfare of others.
2. Positive relationships are a necessary condition for stimulating change in those we seek to help.
3. The synergistic integration of science and practice is essential to our work and includes use of various methods of inquiry.
4. We focus on healthy development across the life span, including work and career, and seek to prevent avoidable problems as well as optimize individual and societal growth.
5. From a holistic frame of reference, we emphasise strengths, resilience, and positive coping in the context of the person’s social and cultural environments.
6. We are committed to the respectful treatment of all. Inherent human dignity, inclusion rather than exclusion, and accepting and celebrating cultural and individual diversity.
7. We believe in social justice and the necessity, on occasion, of advocacy of just causes that promote the welfare of others.
8. We value collaboration, multi-disciplinary practice and research, and sharing Counselling Psychology with colleagues in our own country and around the world.

\(^1\) Throughout the literature well-being is spelt numerous ways and referred to as one word (wellbeing), two words (well being) or hyphenated (well-being). For the duration of this thesis, it shall be referred to as the latter.
In our remedial work with dysfunctional clients and systems, whenever possible we focus on strengths and positive coping in the context of a helping relationship.

(Packard, 2009, p. 263)

As noted by Packard in points four and five, there is an extricable focus on personal strengths, coping, growth and development in different areas of life, including those areas of work. This is understandable, as a key defining and differentiating principle of Counselling Psychology is its drive to engage with each individual’s unique experience. Counselling psychologists work wherever people are, as Altmaier et al, (1998) argues, ‘…Grounding in our specialty’s strengths, allow us freedom to enter areas of practice different from those we have traditionally targeted’ (p. 9). It is this occupational diversity that can also be embraced by topics and areas of research. It is adopting this view that I know is a part of my identity as a Counselling Psychologist to embrace all people from a multiplicity of social and cultural environments and assess how these conditions affect mental health and well-being. I believe Counselling Psychology has the ability to focus on personal factors of resilience, coping and development and it is my responsibility to elucidate what these may be to ‘optimize individual and societal growth’ (Packard, 2009, p. 263). For this reason, upon working in an oncology setting for over a year and seeing the neglect not of the patients, but of the staff, I wanted to use my Psychological knowledge and interest to support them. It has been well documented that Medical staff are rarely ready to observe or identify psychological difficulties (Layard, 2005).

…Therefore, the role of a psychologist, in assessing and addressing psychosocial problems, as well as in alleviating the frustration the medical personnel often feels when dealing with such problems, is crucial and in favour of both patients and staff (Krademas, 2009, p. 20).

2 The field of Counselling Psychology is still relatively new and therefore there is still conceptualisation confusion as how to define the profession. Different Counselling Psychologists have differing ideas as to what it means to be a Counselling Psychologist. I am putting forward my conceptualisation of what it is to be a Counselling Psychologist rather than from the field as a whole. Other Psychologists may disagree with my frame of reference for starting this research.
In this study I aim to explore how professionals working within oncology (not necessarily just oncology Doctors), with different perspectives on self-reported mindfulness perceive their general well-being at work. Within this thesis I am focusing on the strength and resilience of the person, embedding myself within what I believe is the philosophy of Counselling Psychology. Well-being is being explored and created by the constructs of the lived experiences by the individual person. With this being the case, it is hoped that this research will provide interesting insights into whether differing levels of self reported dispositional mindfulness impact well-being as reported by the individuals themselves.
1.2. Thesis Development

Upon commencing the qualification of a Doctorate in Counselling Psychology, I had the task of applying for different placements to start my therapeutic work and development as a future practitioner. For numerous reasons, I decided to work within the area of psycho-oncology, completing therapy with both in and out-patients. It was initially my intention to complete a thesis in regards to how a person deals with the diagnosis of cancer within the first few weeks of hearing those words. I have been relatively fortunate in my short twenty-five years that I have not come face to face with a diagnosis of cancer in my own family. From this somewhat sheltered perspective, I quickly discovered the hurt and devastation that cancer can cause not only to the sufferer, but to the people around them. As a first experience of therapy, it was emotionally draining and mentally exhausting listening to some of the harrowing stories of the patients. It caused me to increasingly focus on my self-care, utilising family, friends and physical exercise. I enjoyed the work, but the way it made me feel was something of a shock. I began talking to other members of staff about how working with patients affected them. I was seeing one or two patients a week; nurses were in sustained contact with patients all day for five or more days. With this being the case, the focus of my thesis began to change from the patients and their experience of cancer to the staff and their experience of working with cancer. If hearing these stories affected me, did it affect them? Were they doing something differently? Upon initial literature searches there were countless studies looking at patients but very few looking at the people who worked with them. I felt that there was a real concern that the professionals working within oncology would become an almost forgotten population.

Through anecdotal evidence, I could see people come in from lunch drained, sitting in silence, bracing themselves for the afternoon ahead. Yet, on some days I saw other members of staff walking in smiling and joking. I began to ponder about the differences between these groups of people. What do they do, which is different, or perhaps more pertinent to the research at present how are they different?

There has been an increasing amount of emphasis from the World Health Organisation (WHO) to alter the way that health in work is perceived, from not merely being the absence of physical and mental disease, but to how individuals
can grow and develop within workplaces and communities. During 2007/8 an estimated 2.1 million people suffered an illness which they thought was created or aggravated by their current work (Hassan et al. 2009). In 2005, a survey was completed by people working within Oncology in Canada by Dougherty et al. (2009). It found that in an inpatient ward where patients with cancer were being treated, 63% of the staff reported abnormally high stress levels. This may be due to a number of reasons, including investing prolonged periods of time in patient relationships, circumventing family issues, witnessing death and having to manage a balance of their own personal lives with that of their professional one (Lyckholm, 2001). Even though the profession might be personally rewarding, there is a high risk involved due to these aforementioned occupational hazards.

When training is focused on looking after and curing patients, it may be difficult when this premise clashes with patients who have an advanced, incurable affliction and can not be cured. Transition from treatment to palliative care has been shown to increase helplessness and hopelessness in staff, which are two concepts inherently linked to the cycle of depression (Whippen & Canellos, 1991).

One of the ways in which I practised self-care was the utilisation of mindfulness meditation, which over the years has been of real benefit to me. Previous research has consistently shown that mindfulness as a practice can improve both health and well-being (Baer, 2003). Few studies however, indicate if self reported, dispositional mindfulness, may play a role in moderating such a thing. This is an important consideration to make as a central question put forward by critics of mindfulness training, is that is mindfulness actually being taught at all? (Teasdale et al, 2000). There have been multiple studies about stress among professionals working within healthcare, but very few about strategies or traits, which might influence well-being (Weiner et al. 2001).

Dispositional mindfulness within this thesis is defined as 'an open and receptive attention to an awareness of what is occurring in the present moment' (Brown & Ryan, 2004, p. 242). To further grasp the definition of mindfulness it can be contrasted with the term mindlessness that occurs when attention and awareness is scattered due to preoccupation with past memories, future plans or worries. This in turn can lead to limited awareness and attention of experiences within the present (Black, 2011). Remaining focused in the present is an integral
part of what it is to be mindful so to not get dragged away into ones own personal narratives when difficult thoughts and emotions arise. It is acknowledging these potential processes while not necessarily being dictated by and habitually responding to them, remaining in the here and now, which makes mindfulness so unique. A further and more detailed discussion of dispositional mindfulness, its definitions and complexities can be found in section 2.4 What is Mindfulness?

It is from here then, that I wanted to use my position as a Counselling Psychologist to my advantage. I did not just want to give the participant two sheets of paper so I could state that \( X + Y = Z \) after several statistical analyses. I did not want to lose the person within the research; I wanted the person to be the research. Effectiveness of mindfulness has been shown (Baer, 2003), but mostly by quantitative outcome measures, potentially producing artificial concepts and constructs. I wanted the participants to be able to express their own perceptions of what their well-being was like when working within oncology. From the position of a humanistic Counselling Psychologist I was able to do this by utilising a qualitative methodology.

It is my position as a Counselling Psychologist that began to shape and form my thesis and it is this what I believe makes it unique. By honouring the professions philosophical position I was able to complete research that perhaps one would not immediately link to Counselling Psychology, but it is hoped that through the eyes of a Counselling Psychologist an interesting and exciting viewpoint can be developed.
1.3. Aims of the Thesis

The aim of this thesis is not to understand the mechanisms behind mindfulness, why one person maybe more mindful than another or gaining insight into the origins of mindfulness itself. The aim of this thesis is to merely explore the well-being of processionals working within oncology who report different perspectives on their levels of mindfulness.

Therefore, this piece of research sets out to explore one main research question;

1. How do oncology professionals, with different perspectives on their own mindfulness, report their well-being when at work?
1.4. Structure of Thesis

The focus of this research was on how professionals working within oncology, with differing levels of self-reported mindfulness\(^3\) reported their own well-being and what we could learn from this. The thesis begins by presenting literature in relation to well-being, stating why it is an important area of research, the complex nature of such a thing, then focusing on professionals working within oncology. A brief reflection is included in regards to why qualitative research is important within this area, but also the difficulties which this may cause. Following on from this, I introduce the concept of mindfulness, its usefulness and effectiveness, focusing on the concept of it as a trait\(^4\) that we all have to varying degrees, rather than something that is learnt from scratch.

Within the methodology, the epistemological position of the thesis is given, followed by research design, method and process. Thematic analysis as a form of data analysis is also introduced, presented alongside a rationale as to why this form of analysis was chosen.

In the analysis section, interpretations are presented, highlighting the themes found within the corpus of data. Initial conclusions are also drawn about the proposed themes and what they might mean in relation to mindfulness.

Within the discussion, the inferred findings, are embedded against previous research, highlighting how a deeper understanding on the effectiveness of mindfulness could be developed in relation to it as a un-fabricated, individualised disposition. Findings and the implications of such are concluded and stated how the research may impact the world of oncology, mindfulness and Counselling Psychology.

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\(^3\) As will be discussed extensively in further chapters, mindfulness has been referred to as either mindfulness with a big ‘M’ or mindfulness with a little ‘m’ (Shapiro & Carlson, 2009). This is to represent if levels of mindfulness were assessed after training or assessed as a naturally occurring trait. When mindfulness is mentioned in this thesis, unless stated otherwise it is referring to mindfulness as a naturally occurring trait.

\(^4\) Trait and disposition will be used interchangeably throughout this thesis and have the same meaning of mindfulness naturally occurring without prior training.
2. Literature Review

2.1. The Issue of Well-Being

The term well-being is complex, nuanced and there is no one set definition of what it actually is. Increasingly it is becoming the focus, not only of scientific scrutiny but of interpersonal enquiry as well. Theorists have found the issue of well-being complicated and controversial. It is in this first section that I will try and elucidate differing positions of what well being is, followed by a focus of well-being at work and finally the well-being of professionals working within healthcare.

2.1.1. What is Well-Being?

The general conceptualisation of well-being is extremely vague. Researchers have tried to provide an over-arching description of what it is to have good well-being. Firstly, in 1967, Warner Wilson presented a broad view on the concept. Based on research at that time, Wilson determined that a happy person was, 'young, healthy, well educated, well paid, extroverted, optimistic, worry-free, religious, married person with high self esteem, job morale, modest aspirations, of either sex and of a wide range of intelligence' (p. 294). Later, in 1969, Bradburn completed his seminal text and distinguished between positive and negative affects, claiming that it is the balance of these two components which produces greater psychological well-being. This reflected an increasing awareness throughout the psychological empirical literature that just as positive affect is not the opposite of negative affect (Cacioppo & ernston, 1999); well-being is not just the absence of mental illness. The field of well-being is now increasing exponentially as a brief search on PsychInfo using the terms ‘well-being’ and ‘mental health’ brought back 28,612 and 12,009 different citations respectively. When the terms ‘quality of life’, ‘happiness’, and ‘health’ are included, the numbers again, increase significantly. In one systematic review, Dagenais-Desmarais and Savoie (2011) found a number of different papers, both theoretical and empirical, which led them to identify ‘23 operationalizations comprising of 42 distinct dimensions’ and ‘while these myriad perspectives have
provided a rich and diverse literature, they have also arguably led to great conceptual confusion regarding the definition and measurement of psychological well-being' (p. 661). General themes and conceptualisations have been found that Keyes et al, (2002) has described as influential, which have attempted to organise the extensive literature, into something more coherent.

With this being said, the literature can be split into two distinct yet overlapping paradigms that revolve around two different philosophies. The first of which can be broadly described as hedonism (Kahneman et al, 1999). The *hedonic approach* encompasses the notion that psychological well-being concerns levels of happiness and life satisfaction, with the main indicators being aspects of increased positive affect. Fundamentally, one strives to find pleasure in all that we do, and increased perceived pleasurable activities equates to a higher level of perceived well-being. Although positive feelings can derive from a plethora of activities, for instance, exercise or even film watching, the prototypical pursuits of the hedonistic perspective is that of sex, substance abuse and material consumption (Kasser, 2002).

The second perspective is that of eudiamonic well-being, which is characterised by striving to develop one's potential and to orientate oneself to the openness and the uncertainty of life while embracing its challenges (Ryan & Deci, 2000). Eudiamonic well-being is less about feeling good and more about being aware of emotions and thoughts, and acting upon them to be true (Ryan & Deci, 2001). Positive feelings can be produced by attempting to maximise, extend and improve one's potential.

Representative behaviours include developing life goals that fit with personal values, overcoming obstacles to these life goals, being authentic and trying to better understand the self and others. In contrast to markers of hedonic well-being, eudiamonic well-being has stronger relations to being challenged, striving for mastery and competence, and effort expenditure (Kashdan & Steger, 2007, p. 160).

The most frequently cited operationalization for this approach is Rhyff's model (Rhyff & Keyes, 1995), which consists of six different dimensions: Environmental mastery, autonomy, personal growth, purpose in life, positive
relations with others, and self-acceptance. The debate between the two theories is both ancient and contemporary and can be quite lively at times. It is not my place, nor my intention to resolve this tension, but rather to highlight the importance of the two theories.

In fact I position myself nearer to one than the other, so from the aspect of 'well-being' within the current research a paradigm position can be found. From the position of a humanistic Counselling Psychologist and the qualitative nature of this research, the eudaimonic concept of well-being seems to resonate true. The eudaimonic concept embraces the challenge of life and in turn infers the uniqueness and individualised variance of perceived well-being. For the purpose of this thesis, it is important not to get too drawn into the complexities and nuances of well-being as this research concerns what might be understood as a facet of what makes up well-being; that being work. Even so, the exact meanings of well-being are typically implied through operationalised definitions dictated through and by the empirical research itself. This in turn accounts for the number of different definitions and ways in which well-being is assessed.

Diener et al, (1998) proposed there were several domains of satisfaction making up well-being. These were: Work, family, health and leisure, finances, self and one's group. The domain, which this research will be focused on, is 'work'.

2.1.2 Well-Being at Work

As in many other areas, well-being is gaining more and more attention within the organisational sciences. In a world created and maintained by financial gain and dependencies, there is a growing burden on people of working age to deliver products to the public. 'Most individuals spend at least half of their waking hours at work, making this life domain a primary focus for most' (Dagenais-Desmarais & Savoie, 2011, p. 662). This burden has inevitably led to psychological distress. The number of people on incapacity benefits has spiralled out of control in the UK in recent years, increasing from 0.7 million in the late 1970s to around 2.6 million in 2006 (Department for Work and Pensions (DWP), 2006). Coinciding with this period, diagnoses of mental health issues have increased from 25 percent in the mid-90s to 40 percent in 2006 (DWP, 2006). Moreover, the introduction of new technologies, which either make current jobs
potentially redundant, or increase stress due to new learning, has increased the speed of change (Currie, 2001). As of 2013, 27 million days are lost a year to work-related health issues (Trade Union Centre, 2013). Hence, there is an increased interest and attention in regards to the issue of well-being at work (DWP, 2005). This can be characterised by the initiative of "Health, work and wellbeing - caring for the future", created by the aforementioned DWP, which has been embraced and adopted by companies, investing deeply in its premise of staff-centred care. Companies are now reaping the benefits of healthier staff and are upholding the fact that well-being is indeed a critical factor in producing and predicting organisational success (Tehrani et al, 2007). It seems that the literature continues to point to increased employee well-being, as equating to increased efficiency and profitability, especially within the private sector (Tehrani et al, 2007).

The bulk of research identifying what constitutes well-being at work for some, has been defined as how one perceives their job satisfaction. In 1976, Locke defined job satisfaction as 'a pleasurable or positive emotional state resulting from the appraisal of one's job or experiences' (p. 1300). However, traditional job satisfaction suffers from several limitations including that of a lack of appropriate methodologies. Furthermore, job satisfaction, has been noted as being narrowly operationalised as work well-being (Clegg & Wall, 1981), and it is important to note that this is only one facet of many. At work, well-being goes beyond the absence of burnout or indeed depression, but includes having a challenging environment to thrive and achieve quality of life in mental, physical and emotional domains (Seligman & Csikszentmihalyi, 2000). (Further aligning work well-being to the eudiamonic philosophy). Just as is the case with generalised well-being, it is difficult to state just what well-being is at work. As Danna and Griffin (1999) mention, there is little or no consensus among academics on its definition.

As has already been explained, and consistent with the perspective taken in this research, well-being is seen as a broad concept. Well-being is guided by a person's own criteria and principles with an over arching emphasis on pleasant emotional experience (Dana & Griffin, 1991). It is affected by various satisfactions of the job itself, from dealing with certain tasks to how supported or how well one gets on with colleagues, reactions to the environment and to the
overall perception of themselves in the workplace. Well-being is a subjective experience, and indeed, needs to be measured by subjective measures.

Well-being is affected by a number of different things including, one which is of particular importance to the current study, that of personality traits, which shall be discussed further in the following sections. Briefly however, this means that the way one interprets and assesses an event, moment or interaction, impacts on the persons perception of well-being. The underlying philosophy of this perspective is that it is not the event which traumatises man, but the way man interprets that event. 'People react differently to different circumstances, and they evaluate conditions based on their unique expectations, values and previous experiences (Diener et al., 1999, p. 277). Circumstances can be short lived and changeable, therefore researchers have studied long and short term subjective well-being. That is, when at work different events happen and unsurprisingly, momentary levels of affect fluctuate. Diener and Larsen (1984) found that when people's emotions were sampled at different times throughout the day, there were fluctuations in both pleasant and negative affect.

From this finding, it is obviously quite hard to predict how happy people will be at any given moment, and different events may have different affects on different people. Referring to the literature, well-being is not a simple construct and therefore should not be measured as such. With this in mind, the working definition of well-being within this study is open and is going to be guided by the data based on the perceptions of dealing with people, interpreting events, the environment, and self determined factors and goals, remaining firmly embedded within the eudiamonic approach. Allowing participants to express themselves fully is the purpose of the research question which covers 'both generalised job experiences (e.g. job satisfaction, job attachment) as well as more facet-specific dimensions (e.g. satisfaction with co-workers)' (Dana & Griffin, 1991, p. 364).

\(^5\) ‘Man’ is referred to here, not to indicate a male, but to indicate the species of humans. Man has been chosen not to offend, but purely for added gravitas.
2.2. The Qualitative Angle

I think it is appropriate to mention here the importance of the qualitative aspect of the thesis, as it follows on from the open definition of well-being that I am trying to explain. Personally, I see the quantitative construct and assessment of well-being an issue for several reasons. It is the quantitative assessments of self-reported well-being which have been used in the past that account for the numerous definitions that has previously been explained.

Fried et al, (1984), for example, mentioned that when self-report measures are used for both stress and stress reaction assessment, there is a risk of common method variance in any resulting statistical relationships. With quantitative assessments, it provides a narrow summary and focus of the events, which are happening. It is also context free, which when assessing the experience and perception of the world around us, it is unusual that to report this experience it is not in the real world and conceptualised by the researcher rather than the researched. Qualitative research is process orientated and based in a context-bound natural setting, therefore potentially representing a more naturalistic perspective of well-being.

Qualitative research also adopts a person-centred holistic approach, which most importantly helps develop an understanding of human experience. Health professionals (this shall be discussed in the following section) focus on caring, communication and interaction with both patients and colleagues.

They focus on human beings within their social and cultural context, not just on specific clinical conditions or professional and educational tasks. Qualitative health research is in tune with the nature of the phenomena examined; emotions perceptions and actions are qualitative experiences (Holloway & Wheeler, 2010, p. 12).

Health professions, in particular nurses, see the patients as more than diagnostic cases, and as human beings instead (Leininger, 1985); therefore research should reflect this and focus on the whole person rather than a singular, focused point. Working within the health care system has a powerful effect on one's life and by being based within the holistic perspective; one is able to observe people in their natural environment. A common complaint about
qualitative research in the health care system is how useful it can be, but Newman et al, (2006) have recently stated that qualitative research can add to the evidence base and of course add to practical knowledge, which can be applicable to clinical settings.
2.3. Well-Being in Health Professionals

Large amounts of literature evidences just how stressful an area working in healthcare can be. Well-being within the health care model is different from *general* occupational health and organisational literature. This is for a number of different reasons including working long shifts at unsociable hours as well as being in constant high pressure situations, thus creating excessive cognitive demands caused by the need for quick processing of overwhelming amounts of information (Levin et al, 2007). Repeatedly, stress comes up as one of the main concerns that negatively impact the psychological well-being of the health care professional.

Stress has numerous consequences and can lead to depression (Tyson et al. 2002), decreased job satisfaction (Flanagan & Flanagan, 2002), psychological distress (Jain et al. 1996), disrupted personal relationships (Gallegos et al. 1990), and even suicide (Richings et al. 1986). Research has even suggested that health professionals are more at risk to be involved in a road traffic accidents when travelling home from work (Barger et al, 2005). A study by Cohen and Patten (2005) suggested that 17% of Doctors reported their perceived mental health as poor. Compared with the general population that is more than double the number. Shanafelt et al. (2003) reported that, even though many clinicians are happy and report a stable balance between work and home life, many clinicians struggle with depression, anxiety, burnout and job dissatisfaction.

This is not only detrimental on a personal level for the health professional and their colleagues but Shanafelt et al. (2002) reported that decreased well-being also has irreversible consequences to the patient-carer relationship. Molleman et al. (1984) reported that 'contact with the doctor or other experts can enhance understanding of his/her illness (certainty) and/or reduce his/her anxiety' (p. 475). In the caring profession, where the profession is to care, when the professional is not 'well' in their own 'being', then the quality of care might dramatically decrease in consideration to the patients perspective.

Creating and maintaining a career as a health professional involves high levels of stress with unwavering amounts of pressure. This is most prominently due to the threat of making a mistake and the raucous publicity which may surround it (Firth-Cozens, 2003). The burden of perfectionism and the misery of any potential errors follow the health professional throughout their professional
working life (Mizrahi, 1984). Currently, the maintenance of well-being is particularly pertinent because over the last decade in the UK, government cutbacks, student debt burden and lack of autonomy have coincided to create a significant threat to practitioner well-being (Spickard et al., 2002).

When looking at physician’s well-being, the key issue is that it affects the performance of the healthcare system as a whole which can affect everyone, from the direct care of patients to the perceived standing of the physicians. This is a particularly pertinent issue at present with the conflicting views from the general public of the state of the NHS. However, the prevalence of well-being within the health care profession varies quite drastically. Perhaps this is because well-being indicators are hard to define and therefore quantify. For example, some studies have postulated that professionals working within healthcare report greater job stress and emotional stress than the general public. Other studies have indicated the same general reported well-being as the general population but increased incidences of depression in female physicians, medical students and residents (Hsu & Marshall, 1987). Irrespective of whether levels of general well-being are the same or different for health professionals compared to that of the general public, it is widely recognised that caring for patients is essential, yet stressful, so the physician well-being is of vital importance.

2.3.1. Well-Being in Professionals Working within Oncology

Oncology is part of the health care profession caring for people who have been diagnosed and are being treated for cancer. It has been noted that working within oncology requires enough energy to confront a multitude of problems with huge self devotion (Lederberg, 1998). Oncology can be a very rewarding career path because of the potentiality of the type of care which is offered to the patient, i.e. long term work with patients. Shanafelt et al. (2003) suggested that, indeed, people may be drawn to this line of work because there is something about them which is in tune with and sensitive to the struggle of the patient. But there is a high risk to this relational dynamic due to the often poor prognosis of many cancers, so that instead of recovery, often, it is in fact palliative care. Lyckholm (2001) mentioned that cancer care is 'inherently difficult and racked by emotional and psychological traumas' (p. 750). Unfortunately, 'oncologists often receive little training in how to effectively communicate with patients.
regarding those difficult issues’ (Shanfelt et al. 2005, p. 24). This issue continues even though they may deliver 'bad news' thousands of times over their career (Baile et al. 2002). It appears that the professional’s well-being and that of the patient is intrinsically linked as patients also perceive the well-being of their carer as important (Lichtenstein, 1984).

Many studies have reported a high incidence of burnout and/or clinically significant depression and/or anxiety in oncology staff compared with other medical professions (Barni et al, 1996). A pertinent question to ask; is working within oncology more stressful than other areas of the medical field? This is a difficult question to answer as a lot of the stressors are the same, like that of the environment, but the illness itself and the course of treatment is different from that of a general physician who for example, sees a broken leg and then moves onto a more severe patient. There is a varying degree of engagement and presenting issues. The oncologist however, experiences sustained and repeated exposure to what is, fundamentally, a life threatening illness, which can be drawn out for weeks, months and even years. Relationships build up with the patient over an extended period of time and then very suddenly break, causing potential distress for the oncologist. Translating this to quantifiable data, when comparing the statistics already mentioned by Cohen and Patten (2005), 17% of Doctors working in the general medical field reported poor mental health. Interestingly, Catalan et al, (1996) when looking directly at oncology staff, 44% reported burnout and/or clinical levels of anxiety or depression. Furthermore, Whippen and Canellos (1991) reported a 56% incidence of burnout using a questionnaire given to 1000 American oncologists. Therefore, there does seem a key difference in the field of oncology.

It is thought that stress in oncology clinics emanates from the imbalance between the coping ability of the individual and the demands of the workplace, with the demands outweighing their ability to cope ... the relationship between the caregiver and the patients may lead health care professionals [in oncology] to experience considerable stress (Isikhan et al, 2004, p. 235).
In relation to specific factors of stress or anxiety when working within oncology, Guest et al. (2010) concluded that there were several commonalities among the 72 oncology surgeons, who responded to a questionnaire in relation to their quality of life. They identified high stress from medical lawsuits, financial worries, work-life balance issues, and the inability to cope with the patients' suffering and death.

2.3.2. Emotional Labour

It is worth considering how much oncology is impacted by the notion of emotional labour (Hochschild, 1979, 1983). The work of professionals working within oncology is made up of more than just physical aspects, as already mentioned. A considerable amount of time is spent interacting with patients and the families of those patients. When professionals work within oncology, emotions are required to be managed as part of the job and because certain emotions are required in certain situations. Even though members of staff may feel exhausted, or when they are upset after the death of a patient or after delivering some devastating news to someone, a pleasant affect is still needed to be shown towards the patients. 'Impressions include the display of normatively appropriate emotions following certain display rules' (Zapf, 2002, p. 238). In this respect, Morris and Feldman (1996) defined emotional labour as 'effort, planning, and control needed to express organizationally desired emotions during interpersonal interactions' (p. 987). It is perhaps this sustained pretence of feeling one thing and showing another, as governed by societal rules, that Hochschild (1983) says contributes to psychological ill health. Drawing upon anecdotal evidence, compare how a nurse or a Doctor treats a patient at an A&E department. It is rushed and frantic - they are on the front line of medical care, so this is entirely appropriate. The main goal is to get the patient in and out as quickly as possible both to satisfy figures and create bed space for other patients. The chance to truly interact with the person is somewhat limited. Compare this with how professionals working within oncology may interact with patients. The illness is enduring, and even if they are outpatients, they come back once every few weeks for an extended period of time to receive treatment. Multiple relationships are bound to be formed and broken during the day, week, months and even years.
The more interactions with clients are required, higher is the frequency of emotion display, the more often emotions have to be shown which are not felt and, consequently, the more negative are the health outcomes (Zapf, 2002, p. 241).

If an interaction is very short it is most likely to be highly scripted (Rafaeli, 1989) and therefore the effort required to mask true emotion is less than that required over an extended period of time (Morris & Feldman, 1996).

The second section of the literature review will begin to focus on mindfulness and its effects on health and well-being. I will begin by explaining what mindfulness is, moving onto how it's cultivated and its effectiveness on different populations, gradually focusing on professionals working within oncology.
2.4. What is Mindfulness?

Mindfulness is an elusive yet central aspect of a 2500 year old tradition of Buddhist Psychology (Siegel et al, 2008). As a philosophy, mindfulness is normally attributed to the Buddha, who developed it as a practice to relieve suffering and attain peace and enlightenment through the increase of self compassion (Armstrong, 2001). Mindfulness is often taught and practised through mindfulness meditation courses as a "scaffolding" to develop further practice (Kabat-Zinn, 2005). It is important to note that even though it was developed from a religious background, in its current form it has no formal connection with religion. It distinguishes itself from other forms of meditation as the aim is not to distance one from reality or empty the mind of thought or focus, but rather to observe the 'stream of external and internal stimuli as they arise' (Baer, 2003, p. 125). It is also important to note that mindfulness is not a relaxation technique, even though it does have that effect (Broderick & Metz, 2009; Hennelly, 2011) but rather concerns being aware of the state of mind of which you are currently in (Dimidjian & Linehan, 2003).

2.4.1 Definitions and Conceptualisations of Mindfulness

By its very nature mindfulness is difficult to define as it has varying conceptualisations (very much like the aforementioned well-being) as it is more of a varying nuance within our consciousness rather than a static trait (Brown, Ryan & Creswell, 2007). Several definitions are presented in Table 1, all touching a similar notion of remaining aware and being present in the moment.
Table 1: Different definitions of mindfulness

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Kabat-Zinn (1994, p. 4)</td>
<td>Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgementally.</td>
</tr>
<tr>
<td>Brown &amp; Ryan (2003, p. 822)</td>
<td>A state of being attentive to and aware of what is taking place in the present.</td>
</tr>
<tr>
<td>Nhat Hanh (1975, p. 11)</td>
<td>Keeping one's conscious alive to the present reality.</td>
</tr>
<tr>
<td>Bishop et al. (2004, p. 234)</td>
<td>A process of regulating attention in order to bring a quality of nonelaborative awareness to current experience and a quality of relating to one's experience within an orientation of curiosity, experiential openness, and acceptance.</td>
</tr>
</tbody>
</table>

There are of course, nuances between each of the definitions as each leading author in the world of mindfulness appears to conceptualise it differently. Focusing initially on Kabat-Zinn (1994) part of the process of mindfulness is not just being aware, but it is a cognitive task that needs to be undertaken and something to be achieved. However, he repeatedly mentions that it is not about doing, or getting somewhere but much more about being. Everyone has the capacity to be mindful, as we are all people and

It is simply a practical way to be more in touch with the fullness of your being through a systematic process of self-observation, self-inquiry, and mindful action. (Kabat-Zinn, 1994, p. 6 - 7).

This can open 'channels to deep reservoirs of creativity, intelligence, imagination, choice, and wisdom within us'. (Kabat-Zinn, 1994, p. 8 - 9). Furthermore, as well as a cognitive task, he also presents its affective qualities of gentleness and appreciation. It can seem quite a complex art form when thinking of it as a task, whereas Nhat Hanh, the Buddhist monk refers to it as simply the actual practice of living consciously in the here and now.
Exploring Brown and Ryan's (2003) definition of mindfulness, they concur with Kabat-Zinn on the core characteristic of such a state as being open or receptive to awareness and attention. As well as non-judgement of one's own thoughts or experiences, they also posit that mindfulness incorporates behaviour 'when individuals behave compulsively or automatically, without awareness of or attention to one's behaviour' (p. 823). All three definitions so far paint the picture of not forcing change or improvement, but rather being with whatever one is experiencing and not being drawn into an internal narrative of the past or future.

Bishop et al. (2004), also argue that mindfulness is the mental process of being open and aware, however as opposed to the other researchers, they came together with the distinct goal of creating an operational definition. They claim that mindfulness is more state like than trait like, and needs to be cultivated. They proposed a two-component model of mindfulness. The first, 'involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events' (p. 232). The second, is the perception of the orientation to the current moment, allowing oneself to be open, curious and accepting. In doing this, they state that

By becoming more aware of thoughts and feelings, relating to them in a wider, decentred field of awareness, and purposefully opening fully to one's experience, clients can abandon dysfunctional change and adopt more adaptive strategies (p. 237).

When we experience a moment, a sensation or an object, we perceive it to be either 'good', 'bad' or 'neutral', but mindfulness clears these inner thoughts about the outer world (Mishra, 2004). A moment of experience becomes just that, a moment, rather than an ideation of what that moment is or what it may become.

The general trend of all of the described definitions is an underlying ability to be open, aware of and to accept current experiences, whatever they may be, without being drawn into a judgemental dialogue. The conceptualisations presented all suggest the notion that in order to get the full benefit of mindfulness, one needs to cultivate such an ability. The propensity for people to
experience mindfulness as a trait however, will be looked at more closely later in this section (2.7 The Capacity to be Mindful).

Mindfulness should not get confused with other similar concepts, even though they may be a part of the mindfulness process itself. For example, concentration may be involved in the practice of mindfulness (Grabovac et al, 2011), when one is focusing on a feeling or a sensation. However, this can only be a precursor for the acceptance, acknowledgement or letting go of what one is concentrating on. Exclusively concentrating on one thing and actively blocking out everything else, is not mindfulness. Lutz et al, (2008) even went on to state that there are different neural systems in action in concentration compared to the processes of mindfulness. In regards to alertness or attention, one may say mindfulness is to be alert of present states - thoughts, feelings and sensations. This is true, however, alertness, just like concentration does not necessarily mean acceptance of what one is being alert to. One can be hyper vigilant but then be caught in a ruminative state of what one is sensing; what it means and how one should act upon it (Schutze et al, 2010). Mindfulness is not just recognising, but it is how one interprets and deals with the stream of external and internal stimuli. Mindfulness is at theoretical odds with any type of attention involving catastrophising, which normally involves interpretation, judgement, conceptual processing and is most often automatically invoked (Sullivan et al, 2005). Awareness is also often cited in definitions of mindfulness, but as with other concepts explained, it is not enough to just be aware as one can be aware one is ruminating but still continue to do so. I consider that mindfulness awareness is a particular type of awareness which is being referenced.

With the practice of mindfulness, awareness is applied at a special pitch ...

... The mind is trained to remain in the present, open, quiet and alert contemplating the present moment. All judgements and interpretations have to be suspended, or if they occur, just registered an dropped (Bodhi, 1984, pp. 75 - 76)

It is important not to get too drawn into complex conversation involving the semantics about different types of awareness or attention (concentration, presence of mind, attention, hyper vigilance etc). It is more important to consider
the definition of mindfulness as not getting pushed and pulled in different directions by one's own thoughts, feelings and sensations. It is the acknowledgement of these thoughts, feelings and sensations, and then letting them go, non-judgmentally to the unfolding of experience moment to moment, which is what makes mindfulness so unique (Kabat-Zinn, 2002).

2.4.2 The Cultivation of Mindfulness

Predominantly, literature has stated that in order to become fully mindful, one needs to learn and develop the art of being that way. As previously mentioned, to be mindful, is the ability to be aware and focus on the present moment non-judgmentally. Admittedly, this is a hard thing to master. Kabat-Zinn (1994) mentions, 'while it may be simple to practice mindfulness, it is not necessarily easy' (p. 8). One of the most common ways to develop mindfulness is to meditate in an open and receptive way, often called mindfulness meditation.

Such practice is said to bring forth insight into one's cognitions or mental formations that may be positive or negative in nature while at the same time providing an avenue to observe rather than to react to one's thoughts and emotions, ultimately providing peace of mind (Jain et al, 2007, p. 11).

Even though meditation gives the preconception of the adoption of strict rules and guidelines to abide by, mindfulness meditation is in fact the opposite. It teaches a flexible thinking style, which is at odds to other forms of meditation, which may restrict such thinking (Kabat-Zinn, et al, 1992). Mindfulness meditation is not thought suppression, and in fact it is almost directly the opposite.

To learn to become more aware and to be in the moment, Kabat-Zinn (2013) recommends daily and repeated practice to develop such skills. Mindfulness then 'has the potential to become a lifelong companion and ally' (p. 3). As a lifelong companion, one doesn't necessarily have to just meditate to be mindful. This is because mindfulness is a way being rather than a way of doing. Therefore, it is possible to do daily activities while being mindful such as washing up, brushing teeth or cleaning the car, for example. The idea is to live
your whole life in the present, waking moment, not just a 45 minute burst during practice.

Meditation however, may not be the only way to cultivate high levels of mindfulness, in that Bishop et al. (2004) suggested that some forms of psychotherapy can develop a very similar state of acceptance and self-awareness by gaining and allowing insight into ones thoughts and feelings.

2.4.3 Effectiveness of Mindfulness

It is only in the last several decades that mindfulness has gained increasing recognition in the medical model of the Western world, through Randomised Controlled Trials. Before this, mindfulness existed only as a Buddhist tradition with meditation and self compassion at the heart of its teachings. Mindfulness however, has gone from strength to strength and different types of training have been developed and been mass produced for the public throughout the world. With increased exposure, the teaching of mindfulness has been recognised and scrutinised under laboratory conditions producing numerous pieces of research proclaiming its effectiveness as both a relapse and propensity prevention programme for common mental health concerns (Teasdale, 1998).

2.4.3a Mindfulness Meditation

'Mindfulness meditation, as a means of relaxation, reduction of psychological distress, and symptom control has a demonstrated utility across a spectrum of health care concerns’ (Carlson et al. 2001, p. 113). Mindfulness meditation may be beneficial for patients with a history of depression, because of the way it systematically enhances intentional awareness and allocation (Segal et al. 2002). This may be because depressed patients have specific cognitive vulnerabilities including rumination and dysfunctional attitudes, which could lead to a risk of future depressive episodes. Previously depressed patients using these mindfulness meditation skills may then be less susceptible to mood fluctuations and reactivation of intrusive and destructive patterns of thinking, feeling and doing, which may escalate into a full relapse depressive episode (Teasdale, 1998). Quasi-experimental evidence suggests that mindfulness meditation might be useful in the treatment of chronic pain, anxiety disorders (Kabat-Zinn et al. 1986) and fibromyalgia (Kaplan et al. 1993). There was also
improvement in lesion clearing rates in psoriasis patients who were receiving an audio taped mindfulness-meditation based intervention during their phototherapy sessions (Kabat-Zinn et al. 1998).

Physical benefits have been seen from the practice of mindfulness meditation in numerous studies including that of a decreased in heart rate (Telles et al. 1998) decreased blood pressure (Sudsuang et al. 1991) and enhanced immune function (Wenneberg et al, 1997). The benefits of the meditation are somewhat varied and striking, even though the meditation aspect of mindfulness is only a small part.

2.4.3b Mindfulness Based Stress Reduction

A more structured, clinical approach has also been developed to cultivate mindfulness and enhance different aspects of well-being. The first programme to be developed was the Mindfulness Based Stress Reduction (MBSR) program, introduced by Kabat-Zinn (1990). Since its initial inception in 1979, as of 2003, there are over 240 such programmes across North America (Carlson et al. 2003). MBSR is a highly specific, structured psycho-educational and skills based package, which contains the mindfulness meditative aspect, with yoga exercises (Smith et al. 2005). It is traditionally delivered as an 8 week programme, with classes that last around 2.5 hours. 45 minute audiotapes are also given to the patient for daily home practice (Baer, 2003). MBSR has been utilised by many people for different presenting issues, and through copious amounts of research, it has been shown to be relatively effective. Studies have shown its effectiveness for problems such as anxiety disorders (Kabat-Zinn et al. 1992), chronic pain (Kabat-Zinn, et al. 1982), epilepsy (Deepak, et al. 1994) and high blood pressure (Schneider et al. 1995). There have been several meta-analyses of the effectiveness of MBSR, such as the one completed by Chiesa and Serretti (2009) in a review of healthy participants. They identified that MBSR was able to reduce ruminative thinking, trait anxiety and increase self-compassion.

... The consistent and relatively strong level of effect sizes across very different types of sample indicates that mindfulness training might enhance general features of coping with distress and disability in
everyday life, as well as under more extraordinary conditions of serious disorder or stress (Grossman et al. p. 42)
2.5. Mindfulness in Health Care Professionals

There have been multiple studies in relation to mindfulness and professionals working within the health care sector. These studies have clarified the impact of stress and the detrimental effects this may have and the importance of a healthy well-being within the professional at work. It is important to note however that most of these studies have been a pre and post assessment after formal mindfulness training, as will be demonstrated in the following studies.

One such instance of this is Shapiro et al. (2005) who offered an 8 week MBSR programme to health care professionals, including Doctors, nurses, psychologists etc. They concluded that the participants assigned to the intervention group (N=10) significantly decreased their reported scores of stress, increased levels of self compassion, decreased burnout, decreased distress, and increased satisfaction with life, when compared to the wait-list control group (N=18). The same lead author, several years earlier, (Shapiro et al. 1998) conducted a similar study with students and lead them through an 8 week mindfulness programme, with elements taken from MBSR. They found that students reported less psychological distress including elements of anxiety and depression. Interestingly, because it promoted a higher sense of empathy it cultivated a greater sense of connection in the relationships they had with their patients too.

Beddoe and Murphy (2004) piloted an MBSR training program with a group of student nurses and found once more that they seemed to show a great deal more empathy following the intervention. Again, a study completed by Christopher et al. (2006), this time with Counselling Psychology students after completing the MBSR, reported a decline in negative affect, perceived stress, and state and trait anxiety. Significant increases in positive affect and self compassion were also reported within the group who completed the full course.

A more recent study, completed by Krasner et al. (2009), with around 70 Doctors, utilised a 52 hour intervention, which involved mindfulness components spread over a year. Again, results suggested that with the cultivation of mindfulness, participants experienced significant changes most particularly in burn out rates and empathy. Looking at these studies collated, all seem to be in agreement that to some extent, mindfulness training for professionals working
within health care is of benefit both to their personal health and care of the patients.

Furthermore, in an interesting development in the world of mindfulness, Schenstrom et al. (2006) found that after providing practitioners based in primary care with a mindfulness based cognitive attitude programme, they recorded a well-being increase in conjunction with the degree of stress at home and at work decreasing after participation.

There has also been a growing trend in introducing mindfulness for medical students to combat compassion fatigue and burnout. For a full review of the studies, please refer to Dobkin and Hutchinson (2013).
2.6. Conceptualisation Confusion

Surprisingly, even though the evidence base for mindfulness and its effectiveness in relation to the cultivation of such a thing is growing, there is still a lack of clear coherent knowledge about what it is about mindfulness, or what people are actually learning, which is so potentially useful. I will provide a brief summary of these, which may perhaps highlight the issue of mindfulness training in relation to how it impacts people. As Kabat-Zinn (2003) himself commented, ‘...MBSR to date suffers from a range of methodological problems, a view with which I concur’ (p. 145). Firstly, Shapiro et al. (2006) suggested that there are three axioms to mindfulness practice. These are,

1. Intention
2. Attention
3. Attitude

They state that axioms are building blocks out of which other things can emerge. They suggested that these three axioms account for a large amount of variance in the transformations, which are normally observed in mindfulness practice. The process of moving through the three phases causes a significant shift in perception, of which they coined the term reperceiving. The act of reperceiving is a meta-mechanism, which over arches additional mechanisms to influence change. These mechanisms are,

1. Self-regulation
2. Values clarification
3. Cognitive, emotional and behavioural flexibility
4. Exposure

These variables can be seen as both potential mechanisms for other outcomes, such as psychological symptom reduction, or as outcomes in and of themselves’ (p. 377). Shapiro's model of mindfulness is very theoretical heavy, but there are indeed laboratory based experiments, which have been conducted to see what it is about mindfulness that is so useful. One such study is that of Deyo et al. (2009), who suggested that mindfulness's ability to decrease ruminative
thinking after a group were put through a Mindfulness Based Stress Reduction Program accounted for increases in well-being and a decrease in depressive like symptoms. Rumination, interestingly, in non-depressed populations has been found to be predictive of subsequent onset of depression. Similarly, Jain et al. (2007) explored mindfulness meditation versus relaxation training in a randomised controlled trial. They also found that mindfulness's ability to decrease rumination and distraction in the observation of thought processes, non-judgementally is a potential mechanism which aids the reduction of psychological distress.

Arch and Craske (2006) findings lend support to the idea that the focused breathing, central in mindfulness meditation was associated with a decrease in negative affect and an increase in emotion regulation. This is a similar notion to what is found by Bishop et al. (2004), with focused breathing being an integral part of such thing. Furthermore, Baer et al. (2006) posited five separate facets of mindfulness. These were;

1. Non-reactivity to inner experience.
2. Observing internal events.
3. Acting with awareness.
4. Describing/labelling with words.
5. Non-judging of experience.

Through exploratory factor analysis, Baer and his colleagues found that all five were moderately correlated, suggesting distinct but indeed, related constructs in what mindfulness is. This five factor model was further confirmed in a study by Baer et al. (2008), and which has been used in a number of subsequent studies, with them eventually creating the Kentucky Inventory Mindfulness Scale (KIMS).

Finally, Grabovac et al. (2011), actually proposed a model derived from Buddhist contemplative traditions of mindfulness. They provided quite a complex and comprehensive mechanism behind mindfulness, which I do not have space to cover, but at the crux of the Buddhist Psychological model are three main foci of common mindfulness practice.
1. Sense impressions and mental events are transient (they arise and pass away).
2. Habitual reactions (i.e. attachment and aversion) to the feelings of a sense impression or mental event, and a lack of awareness of this process, lead to suffering.
3. Sense impressions and mental events do not contain or constitute any lasting, separate entity that could be called a self (p. 156).

However interesting or insightful, no one model appears to be sufficiently comprehensive in describing how mindfulness practice produces significant change, therefore it is unclear what one is learning. It is fair to say that one is just not sure what it is about mindfulness that makes it the useful tool that it is as, 'there are numerous other possibilities and pathways that may play a role in this mysterious and complex process (Shapiro et al. 2006, p. 385). *deleted section*

Once again, it is not my intention within this thesis to explore underlying mechanisms, but I merely want to highlight the common issues and discrepancies in mindfulness training. It is these different factors of what is being learnt in mindfulness training, that detracts from what mindfulness actually is; a disposition.
2.7. The Capacity to be Mindful

A lot has been written about the cultivation of mindfulness through different practices, therapies, and the effectiveness of such interventions, but training does not need to take place to become mindful, as it is something that we all are. It seems to be quite a logical assumption, as even if we are aware of it or not, the moment we are living in is all we have to work with. It is the ability to not get stuck either looking back or projecting forward with our thoughts, feelings or emotions that allow some people to be more 'present' or perhaps more mindful than others. That is, letting go of negative thought patterns and habitual responses, being less distracted and being more present focused (Frewen et al, 2008). 'Mindfulness is now widely considered to be an inherent quality of human consciousness. That is, a capacity of attention and awareness orientated to the present moment that varies in degree within and between individuals...' (Black, 2011, p. 1). Awareness and attention are the primary components of consciousness, which several authors (Averill, 1992; Mayer, Chabot & Carlsmith, 1997) have distinguished from other primary mental modalities such as cognition, emotion and motives. Brown and Ryan (2003) mention

Recognising that most everyone has the capacity to attend and to be aware, we nonetheless assume (a) that individuals differ in their propensity or willingness to be aware and to sustain attention to what is occurring in the present and (b) that this mindful capacity varies within persons, because it can be sharpened or dulled by a variety of factors (p. 822).

It has been noted that there are two main reasons why there is a difficulty in conceptualising mindfulness as a clinical approach, therefore reinforcing why mindfulness should be considered a quality of consciousness. Firstly, clinical approaches tend to facilitate not only mindfulness, but also the outcomes with which mindfulness is traditionally associated with such as compassion or emotion regulation. Secondly, in treatment-orientated conceptualisations, mindfulness can be superseded by the methods through which it is cultivated. For example, Buddhist Scholars have acknowledged that mindfulness can be cultivated in numerous different ways, but have made clear distinctions between
these methods and what they refer to as the nature of mindfulness. Broderick (2005), in one effective guided mindfulness exercise said to "commit yourself to be fully present, here and now" (intention) and "anything that comes into your head is ok" (acceptance), but do these presented elements accurately represent mindfulness? These skilful methods enhance and not generate mindfulness as '...mindfulness is a quality of consciousness manifest in, but not isomorphic with, the activities through which this quality is enhance' (Brown et al, 2007, p. 215).

Furthermore, the original manual for MBCT was published in 2002 (Segal, Williams & Teasdale, 2002), with a focus on preventing relapse in relation to depressive symptoms was predominantly based on the theory of cognitive reactivity and the on-set of depression. Of course however, it was difficult to determine the nature of improvement with there being a lack of tools to reliably assess levels of mindfulness pre and post treatment. Could the improvements be down to mindfulness or some other factors? As Teasdale et al (2000) mention it '...does not allow us to attribute the benefits of MBCT to the specific skills taught by the program versus nonspecific factors, such as therapeutic attention and group participation' (p. 622). There are 'various active ingredients in mindfulness-based interventions such as social support, relaxation and cognitive behavioural elements' (Shapiro et al, 2006, p. 374). At the end of training programmes or therapy in relation to mindfulness, researcher demands may play a significant part in the participant telling the researcher, facilitator or perhaps therapist, things that they think they want to hear. There are numerous variables in the cultivation of mindfulness, which may cloud and complicate the very thing one is trying to learn.

Further evidence for the natural ability to be mindful comes from literature of attachment theory (Mikulincer & Shaver, 2007). They provide a commentary stating of this theory, stating,

The developmental research outlined here suggests the first of three connections between felt security and mindfulness. People who have experienced attentive, responsive, and sensitive caring are likely to be both more securely attached and more mindful. A second connection is that [these two processes] may be related, perhaps bi-directionally. Secure attachment fosters greater attention to relational partners, [and]
mindfulness may facilitate secure attachments through an open, receptive attention to relationship partners. Third, felt security and mindfulness both appear to contribute to a variety of positive outcomes (p. 180).

This perspective, possibly infers mindfulness is part of developmental progression, depending on the environment within which one was brought up, showing that mindfulness training is not necessarily needed to become more mindful than someone else, it is a naturally occurring trait. Mikulincer and Shaver (2007) assessed participants who wanted to attend a three month meditation retreat. Part of the battery of tests involved, was Brennan et al.'s (1998) scale measuring attachment anxiety and avoidance, and Baer's (2003) five facet measure of mindfulness. It was found that

In other words, the more attachment-anxious participants were less capable of maintaining a nonreactive, nonjudgmental stance towards their experience, and the more avoidant participants were less able to notice their experiences and label them in words (Shaver et al. 2007, p. 269 - 270).

However, as previously mentioned, the concept of mindfulness as a practice is varied, nuanced and complex. Mindfulness as a human capacity confuses the issue further still, as different proponents of mindfulness have different views on whether mindfulness needs to be embedded in a meditative context. For example, Bishop et al. (2004) emphasise the role of meditation in mindfulness and, as mentioned previously, focusing on the breath is an essential part to focus purposefully on internal events. This is an opposing view to Dzogchen teaching, who has called the inherent capacity of mindfulness "unfabricated mindfulness" (See Goldstein, 2002). Several pieces of research (Brown & Ryan, 2003; Carlson & Brown, 2005; Levesque & Brown, 2007) have shown that individuals with no formal training of mindfulness have the propensity to be mindful, when assessing it as a dispositional trait.

There is also evidence from Shapiro et al (2006) stating that a persons capacity to be mindful actually increases with age and their capacity to shift perspective [reperceive], and in turn, their perspective becomes more flexible - a
key concept of mindfulness. They concluded that mindfulness practice increases an already naturally occurring process, therefore inferring that each of us, to an extent, is programmed to be mindfully inclined, just perhaps to varying degrees.

Therefore, if reperceiving is in fact a meta-mechanism underlying mindfulness, the practice of mindfulness is simply a continuation of the naturally developmental process whereby one gains an increasing capacity for objectivity about one's own internal experience (p. 378).

Kabat-Zinn (2003) also agrees with this point of view, suggesting that mindfulness can be seen as a scaffolding used to develop the state, trait, or perhaps even skill of mindfulness. He continues,

It is an inherent human capacity. The contribution of the Buddhist traditions has been in part to emphasize simple and effective ways to cultivate and refine this capacity and bring it all aspects of life (p. 146).

There has also been some other evidence from neurological imaging studies in relation to prefrontal cortex activity and dispositional mindfulness as well (Creswell et al. 2007). Firstly, they discovered that higher levels of mindfulness were associated with a greater wide spread activation of the prefrontal cortex. This has implications, as it has identified neural pathways, which may be associated with psychological well-being. To conclude, they clarified

The present study used a residualized mindfulness measure which controlled for a number of individual difference measures, suggesting that unique variance specific to dispositional mindfulness accounts for the present findings (p. 563).
2.8. Focusing the Problem

When looking back at the research presented with regards to mindfulness and its salient effects on well-being, there appears to be two similar themes running throughout. Firstly, the majority of mindfulness research has focused on the training aspect of mindfulness and how increasing that may influence other areas of ones life. I put forward, that the learning of mindfulness takes away from what it actually is; a disposition. As previously mentioned as a Counselling Psychologist, I do not want to do anything to anyone (in my opinion), and I want to see the person for the totality of who they are. Secondly, most effects of mindfulness have been measured quantitatively, therefore perhaps ignoring the individuality of the person they are researching.

I believe that because of all the evidence, mindfulness is being seized upon and being heralded as the next promising cognitive behavioural technique or exercise, which has been decontextualised into a behavioural paradigm, with the aim of driving change or fixing what is broken.

The key issue is that in the past, to assess mindfulness and the affects of such a thing, in whatever domain, a positivist stance has been normally been taken, normally through radical deduction.

Psychology generally and Counselling Psychology specifically has been dominated by positivist and post-positivist research paradigms and associated quantitative methods (Ponterotto, 2005, p. 126).

As explained in the introduction, Counselling Psychology research should reflect Counselling Psychology practice, by listening to the person as a whole. Therefore the Constructivist-interpretivism paradigm can be seen to be an alternate perspective to this. Constructivist approach espouses a hermeneutical position, which means that meaning is brought to the surface through deep reflection (Schwandt, 2000). Through co-dialogue and interpretation, the researcher and participant, jointly create findings through the understanding of lived experience from the point of those who live it daily (Schwandt, 1994), occurring within a historical social reality. As this is the case, from this constructivist perspective, one is taking a relativist position, marking not one but multiple truths as
Reality, according to the constructivist position, is subjective and influenced by the context of the situation, namely the individual’s experience and perceptions, the social environment…” (Ponterotto, 2005, p. 130).

Based on the broad nature of well-being, to obtain a realistic and whole conceptualisation as dictated by the participants rather than a narrow operationalisation given by myself as the researcher, this qualitative stance had to be taken.

2.8.1. Purpose and Research Question

Using recent research, already mentioned within this paper, Kracen (2010) found that increased dispositional mindfulness was a mediating factor in oncologists' well-being, in relation to sleep quality, self-care and job satisfaction. Like most pieces of research in regards to trait mindfulness and well-being, it was assessed and associated using quantitative measures. As explained, however neat, replicable and useful, I do not think this is a sufficient representation of the experience of both well-being and mindfulness. Well-being should be understood as told by the person as a whole, rather than the parameters that the researcher chooses to give it. I do not think that quantitative data truly reflects the nature of mindfulness. The question I find asking myself is: if one wants to understand how a potential trait of the consciousness affects a person in the real world, then shouldn't data be captured in the real world? The world is chaotic, disordered and contradictory, and until research has been completed to assess mindfulness in this contextual state, how relatable these results are remains to be seen.

In this thesis, it is hoped to assess mindfulness in its naturally occurring state, within the context of which it was first intended to be used; that is developed from within the person, not being taught by someone else. As previously explained, with the teaching of mindfulness, it is hard to delineate if mindfulness is being taught at all and considering how the leading authors within the field seem in agreement that is an inherent human capacity, there is very little research on the subject. Differing levels of self reported mindfulness are to be obtained; those who perceive to be quite highly mindful and those who perceive to be quite low. It is the qualitative aspect of this research and the potential
inferences of looking at how different perspectives of mindfulness may influence reported well-being, which makes this thesis unique. Therefore this research only has one research question, which can be found below.

1. How do oncology professionals, with different perspectives on their own mindfulness, report well-being while at work?
2.9. Chapter Summary

Within this chapter, the literature was discussed in relation to both well-being and mindfulness to embed the current thesis in the psychological literature and elucidate what it may contribute to knowledge. It was put forward that 'well-being' is a large area and is very hard to conceptualise in a coherent way as it incorporates everything from perceived quality of life, relationships, health and general satisfaction among other things. It was suggested that because of these different conceptualisations, especially of work well-being, which has often been narrowly defined as job satisfaction, it is important to hear what individuals consider as important to their well-being, rather than being dictated by the researcher.

Mindfulness was then introduced, along with its perceived effectiveness in different areas, particularly that in relation to health professionals. Most of the research in regards to the effectiveness of mindfulness has been after training programmes, with well-being then being assessed by using quantitative measures. With these training programmes, it is sometimes uncertain about what is being taught, with social and behavioural skills sometimes being confused as mindfulness. Research was put forward in relation the capacity to be mindful and how the 'unfabricated' nature of such a thing has been under researched and how this feeds into the purpose of the current thesis.

It is intended for the thesis to be as naturalistic as possible, with different levels of dispositional mindfulness being obtained to explore how well-being is expressed in relation to working within oncology.
3.
Methodology

3.1. Introduction

As outlined above in the previous chapters, the general purpose of this research was to consider the reported well-being of professionals working within oncology, who initially report differing levels of mindfulness. Therefore one research question was proposed, which can be found below.

1. How do oncology professionals, with different perspectives on their own mindfulness, report their well-being while at work?

Within this chapter, I shall firstly give my epistemological positioning as the researcher and present the current methodology in consideration to the different steps of the research procedure. Details of the recruitment, data collection and analysis will be explored, with continual reference to standards of validity appropriate to qualitative methods.

Briefly, to answer the proposed research question, a qualitative research design was used, utilising purposeful, maximum variation sampling methods. Participants were obtained using the Mindful Attention Awareness Scale (MAAS) to gain different perspectives of individual self reported levels of mindfulness (Brown & Ryan, 2003). Having identified participants in this way, semi-structured interviews were undertaken with individuals with scores of relatively high or relatively low levels of mindfulness. The qualitative data generated was transcribed and analysed using Thematic Analysis (Braun & Clarke, 2006). Finally, the ethical issues within the research were discussed to show that I have adhered to procedures put in place by the British Psychological Society.
3.2. Epistemological Positioning

In this section I give an overview of the epistemological positioning within the current research. It is useful to make this positioning clear as my epistemological commitments as the researcher is one of many factors which contributed to my methodological decisions. This openness of philosophical positioning is of vital importance to any research, particularly qualitative as ‘you cannot claim to have no epistemology. Those who so claim have nothing but a bad epistemology’ (Scully, 2002, p. 10). I will firstly describe my ontological and epistemological commitments and then how this connects and influences the design of the current research.

3.2.1. The Constructivism-Interpretivism Debate

It is true that the relationship between theory and methods in qualitative research is complex and controversial. While theories provide a lens through which researchers can plan and conduct research (Anfara & Mertz, 2006), the multiplicity of available theoretical approaches, is indeed confusing. A clear rationale of the epistemological positioning is important because it allows not only the researcher, but for the readers to classify and conceptualise the research (Denzin & Lincoln, 2000). Epistemology can be defined as the theory of knowledge and embarks on the question of how we know what we know (Guba & Lincoln, 1994).

An individual's epistemological position is somewhat constrained by their ontological stance; and so it is here that seems the most appropriate place to start. Briefly, ontology refers to the study of the very nature of 'being'. The key issue is whether there is a 'real' world 'out there', which is independent from us. Personally, I believe that there is no one true reality and because of the known complexity of both the world and of people, any suggestion of a singular truth can only be apprehended by that individual. My personal position, however much an influence, does not dictate the epistemological position of this research. Even so, I pose that this thesis is akin to the constructivism-interpretivism position. Ponterotto (2005) explains that this is the alternative to the received view of the positivist stance. 'In marked contrast to positivism’s naive realism (a single objective external reality), constructivism adheres to a relativist position that assumes multiple, apprehendable and equally valid realities (p. 129).
More often than not authors explain the linear process between ontology, epistemology and methodology as can be seen in figure 1. However, as is the case, a number of factors needed to be taken into consideration.

![Ontology ↔ Epistemology ↔ Methodology](image)

**Figure 1 : Relationship between ontology, epistemology and methodology (adapted from Guba & Lincoln, 1994)**

I believe that this linear process oversimplifies the decisions undertaken to coherently position the piece of research. One is not necessarily constrained by the other. As Haverkamp and Young (2007) explain, 'there is no fixed correspondence between type of research purpose and the three core paradigms' (p. 276). The three core paradigms Haverkamp and Young are referring to are positivism, constructivism-interpretivism and critical theory. Gorard (2004) even states that citing a research paradigm as a starting point for decision making in research is unhelpful and counter-intuitive. So, how is it then that processes interact to influence the current positioning of constructivism-interpretivism?

Firstly, personal ontology does have an impact on the epistemology of the research, therefore one does need to take this into consideration. Secondly, how we go about learning things (i.e. methodology), also impacts ones epistemological position. However, the research question also has a direct impact, i.e. what it is one wants to find out. In regards to the current thesis, the research question was intentionally formed to utilise a qualitative approach, which in turn influenced methodology, and then potentially epistemology. In the same way the research question influences methodology, methodology can also influence the research question in a reciprocal process. Once more, another influence is that of the researchers own skills and interests. As a Counselling Psychologist and a researcher, the very nature of research is to find a gap in the literature, which shapes the research question that one is asking. As previously mentioned, the research question posed within the current thesis is intentionally different to the positivist literature already in existence. This in turn, feeds into a more dynamic and complex process than originally explained in figure 1.
3.3. Methodology

The research method is a strategy of enquiry (Myers, 2009) and although there are other distinctions in research modes, the most common classification of methodology is either qualitative or quantitative. As aforementioned within the previous section, this research is a qualitative piece of research.

Qualitative research attempts to study the everyday life of different groups of people in their natural settings. According to Myers (2009) qualitative research is intended to help researchers understand people and the social constructs through which they live. Within this methodology, complexities and differences of the potentially under-represented can be explored and cherished. An obvious distinction between the two worlds of quantitative and qualitative methodologies is the form of the data, analysis and presentation used. Qualitative research is predominantly conducted through interviews or observation and quantitative through the use of questionnaires, surveys or experiments. Through this process of different methodologies, different claims can be made in relation to what is true, based on the philosophical positions of which they are based in.

There are three primary reasons for utilising the qualitative methodology, all linked to the research question and purpose of this particular study. These are: 1) exploratory, 2) descriptive and, 3) explanatory. As Hesse-Biber and Leavy (2011) explain, exploratory research is the process of conducting research in an area that has been under researched. Descriptive research seeks to richly describe a certain aspect of life. Finally, explanatory research seeks to explain social phenomena and the relationships between different components of a topic. It is the exploratory approach where this thesis will be aligned to, focusing on the descriptions about well-being provided by the professionals working within oncology, particularly paying attention to variants of reported perspectives of mindfulness. Within a qualitative-explanatory research methodology, multi-methods are normally used to approach the research, for example combining questionnaires and interviews, to gain a specific population or viewpoint, as is the case with this thesis.
3.4. Research Design

In the current research, I attempted to explore accounts of reported well-being from professionals working within oncology who had different self-reported levels of mindfulness, indicated by the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003). A qualitative approach was taken to gain rich and detailed insight into their perspectives.

3.4.1. Selection of Participants

3.4.1a Population

Participants were obtained from a private cancer hospital situated in the North West, Manchester, UK. The hospital was relatively small with numbers of staff only reaching around 200.

3.4.1b Purposeful Sampling

In the process of finding suitable participants for the current research, I used a maximum variation sampling method. This technique captures a wide range of perspectives relating to the issue under investigation; in this instance differing perspectives of self-reported mindfulness. In essence, maximum variation sampling is a search for variance in conditions, from low levels of a certain self-reported attribute to high levels. Obtaining both high and low levels of mindfulness was vitally important to answer the proposed research question, so one could explore whether these different or extreme perspectives of mindfulness may influence the way participants report their well-being. Maximum variation sampling was essential so one could focus on a particular attribute (mindfulness) and it's impact of experience of a general topic (well-being). No other selection criteria was used, such as age, gender or professional position as I feel that this would have detracted from the central component of the thesis - mindfulness. Fundamentally, 'sometimes extreme cases are of interest because they represent the purest or most clear cut instance of a phenomenon we are interested in' (Palys, 2008, p. 697).

One other possible sampling method I could have utilised is a random sampling technique and then obtained mindfulness levels in conjunction with the interviews exploring well-being. However this was unable to guarantee the
ability to obtain the appropriate professionals who were on "both sides of the fence". It might have been that all participants were not very mindful at all, or averagely mindful, which again, would not have been appropriate to answer my research question. In fact, using quite contrite terminology, 'mindless states are much more common than mindful states...' (Brown & Ryan, 2003, p.826), therefore obtaining high and low levels of self-reported mindfulness was needed to obtain in essence, opposing views. Furthermore, in relation to the small population, maximum variation sampling can be seen as a definite strength as Patton (1990) mentions.

When selecting a small sample of great diversity, the data collection and analysis will yield two kind of findings: (1) high-quality, detailed descriptions of each case, which are useful for documenting uniqueness, and (2) important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity (p. 172).

The MAAS is a 15-item questionnaire that measures and assesses trait mindfulness (Brown & Ryan, 2003). It focuses on the frequency of which the individual reports themselves as openly aware and attentive to present moment events and experiences. Mindfulness is measured via a 6 point Likert self-report scale varying from 0 (Almost Never) to 6 (Almost Always). The MAAS can be found in appendix a which was given to all participants of the study to gain a self reported rating of mindfulness. The response rate was expected to be quite low, especially within healthcare, as this is a well known problem within research (Asch et al. 1997).

3.4.1c Decision Process for Using MAAS

Upon scouring the literature, there are several assessments of mindfulness. The dramatic increase of these assessments has predominantly been down to the clinical trials of mindfulness groups to assess the effects of mindfulness training. As mentioned previously, many NHS mental health services are beginning to offer MBCT within their care pathways (Williams & Kukyen, 2012) and, figures are needed to show if a) the cultivation of
mindfulness is possible and b) whether this has a positive influence on psychological functioning.

Questionnaires which assess mindfulness as a trait include the Freiburg Mindfulness Inventory (Buchheld, Grossman & Walach, 2001), Five-Facet Mindfulness Questionnaire (Baer et al., 2006), Kentucky Inventory of Mindfulness Skills (KIMS; Baer et al., 2004), Toronto Mindfulness Scale-Trait Version (Davis, Lau & Cairns, 2009), Cognitive Affective Mindfulness Scale-Revised (Feldman et al., 2007), Philadelphia Mindfulness Scale (Cardaciotto et al., 2008), Southampton Mindfulness Questionnaire (Chadwick et al., 2008) and finally, the one chosen for the present study, the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003).

It was Grossman (2008) who emphasised several concerns in regards to self reported mindfulness, including that of scale construction, item misinterpretation and potential bias. Mindfulness is a difficult concept to define, as previously explained, so to operationalise it is even harder (Grossman, 2008). This difference in perceived operationalisations by different researchers clearly has an impact on the way mindfulness is indeed researched. The KIMS (Baer et al., 2004) includes the ability to verbally describe experience (e.g. 'I'm good at finding the words to describe my experience'), whereas others emphasise notions of personality such as openness, curiosity, acceptance (Davis, Lau & Cairns, 2009), and differing mental states (Feldman et al., 2007). However briefly, it is worth highlighting that considering the varying operationalisations given to mindfulness and their subsequent scales from the differing researchers, one can only conclude that each scale measures mindfulness differently, affecting the results of whichever study may decide to use them. It is for this reason, that careful consideration was needed to pick not necessarily the best measure, but the most well rounded and easily applicable for day to day living.

The Mindful Attention Awareness Scale (MAAS), which can be found in appendix a was chosen for this specific study for several reasons. Firstly, the MAAS is heralded as being one of the most popular assessment tools of mindfulness within the public domain (Van Dam et al., 2010) mainly due to its ease of accessibility characterised by the language of which it uses. This is not a coincidence as it was purposefully designed with this intention to 'assess whether a self-report measure taps what is occurring in individuals' day-to-day lives'
(Brown & Ryan, 2003, p. 835-6). With this study being focused on participants who are naive to the art and practice of mindfulness, it was important to choose an appropriate assessment, which utilises simple, layman language.

In collating research about MAAS it also has shown a significant relationship with brain activity after a course in training mindfulness (Creswell et al., 2007) and treatment outcomes in mindfulness based interventions (Michalak et al., 2008). It is for these reasons mentioned that I felt the MAAS offered an all round picture of general day-to-day mindfulness and was appropriate for this study.

One may have considered not using a mindfulness screening measure at all and simply asking participants 'do you consider yourself to be mindful?' and obtaining maximum variation that way. As Mason and Hargreaves (2001) suggest, greater emphasis should be put on qualitative investigations and perhaps research employing interview methods (Teasdale et al, 2002). This was not undertaken however, for two reasons. Firstly, as this was a small piece of research and the time frame to complete it was limited, this did not seem a viable option. Secondly, qualitatively assessed mindfulness is very under researched, and therefore reliability and trustworthiness of this method, or lack thereof, needs to be considered. As mindfulness screening was a vital part of the process, the MAAS was a more valid, reliable resource.

### 3.4.1d Participants

I received 27 replies over a period of three months from participants who had completed the MAAS. From this, 20 indicated that they would be prepared to be contacted for the interview stage of the study. With this being the case, to obtain an appropriate maximum variation sample for this small scale study, the top three and bottom three scorers were chosen, creating a total of six interviewees. I would have liked to interview more participants, but it was difficult to recruit high numbers of professionals working within oncology because of the high pressured environment and the time constraints of which those members of staff are under. It is important here to note that I do recognise that there are limits to this approach, for example ratings might be greatly influenced by subjective stances and experiences. However, it is hoped that results would provide an insight into variants of mindful awareness by obtaining
participants reported scores of this perspective. Within this sample, there were two nurses, one dietician, one pharmacist, and two receptionists. All were white British, with one male and five females.

3.4.1e Scoring the MAAS

The MAAS is a very simple measure to use and to score. From the 15 items, a mean score is calculated. On the official document provided by Brown and Ryan (2003), it simply states 'Higher scores reflect higher levels of dispositional mindfulness'. This gave me lee-way to use the distribution as I wished, with no cut-off point. Average scores were obtained by adding the score of each question and dividing it by 15.

3.4.2. Data Collection

3.4.2a Semi-Structured Interviews

The primary data for this study was collected over a period of two months in the form of semi-structured interviews. Semi-structured interviews employ a combination of structure (to elicit specific information) and open ended (to elicit unexpected types of information) features in the organisation of the questions, with an overarching theme of interest (Rubin & Rubin, 1995). According to Hove and Anda (2005),

The purpose of using interviews in empirical studies is often to collect data about phenomena that cannot be obtained using quantitative measures. In studies where the research goals are of a qualitative nature, it is appropriate to rely on qualitative measures. Interviewing people provides insight into their world; their opinions, thoughts and feelings (p. 10)

The interviews took place at a mutually agreed time within the hospital, in a booked room to ensure privacy and comfort.
3.4.2b Interview Questions

Within this section interview questions can be found which were presented to each of the participants. A full copy of the schedule can be found in appendix b. Below each question, is a rationale as for why it was posed and how it was constructed. Even though the interview schedule was semi-structured, it was important to standardise the general questions that were being asked so '...we can be sure any differences in the answers are due to differences among the respondents rather than the questions asked' (Gordon, 1975, p.35). Semi-structured interviews however, acknowledge that not every word has the same meaning and not every participant uses the same vocabulary, so the interviewer needs to be aware of that (Treece & Treece, 1986).

"Tell me briefly about your role here and why you became interested in working within oncology"

This was initially asked to introduce the participant to the content of the interview, and to facilitate self-reflection beginning with their position within the hospital. It was important to phrase this first question right as it would set the tone for the rest of the interview. It was also asked to give myself, the researcher, an indication if the participant felt comfortable talking or if they would need prompting to elaborate on their thoughts.

"Give me a brief snapshot of your average day, concluding when you walk out the door of the hospital, particularly focusing on your thoughts and feelings"

This question was asked to begin to steer the client towards thinking about their thoughts and feelings about the environment of which they work in. I thought it was appropriate to ask this question, especially one as intimate as this, as it was important to build up a space where the participant felt comfortable and safe. This was done by initially talking about their work and what they explicitly do, followed by personal interpretations of how they feel about doing it.
"In working within oncology, what ways do you feel this affects you either positively or negatively?"

This question was asked in order to facilitate the discussion of how the participant appraised different events. As previously noted within this paper, while all individuals face demands and stresses, there are of course notable differences and variations to the responses of these events, producing consequences for well-being (Larson, 2000). This was quite a key question because it very much is the crux upon which the research question lied and was asked to facilitate a potential variety of views. The participant was encouraged to talk about their feelings by asking probing questions to elaborate on their responses. The wording of this question was particularly important as to not guide them down a path of responding of which they do not believe. For example, thinking they had to respond 'positively' because that is what they think they should say, rather than what they wanted to say. This question may seem quite broad, but I purposefully created it to be so, as subjective well-being is not a static, unitary entity. 'It has multiple facets that must be assessed through global judgements, momentary mood reports... and emotional expression' (Diener et al, 1999, p. 278)

"Do you feel satisfied with the job you are doing?"

Job satisfaction is increasingly mentioned in the literature in regards to psychological well-being and there being a correlation between the two (Blanchflower & Oswald, 1999; Clark et al, 1995, 1997). Within the organisational sciences, job satisfaction has become commonly known as the oldest operationalisation of work place happiness (Wright, 2005), therefore it is right to include a question about it, in its own right.

Moreover, the analysis of well being at work has been referred to multiple times as exclusively "job satisfaction" (Sousa-Poza & Sousa-Poza, 2000) even though there have been arguments brought forward that work-related psychological well-being has been too narrowly operationalised as such (Clegg & Wall, 1981). Job satisfaction obviously plays an integral part in perceived psychological well-being at work. How much is still under consideration but I think it seems to be an influencing factor on psychological well-being so it needs to be explored.
"I would like you to look at this sheet, which mentions the five aspects of well being at work. I would like you to have a look at it and say if any words stand out more than others and then elaborate on why you have chosen them instead over the others."

It was important that I focused a question directly on psychological well-being at work. For well-being at work, generally, 'This relatively narrow scope stands in stark contrast to research on psychological well-being' (Wright & Bonett, 2007, p. 143). One couldn't just ask the question, tell me about your well-being, as if it is complex to me as a researcher, it will be complex to them as a participant. Therefore it was important to offer them a stimulus, which would stimulate conversation in relation to positive and negative affects. There are many well-being scales, such as Andrews and Withey (1976) who first asked people 'How do you feel about your life as a whole?' and presenting them with a seven point Likert scale ranging from delighted to terrible. Recent measures, obviously have multiple items, such as the Positive and Negative Affect Scale (PANAS; Watson, Clark & Tellegen, 1988) which measures both positive and negative affect with a ten point scale. For example, 'In most ways my life is close to ideal' and 'so far I have gotten the important things in life'. However, the point of this study was to listen to the participant and not be dictated by scoring, so questions needed to be relevant and succinct. In searching the literature, Daniels (2000) 'Five Aspects of Well Being at Work', appeared to be an exceptional tool for utilising discussions. The hand out can be found in appendix c. This was chosen as it gives the participant an unbiased broad range of emotions to choose from. Facets comprising affective well-being are amongst the most important, if not the most important factors of psychological well-being (Diener & Larsen, 1993; Warr, 1994). Interestingly, Daniels (2000) goes on to state that

... Measures of five primary factors are best used to explore qualitative differences amongst the components of affective well-being, or where there are reasons for suspecting divergence in the causal processes underlying work-related affective well-being (p. 289).
3.5. Process of Research

3.5a Obtaining Appropriate Interviewees

The first step in the process was creating the online MAAS (appendix a), consent form (appendix d) and participant information sheet (appendix e). A description of how an online questionnaire was created can be found in appendix f.

The hyperlink containing the aforementioned MAAS, consent form and participant information was sent in an email to the members of staff working within the hospital. The email sent can be found in appendix g. Within the first week several completed questionnaires appeared in the 'manage surveys' section of the site, ready to be analysed. However, there were also responses direct to my personal email account from members of staff, from which the questionnaire was sent, suggesting that due to the strict firewalls within the hospital they were unable to open and complete the first part of the research. This proved quite frustrating as I had to deviate from the original proposal of keeping all the data electronic and had to produce hard copies to be filled out by hand. I transferred all the online data, such as the MAAS, consent form and participant information into Microsoft Word and printed sixty copies, stapled them together, ready to be distributed to the staff. They were split into two folders and given to both the in-patient and the out-patient unit within the two staff rooms. Accompanying the two folders, was a locked filing cabinet with room to post completed questionnaires through. I was the only one who had access to the key, so the completed questionnaires remained separate and confidential from the blank ones. A second email, which was sent to the members of staff, (appendix h) explained that there was a way to complete the questionnaire, which included further instructions about where the hard copies were situated and what to do with them once completed.

Between the first email and hard copies of the questionnaire being introduced to the hospital, a six week period was left for them to be completed and returned. Out of the participant pool, which was made available to me, I obtained a response rate of twenty seven. This was particularly pleasing as it meant that almost half of the staff took time to complete the short questionnaire,
which matches what Baruch and Holtom (2008) said, in that the average response rate was for studies that utilise individual data (52.7%).

Participants were identified who would be appropriate to interview after analysing the quantitative data of the MAAS (details can be found in 3.4.1e Scoring the MAAS), according to how low or high they scored on mindfulness. Out of the twenty seven people who responded and completed the questionnaire, six were chosen for the second part of the study. The range of the MAAS was from 2.4 - 5.4, so the top three scorers, including the 5.4 and the three lowest scorers, including the 2.4 were contacted via email. The email which was sent to invite them to an interview can be found in appendix i. Attached to this was a second information sheet, which can be found in appendix j. Participants who completed the MAAS, but did not initial the box on the consent form that asked them to provide an email address to be contacted for the second phase of the study, were disregarded and immediately destroyed as however interesting their scores may have been, they were of little value as I could not interview the person did not provide consent.

After the initial contact email was sent out to the participants whom I wished to interview, several further emails were sent back and forth to organise a convenient time and place for the interview to take place. Once this was organised, the collection of qualitative data could begin, which provided the rich information to answer and explore the research question first posed.

3.5b Conducting the Interviews

The interviews generally lasted about 30-45 minutes, based on the questions, which have been presented previously and that can be found in appendix c. At the start of the interview, I had a brief chat with the participants to make them feel comfortable and at ease within the environment, which also incorporated handing them the second information sheet again. This was the same information sheet that was also attached to the email inviting them to participate in the interview. To reiterate, this can be found in appendix j. The participant was also handed a consent form, which they initialled and signed, which complimented the signature which I produced as the researcher. An example of this can be found in appendix k. The interviews were recorded using
an Olympus VN-712PC voice recorder. The interview was then imported onto a laptop and encrypted to protect the data in the file.

3.5d Transcription

Each of the individual interviews was transcribed by myself onto Microsoft Word 2010. It was important that I completed this process myself, firstly for confidentiality reasons, and secondly to begin immersing myself in the data, which will be described within the following section. Braun and Clarke (2006) will be referenced throughout as their framework for the utilisation of thematic analysis will be used. A brief example of the transcriptions can be found in appendix 1. Full transcriptions are not included because of confidentiality purposes.
3.6. Process of Data analysis

Namely, within this piece of research, the method of analysis of choice was that of Thematic Analysis (Braun & Clarke, 2006). Within this section, a description of what Thematic Analysis is will be given and why it was chosen amid the multiplicity of other approaches available to me. Qualitative data is usually dependent on interpretation, which can be generated by means of a number of different data collection and analysis strategies. A number of decisions have been made, in relation to the analysis, which will be explained. A step by step guide will also be provided as to how the analysis was applied to the current data set to provide a transparent view of the process of analysis.

3.6a Analysing the Qualitative Data

Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail' (Braun & Clarke, 2006, p. 6). It is only until recently, that Thematic Analysis [TA] became a method of data analysis in its own right, which provided the fuel for Braun and Clarke to create their paper elucidating the process of analysis. As up until then, they mention, 'Thematic Analysis is widely used, but there is no clear agreement about what Thematic Analysis is and how you go about doing it' (p. 6). Since it was first conceptualised in the 1970s by Merton (1975), a number of different versions of TA have been bounded about within the field of Psychology (Attride-Stirling, 2001; Tuckett, 2005). While some mark TA as a phenomenological method (Joffe, 2011), Braun and Clarke stand firm that TA is just an analytic method, rather than a methodology, which a lot of other qualitative approaches are. It is because of the theoretical flexibility that produces the position that TA can be applied to a range of theoretical frameworks from essentialist to constructivist and beyond.

We view TA as theoretically flexible, because the search for, and examination of, patterning across language does not require adherence to any particular theory of language, or explanatory meaning framework for human beings, experiences or practices (Braun & Clarke, 2013, p. 120).
As the epistemological positioning within this research has already been discussed and because of the flexibility of TA, the analysis and the position of which the analysis is coming from go hand in hand.

3.6b Inductive or deductive?

A number of decisions need to be made and explicitly stated when using TA. One of these is the process of inferring whether the analysis is inductive or deductive. A deductive approach is a theory driven analysis that determines the data in a sense that potential hypotheses are formed on the basis of background theory and then tested against empirical data. It is commonly referred to as the top-down approach because research starts with the initial theory, then observations are collected to address the aforementioned hypothesis. A confirmation (or not) of original hypothesis can then be had. As this thesis does not have a hypothesis, which is being tested, I do not subscribe to deductive reasoning.

In an inductive approach, themes are strongly linked to the data itself (Patton, 1990), meaning the approach bares some sort of resemblance to that of Grounded Theory. (Differences can be found within '3.6e Rationale'). The inductive approach involves not trying to fit the data into any existing coding frame or analytic conceptualisation. It is therefore not unusual for the themes found, to not be inherently linked to the questions asked of the participants. With inductive reasoning, specific observations and measures begin to detect patterns or regularities forming tentative hypotheses or ideas that can then be explored. Inductive reasoning develops some general conclusions or theories, therefore it is this method of reasoning in which I believe this thesis aligns itself to.

The two methods of reasoning have a very different approach; inductive reasoning is more exploratory and open ended whereas deductive is far more closed. With this being said however, social research is never clear cut and 'even though a particular study may look like it's purely inductive ... most social research involves both inductive and deductive reasoning processes at some time in the project' (Trochim, 2006, p. 1).
3.6c Semantic or latent themes?

A second decision to be made is that of whether the themes discovered will be that of semantic or latent in nature (Boyatzis, 1998). Briefly, semantic themes search for explicit or surface meanings and in doing so the researcher can and does not want to look for anything beyond what is being said by the participant. Contrastingly, latent themes are that which start to examine underlying ideas or assumptions that are theorised as shaping the content of the data. Therefore, for latent themes, the development of the theme involves interpretative work from the perspective of the researcher. As this research involves inferring the aspect of mindfulness behind the content, the analysis will be inductive searching for latent themes.

3.6d Thematic Analysis

TA is a discovery focused technique, with the unit of analysis being segments of data as opposed to numbers or figures like that within the quantitative field. These segments are coded, sorted and organised to search for emerging patterns or connections between the different segments of data. As qualitative research is often criticised due to lack of rigour, attempts to combat this in the data analysis process depends on its adequacy and transparency (Fossey et al, 2002). Insufficient detail is also given to the process of data analysis (Attride-Stirling, 2001). As such, Figure 2 presented on the next page is a step by step guide as to how TA was carried out. This is a general nomothetic framework, and will be individualised in the following section (3.6f). The phases have been generated from Braun and Clarke (2006).
3.6e Rationale

As previously mentioned, there is a multiplicity of research methodologies\(^6\) to choose from. It is important therefore to ask, and answer the question of why is thematic analysis appropriate in this instance?

The method of analysis needs to be in accordance with the research question being asked, which I feel TA does comprehensively in the context of the present research. By using TA it is possible to link various concepts and opinions

\(^6\) As already mentioned Thematic Analysis is not a methodology but a method of data analysis. However, for ease and simplicity, it shall be referred to as the former.
of different situations, at different times and compare these with the data. With this being the case all possibilities for interpretations are possible (Braun & Clarke, 2006). Good qualitative research needs to develop interpretations and be consistent with the data collected. Keeping this in mind, TA is able to detect and identify factors and variables, which might be influencing the participants’ response (Creswell, 2003).

Following on from this, an important part of the current research is not just to explore what participants have to say about a particular subject, but goes one step further and actively looks for potential differences and similarities within them. This makes TA wholly appropriate when compared to other analytical methodologies as one is able to highlight these similarities and differences using TA clearly (Creswell, 2009). With the inherent flexibility of TA one can gather data using different instruments (e.g. interviews and observations, concurrent with psychometrics for sampling purposes), with participants in different environments with conflicting worldviews. TA can produce and present data in a more effective way, representing the potential reality of the data collected (Miles & Huberman, 1994).

There has been some debate about what paradigm each method of analysis falls into, with authors like Ponterotto (2005) arguing that method of analysis should be dictated by epistemological positioning. As TA can be used in an inductive or deductive way, it transcends epistemological positioning however.

Qualitative methodology can be divided into two camps. Within the first are those methodologies, which are tied to a particular theoretical position, such as Interpretive Phenomenological Analysis (Smith & Osborn, 2003), and Conversation Analysis (Hutchby & Woofitt, 1998). For these, there is limited possibility for flexibility within the framework upon which it is used. In methodologies like that of Grounded Theory (Strauss & Corbin, 1998), Discourse Analysis (Burman & Parker, 1993), and Narrative Analysis (Murray, 2003), they are different manifestations of the same method, however, still remaining within the initial framework. In the second camp are methods which are independent from theoretical frameworks and can be used quite flexible amidst a multitude of frameworks. As Braun and Clarke (2006) go into great lengths,
Thematic analysis is not wed to any pre-existing theoretical framework, and so it can be used with different theoretical frameworks (although not all), and can be used to do different things within them (p. 9).

The decision to use TA was also influenced by the way Grounded Theory has essentially been used in different pieces of research. As Braun and Clarke (2006) state, many people don't use Grounded Theory but indeed ‘Grounded Theory-lite’, which in essence is a series of coding procedures very much like that of TA. If I was to have utilised Grounded Theory, I would have had to adhere to the full cut grounded Theory, which requires an analysis to build and develop a theory from the ‘ground’ up (Holloway & Todres, 2003). This is not my intention for the thesis and so a clear process and rationale was undertaken as to why TA was chosen.

3.6f Thematic Analysis within the context of the current research

The following section will be set out in relation to the phases as dictated by Braun and Clarke (2006), so a clear procedure can be defined showing rigour and trustworthiness. However, it is important to note that they set out the phases as guidelines, rather than distinct steps, mentioning

It is important to recognise that qualitative analysis guidelines are exactly that - they are not rules, and, following the basic precepts, will need to be applied flexibly to fit the research questions and data (p. 16).

Furthermore, analysis is not a linear process, even though it is constructed and represented here as one. One needs to go back and forth through the different phases, which develops over time (Ely et al., 1997). Even though two perspectives of the same area were collected; that being high and low levels of mindfulness, the data was analysed as a whole. With this being the case, themes were generated from all participants and similarities or differences were looked at within themes, as per the theory of TA.
STEP 1: Familiarising yourself with the data

This first stage involved being fully immersed within the data, which incorporated being an active member of the data collection within the interview process. With this being the case, before I came to transcribing, I already had initial thoughts and ideas about what I may find and what was interesting. I transcribed the data and became familiar with the different interviews. Examples of the transcriptions can be found in appendix l. It was important that I transcribed the data myself as this has been seen as a critical point of initial familiarisation, where meanings can be created (Lapadat & Lindsay, 1999). After transcription, I began to read and re-read the data in an active way. That is, searching for general trends and meanings and making initial tentative notes and ideas about what the codes may be or what the participant is trying to communicate. Phase one was of vital importance as it provided the grounding upon which the other phases developed from. By the end of this phase I had six fully transcribed interviews, each having small notes on certain areas to influence and aid step two.

STEP 2: Generating initial codes

Phase two began after I had generated small ideas about what codes might come about. Codes refer to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis, 1998, p. 63). It is important to distinguish between codes and themes, as codes generate themes and it is not possible to have one without the other. Coding was done manually rather than through a software programme, to increasingly familiarise myself with the data. I printed out each of the transcripts and went through each of them methodically assigning codes to meaningful segments of data. It is important to note here that the codes generated were data driven, rather than theory driven. It is however, impossible to fully remove myself from what I was looking for; therefore if I knew that a segment had nothing to do with well-being, for example, a participant talking about what they had for breakfast, this was not coded for. Braun and Clarke (2006) explicitly state that segments of data can remain uncoded. After initial coding, I generated 112 different codes over the six interviews. A full list of codes can be seen in appendix m. For each segment of data presented, a code was generated from this.
An example of a coded segment can be seen in Table 2 below. It is worth noting again that as the process of TA is not linear and the codes presented in appendix m are that of the final codes after going back and forth between phases and re-reading transcripts to find something new; TA is an active process. In appendix n, the coded segments for each participant can be found.

<table>
<thead>
<tr>
<th>Data Extract</th>
<th>Line Number(s)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>So, the first year for me was really bad because it was incredibly busy and sometimes it's hard to sort of... to be thinking on your feet because as soon as the phone went down you're having to do something else (12)</td>
<td>23 - 25</td>
<td>12 - High work load</td>
</tr>
<tr>
<td>because I sometimes... sometimes get myself into the mind set that you know, you've got to do this, you've got to do this and you've got to do this and you're trying to do everything, for everyone. (24) And in the first year when... at sometimes that caused me problems in that if I was to maybe '....' I might make an error because I'd been interrupted or something else had happened (25)</td>
<td>27 - 31</td>
<td>24 - Wanting to do everything for everyone 25 - Making mistakes</td>
</tr>
</tbody>
</table>

**Table 2: An example of coded segments obtained from Participant 05LM**

**STEP 3: Searching for themes**

Phase three began after all initial codes had been collated and I had enough individual codes to start grouping and categorising different codes into larger and broader themes. To be thorough within this process I wrote out all the different codes onto a piece of paper and cut them out so I had a clear representation of what was found in step 2. I began grouping them into different areas of interest. I utilised the format of mind maps to visually produce relationships between codes, whilst also beginning to think about how they may be grouped within themes, forming sub-themes and what the over arching theme is representing. I attempted to find a place for all the codes; however, it is not unusual, nor inappropriate to include a 'miscellaneous' theme where codes that did not fit anywhere could be placed.
**STEP 4: Reviewing of themes**

Step 4 involved a refinement of the initial themes which I had already found during phase three. During this phase of analysis it was important to consider if the codes collated together actually represent that theme, or if two themes might be better as one, with different sub-themes within that. To do this, I initially looked at the segments of data behind the code within each initial theme to see if they formed a coherent storyline. It is at this point where I started deleting codes that did not give either a full representation of the data, or could not be placed in any existing themes. The mind maps were refined further still, solidifying what it is that the themes were communicating. When looking at the data found within the transcripts, further coding was done and added to the thematic map as new ideas and concepts were continually generated with me being so involved in the process of analysis. 'The need for re-coding from the data set is to be expected as coding is an ongoing organic process' (Braun & Clarke, 2006, p. 21). A deciding factor of the retention of codes within certain themes is that if the thematic map accurately represented the meaning of the data. Personally, I felt that very little refinement needed to be done as from an early phase there were clear potential themes evident in the transcripts.

**STEP 5: Defining and naming themes**

Step 5 initially involved a stage of further refinement of themes. Final simplified mind maps were generated to represent the final themes, along with distinct names to give a clear picture of what the theme was trying to represent. The visual representation of the refinement of themes, based on thematic mind maps can be found in *appendix o* representing the process of moving through steps 3 to 5.

It is this part of the analysis, which is unique to this part of the research, as to explore who said what viewpoint, I separated the codes, which made up the themes in relation to levels or perspectives of reported mindfulness. A colour coded section can be found in *appendix p* which demonstrates what codes make up what theme, and which participant those codes came from (how they scored on the MAAS), providing a transparent process of analysis. This was necessary before phase 6, so I knew how the narrative of the final analysis would look as this was vital to answer the proposed research question.
From this, interpretations and inferences about well-being could be made for professionals working within oncology. It was also inferred what participants, said what things, based on the differing reported levels of mindfulness. By looking at the themes and noticing any similarities or differences, potential insights were brought to the fore by relating these noted similarities or differences through the lens of mindfulness.

**STEP 6: Producing the report**

In step 6, using the themes generated in the previous 5 steps, a report was produced, which can be found in the analysis section (4. Findings). Within this step it was important that the analytic narrative went beyond a description of the data and a compelling argument was made in relation to mindfulness and well-being. Further descriptive insight into how this was done can be found in section 4, where a clear layout of the findings will be outlined.
3.7. Reflexive Analysis

As part of qualitative research, it is recommended that researchers make their own assumptions and background in regards to the research topic explicit (Morrow, 2005). Within this brief section of the methodology I will attempt to elucidate any pre-existing thoughts about the research topic to be as transparent as possible in regards to my own involvement within the research. This needs to be done for two reasons: to help both contain or 'bracket' personal influences and to provide readers with information to add their own evaluation onto the study (Kasket, 2012). I will split this up into three different categories, which will be situated around institutional, disciplinary and personal positioning.

3.7a Personal Positioning

I chose the topic of professionals working within oncology, because I myself have worked in that environment and experienced first hand how draining the work can be. I also have invested interest in the art and practice of mindfulness as in the past, I have suffered mental health difficulties and utilised mindfulness to its full effects. Therefore, I cannot help but personally acknowledge the benefits of mindfulness. It is also something which I readily profess in my therapeutic work to clients wanting to overcome a variety of presenting issues. The two components of the study (well-being and mindfulness) is something that I am very passionate about, but it is hoped that these factors will not play a determinate role in the findings of the thesis. Nevertheless, they will no doubt have an impact on my understanding of the world and how the two concepts sit within it. In recognising my personal positioning within the research, I have continually acknowledged or been aware of looking for something, which isn't there, to confirm my own personal beliefs. As the interviews conducted were semi-structured, the possibility that leading questions were asked about a particular area of which I found of interest, or of what had already been discussed previously by another participant, is there. The nature of the questions were particularly broad in regards to well-being (this was done intentionally), so I had to be careful and not betray too much of my own formulations and conceptualisations.

Due to the nature of qualitative research and using myself as a tool through which the data was analysed, it was impossible to take myself
completely out of that process. Attempts have been made to counter this potential bias, but researcher transparency is mostly important for the reader so they can decide for themselves to what extent, personal assumptions and potential biases have impacted on the study (Morrow, 2007). Enclosed with appendix q I have presented a list of main assumptions I had before the research, aided by my personal reflexive journal. Through the process of self reflection on my own personal standpoint and reflecting on my own subjectivity it is hoped that I was able to arrive at a clearer standpoint to obtain objectivity.

3.7b Institutional Positioning

Research can rarely take place outside governmental, academic or professional institutions (Parker, 2004). Therefore one needs to consider the expectations of others in regards to the research that is being completed; what is it perhaps that they want you to find, or what it is that will be useful to them? A consideration also has to be made as to how I also position myself within that institution. Consequently, it has been noted that institutional contexts play an important role in influencing and shaping 'decisions' (Bell & Roberts, 1984).

I worked in the hospital where the interviews were conducted for about a year. Therefore, I knew quite a lot of the staff and they knew me. I was inextricably linked to the data collated because I was inextricably linked to the people of whom the data was collated from. I came from a position of a professional working within oncology and so perhaps I had insight into what might have influenced well-being, therefore increasing my involvement within the research itself. As the interviews were semi-structured, I had the opportunity to ask questions, which I felt had affected my well-being, for example that of feeling potentially isolated in my role as a Counselling Psychologist. This may have also been the case when analysing the data because of the potential of obtaining themes that resonate most with me. It is important to acknowledge this aspect of reflexivity, as interpretation is always done through the eyes of the cultural standards of the researcher and the institution of which the research is taking place. Unfortunately, the effects of this can not be fully eradicated, but only be monitored (Frisina, 2006).

Through interviewing the participants in the institution that I worked in, I could class myself as an 'insider-researcher', as I too, at the time the interviews
took place, was a professional working within oncology. There are both positive and negative aspects to being the 'inside-researcher' as Corbin et al, (2009) explain. They state that one has a starting point of commonality with the participant, which then may facilitate trust and acceptance in sharing of experiences. Nevertheless, they also go on to discuss the possibility of the researcher overestimating the assumptions about the shared experience and instead of representing the participants experience, the researchers experience may impede the process of data collection and analysis.

3.7c Professional Positioning

As a Counselling Psychologist it is in my very nature to develop relationships and facilitate discussions in what might be a difficult or sensitive area. I very much had to remove myself from this context of being the 'therapist', which was difficult to do. The participants knew that I was a therapist by profession and it's interesting to consider how this dynamic may have changed or altered the relationship. As I was a 'questioner' rather than a 'therapist', I may have been too rigid with my questions as at times there was a dynamic or moment that would have interested me as a psychologist, which is perhaps at odds as to what should interest me as a researcher. I had to maintain the researcher role, but at times it was difficult to manage this tension and therefore had to restrain myself from exploring inappropriate issues.
3.8. Rigour, Credibility and Trustworthiness of Research

According to positivists, qualitative research is generally questioned in regards to its trustworthiness because the concepts of validity and reliability cannot be addressed in the naturalistic world (Shenton, 2004). The original concept of reliability and validity was to identify an 'absolute truth', which I do not think is obtainable and is something of an impossibility within qualitative research. Mishler (1990) suggests that instead of identifying an 'absolute truth', focusing on the trustworthiness aspect of the study moves validation to the social world, where reality is built up from experiences, evoking the notion that there is no neutral or objective reality at all. Williams and Morrow (2009) present a pan-paradigmatic perspective on achieving trustworthiness and consider three main categories: 'integrity of the data'; 'balance between reflexivity and subjectivity'; and 'clear communication of findings'. The following brief section shall present strategies utilised to maintain trustworthiness and uphold rigour.

Firstly, allowing transparency gives readers opportunity to see the different stages of research, so they have a greater understanding of how and why the research was carried out in a particular way (Yardley, 2008). Consequently, these stages of analysis can be found in the previous sections.

Regular contact with fellow researchers and to my research supervisor allowed me to reflect on my work, assess my own assumptions about the research process and of what the content suggested based on the analysis. It was beneficial for me to utilise a reflexive analysis, to situate myself within the context of the research and to be open and honest with the reader in an attempt to avoid any bias (Morrow, 2007). This can be found in section 3.7 of the methodology. Coinciding with this, a reflexive journal was maintained to help keep an impartial stance (Tufford & Newman, 2012). The aim of this journal was to communicate any pre-existing assumptions which might impact the collation or analysis of data. The reflexive journal was for personal reasons to aid the bracketing process in conjunction with the reflexive analysis. Bracketing in research is a process as described by Lowes and Prowse (2001), mentioning 'any preconceptions or beliefs held by the researcher should be examined, acknowledged and put to one side' (p. 473). Not all researchers agree with the process of keeping a reflexive journal however, namely due to its private nature, which may not elucidate any preconceptions at all (Rolls & Relf, 2006). In many
ways they are right as it is impossible to completely detach oneself from the data but, it is hoped that acknowledging this also adds to the transparency of the thesis.

Another criterion for trustworthiness of qualitative research is that of coherence (Elliot et al, 1999). This refers to achieving a coherent story line and framework for the data to sit. At the end of the process of data analysis I took part in a check for coherence with a colleague on the course to assess if the themes generated made sense to an external source. This, combined with discussions with my primary research supervisor, hopefully maintained trustworthiness throughout.
3.9. Ethical Considerations

There were a number of ethical concerns to consider within the current research. Ethical approval was given by the School of Education at the University of Manchester and was carried out in accordance with the British Psychological Society of Human Research Ethics (BPS, 2011) and was informed by the Health and Care Professions Council's Standards of Conduct, Performance and Ethics (HCPC, 2008). Ethical clearance was also given by the HCA, who were the governing body of the cancer hospital used. The application form to obtain clearance to complete the present research can be found in appendix r.

Great care was taken into how to obtain and reach the largest number of participants within the hospital, without disrupting the daily routine of the practitioners. It was decided the least intrusive, but most effective way to access the participants was through emailing the staff individually and attaching the MAAS and any accompanying documentation. The population I had available to me, had work email addresses, which I had access to from a central database, which I was given permission to use by the hospitals director.

As already mentioned, to obtain the desired a sample, an online survey was used. Therefore, it was appropriate to follow the guidelines as presented by the British Psychological Society Guidelines for Ethical Practice in Psychological Research Online (BPS, 2007). Participants were required to read a participant information sheet (appendix e) prior to completing the questionnaire, which had both myself and my research supervisors contact details. A potential problem in online research is that participants may not necessarily read all of the information given to them. Nevertheless, in the BPS guidelines it explicitly states that if a participant has given 'informed' consent, then this is sufficient to acknowledge that they have read through the appropriate information. With the program used to create the questionnaire, I was able to make it compulsory that in order to complete the questionnaire, they had to 'tick' the corresponding box of 'I confirm I have read all information' within the consent form. This can be found in appendix e. Finally, completing an online questionnaire gave the participant opportunity to withdraw at any time or choose not to complete it at all without any explanation.

The appropriate participants were then asked to attend an interview, where they were given a further information and consent sheet, found in
appendix j and k respectively. The interviews were semi-structured and so participants were given the opportunity to ask any questions or withdraw at any time. Process consent (Haverkamp, 2005) was also considered - but not used - as I monitored participants comfort level throughout the interview. If need be, I could have reminded them that they were free to withdraw at any point and were not obliged to answer any of my questions. Following the interview, participants had the opportunity to ask any questions they had about the project and were again reminded of mine and my research supervisors contact details.

Confidentiality also needed to be considered throughout the research. All electronic data including transcripts and interview recordings were kept in encrypted files. Any paper copies of the questionnaires which the participants may have utilised were in a locked unit, which people could 'post' through after completion. The online survey was on a secure site, which required a username and password to access. For participants who either did not want to be contacted or I did not want to interview, their data was immediately destroyed. Questionnaire data was given a number and stored separately to the names and contact details of the participants. Finally, participants who I interviewed were told that no identifying information was to be used and any quotes used would not be identifiable. Where there was any doubt, for example a family members name, I checked to see if they were happy for the quote to be used, or they wanted it to edited in some way.
3.10. Chapter Summary

Within this chapter I have outlined the research design for the current thesis. I began by stating my epistemological positioning, so the research could be embedded within the context of that philosophical stance. I stated the complexity of coming to a rationalised decision, dependent on a number of different factors. My ontological stance is that there is no one objective truth, but many, dependent on the experiences and values of an individual (Ponterotto, 2005), aiding the position of constructivism-interpretivism. I described the step-by-step guide of how I used Thematic Analysis, which included an added step to make inferences on how participants spoke differently about well-being and their differing perspectives of personal mindfulness levels. A rationale was also given as to why this analysis method was chosen, whilst maintaining transparency of both the research process and researcher values throughout. The chapter was concluded in relation to ethical considerations, and how I intended to manage them.
4. Findings

4.1. Introduction

This chapter intends to outline the findings of the research. For reference, there was one research question, which was posed to explore the potential inferences between mindfulness and the reported well-being of professionals working within oncology. This was:

1. How do oncology professionals, with different perspectives on their own mindfulness, report their well-being while at work?

Within this chapter, I describe the interpretative findings of the qualitative data, in which the semi-structured interview data was analysed using Thematic Analysis (Braun & Clarke, 2006). I then, inferred what the content of the themes may mean, based on the participant sample which included differing perspectives (high and low levels) of personal levels of mindfulness.
4.2. Qualitative Findings

The data from the semi-structured interviews was analysed using Thematic Analysis (Braun & Clarke, 2006). Although the process of analysis has already been discussed at length within the methodology section, it is important to reiterate what the analysis involved, to maintain a sense of transparency.

Firstly, the interviews were initially transcribed to familiarise oneself with the data where notes and annotations were made to begin to acknowledge any themes or trends emerging within the data. The second phase began by generating initial codes, or meaning segments. These codes ranged from a couple of words to around six lines. In phase three, the codes were brought together to begin identifying any overarching themes, which were initially represented in the form of mind maps. Phase four involved the reviewing of themes, which consisted of either code deletion or inter-theme amalgamation. Phase five involved further refinement and final naming of themes. Within phase five, it was possible to see what codes came from what person and so possible inferences could start to be made. The final phase, phase six, is the one being presented currently; the presentation of findings and inferences.

During the coding and thematising, five themes were generated. These were 1) Individual impact of working within oncology, 2) Patient relationships, 3) Staff relationships, 4) Transition from Work to Home and 5) Environmental responses. Table 3 displays a representation of the five themes, followed by the sub-themes which they were then split up into.

What follows is a description of each theme, with illustrative quotes embedded throughout the text. It is important to note that the quotes used within the presentation of findings are ones which I feel are of particular importance or of most relevance to the theme being presented.

4.2.1. Levels of Mindfulness and Language Used

Before I continue, it is important to consider about what is meant by different levels of mindfulness, or higher and lower levels of mindfulness. Once again, it could be said that crude groupings of individuals has many shortcomings, however, I consider mindfulness to be a perspective of the self and how one considers oneself to be situated in the world around them. After
maximum variation sampling, it was possible to get two views on the same process - that being mindfulness.

I am not creating two separate groups as all participants are one and the same, although potentially at different ends of the mindfulness spectrum. It is therefore not the case that one participant is mindful and the other participant isn't, but one is perhaps less or more mindful than another. It is hoped the language does not give this connation, and is presented in a way, which makes sense to the reader to aid understanding of the analysis. Therefore, below gives an indication of the terminology being used.

- **Higher Level Mindfulness**

This indicates that the participants reported an increased awareness to internal and external experiences, indicated by a higher score on the MAAS. When 'higher mindfulness' is reported in the analysis section, it is referring to an increase of perceived awareness of what is going on in the present moment, without falling into a distracting personal dialogue, as this is the construct upon what the MAAS is built upon.

- **Lower Level Mindfulness**

This indicates that the participants reported a decrease in awareness in regards to internal and external experienced, indicated by a lower score on the MAAS. This is not to suggest that participants are not aware of their surroundings, but perhaps, as the MAAS suggests, spend more time on 'automatic pilot' and are focused on past or future events, potentially ignoring what is going on, or what it is they are doing in the present moment.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-Theme</th>
</tr>
</thead>
</table>
| Individual impact of working within oncology | a) Emotional content  
b) Personal consequences and perceptions |
| Patient relationships | a) Importance of relationships  
b) Protecting oneself  
c) Closeness of relationships  
d) Impact of deterioration of patient |
| Staff relationships | a) Ability to communicate  
b) Feeling supported |
| Transition from home to work | a) The ability to leave work at work  
b) Impact outside of work |
| Environmental responses | a) Self Imposed Work  
b) Reactions to the Environment  
c) Job enjoyment |

**Table 3: Full list of themes and sub-themes**

**4.2.2. The Presentation of Findings**

For transparency, the qualitative findings shall be presented using all participants, regardless of the score on the MAAS. It is after the initial presentation of the themes, that what the qualitative comments might mean in relation to the different perspectives of reported levels of mindfulness shall be inferred.

This was done by utilising the process as described in the methodology section. It is only after the presentation of themes and the presentation of any potential similarities and differences, that the make-up of each theme based on what level of mindfulness the qualitative coded comment came from that potential ideas could be further inferred and potentially strengthened.

Throughout the presentation of themes however, participants will be presented with reference to their levels of mindfulness for the reader to consider.
themselves and again, to remain a sense of transparency. For ease, participants with higher levels of mindfulness shall be indicated with HM (High Mindfulness) and those with lower levels, referenced as LM (Low Mindfulness). For example '01HM', indicates participant one, high levels of mindfulness.

4.2.3. Participant Demographics

It has been intentional that the 'middle' ground of scores has been omitted. As described in the methodology section maximum variation purposeful sampling was used to gain both the higher and lower levels of mindfulness to gain the most varied perspective of one thing; to assess how this disposition may influence the potential similarities of differences of reported well-being. It was unsure what the spread of scores would be, and so a boundary or cut-off point was intentionally omitted. In Table 4, which can be found below, the scores of the MAAS can be found along with the given participant number, which shall be used as reference throughout the findings section. The questions asked of the MAAS indicate the level of awareness in regard to the present moment and not being cognitively, somewhere else. This was represented by the qualitative nature of the questions such as 'I forget names immediately after I have been told them'. Therefore higher mindfulness suggests greater awareness of experience. Scores are merely presented to represent the different perspectives of reported mindfulness that were being used as part of the sample, so when one refers to higher or lower mindfulness, the reader is more aware of what that represents.

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<thead>
<tr>
<th>Participant</th>
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<tr>
<td>01</td>
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Table 4: The highest and lowest scorers of the MAAS who were contacted to complete an interview.
4.3. Individual Impact of Working within Oncology

This emerged as the most central theme, i.e. as most directly related to my primary research question, as this was specifically about emotion and what participants said they felt when they were at work. Two sub-themes were found; emotions and personal consequences. Emotions were, the emotions described by each participant and personal consequences, were how these aforementioned emotions affected them in their work, impacting perceived personal well-being.

4.3a Emotional content

A variety of emotions was picked up on, to varying degrees. The first of which was the 'depressed' feeling which was mentioned by a number of different participants. A variety of perspectives were put forward, including not feeling down, characterised by,

'I don't think I feel depressed or anything by the nature of this environment or this field of work or anything like that'. 02HM (420-421)

One continues to explain the potentiality of feeling down but doesn’t see this as a problem, mentioning,

'It can be a bit depressing and it can be a bit upsetting I suppose, but, so far nothing has been so bad that I've got really upset or anything like that so...' 02HM (127-129)

And another participant actually states

'It doesn't depress me'. 01HM (263)

A participant even expresses an interesting emotion of 'happiness' stating,

'Most days I feel... happy that when I walk out of the door that I've done everything I needed to do' 03HM (30-31)

On the other hand, others stated, that they do get and feel down quite a lot,
'I am depressed, I know I am. There are periods of time where I can't stop crying and sometimes it is work related...' 04LM (392-393)

And another mentions,

'I do get incredibly down about it sometimes, you know' 05LM (78-79)

A final participant expressing a negative emotional response as well, stating,

'Yeh, it's more of an emotional response really, negative emotion, you get a bit fed up with it at times really'. 06LM (136-137)

Other emotions explained by several of the participants are that of anxiety, for instance. Again, different perspectives were put forward of being either affected or not.

'I don't think being overly anxious is something I get worked up about' 02HM (413)

This was similar sentiment expressed by another,

'Well, no, I don't really get anxious if I'm honest'. 01HM (257)

This is slightly different to other participants, who mentioned that they're in a constant state of anxiety.

Erm... the anxiety, depression and tiredness because that's what I am. Yeh, I'm in a constant state of anxiety' 04LM (351-352)

Continuing

'I'm always on edge, I'm an edgy person anyway, I know I am and that's probably why I can't relax, but, erm... I don't know...' 04LM (356)
These sentiments seem to be again, echoed by a participant,

‘Working here obviously I am stressed and sometimes a bit unhappy with the way things are going, I do get pretty down, you know.’ 06LM (177-179)

Concluding with another participant, who introduced the concept of stress further,

‘I am stressed... I know I'm stressed’. 04LM (202)

Interestingly, stress is also mentioned by another participant, but perhaps to a lesser degree, stating,

‘Yeh, I mean obviously there are days where you feel more stressed and when you've done what you need to do and you finally leave it's a bit of a... relief almost to leave’ 03HM (42-43)

4.3b Personal Consequences and Perceptions

A variety of viewpoints, some apposing, were expressed in regards to the consequences stated of the aforementioned emotions. Firstly, for example, participants described their general feeling of when they leave as,

‘Erm, knackered probably!’ 02HM (124)

And another mentioning their tiredness, when they exit the building, saying

‘I don't get tired [in the day], only when it's the end of the day and I'm on my way out of work... ’ 01HM (292-293)

Something similar is explained again as one goes on to state,

‘Knackered basically. Not physically drained but mentally...’ 06LM (49)
This could show that working within oncology is tiring work, which is somewhat expected. It is interesting to consider what this tiredness may lead onto and if it explicitly affects them in their working life. One participant continues,

‘Because you know you’re tired and because you know you’re not focusing as you should be doing, that’s when it starts to happen and you start to spiral downwards’. 04LM (157-159)

Then perhaps commenting on her levels of rumination,

‘Your tiredness is just what you’re physically doing, you think, think, think, your brain never stops’. 04LM (470-471)

When this negativity was opened up, stress was discussed by some of the participants as a personal consequence and how stress, negativity, and feeling down affected them. For instance, a participant mentioning with increased low mood, remaining positive becomes difficult

‘When you become stressed, I sort of feel I lose interest in it and it’s not that I can’t cope with it, because I can, but it’s difficult to remain, I suppose going back to what you were saying... positive really’ 06LM (140-142)

And again, by another

…but negative yes... everyday you think there by the grace of God’. 04LM (211-212)

This participant then mentions that this makes him want to leave, stating,

‘Well, I mean, work isn’t supposed to be fun but the stress sort of takes the enjoyment out of the work and you just always think, I can’t wait to go home now because this is coming all a bit much’ 06LM (137-140)
Compare this to the way others responded to the question of how work affects them,

'Erm... but negative... I don't feel it affects me in a negative way' 01HM (215-216)

And another mentioning,

'I don't think it really affects me' 02HM (450)

Increased stress or perhaps lower mood can also have big implications on the behaviour of a person, for example making mistakes, which was implied within the responses in some of the participants. When working within a medical setting this may have severe implications.

'...I was working for a consultant, who was a fabulous guy and erm, there was a point where I'd made a few errors in letters and things, which I never normally do...' 05LM (479-481)

Then when asked directly

'So did you make more mistakes when you were more stressed?'

Yes, when I had more to do' 05LM (487)

Stress caused a negative behavioural change in her by letting things get on top of her and making mistakes. This is again mentioned by another participant,

'I think I've made a few mistakes, but you know it's not been noticed ... and you've been awake all night and then you've got to come back and check something that it was ok, you know'. 04LM (327-330)

As well as an inhibitory behavioural response, there was also a mentioning of a physiological one. Several participants mentioned how their work had affected
their health, which is of course a vital part of ones well-being. For example, after making those mistakes she continued,

'I have had panic attacks since working here' 04LM (328)

And

'...at my time of life I do feel as though I am trying to do too much because, erm... medically, I'm feeling a little bit... you know. Sometimes I'm too tired and I do have an irritable bowel and that sometimes kicks off when you try to do too much'. 04LM (277-280)

The second person who complained of a physiological problem because of their work suffered quite a severe problem, explaining,

'...maybe that could be the result of last year, when I had a retinal vein occlusion or... that's kind of, I don't know, frightened me a little perhaps, well a lot to be honest at the time' 05LM (369-371)

The stress seemingly had manifested itself to a physiological process and her body needed to give her a warning sign,

'Yeh, because obviously I wasn't aware of whatever was going on inside of me' 05LM (419-420)

From what she is saying, it appears that she only became aware of what her actual stress levels were like, when something went wrong with her physically and only then could she change her work routine, or implement any stress relieving strategies.

4.3c Concluding Remarks and Inference to Mindfulness

This first initial theme generated some interesting insights into the reported well-being of professionals working within oncology, particularly when further exploration is completed in regards to how participants perceived their
own levels of mindfulness. There were different perspectives mentioned, which seemed to coincide with the spread of reported mindfulness as represented by the MAAS. It could be said that the participants who had a lower level of mindfulness perspective, used more negativity to describe their general well-being, with words like depressed, anxious and stressed. Potentially, as a result of this, when opening up the results further, it was those participants who described a lower mood (anxiety and depression) that also stated that they may make more mistakes and experienced physiological problems.

On the other hand, the participants who didn't mention any negative affects were the ones who perceived their mindfulness as the highest. Several participants stated that they did not feel very down at all and were 'not affected' at work, with one mentioning the word 'happy'. Two overall views were mentioned, which were of stark contrast to each other. It was interesting to consider that the participants with differing perspectives of their own mindfulness, seemingly reported their emotionality and consequences of working within oncology differently too.
4.4. Patient Relationships

A big part of professionals working within oncology is the cultivation, maintenance and break down of the relationships with cancer patients. Within the interviews, this was found to be a central theme in relation to what affected their well-being. This is understandable as the majority of their work, whether directly or indirectly is treating patients. How staff reacted to this process may have critical implications for their psychological well-being while at work.

4.4a Importance of Relationships

The first point picked up on was how much enjoyment people got from the relationship with their patient, influencing well-being. Within this theme, it was one factor, which all participants mentioned as one of the best aspects of the job.

'Yeh, I love it, you seem them once every two to three weeks, so they become more like friends than patients, so yeh, you build up a really good relationship with them, so, I do enjoy that'. 06LM (42-44)

Another echoing his thoughts,

'From that respect, I do enjoy the job'. 05LM (240)

Several other participants also enjoyed the relationships with the patients as one mentions,

I love.... I love being with patients, you know long term patients, because I'm in HTU, the transplant unit, so all of our patients are in for... when they come in for a transplant, they're in for three weeks so I like developing that rapport with people and you get to know they're family and... to me that's a better aspect of nursing to how I'd like to be a nurse rather than, you know, like an A&E type nurse where they just see them, treat them and then go somewhere else, you know' 02HM (25-31)
Another reiterates how much she gets from the forming of the patient-carer relationship.

'I enjoy looking after the patients, I'll rephrase that. I enjoy looking after the patients and I enjoy the job I do. Erm, I enjoy, you know sitting and chatting to patients, you know about their sort of, their weeks since their last chemotherapy...' 01HM (57-59)

For some it is what makes their job worthwhile as just being with the patient gives them great satisfaction. For instance,

'Erm, some days I can feel really... well most days feel really, a sense of worthwhile that I've done something that has helped that patient on the bed to improve their overall quality of life and when you get feedback from patients as well when you've suggested something that they feel they can incorporate and carry on with them, that does make you feel good'. 03HM (81-85)

And

'It makes me feel... good I'm helping you know, because not everybody could do this job I don't think. Like I said before, it gives me a sense of worthwhile and pride I suppose.' 01HM (206-208)

And a final participant,

'But, I think because cancer can be so devastating, knowing that I'm helping in some small way, I think it makes everything worthwhile. What I get back from seeing a patient leave here, going back home makes everything worthwhile. You think, yeh, I know why I came into this profession, it's to help and when you know you have helped someone, however small, it makes me feel good' 02HM (469-474)
This cultivation of a relationship with a patient is quite an interesting dynamic as with cancer, especially within the unit that the interviews were conducted, the termination of the relationship, whether that be death or discharge is inevitable.

4.4b Protecting Oneself

How do members of staff deal with this breaking down of a relationship, repeatedly on a day to day basis? Several participants expressed almost coping strategies that they use to get by. Firstly,

'I can't take on board because I'd never be able to do my job otherwise. If I got completely wrapped up in the patients, I'd never be able to do my job, I'd be a complete and utter wreck' 01HM (98-100)

And states her work as

'Clinical' 01HM (140)

Seemingly, this participant is unaffected by the break down of relationships because she knows that she can't be affected by them. This is a similar experience shared by another participant,

'...I'm not saying I'm hard or anything like that, it's just... I think maybe I've got a tough exterior... a tough front a little bit, I don't know.' 02HM (101-102)

This way of being 'clinical' is also shared with other participants, for instance one mentioning,

'...you become used to it a little bit, so, and, you do try to detach yourself a little bit from it.' 06LM (100-101)

The participant goes on further to explain this detachment
'Because you can't obviously when someone does come in and they do look really poorly, you can't show you're kind of shocked even though you are so you've always got to be, you know, upbeat in front of them.' 06LM (85-87)

Another mentions,

'No, but it's when you think about it, when you're talking about emotions when you're having to think clinically and then you're having to be emotional then that could cause problems, do you know what I mean?' 05LM (206-208)

This might be easier for some than others however, for example

'I can't show my feelings because if I show my concern then how are the patients going to feel? "Oh God", they'll say "why is he worried about me? If he's worried then there must be something wrong." It's draining almost performing for the camera you know, when sometimes you do want to say "shit, that is really bad, I'm so sorry". 06LM (62-67)

Finally, reiterating this point, a participant concludes,

'Erm, I don't know. You've got nothing... there's nothing personal there with the patient ... but there's nothing... you're not emotionally attached to the patients. Again, it sounds hard, but you're there, we're here to do a job.' 01HM (175-180)

4.4c Impact of deterioration of Patient

If professionals working within oncology adopt the 'clinical' stance, it is important to consider how effective it is at protecting their well-being. Interestingly again, a variety of views were mentioned from across the spectrum. Firstly, one participant mentions

'I think I dealt with it alright, it didn't make me feel like I wanted to go home and be depressed or anything like that or particularly physically upset or emotionally upset or anything like that'. 02HM (92-94)
And

'Well, I've not got, I haven't got upset, no'. 02HM (64)

For this participant, her apparent disconnect works quite well as she calmly states that she doesn't get upset about patients deteriorating. This non-emotionality is reiterated again, by another, mentioning,

'So, I am really in touch with my emotions outside, but inside, it is, just, you have to be hard. And I don't think it's a bad thing because it helps me and in thirteen years of working so far I've never said "oh it's getting too much for me or anything like that"' 01HM (411-413)

Interestingly, these two participants show no emotion and really are not affected by what goes on at all. These were the only two participants to mention 'no sadness', the remaining, seemed to mention it to varying degrees.

'Well, I mean, it makes me sad. Sometimes it does make me emotional and cry, but you've got to remember that these people have been through a lot and I think through the years, a lot of the time it is actually a relief.' 03HM (116-118)

This is perhaps opposite to other perspectives, for instance

'You just have that moment because you can't help but feel sad. It's terrible’

05LM (163)

And another mentioning,

'Not physically but mentally drained because it's really, you know, when you see people coming in who are really poorly and erm, you know that kind of effects you a little bit when you see them go down hill a little bit and yeh, so you just feel emotionally drained'. 06LM (49-52)

A final participant stands out on her own saying,
'I can't cope with it. I'm not a nurse; I've always said that I can't cope with that aspect of it. If I know them quite well and they're on the ward and they're not recognisable I just tend not to go in because I think 'Oh God, I'm going to start' 

04LM (481-483)

She even goes on to say

'...but you know, when someone passes away here, you really got close with them, you find that you're driving home and... *sniffs*, but I mean, it's deeper than that, it drags you down. It's not just having a good cry and getting it done with, I do think... I am prone...' 04LM (400-402)

This participant is obviously very affected by the breakdown of the patient and even states explicitly that it's more than just a moment, but a real lowness, which stays with her persistently dragging her further and further down causing seeming psychological distress.

4.4d Closeness of Relationships

Remaining with the concept of 'clinical-ness', it brings up the connotation of not being able to truly interact with the patient, or perhaps being particularly standoffish. As participants mentioned enjoying the relationships it may have the detrimental affect of being unable to form close relationships and receive that positive feeling of closeness. Especially for some participants this does not seem to be the case as three mentioned the ability to sit and listen.

'I empathise with the patients. I sit and I listen and I listen and I listen. And, you give advice on quality of life. It's about quality of life for the patient and certainly looking after oncology patients it's about somebody just listening to them'. 01HM (104-106)

And another,

'You've gone through quite a lot in life and it's nice to be able to sit with the patient, have time with that patient' 02HM (318-320)

And finally,
‘I empathise with the position that they are in or information that they've divulged to you because I think maybe the time I get to speak with patients, they don't just get to talk about food or what we were talking about that time, they do often bring up, erm, how they’re feeling or anxieties and things, and I think it's important to at least address those, even though I may not be the person that deals with it.’ 03HM (231-237)

As this participant continues, it could fundamentally come down to the feeling of trust,

‘Personally I actually feel quite honoured that they've trusted me enough, or comfortable in the situation that they can tell me that. I think it's part of the trust thing’. 03HM (247-249)

One participant comments on this, stating how nice it is that the patients feel as though they can talk, and she's around to listen to them.

‘It's nice to know that they feel relaxed and sort of, within this sort of environment that they're coming in for their treatment for cancer they're sort of lost within the... even though they're sat in a chair and receiving chemotherapy or whatever they may be receiving. But they're sort of lost and they're still sort of able to talk about the nice things, you know, just about getting out and about and their families, what you've been doing and, it's nice to know that they feel sort of relaxed and comfortable talking to a complete stranger really when you think about.’ 01HM (71-78)

However, when looking at other participants, when talking about sitting and being with patients, one is unable to do so, and instead perhaps decides to think about oneself,

‘They come in and you know, you're listening to them moaning constantly... sometimes if you're not feeling very well, you think, well, nobody ever bothers about me, you know’ 04LM (243-245)
And another mentioning,

'It's hard listening to these people you know, it's constant. It's painful' 06LM (70-71)

As well as not being able to listen, another participant shows concern about how this clinical-ness is being portrayed to the patient,

'Well, I think I have to and I do yeh, so I suppose I am, even though I think I am warm, sometimes I might come across a bit clinical because I don't want to get overly involved you know. I guess I'm worried that my personal side might come out a bit more, so I perhaps I don't listen to the patient as much as I should’ 05LM (217-220)

4.4e Concluding Remarks and Inference to Mindfulness

In conclusion, it seems that the participants interviewed, most expressed satisfaction when working with patients and it is the one thing which they seem to enjoy while at work. The enjoyment came from the interaction side of the relationship and receiving something in return from helping that person. With that being the case, most participants who were interviewed expressed a need to be 'clinical' to protect themselves from the emotional aspect of caring for the patient. This involved becoming emotionally detached and remaining at distance.

However, it is interesting to consider that even though most participants talked about and explained this 'clinicalness' some participants got more upset than others when these relationships broke down. When exploring who said what, in relation to the spectrum of mindfulness, it could be inferred that the participants who reported to get more upset at the deterioration of patients were those who expressed lower a level of mindfulness, potentially showing an ineffectiveness of their forced 'clinicalness'. Those who reported not being affected, were actually those who considered themselves as more mindful.

It was also interesting to consider the closeness of the relationships themselves. An interesting notion which was brought up in the reported well-being was the different opinions put forward in regards to being able to be 'with' the patient. That is, those who could stay and listen to the patient, and perhaps be
more personable, and those who had difficulty in hearing the patients stories and not being able to cope. When considering who voiced what opinion, it was perhaps the participants who suggested they were more mindful that expressed the former rather than the latter.

Within the current sample, it could be said that some participants are seemingly still able to form a meaningful relationship characterised by listening and showing empathy, even with a sense of clinicalness or backing off. The different viewpoints of 'patient relationships' seemed to coincide with the different perspectives of personal mindfulness. That being, those who reported more positive relationships were those who seemed to rate themselves as being more mindful.

Following on from this, just as patient relationships are important to well-being; it was found that staff relationships were also found to be important in the process of well-being at work.
4.5. Staff Relationships

Within a working environment staff relationships are important when working within a team. On average, members of staff are spending fifty hours within the workplace and so long hours may result in close bonds forming between different people. In developing this theme, it was interesting to delineate the emphasis and closeness or lack thereof that participants put into forming or maintaining these seemingly vital connections at work. Again, different viewpoints were expressed.

4.5a Ability to communicate

The first point, which was picked up when looking through the transcriptions was the ability to 'share' with colleagues. For instance one participant, stated,

'Most of the time I probably share it with my colleague who is the physio who is based where my desk is, and then sort of, move on' 03HM (134-135)

It is this usefulness of sharing and expressing one's distress to another person in a similar situation that potentially acts as a comforting blanket and allows her to be able to move on. As another continues,

'I mean we're a small team, so we're quite a close team I would say. I feel comfortable and if something was bothering me; I'd certainly be able to talk about it to another member of the team, to lighten my load...' 02HM (240-242)

Here she recognises the closeness of her team and how that closeness, like most relationships translates to an ease of communication. These two participants are able to talk to their colleagues about whatever they are feeling. Continuing,

'Yeh, yeh. I think, it's not a... it's just obviously a support thing that you know someone else is having those feelings as well' 03HM (136-137)

She expresses that there is almost a comfort in the commonality that one is not alone in going through those feelings, whatever they might be.
'Plus, you've got colleagues to keep you chirpy and talk about stuff that might be on your mind' 01HM (291)

Without being able to form these close relationships, the benefits of which, which have just been demonstrated, cannot be experienced. Not all of the interviewed participants were able to talk to other members of staff so easily however.

'Well, I just sort of offload to my friends really, but I don't express it here if I can' 06LM (230)

This potentially could be seen to be an active choice as the participant goes onto explain that they don’t want to communicate their feelings to other members of staff, explaining,

'I feel it's a weakness when you need, not help sort of thing, but you know what I mean, because you know, just pull yourself together and you'll be damn fine' 04LM (611-614)

This is also a similar intention of avoiding sharing emotions to other members of staff quoted by someone else,

'I don't know, it's sometimes difficult I think to talk about if there's something wrong with you in a cancer ward because, when it's not cancer it pales into insignificance really, doesn't it. And, I didn’t want people to see me upset or worry about me, so I guess I just did what I always had done and try and get on with it.' 05LM (403-407)

The concept of trust is also considered with other members of staff, saying,

'I know it sounds awful but there's certain people you can trust and some people you can't...' 04LM (130-131)
4.5b Feeling Supported

Being able to ask about something, which one is not sure of, is partly feeling confident, but also having the perception that you have the support of people around you.

‘I think being supported from my colleagues I feel supported that I'm doing a really good job’ 03HM (373-374)

Another mentions,

‘I think we're quite well supported by each other’ 02HM (375)

And

My manager appreciated the input we have and the role of continuity as well, so that's good as well and makes you feel good as well' 03HM (360-362)

Again, compare this to the opinion of another participant who states, that in fact,

‘The biggest problem here is, I don’t feel supported’ 04LM (313-314)

And again, mentioning,

‘Here I feel as though I am on my own, which makes you feel absolutely terrible and down quite a lot of the time’ 04LM (317-318)

Finally addressing the fact that they don't get any recognition for what they do,

‘But then you're getting picked for 'oh, there's such and such didn't do this, there's never any sort of supportive... I know sometimes I say oh it's a load of nonsense but people do want to feel wanted, you know’ 04LM (449-452)

This lack of recognition, or potentially not feeling wanted can be possibly detrimental to well-being.
4.5c Concluding Remarks and Inference to Mindfulness

Within this theme, interestingly again, different viewpoints were put across about staff relationships in relation to well-being when working in oncology. Through the qualitative comments, and looking at how the theme was comprised, it appeared that the participants who reported that they were able to generate relationships with colleagues easier were those who were perhaps also more mindful. This was characterised by comments, which in analysing the transcripts led to being more able and willing to share emotion because of the perceived support of the people around them. Several participants however, mentioned feeling isolated and that the sharing of emotion to colleagues was a weakness. One participant even questioned her right in doing so because of the people suffering from cancer situated around her. As these were opposite viewpoints to the participants with a higher perception of mindfulness, it seemed to coincide with other inferences in that those participants who reported a lower level of mindfulness at the beginning of the study, were potentially not able to feel completely comfortable in relationships with other members of staff.

Potentially, similar to the theme of patient relationships, those members of staff rating more highly on the MAAS; might be able to form a closer connection to others and feel able to share emotional aspects of their job.
4.6. Transition from Work to Home

It has already been covered in great depth within the present research that well-being encompasses multiple situational and environmental factors, which all have an influencing and maintaining effect on how well-being is perceived. For all the participants interviewed the majority of their waking week is spent at work, when in comparison only a tiny amount is spent at home. Therefore, it is completely understandable that the transition from work to home and vice versa was found to be one of the themes because of the time imbalance between the two. Even though the conversations were initially supposed to centre exclusively on well-being within the work place, conversations developed into how well work and the emotionality of which that may bring, is contained within the construct of the hospital. Working within oncology is highly stressful and being able to leave work at work, one is able to recharge the batteries. However, as will be explained, when professional life bleeds into personal life, it may have detrimental effects on well-being both inside and outside of work when one is unable to switch off.

4.6a Ease of Transition

In looking at the different perspectives, without prompting, participants began to mention the ease or lack of such a thing in which they can leave work at the door from which they exit.

'Erm, when I walk out of the door from work to my home life, my work stays in work’ 01HM (41-42)

The transition of the professional to the personal is seemingly quite easy for the some participants who pick up on the point of leaving work at the end of the day, saying,

'It doesn't seem to have any lasting effects on me, when I get out of this place. This is me and my profession here and when I leave here, I probably change into somebody else' 02HM (146-148)

And another stating,
'I used to be in walking distance and I thought that was quite good in the twenty minutes home, you've shaken things off again and you can enjoy your evening.'

03HM (342-344)

With the ability to keep appropriate emotions in and out of work, it seemingly allows the person to adopt different roles and be the nurse to the patients, and the mother to her children.

'You know, and it's almost as if, when you put your uniform on you turn into nurse mode, when you take it off, you turn into Mum mode or that type of thing'

01HM (293-295)

There seems to be an ease in which she talks about the two roles she adopts; the worker and the Mother and is quite confident in her natural ability to not let one affect the other. Interestingly, this notion of simple role transition is also shared by another participant, saying

'...I've got teenage kids and stuff and I think I'm a normal Mother when I get back home, or as normal as I ever am going to be!' 02HM (134-136)

Developing comments further within the theme, one more goes onto explain,

'Certainly, from a different role perspective, when I did the chemotherapy course back in 2002, we had to do an oral exam and one of the suggestions the lecturers gave was to, erm, if you want to be in that mind set of, erm, nurse, then you can wear the uniform. Wear the nurses uniform exam for the oral exam and it worked' 01HM (301-304)

And then

'...when you walk out of work, you leave work at work, you know, the emotional side of things' 01HM (162-163)
It seems fair to say that the transition to work and back again is seamless, with the help of a uniform. It is a very physical representation of the two 'people' she may become. Reiterated once more,

'I take my uniform off and then I'm just a Mum again. 02HM (145-146)

Being all things to all people is obviously quite difficult for some participants, perhaps because of the variety of people you need to be, which is quite a challenge when adopting the different roles.

'Yeh, you have to be all these different things to all these different people. Then you start the guilt at home, you're guilty and [says names] says you're stupid feeling like that, but I should be asking the mum and mother in law for this and I should be going out seeing these friends, something has got to give' 04LM (583-586)

Further opposing perspectives are also given by some of the other interviewees, who also mention the difficulty of being all things to all people, for instance, saying

'But you are already committing your whole life and something to someone else for most of the week, you know. So it is, it's quite difficult...’ 04LM (592-593)

This notion is also mentioned by another participant, perhaps because it is hard to take that 'mask' off.

'It's hard to take that mask off at the end of the day. It is hard to switch to [says name] the friend' 06LM (61-62)

**4.6b Impact outside of work**

If there is a difficulty in keeping work inside of work, then it is an understandable leap to explore just how work may impact that person outside of work.
'You know, they just push you to the absolute limit but you never show it sort of thing. No, at home it's different isn't it. You go home, you need to kick a cat when you walk through the door' 06LM (185-187)

It is interesting that the notion of a 'uniform' is reiterated by another participant using another metaphor calling it the 'Alex smile' - a false sense of external calmness, which impacts her at home,

'...you come out of here and you're on this... *breathes in* because you have to be. They used to call it the Alex smile, and then you've got to be yourself again and because you've come down, you crash; you walk through the door home and whatever anyone says to you its RAHRAHRAH. You know, you don't mean to be like that it's just leave me alone for five minutes'. 04LM (571-576)

The *breathes in* motion could also be linked to the adrenaline needed and utilised in work to keep the professional on their toes, but it can be quite hard to release this, as she continues,

'I'm always in that mind set that every time the phone goes there's an adrenaline rush at home because you think that someone is going to be calling about something' 04LM (200-202)

This notion is mentioned by another participant, stating,

'I know that's kind of a strange word to say hyped, but, so, when you get home, you're still in a sense, you know racing, you're still that...' 05LM (110-112)

This potentially could be linked to the 'clinical-ness' previous explained in the patient relationships theme as fundamentally it seems that the examples of the lower level mindfulness participants presented, can't come out of that role very easily at all. This can be characterised by several examples, including,
'And sometimes I can walk down the road and think 'oh'. It'll just come into my head, little things I've done. It doesn't halt me or anything like that. I sound totally work obsessed' 05LM (564-566)

And

'You go home and think about people in a good way and a sad way you know because sometimes there's a lot of success stories as well and it's sometimes nice to hear people getting, you know, being well for a while and things, but you think about your patients and things like that' 06LM (70-83)

This seems to particularly affect one participant as she mentions several instances where she starts panicking about work at home, mentioning,

'But some days you go home and you just can't stop thinking about it. If you've had a near miss or you know you haven't checked something properly it's going round and round and round in your mind. I mean, I've woken up at 3 o'clock in the morning and thought... having a mini panic attack thinking have I... God, I didn't check such and such' 04LM (145-150)

A similar notion is also mentioned by another, but perhaps not to the same extent mentioning that she considers it normal and potentially does not interfere with home life as much,

'I mean sometimes I go home and think about if I have done something right and or something wrong, but, I think it's like normal I suppose' 03HM (349-350)

Two participants of the sample seem to not even think about work when they get home as they don't see that it serves a purpose, mentioning,

'You can't take things home' 01HM (401)

And another stating,
'When I get home I switch off quite well really. I mean, once you leave here you can switch off' 02HM (413-415)

Again, drawing upon different perspectives characterised by different quotes, one actually states the opposite in that,

'I can't switch off: I'm one of those people. I don't even switch off when I get home, when, you know, which annoys my husband...' 04LM (191-192)

Because

'. . .Sometimes I have taken things home to [name of husband] and said 'you never guess what' and he's listened to me but other times he's gone mental and he said 'will you just stop talking about all these people who have died' 04LM (600-603)

There is an active part of this participant, which wants to share her experience of what has happened, but it seems to affect her relationships at home so is unable to. This is on the contrary to another and her explicit refusal to mention work at home.

'. . .because my husband or my kids they haven't got a clue with the terms of whatever and that's probably one of the reasons I don't talk about my work because it doesn't, certainly my husband, he doesn't understand'. 01HM (310-313)

4.6c Concluding Remarks and Inference to Mindfulness

This current theme was not saying that thinking about work at home is not normal, because to some extent having thoughts or reliving moments about the previous day are no doubt expected and understandable. It is how much this rumination of the day affected the person and if they perceived it to be unhelpful. Accordingly, different participants had different perspectives on if and how it affected their reported well-being. From the examples given, the participants who seemed to communicate a difficulty or inability to detach themselves from their profession when they went home, were the participants who reported lower
levels of mindfulness, initially. Participants mentioned needing to be different things to different people and the difficulty that that may have brought to them. *Deleted sentence*

Participants mentioned being able to, or having to remove something, like their uniform, or more hypothetically, a ‘mask’ or ‘Alex smile’. Removing this, again, did seem easier for some than for others. When consulting the different levels of mindfulness and who reported what, it seemed that the participants who potentially found it most easy to remove the ‘mask’ were those of reported higher mindfulness. The work-life balance, when considering participants with a more mindful perspective seemed much healthier than those of the lower levels of mindfulness, when looking at how the theme was expressed by the different participants. When one can’t switch off and do enjoyable things at home, which was mentioned by several participants, it impacted them in different ways, for example one participant mentioning snapping at their partner.

The final theme generated, was the perceptions of the environment when working within oncology, including the concepts of how they situate within it and of the environment around them.
4.7. Environmental Responses

Each individual has their own beliefs, experiences and structures to frame and situate themselves within the workplace. This theme is split up into three sub-themes. Firstly, self-imposed work, which looks at how much work the individual, puts on themselves and how much stress this may bring. Secondly, in reactions to the environment, the way the participants perceived the world around them and their responses to this was explored. Thirdly, in job satisfaction, it was considered how much job satisfaction individuals took from working within oncology.

4.7a Self Imposed Work

Like other professions within the medical world, staff working within oncology are asked to work set times or shifts throughout the week to complete whatever work they may have to do. However, it is not always the case that staff remain within these hours because of the amount of work, which they want to get done. For instance, one states

'I'm not saying don't do it in your lunch hour, but you know, so, it is quite full on really, but that's how I am really. People think I'm weird because you know, I work through my coffee breaks and just to get is sorted and so I'm on top of things, you know’ 04LM (180-183)

This is a very similar concept as mentioned by a second participant in the data when talking about constantly working and not giving her a break to wind down.

'Well, I tend to come in earlier to work, a) to get a coffee and look at the email and then I sort of like break into the day' 05LM (296-297)

And

'...I do ridiculous things, like I'd work through my lunch hour or I'd stay after work or I'd stay and sometimes I'd help other teams...' 05LM (72-74)
With these two participants there seemed a need to come into work early, or work through breaks because there is a perception that there is so much to do and they feel that the only way that they can cope is to eat into their own personal time. Interestingly however, another perspective, is an interviewee explicitly expressing a conscious effort to not stay late or work through breaks. Different people seem to prioritise the need for overtime differently.

‘...I think yeah, you do, do overtime and you don't really get that time back. I don't try and stay longer than I need to, it is literally, what is essential today and get that done. I try not to stay over though, I mean, I find that ridiculous’. 03HM (327-330)

With this self imposed level of work it could appear to not be that useful to some participants as they begin to criticise their own thought processes,

‘Yeh, you are. It's kind of like, I suppose, my thought processes are a bit stupid, maybe a bit old fashioned because it's like, let's just save the day, let's just get it done, almost superhuman, which you're not' 05LM (505-507)

Which is similar a similar notion mentioned by another, in wanting to do everything,

*I'd rather be working like an idiot and making sure it's right then you don't get complaints or offending people than be a little bit slap happy and, you know what I mean...' 04LM (265-266)

And then another

'you know having to look after patients, consultants, nurses, do your admin work, answer the phones and when you're on your own having to deal with all that and I can stress myself out' 06LM (129-131)

He continues,
'And... You just have to get on with it really. But obviously it's not ideal, because when you give yourself more and more work, it becomes more difficult to cope with it, you get frustrated and I don't know, it just becomes difficult sometimes'

06LM (168-171)

And finally,

'I'm like, look, [says name], at the end of the day I'm trying to do far too much and you know, it's difficult isn't it but I can't stop doing it' 04LM (525-527)

In some respects she states that she is her own worst enemy, driving herself to do more and more. In doing too much, one potentially puts oneself at risk to factors already mentioned within the first theme stated. However, this viewpoint is not universal as another seems to be able to take a step back and acknowledge their limits.

'I know my own limits and when to take a step back though...' 02HM (198-199)

4.7b Reaction to Environment

There were also mentions of the reactions to the environment, and how one dealt with it, either perceiving it to busy, or stressful.

'Yeh, I like to be busy' 02HM (194)

Here there is a sense that she wants to do more work to keep her engaged and interested within the workplace. Interestingly a similar notion was put forward by another more mindful participant stating the satisfaction she may gain from being kept busy,

‘...if you've had a really, really busy day like that, you feel quite a sense of achievement’ 03HM (48-49)

One continues,
'And, the job is varied in every way possible so I don't get particularly bored at work' 01HM (287)

The variety of the job seems to stop members of staff becoming bored and allows them to be more engaged in their work. Another participant mentioned,

'I do like having a mixed role because it's interesting and you don't get bored. Because quite a lot of jobs, you just come in and do it where working for.... what we're doing now, that's not the case. There is such a lot of variety' 05LM (536-539)

However, this could potentially be detrimental to this participant because, she goes onto mention,

'If you could divide yourself up into three people it would be perfect because, physically, that's what you needed to do. You needed to be two people, if you were to do it to perfection’ 05LM (496-498)

This potentially comments on her quality of work and her not feeling as though she's doing anything well, which can lead to a lack of a feeling of accomplishment. One participant, however, considers the environment stressful, perhaps because of the variety.

'Yes it is really, really stressful because the workload can be quite demanding' 06LM (128-129)

And another,

'it is a stressful environment because everybody wants things done...’ 05LM (69)

And again, mentioning,

... but if it's a bit more rushed or pressured to do it on time then... it sort of can be a little bit stressful’ 04LM (135-136)
It is interesting to consider other peoples reactions to the environment,

'It's when those unexpected patients come in that need things right there and then so it's probably the skewing of your time plan that creates the... I don't know, but I think it's the thinking on your feet part of the job that I enjoy; never a dull moment' 03HM (58-61)

And another mentioning,

'I think I thrive more in a bit more of a stress like environment as apposed to being in a quiet environment, you know' 02HM (205-206)

4.7c Job Enjoyment

With this being said, however all participants iterated that even though it can be difficult and draining at times, they still enjoy their jobs.

'...But I'm also enthusiastic and take pleasure in my work'. 06LM (191-192)

And

'I do enjoy what I'm doing'. 05LM (519)

And

'Erm, I love doing what I do'. 04LM (208)

Then the following participants,

'Yeh, I love it'. 02HM (185)

And

'I do enjoy coming to work, it doesn't depress me. I enjoy coming into work to do what I'm doing', 01HM (263-264)
And finally

'Well, I think there's lot of unhappy people here and don't enjoy working here, but I do, I'm really happy here and enjoy the work which I do'. 03HM (367-368)

It seems that the enjoyment factor of work is incredibly important because when working in such an emotionally draining environment, without a reason to come to work, it could potentially become too much.

'Yeh, you need to enjoy it or you wouldn't be here otherwise for 12 and a half hours as if it's a depressing day or a traumatic day you wouldn't be able to cope with it would you. I don't think.' 02HM (370-372)

4.7d Concluding Remarks and Inference to Mindfulness

Several participants communicated almost a need to work through lunch and breaks but surprisingly, ultimately criticising their way of working. When referring to the spectrum of mindfulness scores, there is a potential that those particular views could be associated with the lower scores of reported mindfulness. Further looking at the building blocks of the themes, the opposite is stated by the more mindful participants, in that it was 'ridiculous'. Subsequently, when analysing the transcripts it was potentially found that continual work might have had a detrimental effect on well-being.

The second sub-theme of environmental factors also had implications for well-being, because of how participants viewed the environment they were situated in. The variety of the job seems to be a key figure for all participants, and that it is indeed where some enjoyment of the job comes from; there is always something new to do. However, this seemed to be more stressful for some than for others because they were perhaps unable to keep on top of things, and potentially ended up doing too many things for themselves to keep up with. The participants who potentially seemed more engaged in their surroundings and thrived in the stressful surroundings, were actually those with a higher perspective of mindfulness.

However, when participants were talking about their personal satisfaction within the work place, all expressed enjoyment in the work that they do.
4.8. Chapter Summary

In this chapter, the data was synthesised to produce a report of the findings with potential interpretations. Five themes were identified from the corpus of data, surrounding the concept of well-being of professionals working within oncology. These were: individual impact of working within oncology, patient relationships, staff relationships, transition from work to home, and finally, environmental responses.

It was stated at the beginning of the chapter that themes would be presented, and then inferences made about the levels of mindfulness, in accordance to the research question first presented. In reference to the research question, different levels of reported well-being potentially coincided with how individuals reported mindfulness. That is, the higher levels of mindfulness initially reported by the participants, seemed to be impacted less than other participants interviewed, when working within oncology. The participants at the higher end of the mindfulness spectrum seemed to report being less affected by the deterioration of patients, with the potentiality of these participants also being able to communicate with members of staff more, as some reported feeling more supported and included within the team, whereas several other participants, aligned to the lower levels of self reported mindfulness, suggested the opposite.

Again, there were different views about how easy it was to keep work within work and how much it impacts the individual outside of work. Different perspectives of this, were potentially reported by participants who had different perspectives on their own levels of mindfulness. The more mindful participants seemed to express an ability to keep work within work and adopt the different roles required outside of work, as there was a mentioning of being able to be the 'nurse' and the 'mum' without too much conflict between the two. Once more, somewhat of the opposite view point was expressed by some, which was taken by the participants who reported lower level mindfulness.

Finally, all participants mentioned how busy working within oncology is and of the enjoyment within that, however through analysing the transcripts it appeared that some found it more of a stressful environment than others. Ending on a positive note, all participants stated that they enjoyed their job. These conclusions will be discussed further in the following section, namely the discussion, which shall be the next chapter.
5. 
Discussion

5.1. Introduction

The presented thesis had one main research question, which shall be reiterated again for continuity.

1. How do oncology professionals, with different perspectives on their own mindfulness, report their well-being while at work?

This chapter will provide a full summary and interpretation of the results, which will be discussed in relation to previous literature in attempt to embed the current research findings within the psychological field. Limitations will also be discussed, concluding with final remarks and recommendations for future research.

To reiterate, the purpose of this thesis, was to research mindfulness from the humanistic perspective, using constructivist-interpretivism framework, which I believe can be associated with my position as a Counselling Psychologist. Very little research has been conducted in regards to differing levels of dispositional mindfulness, especially in regards to individualised reported well-being obtained in a naturalistic setting by qualitative enquiry. Therefore this thesis hoped to provide insight into this process using the population of professionals working within oncology.

5.1.1. Summary of findings

Five themes were found using thematic analysis which were, impact of working within oncology, patient relationships, staff relationships, transition from home to work and environmental responses. Within each of the themes, the differences and similarities of the qualitative comments were interpreted and inferred, relating those comments to the different perspectives of levels of self-reported mindfulness reported by each individual. It was found that there were some potential differences in relation to how participants reported their well-
being in regards to the five themes, which upon further inspection, was potentially related to the differing levels of mindfulness. Interestingly, this is consistent with previous literature on the benefits of being mindful, reducing negative affects, and improving positive affects (Brown & Ryan, 2003). It is however, the first piece of research to consider differing levels of mindfulness in relation to qualitative experience without the use of quantitative psychometrics and radical deduction. This is an important acknowledgement to make which embeds the current research within the context of mindfulness as a whole.

Brown, Ryan and Creswell (2007) stated that mindfulness could be classed as an innate trait and therefore could be improved but not explicitly generated through training and practice. As dispositional mindfulness is still a relatively new concept, the research in regards to this area is limited to say the least. Even within the context of mindfulness as a whole, its been said that a broad range of theoretical and methodological perspectives to illuminate this phenomenon are needed (Shapiro et al, 2006) therefore, the finding of potential differences in how professionals working within oncology qualitatively report their well-being should not be understated. As different perspectives of personal mindfulness were obtained, it was interesting that these different positions, potentially brought different opinions in reported well-being.

For the purpose of this study, it was important to let the participants dictate what was significant for them in relation to their well-being when working within oncology. The themes found are not dissimilar to those already found within oncology research. For example Guest et al, (2010) reported that in surgical oncologists work-life balance was a particular issue and balancing time between the two was particularly difficult. They suggested that working within oncology put particular strain on personal relationships at home. Patient relationships have long reported to be of vital importance to both the carer and the patient in facilitating well-being (Gupta et al, 2007; Roter, 2000), with the present research confirming those findings. Staff relationships have also been found to be important in relation to well-being at work, with increased feeling of a high support network producing a more positive affect, which has then been associated with less stress and decreased burnout (Kash et al, 2000). Finally, the environment of oncology has been repeatedly inferred as being inherently stressful and may affect both physical and mental health (Folkman & Lazarus,
1986), so how one responds to that environment is important, with mindfulness potentially reframing focus and attention producing greater reported well-being.

It has been acknowledged that some nurses can deal with stress effectively, while others do not (Maslach et al, 2001; Quattrin et al, 2006). There is a myriad of factors which may influence this, but particular attention has been paid to resilience (Ablett & Jones, 2007). Potentially, it could be said here that increased mindfulness may aid resilience to the stressful environment of working within oncology. Tugade and Frederickson (2004) state that resilience is the 'effective coping and adaption [when faced] with loss, hardship, or adversity' (p. 320). Masten (2001) suggested that everyone has the ability to develop resilience, but this thesis potentially may show that that capacity is inherent within all of us, to more or lesser degrees, which may impact day-to-day living.

The field of mindfulness studies is still in an early phase, despite the exponential increase of recent papers and interest from within the academic domain. Much of the research has concerned clinical trials and the efficacy of such, and much of which has been quite positive (Baer, 2003), but unfortunately has also been quite positivist. Different levels of dispositional mindfulness potentially evoked different responses in regards areas of working within oncology, in relation to well-being. Each of these areas will be discussed, and how the qualitative comments may embed themselves within the current literature, surrounding both mindfulness and oncology.
5.2. Working within Oncology

Experiencing stresses and strains are all part of working life, particularly within oncology. Therefore, individual coping mechanisms for stress have commonly been cited as being far more important and useful than the organisational strategies that may be offered (Pearlin & Schooler, 1978) as 'managers cannot probably eliminate all work-related stress. The strategies employees use to cope with their own stress, thus become more relevant' (Ashford, 1988, p. 30).

In regards to individualised coping mechanisms, particularly focusing on mindfulness, there did seem to be a clear distinction that participants who expressed more negative emotions such as 'anxiety' and 'depression' tended to have initially reported lower levels of mindfulness. The more mindful participants on the other hand, denied any negative affects at all. For instance, two participants claimed that they didn't get anxious or depressed, while a further participant even went on to state that they experienced the positive emotion of happiness; the only participant to do so. Interestingly, this is actually consistent with previous literature showing the effects of cultivated mindfulness in decreasing perceived levels of negative affectivity within the workplace, when assessed using quantitative measures (Ramel et al, 2004).

In terms of being in the workplace, a significant body of literature has been developed on the importance and benefits of increased positive mood and the decreased negative affective experiences of which that may bring (Isen, 1987; Losada, 1999; Miner et al, 2005). Cohn et al cited within Glomb et al, (2011) 'suggested that positive emotions enable individuals to build important cognitive, physical, and social resources such as resilience’ (p. 135) Davis (2009) wrote that,

The capacity to harness positive emotion in daily life may be a key ingredient to resilience, helping individuals to persevere in the face of challenge, speeding recovery from transient life difficulties, and sustaining quality of life in the face of more chronic stressors (p. 62).

The more mindful participants are perhaps more equipped to persevere with their negative emotions and through the paradoxical nature of mindfulness,
alleviate negativity, based on the data extrapolated from the interviews. With higher levels of mindfulness seemingly aiding one to remain positive in the face of stress, one may not experience the negative emotions as mentioned by the less mindful participants. This is of vital importance for a healthy perception of personal well-being at work.

The tentative inference of participants who reported higher levels of mindfulness perhaps reporting less emotional negativity does fall in line with theorists who have suggested that after a mindfulness training course, symptoms of anxiety and depression reduce, by modifying emotional regulation capability (Chambers et al, 2009). There is evidence that MBSR and long-term mindfulness meditation may directly influence cognitive control of negative rumination (Ramel et al. 2004), however, this present study may propose the idea that long-term meditation may not be required and some have the natural ability to already be flexible in their emotional responses, potentially producing positive outcomes, particularly in relation to how they qualitatively report their own well-being.

As already mentioned within this piece of research, working within oncology is highly stressful, which can impact the person situated within that context in numerous ways. In the 1970s Richard Lazarus attempted to elucidate the stress process. He determined that stress is how one interprets or evaluates – consciously or unconsciously – the importance of a harmful or threatening event. With this finding, the nature of stress shifted from the actual mechanical response to threat, to the individual’s interpretation of the event. Lazarus and Folkman (1984) stated that the key elements of the stress process were the individual’s interpretation of the threat and the individual’s perception of his or her ability to cope with it. With mindfulness being centred on the way one interprets internal and external stimulus, it seems appropriate that with Lazarus’ theory, mindfulness may be central in this stress process, producing the potential findings. That is, when levels of stress were reported by individuals, those who reported more stress during the interviews were those who initially reported a low level of mindfulness.

Stress reactions could continue months or even years, and with this being the case, unless stress relieving strategies are adopted, the person has no chance to recover and negative effects and consequences can arise. Acknowledging the biological model of stress, when stress continues for a long period of time, the
balance of the hormone cortisol shifts, which pushes the body into a higher working gear. This is supposed to be activated in certain situations, but when stress is prolonged, the body’s sensitivity to cortisol decreases and the inhibitory system does not function properly. When there is no inhibitory effect, the cortisol levels are constantly high and will become difficult to normalise, giving the feeling of constant being 'on edge" (04LM, 356). This may lead into other physiological processes such as the ones described by some of the participants in this study, like that of panic attacks and retinal eye occlusion. Stress and the salutary physiological effects cannot be disentangled and so it is interesting to consider how mindfulness may play a role within this. That is, the same participants who reported stress, also reported the aforementioned physiological affects. Delgado et al, (2010) reported that after an MBSR programme, there was a decrease in cardiac defence response from participants, as well as showing a significant reduction in the amount of health complaints. Again, one needs to consider the function of mindfulness and the potentiality of the awareness that it might bring in regards to knowing when one is stressed and when too much is just too much, as potentially demonstrated in the current thesis.

According to Olofsson et al, (2008) 'prolonged negative stress develops gradually but considerable time can pass before the individual is aware of it' (p. 352). Much like thought observation, it has been noted that mindfulness influences self-regulation through generating bodily awareness (Siegel, 2010). There is real evidence embedded within the results presented, based on the qualitative comments on different participants, that those who reported lower levels of mindfulness were the participants who stated that they unaware of things going on inside the body.

'Yeh, because obviously I wasn't aware of whatever was going on inside of me'

05LM (419-420)


An implication of this stress or negative affect, as well as the physiological responses is the mistakes that were made as a consequence. In an environment such as oncology, the consequences can be catastrophic. The
participants who mentioned making mistakes when they felt under pressure, did have lower levels of reported mindfulness. Previous literature, such as Dane (2011) found that decreased dispositional mindfulness lead to increased errors at work (e.g. forgetting, distraction, blunders). Interestingly, this was something that was not mentioned by the participants who reported themselves in having higher levels of mindfulness. There has been literature which has displayed an interaction between depressed mood states and memory showing that when one feels lower, memory decreases (Ellis & Ashbrook, 1989). When memory decreases, mistakes can be made and when one notices mistakes being made, it has the potential to develop into a feedback loop. With anticipatory anxiety developing because of the fear of making another mistake, when more anxiety develops, more mistakes are made (Firth-Cozens, 2003). Several participants potentially demonstrated this process of how negativity and stress can lead to more serious events.

Too much stress, can adversely affect mental and physical health (Schneiderman et al, 2005), so it is important to protect ourselves from this. Mindfulness based stress reduction, which does teach participants to observe thoughts, without acting on them with impulsivity has been shown as an efficacious tool for the reduction of stress (Baer et al, 2006; Kabat-Zinn, 1994). As previously mentioned, the participants who reported themselves to have higher levels of mindfulness mention not being stressed or 'affected' by work and with this willingness to expose and explain their non-reactivity, potentially show that the effects of mindfulness may be present when they were not trained and outcomes not being dictated by measures. This coincides with much of the quantitative literature, particularly Kobassa et al, (1982) who identified a constellation of attitudes, beliefs and behavioural tendencies called ‘hardiness’ which characterise people as more able to deal with stress and therefore less vulnerable to burnout. Furthermore, effects of negative mood states have been found to increase risk on everyday decision making increasing the potential for mistakes to be made (Hockey et al, 2000). The researchers also stated that fatigue played a significant part in this process as well.

Fatigue or tiredness was something that all participants mentioned and considered, when asked about their well-being at work. Considering previous research, if all felt tired then mistakes, anxiety and depression, could develop -
however, this was not the case. Potentially, looking at the theme as a whole, an interpretation could be that those participants who were more mindful could be more resilient to ‘tiredness’ and be able to fight off its psychological affects until the end of the day. That is, they were tired, but seemingly it did not affect them. The participants who got tired but then began to suffer and reported negativity, were those where also had a less mindful perspective about themselves. In a study completed by Surawy et al, (2005) after a meditation exercise, participants showed improvements in subjective levels of fatigue. Reiterating the importance of this, Riedel and Lichstein (2000) found that increased tiredness can be related to a number of risk factors for poor health outcomes as well.

Considering the findings presented, there seems to be a domino-effect like process of negative affective states, with one facet of well-being, for example stress, influencing another, like that of anxiety or depression. Anxiety, particularly within this study can lead onto mistakes and potentially decrease performance. These cannot be discretely separated and if a professional working within oncology experiences one, it might seem as though they are potentially more likely to experience the other. If increased dispositional mindfulness can stop this process, before it starts, then the consequences of low mood and negativity does not seem to come to fruition, as seemingly demonstrated by those participants who initially reported higher levels of mindfulness.
5.3. Dealing with Patients

The patient-carer relationship has consistently been cited as bringing great satisfaction to both the patient and the carer (Utriainen & Kyngas, 2009). Coinciding with this, participants in the current research mentioned great enjoyment in the communicative process of dealing with patients, regardless of their personalised perspective of mindfulness. In fact, according to previous studies, patient care is the most important factor when considering job satisfaction (McNesse-Smith, 1999). Perry (2005) stated that the patients of those clinicians, who believe they are giving high quality care and have a strong connection to their patients, are more satisfied with their careers. It has also been found that better perceived patient interactions by the carer, promote a greater sense of well-being within the carer (Grunfield et al. 2005; Meier et al. 2001). It is understandable, however paradoxical, that these relationships also cause great distress as well; namely due to the deterioration or death of the patients they were caring for. It is indeed a high risk, high reward payout.

The break up of these patient relationships has commonly been found to be a major contribution to the negative well-being of professionals working within oncology (Redinbaugh et al. 2003). Interestingly, within this study there seemed to be a range between not being affected at all by the death of the patient, to being severely traumatised by the process.

To mediate emotional responses, several participants expressed some form of 'clinical-ness' to not get too close to the patient, to protect themselves. Understandably, clinicians need to continually negotiate closeness with their patients; not getting too attached but not becoming too detached either (Wolpin et al. 2005). Wolpin et al completed a focus group with oncologists to assess their interactions with patients and how they managed the fine balance of personal and professional investment. One mentioned

If I get too close to my patients and allow myself to become emotionally entangled in their suffering... I risk becoming paralyzed in grief. But I don't allow my patients agony to hurt me at all...' (p. 454).

This is very similar to what was mentioned by the participants in the present study, for example, participant 01HM stating
'I can't take on board because I'd never be able to do my job otherwise. If I got completely wrapped up in the patients, I'd never be able to do my job, I'd be a complete and utter wreck'. 01HM (98-100)

The closeness of the patient-professional relationship has been linked with the intensity of emotional impact that a patient's death has on the clinician (Field, 1998). That is, the closer someone is to a patient when they die, the greater affect is has on their well-being. There is a fine line between not wanting to be too involved with the patient to avoid any negative consequences from the deterioration of the relationship, to being involved enough to generate a sense of satisfaction or enjoyment from that interaction.

In the process of the reciprocal interaction between closeness and distance, the level of mindfulness may play an integral part. As previously mentioned, to varying degrees, several participants mentioned the idea of not getting too close to the patient and it having to be that way in order to protect them emotionally. Upon further analysis, the participants who seemed to manage and report to deal with this tension quite easily, were also the participants with reported higher levels of mindfulness. Participants who seemed to have much more difficulty in the constant balancing act in relation to the depth of the relationship, were actually those who could be considered to have a lower self-evaluation of mindfulness. By definition, mindfulness is about forming a sense of compassionate introspection, where one is able to be aware and be in tune when the relationship is becoming too close. If you consider the attention aspect of mindfulness it '...refers to the use of flexible, voluntary and functional attentional processes that allow contact with aspects of the internal and external...' (Fletcher at al. 2010, p. 50). With one being aware of oneself and indeed the other, the carer may then be more flexible in their positioning within that relationship. The analysis may suggest something of this process, demonstrating mindfulness in action.

The ability to manage patient interactions is to protect oneself from compassion fatigue or emotional labour. Compassion fatigue is the emotional affect of being indirectly traumatised by helping those who experience primary traumatic stress (Figley, 2002). In a study completed in Brazil, oncology nurses
commented that one of their highest stressors was watching suffering and being unable to help (de Carvalho et al, 2005), and ultimately feeling out of control of the situation. Mindfulness has been found to aid the person to feel in control in these aforementioned out of control situations (Langer et al, 1984), which plays a prominent role in individual coping resources (Moos & Billings, 1982). People with feelings of high-efficacy, for example, are thought to be more active and persistent in their ability and efforts to handle threatening situations, like that of a death of a patient (Moos & Billings, 1982).

With this give and take of the patient-carer relationship, it was interesting to see how much impact this had on the ability to still cultivate a meaningful relationship, perhaps characterised by listening or empathy. The participants who stated being able to listen and understand what the patient was going through, were actually higher on the mindfulness spectrum. Conversely, participants who stated that they couldn't listen to others were on the lower end of that spectrum. Even though this is a tentative inference, this position does agree with previous research conducted by Shapiro et al, (1998). That is after a MBSR training course there was inadvertently an increase of scores on empathy. The idea that one considers oneself to be able to listen and be more empathic can in itself reduce the patients suffering as it aids the patient to psychologically adjust to the diagnosis, increasing their quality of life (Butow et al. 1998; Morris & Royle, 1988).

Empathy is one of the core conditions as mentioned by Carl Rogers (1963) and it is interesting to consider that even though the participants coming from a more mindful perspective who may actually be actively distancing oneself from a patient, they are still displaying one of the core features of a successful relationship. This may facilitate the patient to open up more and in turn, give the care giver a greater sense of worth while and enjoyment. The depth of the connection with the patient is an important thing to consider as healthy relationships with patients and a strong, deep human connection, seem to have an impact on job satisfaction (Perry, 2005). According to Perry (2005), the deep connection with a patient comes true by affirming the value of the person; instilling hope and helping them find meaning in their life in light of their experience with illness. In turn, Kim et al, (2004) found that increased physician empathy improved patient outcomes in relation to satisfaction and compliance in
medication, which then gives the carer a sense of worthwhile and accomplishment. When trained in mindfulness, it has also been shown to increase empathy levels (Dobkin & Hutchinson, 2013). However, it is worth considering the interesting notion of increased dispositional mindfulness also displaying this and impacting how a person reacts within and describes their inter-personal relationships, as characterised by potential inferences explained.

Looking at the data of the patient relationship as a whole, the participants who were most impacted by the deterioration of the relationship, was those again, who were on the lower end of the mindfulness spectrum, which they reported at the sampling stage of the study. This is consistent with studies in which mindfulness has been cultivated in health care professionals and those in training (Christopher et al. 2006; Shapiro et al. 2005; Shapiro et al. 2007), showing that even though mindfulness was not explicitly taught, it still may have a salient impact on the person in how they qualitatively report their well-being.

Mindfulness requires one to be in touch with the emotion that one might be feeling and it could be that the 'more articulate exploration of the issues inherent in palliative oncology leads to a better adjustment through traumatic experiences' (Wolpin et al. 2005, p. 455). When considering the process of forming, maintaining and ending of a relationship, the participants who described finding it difficult to listen to patients and then being impacted when something happens to the patient *deleted sentence*, were the participants with a lower level of mindfulness. Those participants who described the process quite easily, were of the perception that they were more mindful. It is worth considering this process and what it is perhaps about that individual that acts as a buffer to protect the professional when something traumatic, like a death happens. Potentially, the levels of mindfulness is an interesting inference and is consistent with other research in regards to being able to receptively process a variety of traumatic experiences (Arch & Craske, 2006; Eifert & Hefner, 2003).

The finding in this theme is surprising and is actually opposite to what one might expect and what has been found previously. In a recent large study of NHS staff based within the UK, Wall et al. (1997) found that staff working directly with patients were actually encountered stresses to a more intense level, in terms of work load and repeated exposure to the emotional and psychological needs of the patient, compared to other professionals. Conversely, within this
thesis nurses, who reported to have high levels of mindfulness, were those least affected, as apposed to the receptionists and pharmacist with self-reported, perceived lower levels of mindfulness. It is worth noting again that this is a relatively small sample and this may be an area of future research, which shall be discussed further in 'future research 6.6'. Increased dispositional mindfulness however, needs to be considered in this process as those who got least upset, conversely had more contact with patients. The participants who did not get upset are perhaps in the minority rather than the majority, as it is easier to be less mindful than it is to be more mindful (Carlson et al, 2007).

One cannot discount the roles and job titles in which the different participants adopt and what is actually required of them, however. For example, the more mindful participants dealt with patients more often and the less mindful participants dealt with more clerical and organisational issues. This finding could be conceptualised in different ways, including the potentiality that because nurses are trained to deal with patients, they naturally build up this level of mindfulness, characterised by awareness. with differing roles require differing skills. This can be explained eloquently by Glomb et al (2011),

For example, jobs with hefty interpersonal interactions, we might expect empathy to play a major role. For occupations with high emotional content, we might expect decreased rumination, and improved affective regulation to be the critical pathways of performance. For jobs that a routinized and have high task complexity, response flexibility may be key. Although some processes (e.g., increased self-determination and persistence) can be expected to beneficially affect many job types, we believe that the role of mindfulness in performance largely depends on the task and the contextual features of the work (p. 142).

Even though both participants enjoyed the interaction of the patient relationship and did seem to increase well-being, the ability to deal with emotions after a traumatic event may be to do with the consistency of which they experience them. Potentially, even though most participants expressed a need to be ‘clinical’, because the nurses need to utilise this process more, they have become better at it.
5.4. Working with and communicating with staff

Staff relationships were an important theme as feeling part of a team has been found to promote a greater sense of belonging. Gersick et al. (2000) characterised this by saying,

To join a profession is to join a community of people. Much more than meeting rooms and offices where we work, our relationships with individuals and groups constitute the environment in which we live our professional lives. Such environments can be nurturant sources of learning, inspiration, and enjoyment, or they can be destructive sources of frustration and injury. They send us powerful messages about who we are and how we are valued. They shape our expectations of what our careers should be, or ought to be (p. 1026).

A fundamental finding of social psychology is that individuals thrive through social connections with others (Baumeister & Leary, 1995). The literature surrounding work place relationships is quite extensive, showing that close colleagues build up resources to help protect individuals from work place stressors, foster communication, generate creativity and promote citizenship behaviours (Dutton & Heaphy, 2003; Thau, Aquino & Poortvliet, 2007). Within the nursing field, it is the one process that nurses engage in that has been associated with job satisfaction and indeed well-being (Blegen, 1993). With this being the case it seems to make sense how a theme manifested itself in regards to how professionals talk about their well-being, as colleagues can take a lot from these dynamic relationships. It seems some participants potentially have more solid relationships with colleagues at work and find it easier to share with each other what they are going through. One can only infer the role of mindfulness in this process, in that those who reported being able to communicate openly, seemingly reported higher levels of mindfulness. The concept of lack of social support has also been linked to the idea of increased stress (Olofsson et al, 2003). Therefore, one cannot but help to view themes as a whole rather than distinct facets as they all may be interlinked.

Stasser and Titus (1985) have contended that once information is shared, it is more likely that the sharing will be repeated. The results seem to suggest that
perhaps the participants who are more able 'let go' and be more willing to expose themselves and trust others are those who reported themselves to be having higher levels of mindfulness. In fact, trust and mindfulness can very rarely be separated in that trust is necessary for mindfulness and mindfulness is necessary for trust (Hoy et al. 2006). It could be noted that when looking at some of the comments by other participants, words like 'isolation' were mentioned, as opposed to other members of staff who reported a strong bond between themselves and colleagues. In relation to mindfulness theory, there have been several studies, which have shown that after training, mindfulness produced greater reported satisfaction of relationships (Barnes et al, 2007). Mindfulness has been positively associated with the ability express oneself in various situations (Dekeyser et al, 2008) increasing well-being. It is interesting to consider then, the participants who mentioned perhaps having difficulty in forming relationships were also the participants who reported more negative affect.

Isolation could cause a number of detrimental effects including feeling as though a decision is made on ones own and increasing stress levels. Drawing upon organisational literature and the seminal text by Isabel Menzies (1960) about nursing anxieties, she stated that

…individuals spend much time in private rumination over decisions and actions... The practice of checking and counter-checking is applied not only to situations where mistakes may have serious consequences, such as in giving dangerous drugs but to many situations where the implications of the decision are of only the slightest consequence... (p. 104).

It has already been discussed how the threat of making a mistake might affect the person, but Menzies (1960) goes onto suggest that if one can't communicate and get help from others, the stress and anxiety will maintain rather than decrease. Fundamentally, without these relationships and trust, the person may find it difficult to complete this checking procedure with others, therefore continuing their negative rumination. This can obviously affect the person and how they perceive their own psychological well-being.
It is worth considering how the concept of mindfulness has influenced staff relationships and potentially the ability to voice one’s own concerns, emotions and thoughts on different situations.

It is at this intersection of unconscious goals or plans and habituated responding that the interplay of mindfulness is illuminated. If particular plans and schemata are activated in an overlearned or automated fashion, it is possible for them to become routinized that they escape periodic revaluation of their effectiveness and so become mindless response patterns (Burgoon et al, 2000, p. 109).

Mindfulness on the other hand is the act of scrutiny and refinement on the basis of experiences and the ability to break set (Langer, 1989). Brown and Ryan (2003, 2004) showed (quantitatively) that increased mindfulness was positively related to openness, relatedness and interpersonal closeness. Particularly from the comments of some of the participants, a similar process may be happening at present. This is an interesting finding, as all previous studies in regards to mindfulness and social relationships have been measured after a MBSR training program, like that of Shapiro and Schwartz (1999) citing an enhancement in interpersonal behaviours. Within those programs new behaviours were taught and adapted, influencing future interactions (Kabat-Zinn, 1990, 1994) and therefore putting into doubt whether it is mindfulness influencing change. This finding shows that there is real scope, that by using qualitative means, mindfulness as a trait may both promote and facilitate stronger relationships within the workplace, at least with this particular sample.

Finally, there was a notion of recognition making the participant feel good in relation to well-being. Khan’s (1990) conceptualisation of well-being stated that people are more cognitively and emotionally engaged when basic human needs are met. One of those needs is to form relationships with others. The results within this thesis seem to indicate a similar process in when one feels included, well-being increases. ‘Moreover, employees who tend to experience more positive moods are more sensitive to the reward signals of the environment such as pay rises and other forms of recognition’ (Glomb et al, 2011 p. 135). If mindfulness may be able to generate closer relationships with members of staff,
then one is in a position to feel wanted, needed and supported. This potentially could be inferred in the present thesis as those who felt 'supported' reported higher levels of mindfulness whereas participants with lower level mindfulness potentially stated the opposite. Harter et al, (2003) concluded that with stronger relationships, staff have the opportunity to discuss progress and receive feedback, which can build intellectual resources and facilitating resilience at work.
5.5. Role Change

Work-life balance is essential for stable general well-being within both contexts (Greenhaus et al, 2003). Several participants within the study mentioned an inability to ‘switch off’ and found themselves constantly thinking about work at home. One participant even mentioned waking up with panic attacks in the dead of night and whenever the phone rang; it would be work telling her she had done something wrong. A similar concept mentioned by a participant in another study completed by Khong (2011), with a woman who had just returned from sick leave due to stress said that she was constantly on ‘speed dial’. *deleted sentence* Opening up the data further, those who described a difficulty in switching off, were those who reported lower mindfulness levels as opposed to those who found it easier were potentially reported to be more mindful.

This personality ‘split’ between personal time and work time, seems skewed towards work time within some participants more than others. Therefore there is a potential that some participants may seem more stressed than others, as they seem to always be in a heightened state of hyper vigilance - they never come down. They find it hard to not think about work when outside of work itself and perhaps come ‘home for their hours of leisure and dreaming of their pensions’ (Burkitt. 2005, p. 96)

The transition from work to home was punctuated by comments of the ease of adopting and assuming different roles and positions. Two participants mentioned the ease of which they can transition from being the nurse to the mother, potentially with the help of their uniform. With consideration to Marks and MacDermid (1996), they define work-life balance as,

The tendency to become fully engaged in the performance of every role in one's total role system, to approach every typical role and role partner with an attitude of attentiveness and care. Put differently, it is the practice of that even-handed alertness known sometimes as mindfulness (p. 421).

The current findings, reflect this process, in that the attention to roles is not evenly distributed and more focus is given to one than the other. Potentially, for the less mindful participants, because of the already explained perception of
increased stress, their attention is focused more on the job than at home, causing distress in both areas and ultimately decreasing well-being.

Kofodimos (1993) suggested that imbalance - particularly work imbalance - arouses high levels of stress that can detract from positive well-being. Marks and MacDermid (1996) continue that balanced individuals, that is, individuals who give equal time to both home and work life experience less role overload, greater role ease and less depression than those who may be considered less balanced. It is the concept of role conflict that was brought to the fore within this theme and being all things to all people which induced conflict. One participant stated that her partner gets angry with her when trying to talk about work when she goes home. A healthy balance has been known to reduce family conflict and stress, which all contribute to and detract from well-being (Frone et al, 1992).

This general theme could be re-framed as boundary management, where one exits and enters roles on a micro basis (Schein, 1971). It is suggested that micro-transitions are based on everyday role transitions and macro-transitions are larger and more infrequent changes. Ashforth et al, (2000) commented that work-home transition is one of these major micro-transitions. According to what can loosely be described as 'boundary theory' (Michaelsen & Johnson, 1997), individuals create and maintain boundaries as a means of ordering and simplifying the environment. These 'mental fences' (Zerubavel, 1991) are erected around different events and occasions. Mindfulness needs to be taken into consideration in relation to how easily these metaphorical fences can be constructed. For example, with a more secure mental fence, the more mindful participants seemed more able to adopt different role identities, when referring to the levels of perspective mindfulness of the participants in which the comments came from.

The participants within this study all mentioned a need to be 'clinical' to remain detached from patients, however, this is different to what they might be expected to be at home, with Greenhaus and Beutell (1985) noting that the persons family may expect them 'to be warm, nurturant, emotional and vulnerable in his or her interactions with them' (p. 82). If participants who could be described as more mindful within this research can adopt these different roles easily, perhaps it is the increase in cognitive flexibility that mindfulness has been
shown to provide (Moore & Malinowski, 2009). Cognitive flexibility can be defined as the human ability to adapt cognitive processing to face new and changing conditions, which is intrinsically linked to attentional processing (Canas et al, 2003). As mindfulness is dependent on (re-)investment of attention on a moment to moment basis then mindfulness should lead onto this cognitive flexibility, reinforcing the potential inferences found within this thesis.

As working within oncology is a particularly stressful field of medicine, it may be difficult for the members of staff to wind down without any sort of personal coping or protective implement. Utilising statements from other themes, certain participants reported more stress than others, therefore potentially, to reach 'normal' baseline levels of emotion, it takes longer than those who reported less stress, therefore encroaching on personal time at home. That is, when referring to quotes embedded within the thesis, those who express a disengagement with work more readily, were found to have higher levels of self-reported mindfulness. As mindfulness’ processes involve attention on awareness, it has been shown in previous studies that after training the time taken to disengage from emotionally upsetting pictures, is quicker than those who did not undertake the training (Ortner et al, 2007). Participants mention something of working creeping into their head when they are at home and not switching off, particularly those who reported lower mindfulness for example,

'I can't switch off; I'm one of those people. I don't even switch off when I get home, when, you know, which annoys my husband...' 04LM (182-183)

Mindfulness has been associated with increased concentrative capacity and through awareness and acceptance to the present moment, individuals are more able to develop a range of adaptive coping skills (Shapiro et al, 2006). Research completed by Dane (2011) who stated that when individuals pay more attention to the role at hand, they become more effective within that area. This is not to say that some participants are more or less effective within their roles in the hospital than others, but not being attentive or fully 'present' in certain roles, as demonstrated within this thesis can have detrimental consequences.

To comment further on this theme in relation to the psychological literature, I feel that further research needs to be conducted within this area. It
does however, potentially concur with quantitative research completed by Allen and Kiburz (2012), who found that increased trait mindfulness had a potential indication of a healthier self-reported work-life balance indicated by effectiveness and satisfaction within each role.
5.6. Your own worst enemy

An initial concept within this theme was the way participants personally situated themselves within the environment, that is, how much pressure they put on themselves to do work and how this affected well-being. Several participants mentioned feeling as though they had to work through breaks but actually became drained and exhausted in the process. Interestingly, when analysing where these comments came from, it was the lower level mindfulness participants that mentioned this concept. An interesting dynamic was found between the need to do a lot of work and the potential detrimental effects this had on stated well-being. Some mentioned the idea of 'not being able to stop' and giving oneself more and more work to do. Interestingly, this could be linked to some nursing literature on 'exertion' (Lief, 1985) and how much we feel as though we need to do. Lief mentions,

It is not the blind exertion of a worm digging though a tunnel, nor is it the compulsive speediness that comes from trying to confirm that we are hard-working. It is a steadiness of energy, like the gait of an elephant. The elephant moves along imperturbably, while covering great distances. True exertion is also necessarily far-seeing. When we are narrowly focused, we find ourselves working harder and harder until we burn out (p. 16)

Put crudely, to be 'mindless' is to be the worm and mindful is to be the elephant. It is an interesting potential inference that, those who work hard, without giving themselves breaks are those who perhaps reported their mindfulness as quite low. Research has suggested that breaks can provide the necessary antidote from busy schedules, mitigate the negative effects stress can have on work judgements and improve working relationships (Kim & Wright, 2007; Prizzia & Helfand, 2004). As a participant mentioned, who expressed an opposite thought to others in that she reported having the ability to 'step back' and allow herself to take a break, while another stated it being 'ridiculous' to work longer than necessary. Interestingly, these participants are also high on the self reported mindfulness spectrum. As Jett and George (2003) stated
Additional research has addressed the importance of recreation, idle time, or periods of non-taxing work in maintaining emotional well-being, job satisfaction and high levels of work performance in the long run (p. 499).

This finding of self-imposed work also relates to the finding by Butterworth et al. (1999), who found that stress is highest in those who show the greatest levels of commitment. In addition, mindfulness has been seen to control autonomous regulation (Weinstein & Ryan, 2011). When individuals have more information on their own internal narrative, with more awareness, behaviour can be more autonomous because they can openly consider their own needs and values (Ryan, 1995). This could be related to the more mindful participants feeling more able to take a step back than those who are perhaps less mindful imposing a lot of work onto themselves. As Weinstein and Ryan (2011) continue,

Rather than imposing judgments on their own desires, they accept those judgments as they are, and can therefore pursue their own interests and values as they appear, without imposing personal contingencies and expectations on them. When one is mindful of the present, one can more reflectively follow important and currently interesting pursuits, making decisions with sensitivity to one’s present needs and desires (p. 11).

It is interesting to note that on a number of occasions literature has stated that workload is a major contribution to stress when working within oncology (de Carvalho et al, 2005; Maytum et al, 2004), but the current findings reflect how much work individuals put on themselves with the tentative concept of personal triggers of stress. As the sub-heading suggests, we can be our own worst enemy. As demonstrated however, not everyone wanted to work though breaks and work overtime and again, mindfulness potentially needs to be considered in the role of over involvement with the professional duties of working within oncology.

The majority of participants mentioned that it was busy, which was not unexpected. It is not unusual that employees want and strive for variance to break up the potential monotony of day to day life. This can be related to the
philosophical theory of French Marxist, Lucien Seve (1978) who wrote about the personality of individuals living in a capitalist society. From his Marxist position, he stated that personality is made up of the activity one engages in and thus a personality can be split into factors of time. Most people’s lives can be split up into two categories; those are firstly activities which are of a personal interest – usually ‘free’ time – and secondly, the time which is spent doing things for others. Time is split up unevenly between the two categories, with the latter time normally being time given up to an employer.

For Seve, there is a limiting or an exploitative nature of capitalist culture in that too much time is spent under the control of others, doing what they want rather than what you want. Seve also split time in a person’s personality between learning new activities – which would be the most rewarding, and varied, to time being spent on monotonous tasks that have already been learnt. ‘Although Seve never says this explicitly, his writings conjure up a world in which work is regular and routine, with the carving out of biographical time monotonously predictable’ (Burkitt, 2005, p. 96). The assumption here is that most of the time, people spend time doing boring tasks, because they have to rather than because they want to. Perhaps the results presented suggest something similar in regards to several participants inferring that they like to do lots of different things at once, perhaps to disrupt this capitalist monotony by keeping things interesting and not boring as boredom has been linked to decreased well-being.

There does however, appear to be a difference in the way one reacts to the busy, ever changing environment. Several participants mentioned either the 'satisfaction' or 'enjoyment' that being busy gave them and ‘thriving’ in a stress like environment. The environment is the same for everyone, so how one describes that environment is telling of how they appraise and interpret it. Stress appraisals concern the cognitive processes or how one interprets or evaluates a situation. As mentioned already within this thesis, events can be interpreted as good, bad, or neutral, positive or negative, or as involving challenge, or threat, harm or loss. As Weinstein et al, (2009) mention,

Individuals often appraise a situation in a way that alters the emotional significance or meaning, either by changing their view of the situation or their perceived capacity to manage the demands that it presents (p. 375).
These findings potentially concur with previous findings of how higher levels of mindfulness impact the quality of attention deployed to the existing environment. If the busy environment is the same, then mindfulness may 'turn down' the negative appraisal of events. For example with the more mindful participants seemingly mentioning the enjoyment of the busy environment, they potentially positively appraise it, which results in them behaving differently. With other participants, they appraise it as 'stressful' and negatively, therefore acting in accordance with this concept. In agreement with Weinstein et al, (2009), '...mindfulness may enhance mental health and well-being [with] a reduced tendency to perceive situations in stress inducing ways' (p. 375).

The response to the stressful environment is an important one to consider as participants mentioned engagement and satisfaction with the varying environment to varying degrees. Potentially, within this research, there were two ways of coping, either active engagement or avoidant coping. Upon further inspection, those who described increased engagement were of higher level mindfulness, and those who described the environment as all being a bit much, were of lower level mindfulness. Approach coping (direct action to deal with stressful environment) is perhaps considered more adaptive than disengaging with the environment and situation. Citing Schontz (1975), he believed that these positive strategies are believed to assimilate and transcend stress in a way which is ultimately beneficial to well-being.

On a lighter note, it was interesting to see that even though stressors were mentioned, particularly within participants who described low levels of mindfulness, all participants mentioned how much they enjoyed working within oncology. This is at odds to previous literature stating that health care workers are deriving less pleasure from their jobs (Landon et al, 2003; Zuger, 2004). It is paradoxical that some participants mentioned how stressed and upsetting they found their job but still stated that they enjoyed what they did. This could be potentially linked to Grunfield et al's (2005) study, in which they found that out of 122 oncologists 58% reported a high level of overall job satisfaction, but yet 53% indicated high emotional exhaustion verging on burnout. One cannot help to consider the role mindfulness or lack thereof in this inferred conclusion. Perhaps the least mindful participants are just unaware of the paradox of the enjoyment of their job and the stress of which it brings.
Within all themes found, mindfulness seemed to be a factor in consideration to how well-being was experienced, perceived and maintained by professionals working within oncology. That is, those who initially reported low levels of mindfulness, seemingly, based on the interview and analysis, reported their well-being as low too. Interestingly, it seems to concur with much of the literature in relation to mindfulness as a cultivated component of the consciousness, although in the present study, what it impacted was dictated by the participants themselves and not the researcher.
6. Conclusion

6.1. Introduction

This thesis set out to explore the reported well-being of professionals working within oncology, who had different perspectives on their own levels of mindfulness. In this concluding chapter, I summarise the purpose of the study and discuss the findings and key issues that arose from them. Moreover, the studies limitations, contributions to the mindfulness, oncology and implications for Counselling Psychology are also explored. Finally, I conclude with future research, which may help to develop this research area further and how the research has impacted myself.
6.2. Purpose of Study

The research undertaken was to answer the question of 'how do professionals with different perspectives on their own levels of mindfulness working within oncology, report their well-being at work?'

There have been numerous pieces of research on mindfulness and its affects in different areas after a training programme, but very little in regards to it as a naturally occurring disposition. Coming from the humanistic background of what I believe it is to be a Counselling Psychologist, it was apparent that a lot of research in regards to well-being has been quantitative and linear, which has then been associated with mindfulness after forced cultivation. The focus was to hear what professionals working within oncology stated about their well-being, reflecting the naturalistic environment in which we all exist in, therefore researching the person rather than researching what has been done to them.

I chose the area of oncology because of personal experience as well as being known to be a particularly stressful area of medicine. Much attention being given to the patients, but very little to the staff themselves (Lyckholm, 2001).

Semi-structured interviews were used to guide the participant in talking about their personal experiences of work. Thematic analysis was used to analyse the data where several themes emerged. These were well-being in relation to; impact of working in oncology, patient relationships, staff relationships, transition from work to home and environmental responses. Presenting these findings, differences were found in how well-being was reported by each participant. It was interesting to consider that the participants who expressed different views of their levels of mindfulness, also had differing views on their own well-being. That is, potentially those who initially reported lower levels of mindfulness, reported a more negative view of well-being.
6.3. Main Insights from Findings and Literature

In exploring the reported well-being of professionals working within oncology, five themes were generated. These were, impact of working within oncology; which indicated emotions and personal consequences of working within oncology. Patient relationships; the ability to cultivate and maintain a safe but close distance to the patient. Staff relationships; the ability to communicate and feel supported by other members of the team. Transition from work to home; the ability to adopt different roles easily without any being compromised. Lastly, environmental responses; how one reacts to and describes the environment and the personal drive one has within it.

6.3a Impact of Working within Oncology

Within this theme it was inferred that those who reported more instances of physiological problems also reported higher levels of expressed stress and more overall negativity mentioning 'anxiety' and 'depression'. This is consistent with psychological literature on health and well-being in oncologists, showing that there are incidences of these factors (Barni et al, 1996). Those participants however, who refuted feeling depressed or anxious actually had the perspective that they were more mindful. Ramel et al, (2004) concluded that after a MBSR programme, participants experienced less stress within the work place, which perhaps coincides with the findings presently. This increased level of stress was also linked to making more mistakes in their work, which potentially increased anticipatory anxiety for fear of making a mistake because of the high consequences it may bring.

6.3b Patient Relationships

'Patient care, especially high-quality patient care is a major factor generating job satisfaction' (Utriainen & Kyngas, 2009, p. 1006). It was not unexpected to find this theme within the corpus of data because the majority of time within a helping environment is spent helping or looking after patients. All participants mentioned that patient interaction gave them great enjoyment.

Developing a close relationship with patients is important, as it has been found both to improve patient quality of life (Butow et al, 1998) and, as already mentioned, increases satisfaction with the job (Perry, 2005). The process of
developing a close enough relationship to reap the benefits of the interaction, but keeping a safe distance as not to get too involved in the relationship to be personally affected when a patient deteriorates is seemingly important. It was inferred that those participants who reported that they were more able to keep themselves at a safe distance and protect themselves from the negative affects of patient deterioration were more mindful than those participants who described getting very upset. This break up of relationships has been found in the past to have upsetting consequences for the carer (Redinbaugh et al. 2003). One may potentially be more able to tune with their own emotions as increased mindfulness involves being alert and open to internal processes. The 'more articulate exploration of the issues inherent in palliative oncology leads to a better adjustment through traumatic experiences' (Wolpin et al, 2005, p. 455).

6.3c Staff Relationships

A fundamental finding of social psychology is that individuals thrive through social connections with others (Baumeister & Leary, 1995). When one is able to form relationships and communicate with other members of staff, well-being has been known to increase (Blegen, 1993). Decreased social support has also been linked to increased stress (Olloffson et al, 2003). Through the findings it was observed that there were different views in relation to forming relationships with other members of staff. Drawing upon the psychological literature, sharing and communicating emotions can only be seen as positive. Mindfulness was discussed in terms of trust and openness, in regards to one cannot be trustworthy without being mindful (Hoy et al, 2006). It was noted that the more mindfulness participants seemed more able to form relationships it may make one more trusting of others to receive the benefits of staff relationships, including feel supported.

6.3d Transition from Work to Home

Transition from work to home was discussed in relation to the constant changing of roles and how easy it is for one to be able to switch from the nurse for example, to the mum. In the past, mindfulness has been associated with increased concentrative capacity and attentional control in different contexts (Brown et al, 2007). It was inferred the participants who were able to maintain a
balance between the different roles they adopt, were actually those participants who also expressed higher levels of mindfulness. 'Boundary theory' (Michaelsen & Johnson, 1997) was introduced and the concept of mental fences.

6.3e Environmental Responses

Within the final theme, how participants reacted to the environment and how they personally situated themselves within that environment was discussed. Self imposed work seemed to be a significant factor for some participants, in that they reported giving themselves more to do, not giving themselves any breaks and cited coming in early. Other participants stated the opposite and found it 'ridiculous'. This was discussed in relation to mindfulness and the autonomous nature of such, in considering their own values and needs (Ryan, 1995). Workload is a major contribution to stress when working within oncology (de Carvalho et al, 2005) which was discussed in reference to perceived exertion.

In regards to the environment, all participants remarked on the busyness of the environment, however, individuals reacted to the busyness in different ways. Potentially, again, this was looked at through the lens of mindfulness when exploring who said what within the data. Therefore, in agreement with Weinstein et al, (2009), '...mindfulness may enhance mental health and well-being [with] a reduced tendency to perceive situations in stress inducing ways' (p. 375).
6.4. Summary of the key implications of the thesis

Summarising the main significant points that came from the current thesis, the following key implications can be identified:

- Mindfulness may not need to be trained in order for it to be of use and of significance in a particular environment.
- Paying attention to relationships, both with patients and with other members of staff is important.
- Having a good work-life balance is important.
- Mindfulness may play an important part in helping oncology staff to cope with their work more effectively.

This research may show that people have the strength and capacity to grow and develop in certain environments. As humans, we show great resilience, characterised by mindfulness, to stressful events and traumatic incidents and this research shows that it is not necessarily what one does, but it is how one is, which is most significant.

Before further implications are discussed, it is appropriate to note that as is the nature of qualitative research, tentative conclusions and ideas can only be inferred for the sample questioned at that particular time. Further generalisations are hard to make, but possibilities and ideas can be suggested.

6.4a What does this mean for mindfulness?

This seems to be the first piece of research that has assessed mindfulness in a naturalistic setting and has provided some interesting insights into how this may affect a person, when situated within the real world. The most significant finding is when participants are allowed to talk about well-being in relation to their own experiences, values and constructs, mindfulness may play a part within this process. That is, there were differences in reported well-being by each of the participants, which seemed to be to coincide with the reported mindfulness of those participants. Qualitative research is dictated by the data generated from the participant and therefore provides a more complex and comprehensive insight.
into the phenomena being studied by providing results situated within context, which quantitative data may be lacking (Barbour, 2001).

Interest in the underpinnings and enhancement of well-being has been growing in recent years (e.g. Ryan & Deci, 2001), and it is hoped that the present research invigorates this trend as this study may show that in a naturalistic setting, mindfulness may have a part to play in maintaining and encouraging mental health. The present research compliments studies, like that of Brown and Ryan (2003) suggesting that as well as in quantitative methodology, mindfulness may translate to a qualitative framework, particularly within the area of oncology. When looking at the results as a whole, there is a potential inference to be made of lower mindful participants implementing less acceptance and openness than the higher mindful participants, characterised by increased reactivity, decreased effectiveness of different roles and potentially less close relationships both with staff and patients, as described by the participants.

This thesis may contribute to the support of using mindfulness based interventions to improve well-being. As no training was conducted within this piece of research, mindfulness was inferred in its un-fabricated form, meaning mindfulness potentially had an effect in its purest form in how one perceives and reports themselves and the world around them. Even though there are doubts if mindfulness training programmes actually teach mindfulness (and of course if it is in fact mindfulness at play within the current study - which shall be put forward in the limitations section) mindfulness training should be encouraged because of the potential effectiveness it may have. Such training might strengthen what is already there, increasing well-being amongst people experiencing stressful conditions, alleviating negative psychological and physiological consequences.

### 6.4b What does this mean for oncology?

This present finding could have several implications for the field of oncology. Firstly, as mentioned, this research does have the potential to infer that in regards to the experience of well-being there are varying views, from different perspectives of mindfulness. This decreased reactivity has shown previously, to be as a result of mindfulness and being more open to expose oneself to these potentially damaging events (Weinstein et al, 2009). Therefore, potentially the
assessment of mindfulness, could act as a potential predictor of future stress and burn out. As Hopkinson et al, (2005) mention, finding effective strategies to prevent burnout will improve success of nursing retention.

Secondly, if these professionals were encouraged to be reflective on their own practice and consider their own attitudes one may be able to consider how they are working and what potentially they need to do differently. Drawing upon literature from paediatric oncology settings, Hinds et al, (1994) assert that graduates who had a wider range of coping strategies were least likely to resign within the first twelve months of starting work.

A significant part of the data seemed pointed to how much professionals were impacted by the deterioration of the patient. Interestingly, it is also what gave all the participants most satisfaction in their job. *deleted section*. This may suggest that there are perhaps differences in inter-personal style, from different members of staff influencing relationships with patients and other members of staff. It has been noted in several studies how 'nurses need to find the right distance, so that they are protected on the one hand, and on the other are able to listen...' (Escot et al, 2001, p. 278). The aforementioned researchers suggested the need for intervention training in regards to this. By not getting too close, they are not psychologically harmed if that patient deteriorates. As is the purpose of the thesis, one cannot help but consider the inference of mindfulness in this action, as those who were more affected, did seem to be those who were less mindful.

As working with patients has the potential to cause a detrimental affect to well-being the comments by the participants potentially show a lack of care towards members of staff in helping them emotionally with these difficulties. Factoring in personal and anecdotal evidence, the cancer hospital where I worked at, had no psychological input for members of staff, therefore, some of the interpretations found in the thesis, potentially confirm previous thoughts before the research started about the neglect of members of staff working in such an emotionally draining environment. If some members of staff are unwilling to talk about emotions and experiences to other members of staff, the provision of psychological support may be useful. This may both strengthen mental boundaries, so one does not take work home with them, and be a trusting and
accepting environment, for them to feel comfortable in discussing difficult topics in. As demonstrated by some comments within this thesis, this may be a rarity.

Through being aware of internal and external states, the person may be more able to assess what might be the more adequate behaviour may be displayed rather than potentially maladaptive behaviours mentioned within this study by some participants such as 'wanting to escape', 'rumination at home', and doing 'excessive amounts of work'. It might be encouraging and useful to promote mindfulness, or indeed any adaptive coping strategies in the field of oncology, to promote a healthier balance between different life domains. The thesis also sheds potential light on the need for professionals working within oncology, or potentially health care in general to complete reflective practice. In doing so, they may be able to understand and examine their own personal attitudes and circumstances, becoming aware of how they overcome challenges and what might be a more beneficial behaviour.

6.4c What does this mean for a Counselling Psychologist?

An important question to consider is how the current research is related to and can impact the field of Counselling Psychology? Firstly, Counselling Psychologists do work within the field of cancer and therefore can be characterised as a professionals working within oncology (MacKinnion et al, 2013). Just as nurses and other such professionals deal with patients deteriorating and other such stresses described within this research, so will Counselling Psychologists. The most important part of therapy is the relationship itself and it has been proposed that it is the relationship that heals rather than the act of psychotherapy itself (Norcross & Lambert, 2011). There is growing evidence from the world of common factors that it is not what one does in therapy, but it is how one is (Wampold, 2001). Freshwater (2002) has established the value of the therapeutic relationship as undisputed. The strength of the relationship and successful outcomes within therapy is synonymous and works,

Because of common elements found in effective models of therapy and the process of therapy itself, rather than because of specific ingredients found in models (Blow et al, 2007, p. 298).
There is of course evidence to suggest that mindfulness can increase the potency of the therapeutic relationship, characterised by therapeutic skills like that of empathy and trust (Segal et al, 2010).

For Counselling Psychologists who work with those who are emotionally distressed, the occupation is in itself, inherently stressful. There is an increasing amount of literature in regards to how this affects the therapist in terms of ‘compassion fatigue’ (Figley, 2002; Weiss, 2004), which is often cited due to the emotional labour that makes up the bulk of the therapeutic work (Mann, 2004). Listening and dealing with a patients psychological issues, requires great personal investment by the therapist, which can lead to burnout and short lived careers. With the act of therapy being particularly stressful, research has indicated that stress related psychological problems among therapists are normally apparent in those employed in high demand setting such as hospitals (Vrendenburgh et al, 1999).

It is worth considering that relationships with cancer patients are completely different to those relationships with clients who have a primary care mental health issue. Firstly, because of the lack of tangible 'improvement' a cancer patient can make, it is hard to see past the cancer diagnosis as one is unable to take that away and therefore what is considered a 'successful outcome' is blurred. Secondly, depending on the cancer and severity of such, one needs to be aware that the relationship may terminate prematurely because of illness or death. With the therapeutic relationship being so important it is important to consider what the present thesis might tell us in relation to this process? When looking at the results embedded within this study, Counselling Psychologists do not have the luxury to 'avoid' contact with patients. It is their job to be in that relationship with the patient and so prolonged in depth contact is both essential and necessary. It could be tentatively suggested that if Counselling Psychologists, reported themselves as having a higher perspective of mindfulness, they may indeed report this process differently.

The psychologist may commit to the relationship whole heartedly as they do with other clients and cultivate a very meaningful relationship and perhaps help the client. However, if the client can be seen to go physically worse week by week, this might affect the psychologist, impacting their general well-being. With this being the case, and the forming of a relationship with the cancer patient
essential, like the nurses described within the research study presented, who stated a healthy balance of closeness and distance of the relationship, this could also be of interest to the Counselling Psychologist. Increased mindfulness which the Counselling Psychologist may possess could have an inference on how they perceive their own well-being when and if the relationship breaks down. This, in the long term may aid the longevity of a Counselling Psychologists career when working within psycho-oncology. More research, especially in relation to Counselling Psychology needs to be done within the area, as Gauthier and Gagliese (2012) identified several studies associated with cancer care giving contributing to negative bereavement outcomes for the carer.

Looking at the data, one might infer from the results that when one has a greater awareness of one’s internal state, one is able to acknowledge when too much is too much and when one needs to take a step back. This awareness, is vitally important for a Counselling Psychologist as it is important for successful therapeutic work with clients (Baer, 2003) as it can be argued that one cannot understand others before he has at least acknowledged what may be going on within himself (Sedgwick, 1994). This is important to consider and emphasises why regular supervision and indeed personal therapy is important while in training and through ones professional career.

Psycho-oncology and the mental health care of the patient is not as well catered for, when compared to the physical care. With this being the case, Counselling Psychologists who work within the service might be relatively isolated in relation to both the number of fellow psychologists they are working with and in regards to other professionals understanding what it is they actually do, therefore increasing the risk of loneliness and isolation. Work relationships have been discovered to be vitally important when working within oncology and therefore interpreting the findings through interpersonal effectiveness and mindfulness, one may need to consider its role within this.

Perhaps one also needs to consider how a Counselling Psychologist may use this research in occupational settings when conducting therapeutic work with professionals working within oncology. The themes found may potentially be key to a healthy well-being when working within oncology, so if Counselling Psychologists can focus therapeutic contact on these issues, change may indeed be facilitated.
6.5. Limitations

6.5a Methodological Issues within Research

Qualitative approaches as a whole are incredibly diverse, complex and nuanced (Holloway & Todres, 2003) and therefore they do not come without their difficulties and limitations. Firstly, it is important to consider the relationship between the researcher and the researched. In regards to the natural science model, phenomena or events are seen to be independent and unaffected by the behaviour of the researcher, therefore promoting the idea that the research can be viewed as value free and objective in approach. However, there is the opposing view that 'people are affected by the process of being studied and that the relationship between the social phenomena is interactive. In this case, the researcher cannot be objective and cannot produce a 'privileged' account' (Snape & Spencer, 2003, p. 13). Therefore, even though practical steps were put in place in regards to remaining impartial, for example the reflexive analysis, 'a researchers background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions' (Multerud, 2001, p. 483 - 484).

Within qualitative research the questions of whether the researcher affects the research or the researched have all but become obsolete and a commitment to reflexivity has taken its place. Haraway (1991) stated that once this is shared, bias, in the sense of skewedness, is accounted for but not eliminated. Dependent on different positions and perspectives, different researchers might access different representations of the phenomena found. This is not to say that one is more valid than the other but results in different ways of understanding. Validation by consensus or repeatability is seldom adequate for qualitative research and so qualitative research can not be taken out of the context in which it was obtained. Even though reflexivity was taken into consideration, there still may be bias and the results could significantly differ if another researcher from a different background implemented the same tasks and methods.

In regards to qualitative research as a whole, there is also a preconceived notion that meanings are objective and universal. Brenda Dervin's (1998) stand point is that information is subjective and is defined as 'ideas, the structures or
pictures imputed to reality by people' (p. 22). This therefore, introduces the idea that there are subjective meanings of one phenomenon within a group showing inter-subjectivity. Shutz (1992) suggested that people generally assume that meaning is shared until obvious evidence is encountered that others do not share the same meaning. This is important to consider as at the time the data was collected, I was not working within the area of oncology and therefore naive to the environment of the hospital and potentially some terminology. It is worth considering that even the concept of anxiety or stress could have different meanings for different people (including myself) and the concept, based on my own ontological stance, may not be universal.

The method used to analyse the data, that being thematic analysis (Braun & Clarke, 2006) is also not without its problems. While explained in the methodology section, the flexibility of thematic analysis is one of its greatest assets and advantage. It also is a disadvantage because it can almost paralyse the researcher in deciding what particular aspects to focus on. This potentially increases the chance of researcher bias, which has been mentioned previously. Other disadvantages may appear when you consider thematic analysis alongside other qualitative analytic techniques. Particularly relevant for this study, unlike narrative or other such biographical approaches, one is unable to retain a sense of continuity or contradiction through one individual account. It is sometimes these contradictions which unfortunately prove most insightful. Even though each theme should be represented and be able to stand alone, it is impossible to keep them completely discrete because one needs to look at the data as a whole and in the context in which it is embedded rather than an abstract concept of differing statements.

Therefore, if a narrative synthesis was used, for example, the results may have been different, by developing a story over time, that is, how their well-being has changed since they started working within oncology as narrative analysis needs to embody some form of transformation over time. One could then see how stark this transformation was between participants with higher and lower levels of mindfulness, inferring how this played a part in the longitudinal nature of their life, rather than a snap shot of the present moment.

There were potentially threats to the reliability of the collected data due to the method of the semi-structured interview. ‘The success and validity of an
interview rests on the extent to which the respondent’s opinions are truly reflected…’ (Newton, 2010, p. 4). Because the interview was semi-structured from one interview to the next different questions were asked, potentially picking upon the things that I, the researcher found interesting. Therefore unintentional leading questions may have been utilised as I had a preconceived notion of what is and what isn’t worth discussing. Denscombe (2007) discussed research which demonstrated how people respond differently depending on how the interviewer is perceived. This is called the interviewer affect. ‘In particular, the sex, the age, and the ethnic origins of the interviewer have a bearing on the amount of information people are willing to divulge and their honesty about what they reveal’ (p. 184). This is particularly important in regards to the topics discussed and the emotionality of what was attached to them. Despite this, it is of course impossible to completely evaluate or eliminate these affects.

A final methodological limitation could be that of how the sample was obtained - through psychometric assessment. It is worth considering that this may seem at odds to the constructivist framework the current thesis stated. It is however the only way in which the research questions could be answered as there is no other way to obtain self-reported levels of mindfulness. This is not a worldwide view as Grossman (2011) suggests that qualitative assessment of mindfulness, even though more labour intensive, should be considered. However, as a questionnaire was used, as is the case with all questionnaires, subjective variance may have occurred. That is the number five for example, might be different to another participants interpretation of the number five.

6.5b Research Limitations

As well as methodological issues, there are also limitations that need to be considered in relation to decisions made by the researcher to complete this study. Firstly, is that of the issue of sample size. It is quite a difficult issue to contend with because generally, the sample sizes of qualitative research are not governed by steadfast rules (Bradley, 1993) and numbers are often fluid. However, it is worth considering that the size of six participants is still relatively small. This was because of a number of different reasons including the environment and the research question itself. The hospital chosen was a private hospital and therefore the numbers of staff there were relatively limited, meaning
the participant pool of the differing levels of mindfulness was significantly decreased. With a larger response rate, potentially a greater spread of mindfulness would have been found and more perspectives in regards to well-being recorded. Rogelberg et al, (2000) found that in a study of non-response bias, non-respondents were found to possess greater intentions to quit, lower levels of organisational commitment, job satisfaction and satisfaction with supervisors when compared to respondents. This perhaps should have been taken into consideration as a study completed by Asch et al, (1997) found that physician samples tend to have lower response rates than non-physician samples.

With this being said however, participants were recruited from a busy oncology unit and even though participant numbers were lower than expected, a range of different professions within the oncology world were obtained. This did provide an interesting insight into the field of oncology and provided myself the researcher, with rich data about the reported well-being. As differences were found in how well-being was reported, it was always known that this would have been looked at through the lens of mindfulness. Based on previous theory, this leap of inference made sense, however it is also worth considering that differences in reported well-being may also be looked at through different lenses. The problem is however, deciding what lens to choose to look at the data from, with an endless universe of possibilities.

There was an intentionality to link mindfulness and well-being from the beginning of this thesis. This was done so because of the previous research suggesting a link between mindfulness and psychological function such as positive state states of mind (Branstrom et al, 2011), lower levels of psychological disturbance (Carlson & Brown, 2005) perceived quality of life (Nyklicek & Kuijpers, 2008), stress (Brown & Ryan, 2003) and mood (Carmody & Baer, 2007). However, these studies measured direct correlation on distinct subsets of well-being via quantitative assessment, so they knew exactly what they were investigating. As communicated within the literature review the concept of well-being was intentionally left open within the current thesis, as to be directed by the participants themselves. With this being the case, even though previous evidence suggests a link between mindfulness and well-being, one cannot be sure how strong the link is within this study due to the reported well-being of this particular sample, being essentially an unknown construct. Within
the research, well-being encompassed positive mood states, healthy relationships and a happy work life balance. Even though previous research has linked mindfulness and these concepts together, they have not been linked with mindfulness under the large umbrella of well-being. The reason for this research was to capture a multidimensional representation of well-being, but because of this, one may have to treat the interpreted results with caution and initial strengths may lead to a slight weakness.

It is still worth nothing that even if self-reported mindfulness did play a factor in responses, it may not have been the only factor involved. The underlying mechanisms of mindfulness are still relatively unclear and because of the complexity of studying the consciousness, this study could be classed as being relatively over simplistic. In relation to mindfulness based interventions, there are many different elements ‘such as social support, relaxation and cognitive behavioural elements’ (Shaprio et al, 2006, p. 374). Therefore there is a difficulty to infer that it is just the process of mindfulness, which is influencing perceived well-being and behaviour at work. Even though the MAAS has been assessed for reliability and validity (Brown & Ryan, 2003), other factors could have been influencing their responses and what was found in this study may not be necessarily linked to the levels of mindfulness found. It has been reported recently that there are inconsistencies in the measurement and conceptualisation of trait mindfulness (Kuyken et al, 2008; Grossman et al, 2010). In concurrence with this study, mindfulness has been conceptualised as unified (Walach et al, 2006; Chadwick et al, 2008) but the difficulty is that because this research is qualitative, specific tasks can’t be measured such as cognitive control flexibility or perceptual ability (Anicha et al, 2012) to see what is at play, therefore no detailed inferences can be given. Previous research has demonstrated that the ability to deal with stress is dependent on a number of different factors. Factors that may influence the ability to cope include social, team or organisational support (Ekedahl & Wengstrom, 2008), personal views, attitude and circumstances (Hinds et al, 1994), and personal and professional experiences (Ablett & Jones, 2007).

With this in mind, what is not known is whether the differing perceptions of well-being are influenced by different perspectives of mindfulness, or are the differing levels of reported mindfulness because of better well-being influenced
by other factors in their life? Well-being can be generated from different areas, such as the engagement of the different roles by each participant. It is perhaps important to consider that the more mindful participants were made up of two nurses and a dietician and the less mindful participants, two receptionists and a pharmacist. With different roles, different needs are required. For example, is working in a clerical environment, rather than a clinical one more stressful? The work load is potentially different, and the potential pathways into the career is different too. Nurses receive extensive training on treating patients as that is at the forefront of their job, whereas members of staff working in other areas, dealing with patients is a consequential factor and therefore are less prepared for it. Fundamentally, due to the job, mindfulness may have already been cultivated through different means, through training. Furthermore, Maslach's (2003) comments need to be considered that organisational and situational factors play a large role in stress and burnout. Systemic issues interact with stress in the workplace and also need to be taken into consideration in the deterioration of psychological well-being.

As explained previously within the literature review, mindfulness is a complex concept, especially when it is considered as a disposition. Mindfulness is a very particular way of paying attention in the present moment, so it is fundamentally different from other types of attention like hyper-vigilance, concentration and alertness. In essence, there is a difference between normal awareness and mindful awareness. With the sample obtained, even though different levels of mindfulness were required, the more mindful participants may not have been mindful at all as there is nothing to say that they are paying attention, or giving awareness in a non-analytical manner. They 'may be involved in a very different kind of paying attention, marked by high levels of judgementalness and low levels of patience, tolerance, or kindness' (Grossman, 2011, p. 1035). This is perhaps a reflection of the definition confusion of mindfulness and therefore suggesting more effort needs to be done to distinguish mindful awareness from other forms of awareness. 'If you confuse and mix all these states of mind together and don't make these distinctions ... everything gets muddled...' (Berzin, 2013, p.11). This is not only a limitation of the MAAS, but the assessment of mindfulness as a whole.
The current thesis has been transparent in that it has been approached from the perspective of a Counselling Psychologist. Within the conclusion section (6.4c) implications were iterated for a Counselling Psychologist working within an oncology unit, but perhaps the usefulness to the Counselling Psychology field as a whole, is perhaps limited. It is an inherent issue in qualitative research about the generalisability of qualitative research, therefore I have reservations about making sweeping claims about what this research may mean in other environments. It is worth considering that this is more a theoretical thesis written by a Counselling Psychologist and potentially, not for a Counselling Psychologist. It may not have a direct impact on general practice, but it is hoped that in whatever field of practice one may be in, it will encourage reflection and consideration to how one situates themselves within the environment. *Deleted section*
6.6. Future Research

As this is the first piece of research within the area of mindfulness in relation to qualitative experience, it might be worth considering that this is a stepping stone for further research and findings to emerge rather than it being classed as an ending in itself. Inferences were made, not definitive conclusions, therefore further exploration in this area is certainly needed.

It may be beneficial to interview participants from one area of oncology, for example those who just work in direct contact with patients. This could therefore elucidate further whether it is the type of job having an impact, particularly on their sense of well-being at work or mindfulness could be inferred as playing an important role in nurses, for example. Do nurses have different perspectives of their well-being? Are all nurses quite high on the spectrum of mindfulness from their perspective?

The study of mindfulness, particularly in relation to the dispositional mindfulness is still very much in its infancy so the questions of how mindfulness forms and how it seemingly has a salient impact upon ones perceived well being, physical health and work behaviour still need to be considered. If increased mindfulness is inherent in staff working more directly with patients, it is worth looking at and considering why this is the case and where it has come from.

This was the first piece of research to infer the differences within qualitative comments on the perception of themselves based on individuals until reports of mindfulness. Therefore, it might be interesting to expand this focus further, looking at different environments and different factors other than well-being. Potentially, each of the themes found could be opened up an explored in a research study of its own. Further research also needs to be considered in relation to different populations. This research was focused on staff working within oncology, but it may be useful to research viewpoints of other health care professionals.

Further research still needs to be completed in relation to the mechanisms of mindfulness. As Kabat-Zinn (2003) explains, it is not uncommon for the first generation of studies in relation to a particular phenomenon to be descriptive (this thesis included) rather than the understanding of mechanisms and pathways of change. A greater understanding of specific elements of mindfulness that influence particular dimensions of functioning, need to be explored and
developed to create a deeper insight into what is actually so useful about mindfulness, and to be able to develop more efficient interventions. Fundamental questions such as 'What is it?' and 'How does mindfulness produce such salient positive results?' still need to be answered. I believe research should shift from exploring if it works, to how it works.
6.6. Impact upon the Researcher

I found it a privilege to hear some of the views mentioned by the professionals working within oncology. To hear the differences of what some of those views were has been particularly eye opening.

I think conducting this piece of research has reminded me, and hopefully the reader, that behind every professional is a person with their own emotions, thoughts, needs and history. When coming into contact with people in positions, such as the ones presented here, I think it is easy to forget that and to just see them as a nurse or a receptionist. It has reinforced the fact that these are real people, who are affected by real things like everybody else. People working within oncology may be able to treat, heal and be perceived as the perfect professional, but conducting this research, I have perhaps realised that this is not always the case.

It has made me consider my own practise, as to many people I am considered the ‘professional’, in whatever context I may be working. From some of the participants experiences, it reminds me of what it is to be professional, and that sometimes it is not about being perfect, but in fact being honest about ones experiences and of the struggles one sometimes faces.

It is the enjoyment of the work, expressed by the participants within this study, which has also impacted me. Without that enjoyment, things would get too much and so the positive side of things, even though negative affects were mentioned by some, must be enough to keep them returning to work. Resulting in this process, it has reminded me to reflect on what is happening to myself in the present moment and to fundamentally be more mindful.

If I ever choose to work in the field of psycho-oncology once more, I now feel as though I can bring a lot to the team as I feel I am more connected to the dialogue of those professionals working within that setting. Not only have I heard what that dialogue is, I have presented it and potentially inferred what it is that might be influencing different perspectives of the same environment. I have become more compassionate to those in a helping profession and so perhaps more compassionate towards myself, as I very rarely acknowledge the difficulties in my work and put myself under a lot of pressure to do well and not get things wrong. That however, might just reflect my mindfulness or lack thereof.
6.7. Chapter(s) (5&6) Summary

It is hoped that the previous two sections elucidated the findings, embedded the findings within previous research and brought to the fore implications to the field of mindfulness, oncology and Counselling Psychology. I did this by initially discussing the core findings and predominantly relating to the literature to mindfulness.

The main discussion focused on the core areas of which themes were found. Firstly, in relation to the impact of working within oncology, findings were discussed referring to participants with potentially decreased emotional reactivity. Processes were introduced which referenced why higher levels of perceived stress lead onto negative consequences, and how increased mindfulness potentially altered the perception of stress inducing events by drawing attention to the event rather than avoiding it.

The results were also discussed in relation to the idea of the importance of healthy relationships both with staff and patients. Being able to deal with the death of patients is integral to a healthier outlook on well-being, especially with professionals working within oncology. Members of staff who did not really express or experience any negative affects from the deterioration of the relationship were potentially more mindful, and being in tune to when too close is too close. Similar processes were inferred with staff relationships by being open and trustworthy, all of which have been mentioned by participants who were perhaps more mindful than others.

'Boundary theory' was introduced and micro-transitions from one role to the next. Again, introducing cognitive flexibility, it was inferred that those who were able to transition seamlessly from work to home, also had a higher perspective of mindfulness. That is opposite to other views, perhaps stated by the lower mindful participants that they were affected by work at home, citing intrusive thoughts and relationship difficulties.

Final discussions were presented in relation to the dealing of a busy work environment, as interestingly, most participants stated that they enjoyed the environment, especially the variety and busyness. However, it was proposed that that some participants worked more intensely without any breaks or acknowledging within themselves when they needed to 'take a step back'.
In the final chapter, conclusions were drawn about what the themes meant, particular in relation when they are inferred to levels of mindfulness. I reiterated why these results are important for oncologists, Counselling Psychologists and the field of mindfulness. Limitations were mentioned in relation to both methodological and research issues. To end the chapter, future research was suggested, proposing further research in regards to how research may also need to be generated in the oncology field, looking at the particular aspects of well-being found within this study. Finally, some brief reflections were given by myself, the researcher about how the research piece as a whole has impacted me and my role as a Counselling Psychologist.
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Appendix a

Mindful Attention Awareness Scale (MAAS)

Instructions: Below is a collection of statements about your everyday experience. Using the 1 - 6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

<table>
<thead>
<tr>
<th>Almost Always</th>
<th>Very Frequently</th>
<th>Somewhat Frequently</th>
<th>Somewhat Infrequently</th>
<th>Very Infrequently</th>
<th>Almost Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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I could be experiencing some emotion and not be conscious of it until some time later

I break or spill things because of carelessness, not paying attention, or thinking of something else

I find it difficult to stay focused on what's happening in the present

I tend to walk quickly to get where I'm going without paying attention to what I experience along the way

I tend to notice feelings of physical tension or discomfort until they really grab my attention

I forget a person's name almost as soon as I've been told it for the first time

It seems I am "running on automatic," without awareness of what I'm doing

I rush through activities without being really attentive to them

I get so focused on the goal that I want to achieve that I lose touch with what I'm doing right now to get there

I do jobs or tasks automatically, without being aware of what I'm doing

I find myself listening to someone with one ear, doing something else at the same time

I drive places on 'automatic pilot' and then wonder why I went there
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<th>3</th>
<th>4</th>
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<td>Always</td>
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<td>Infrequently</td>
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I find myself preoccupied with the future or the past  
I find myself doing things without paying attention  
I snack without being aware that I am eating
Appendix b

Semi-Structured Interview

Opening Statement

The aim of this interview is to look at how you perceive your own personal well-being at work. I'm interested to see how well or not you feel that you are coping at work, at present.

Well-being encompasses many things which may involve your levels of anxiety, job satisfaction, general happiness and just general experiences of working within oncology. I would like to explore and encourage you to talk about these experiences more.

I have a few specific questions to ask you but I am interested in what you have to say. I’ll mostly just listen to your responses to the questions I have, but sometimes I may need to ask for clarification or check I’ve heard what you’ve said correctly. It should last somewhere between 30 minutes and an hour.

- Tell me briefly about your role here and why you became interested in working within oncology
- Give me a brief snapshot of your average day, concluding when you walk out the door of the hospital, particularly focusing on your thoughts and feelings
- In working within oncology, what ways do you feel this affects you either positively or negatively?
- Do you feel satisfied with the job you are doing?
- I would like you to look at this sheet, which mentions the five aspects of well-being at work. I would like you to have a look at it and say if any words stand out more than others and then elaborate on why you have chosen them over the others

Prompts

Can you tell me more about that?
Would you care to give me an example?
### Experience of Well-Being

These may help in thinking what you may like to talk about in relation to your well being at work.

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Comfort</th>
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<tbody>
<tr>
<td>Depression</td>
<td>Pleasure</td>
</tr>
<tr>
<td>Bored</td>
<td>Enthusiastic</td>
</tr>
<tr>
<td>Tiredness</td>
<td>Vigour</td>
</tr>
<tr>
<td>Angry</td>
<td>Placid</td>
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Appendix d

Dispositional mindfulness in relation to the stated well-being of professionals working within oncology

Consent Form

If you are happy to participate please complete and sign the consent form below

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<th></th>
<th>Please Initial Box</th>
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<tbody>
<tr>
<td>1.</td>
<td>I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information, ask any questions and have had these questions answered satisfactorily</td>
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<tr>
<td>2.</td>
<td>I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason</td>
</tr>
<tr>
<td>3.</td>
<td>I agree to be contacted for an interview</td>
</tr>
<tr>
<td>4.</td>
<td>I agree that any data collected may be published in anonymous form in academic books or journals</td>
</tr>
</tbody>
</table>

I agree to take part in the above project:

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
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</table>
Dispositional mindfulness in relation to the stated well-being of professionals working within oncology

You are being invited to take part in a research study as part of a counselling psychology doctoral thesis. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any questions, contact details are provided at the end of the information sheet. Take your time and please press 'next' to continue. Many thanks.

What is the aim of the research?

Working in health care is a very stressful occupation, but there are particular nuances, which makes working within oncology particularly draining. These pressures inevitably encroach on different areas within your work and may be detrimental to your overall well being. The current research is looking at a particular aspect of the consciousness (mindfulness), which we all have at differing levels, and how well it acts as a variable of well being when working within oncology.

Why have I been chosen?

You have been asked to take part because you are an employee of the HCA who works within oncology on a daily basis.

What will I be asked to do?

1. You will be asked to complete a short questionnaire to measure your levels of mindfulness. The assessment tool is called the Mindful Attention Awareness Scale. It should only take three minutes to complete and involves marking where you feel you are on a particular scale.

2. On the next page there is an option to leave your name and email address. It would be most helpful if you could fill these in, as in the second phase of the study I am interested to hear about your experiences of well being at work. You may be asked to take part in a very informal face to face interview to discuss this at a later date. Further information will be given to you, if you are asked to take part in the interview.

What happens to the data collected?

The data from the Mindful Attention Awareness Scale is only used to select who the researcher would like to have a discussion with about their well being. After participants have been chosen, all data collected from the questionnaire will be destroyed.
How is confidentiality maintained?

All efforts will be made to ensure that confidentiality is maintained. As mentioned above, data provided from the Mindful Attention Awareness Scale, after being analysed, will be destroyed.

What happens if I do not want to take part or change my mind?

Participation in this research is voluntary. If you sign the consent form but then change your mind at any point in the completing the questionnaire, you are free to do so.

What is the duration of the research?

The Mindful Attention Awareness Scale will only take approximately three minutes to complete.

Will the outcomes of the study be published?

The outcomes of the study will form part of a University thesis, and there may be further publications in academic journals. In these publications there will be no identifiable information written about you.

Contact for further information

Researcher:

Andrew Greaves, Trainee Counselling Psychologist at the University of Manchester

Email: andrewjgreaves@hotmail.co.uk

Phone: 07850470512

Supervisor:

Dr. Clare Lennie, Lecturer in Counselling Psychology, at the University of Manchester

Email: clare.lennie@manchester.ac.uk
Appendix f

The online documentation was set up using a program specifically designed for the students of the University of Manchester. The software can be found via the web address of https://selectsurveys.humanities.manchester.ac.uk/Login.aspx. The following steps show how I created an online document where participants could mark their consent and fill out the questionnaire, which could then later be analysed to see who was most appropriate to ask for an interview.

1. Upon entering the web address Figure 3 appears, where a username and password needs to be inputted to confirm you are a registered member of the University of Manchester.

![Figure 3: Logging in](image)

2. Upon entering the website, I had to create a new survey, which encompassed the MAAS and personalised information sheets which were appropriate and particular to my research. I chose the title of the survey, to be the same as the title of the current thesis and selected what types of questions the questionnaire would exhibit. As can be seen in figure 4 below, the multiple answers selection was chosen to create the likert scale of 1 - 6 as used in the MAAS.
3. During the formatting stage of the online questionnaire, the questions and answers of the MAAS had to be inputted manually, along with a few short sentences to direct the participant in how to complete it correctly. Figure 5 shows how the MAAS was created before it was available to be published online.
4. Figure 4 (the selection of type of questionnaire) and Figure 5 (formatting) were repeated to create both the consent form and the participant information sheet. It was possible to ensure that the participant understood the research and consented to taking part by making it impossible to click 'next' without having ticked the boxes displayed on the consent form. In total, the participant had to click through three pages. These were; participant information, which appeared automatically upon clicking the link, consent form, the MAAS and finally a page thanking them for giving up their time to take part in the research. Figure 6, as seen below, shows the first page of the completed online questionnaire, as seen by the participants.

Figure 6: Final layout of online questionnaire
Dear Staff,

As you may have been made aware, I am emailing you to take part in my Doctoral thesis in relation to well-being when working within oncology. I have been on placement at the Christie while studying for my Doctorate in Counselling Psychology and have become increasingly interested in the area of oncology and what affects it has on you, the staff. If you would like to take part, please click the link below where a new window should open with information about the research and simple steps to follow to participate.

https://selectsurveys.humanities.manchester.ac.uk/TakeSurvey.aspx?SurveyID=96KL5o55

I know that you are very busy and I appreciate you taking time to help me with my research.

Thank you,

Andrew Greaves
Dear member of staff,

I am sorry to email you once more, but I have received several emails regarding being unable to open the link, which the questionnaire is situated. If you are unable to open the link, I have placed hard copies of the questionnaire in the staff room of both the day unit and outpatient unit. They are situated in a locked filing cabinet. I am the only one to access it. Please post them through the top and I will collect them in due course.

Please take the blank copies from the folder entitled 'BLANK QUESTIONNAIRES', fill them out within your own time and return them to the locked cabinet.

If you have any other queries, please do not hesitate to contact me.

Kind Regards,

Andrew Greaves
Dear [Name of Participant]

As you may remember, you recently filled out a questionnaire for my thesis entitled 'Dispositional mindfulness in relation to the stated well-being of professionals working within oncology'. I have since then analysed the data and as you agreed to be contacted, I would like to invite you to take part in the interview stage of the research. I have attached an information sheet, so you have further details on the next part of this study.

I understand that you are very busy and time is quite precious, but I will be as flexible as I can, to ensure we can have this face to face interview. I can do any time on Monday, Tuesday or Friday. I would like to complete the interview at some point between the 3rd and 24th May 2013, so if you could get back in touch with me and suggest a time and date, we can work out the details (e.g. where it will take place) from there. You are not required to prepare anything for the interview as I must stress, it is very informal.

I look forward to hearing from you,

Kind Regards,

Andrew Greaves.
Information Sheet

You are being invited to take part in a research study as part of a counselling psychology doctoral thesis. Before you decide it is important for you to understand why the research is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish. There will be an opportunity for me to go through the information sheet with you and answer any questions you have, contact details are provided at the end of the information sheet. Take your time to decide whether or not you wish to take part. Many thanks.

What is the aim of the research?
Working in healthcare is a very stressful occupation, but there are particular nuances, which makes working within oncology particularly stressful. These pressures inevitably encroach on different areas within your work and may be detrimental to your overall well being. There has been a handful of studies that implement strategies to improve well being at work, but this research is looking at a particular aspect of the consciousness (mindfulness) and if this is a natural mediating variable of well being when working within oncology.

Why have I been chosen?
You have been asked to take part because your score of the Mindful Attention Awareness Scale fell either within a high or low bracket and I would like to hear if this is an influencing factor on your well being at work.

What would I be asked to do if I took part?
You will be asked to an interview which should last between 30 minutes and an hour. This can be conducted at a time and location convenient to you. Within this interview you will be asked about your well being and reasons for feeling this way.

What happens to the data collected?
The audio recording of the interview will be deleted after transcription and the electronic document containing the transcription will be kept in a password protected file. Any paper copies will be kept in locked storage. Only the researcher will have access to the transcribed interview. Some quotes may be used in the write-up of the research, but these will be in no way identifiable: where there is uncertainty, the researcher will check this with you. After transcription you will be sent a copy of the document for you to check over.

How is confidentiality maintained?
All efforts will be made to ensure that confidentiality is maintained. As mentioned above, the electronic data will be kept in password protected files and
there will be no identifiable information contained within the write-up of the report. Any hard copies of the transcript will be kept in locked storage. You will be referred to by a pseudonym in any written reports and any quotes used will be non-identifiable. These safeguards are in compliance with the University of Manchester regulations on data protection.

**What happens if I do not want to take part or change my mind?**
Participation in this research is voluntary. If you sign the consent form but then change your mind at any point in the interview being recorded you can withdraw from the research. Finally, you can change your mind and withdraw from the research after reading the transcript, if you choose to see this.

**What is the duration of the research?**
The interview will last between 30 minutes and an hour, with additional time commitments of checking the interview transcript.

**Where will the research be conducted?**
As detailed above, the interview will be conducted at a time and location convenient to you.

**Will the outcomes of the study be published?**
The outcomes of the study will form part of a University thesis, and there may be further publications in academic journals. As detailed above, in these publications there will be no identifiable information written about you.

**Contact for further information**

*Researcher:*
Andrew Greaves, trainee counselling psychologist at the University of Manchester  
Email: andrewjgreaves@hotmail.co.uk  
Phone: 07850470512

*Supervisor:*
Dr. Clare Lennie, Lecturer in Counselling Psychology, at the University of Manchester  
Email: clare.lennie@manchester.ac.uk
Mindfulness in Relation To Experiences Of Well Being Of Staff Working In Oncology

Consent Form

If you are happy to participate please complete and sign the consent form below

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<td>I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason</td>
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<tr>
<td>7.</td>
<td>I understand that the interviews will be audio recorded and transcribed</td>
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<tr>
<td>8.</td>
<td>I agree to the use of anonymous quotes in any write-up</td>
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<tr>
<td>9.</td>
<td>I agree that any data collected may be published in anonymous form in academic books or journals</td>
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This first question is really just to ease you into the conversation, erm, so to not provoke any anxiety about hard questions straight away! Erm, but tell me briefly about your role here and why you decided to work within oncology.

My role at the Christie clinic is Junior sister, erm, when I was first employed I was based over on the haematology transplant unit, as a junior sister, and, erm due to staffing levels, vacant staff vacancy, study leave, erm, they were struggling for, erm, staff on the day case out patient unit so I was asked to come over just to sort of fill a space in really to administer chemotherapy and obviously offer my expertise to, erm, to the day case patients. Erm, primarily my background is haematology, which is blood cancers, leukaemia’s, so I'm fairly new really to the rest of the umbrella of cancer to oncology patients. Certainly coming down to the day case unit, which was November last year, erm, the sort of oncology treatment part of it, as I say, been fairly new, whereas I'd done sort of the other side of the cancer part really. So I've looked after cancer patients if you like for thirteen years since I've qualified.

Quite, quite a while then. But as you say, it's been quite a transition coming down here to the day case unit.

Yeh, interesting, interesting. You know, for the first sort of 12-13 years of my nursing career it's solely been haematology, but, to get to know the other part of it, the transition has gone quite smoothly really. It's not taken me that long really to get me into, certainly from a a whole host of drugs and chemotherapy regimes and stuff and I've, even though you get to know little bits throughout the years and throughout your nursing career, you... unless you're doing it all the time you don't sort of, get to remember them if you like, it's there in the background. But the transition’s been quite easy.

And you sound quite surprised by that.

I am, yeh, I'm surprised how quickly I've picked it up really, but then doing it on a daily basis, certainly for the last 5-6 months now, sort of yeh.

Obviously become more practiced and confident. I suppose my next question is then, if you could give me a snapshot of you average day, and I know it might be difficult as all days are different working in an environment like this. And I suppose the main thing I'm thinking about, what would be, when you walk out of that door to go home, your general feeling of what's gone on

Erm, when I walk out of the door from work to my home life my work stays in work. The only issues that I would, if you say, take it home with me are... work related issues. Nothing to do with the patients. For instance, if I had a conflict with a member of staff or, you know... a sort of policy or a guideline, something to do with people as in people you work with rather than the patients and the drugs and that type of thing. That would be something I would take home rather than the patients and the patient scenario and the relatives and conditions.

So more of the organisational aspect.
Yes
I suppose that's what you do and don't take home, but what's your experience of how the day went? Is it stressful is it, satisfaction, is it enjoyment? What sort of words would you use to describe it.

A mixture of all of those really. I do enjoy coming to work. I enjoy looking after the patients, I'll rephrase that. I enjoy looking after the patients and I enjoy the job I do. Erm, I enjoy, you know sitting and chatting to patients, you know about their sort of, their weeks since their last chemotherapy. You know, about their side effects about their symptoms and just sort of generally... how their life is, you know. Certainly from patients that I've looked after in the past, erm, when they come in for their two or three week chemotherapy regimes, it's to them, it's a catch up. It's about, you know, how things, what their life is like and that type of thing, rather than them coming in, to sit in a chair, to receive chemotherapy and have that done to, you know sort of feeling really. It's about, you know, it's a catch up for them, just to see how everybody is and, you know, yeh.

And how do you experience that, the patient telling you personal stuff, rather than clinical stuff or professional stuff. How is that for you?

It's nice to know that they feel relaxed and sort of, and sort of within this sort of environment that they're coming in for their treatment for cancer they sort of lost within the... even though they're sat in a chair and receiving chemotherapy or whatever they maybe receiving. But they're sort of lost and they're still sort of able to talk about the nice things, you know, just about getting out and about and their families, what you've been doing and, it's nice to know that they feel sort of relaxed and comfortable talking to a complete stranger really when you think about.

So, that's the nice feeling, that they're able to talk to and that you're an approachable person.

And even from my point of view, you know, having young children and stuff. Getting their view on how they've brought up their children and stuff like that, have you tried this and have you tired that and as I say it's just a sort of a general catch up and a chit chat for however long they're here for really.

And they must bring some not so nice things sometimes, or not? Or is that a complete assumption on my part?

No, no, it's not all plain sailing. Their chemotherapy treatment at some stage comes to an end. You know, they get progressive disease, erm, disease takes over them, you know, so much that they can no longer have chemotherapy but, that's a part that... you can't take on board.

You can't take on board?

I can't take on board because I'd never be able to do my job otherwise. If I got completely wrapped up in the patients, I'd ever be able to do my job, I'd be a complete and utter wreck.
Participant 02HM

Ok, this first questions, is just, erm, to get you started in the conversation really, nothing too taxing. But tell me briefly about your role here and why you decided to start working within the oncology area.

Er... as I've said I'm fairly newly qualified, I, with my elected placement when I was still a student was in haematology and oncology because it was something that had always interested me, when I started you know... wanted to be a nurse. So, when I was qualified I got my degree and I tried to go where I'd done my training on the oncology suite there but they weren't taking on any... they didn't have any newly qualified people, so I stayed where I had done my training and I did a year of acute respiratory to get some, you know, basic clinical knowledge and then the opportunity came up here to work within the haematology, through someone I did my access course with. So, I came up here, had the interview, got the job and... I'm still here.

Ok.

It's a field, which you know, obviously massively interests me, there's so much going on, so many interesting new drugs and treatments and you know... you never stop learning in this environment.

So, I was going to say, what particularly interests you in working within this area, because, you know, it is obviously massively heavy....

I love.... I love being with patients, you know long term patients, because I'm in HTU, the transplant unit, so all of our patients are in for... when they come in for a transplant, they're in for three weeks so I like developing that rapport with people and you get to know they're family and... to me that's a better aspect of nursing to how I'd like to be a nurse rather than, you know, like an A&E type nurse where they just see them, treat them and then go somewhere else, you know.

Yeh, yeh, so you enjoy the cultivation of the relationship side of things and getting to know the patients.

Yeh, yeh, yeh, it's interesting It is for me anyway.

Well, what is that... that relationship, what does it give you in return, if that makes sense?

Well, I don't get involved, I don't get personally involved because it's just.... nice for them to be treated by someone who knows a little bit about them, erm.... continuity of care and all that sort of thing. We're only a small team on HTU, there's only six nurses there, so, whoever is treating them they do get to know over a period of three weeks fairly well. It makes them feel quite comfortable and confident in their care, so...

It sounds as though as well, because you said you don't want to get too personal as well, there's a professional and personal boundary, which you don't...
Well, you're not supposed to get involved with patients really, but I suppose when you looking after somebody that may or may not be at the end of life, then it's bound to be a little upsetting, it's only normal isn't it. But so far, I've not felt upset yet. I genuinely haven't been upset, not that I mean to smile about it or anything.

No, no, no.

I don't know whether I'm getting hard in my old age or what [laughs], or whether it's something as a professional I might not do, you know.

You said that with a little sense of surprise as well.

Well, I've not got, I haven't got upset, no.

Is that something you were expecting you would do?

I think I probably... I thought I might do yeh because I've seen other girls get upset, you know, other nurses to get upset over different aspects of patients care and stuff like that.... I'm sort of like waiting for it to come if you know what I mean, I feel like it might be out there somewhere, but as of yet...

You're still waiting on that patient.

Yeh, possibly yeh.

Ok, so, you say you don't get upset when you have invested some time into a patient and that patient goes down hill, I mean what does happen, to you personally?

The worst thing for I think is when someone actually reaches the end of life here on our unit and realistically it's dealing with the family afterwards, for me. You know, when they're all very upset and they probably realise in their own minds that their family member is going to die, but when it actually happens, they're all upset on the other side of the room an that's the worst part for me. You know, seeing them upset and not necessarily the patient dying because it was expected, you know with the way in which the disease was going. And really, since I've been here, that's only happened to one family, really. You know, when they've been very upset because everyone deals with grief in a different way, don't they. Some people just close the ranks in the family and they might come in and all sit in here and be upset or be out there in front of us nurses showing themselves to be upset. So really, I've only really experienced on or two families grief, you know.

And how did those experiences impact you?

It's not a nice experience dealing with somebody whose just lost their Dad, or just lost somebody. I think I dealt with it alright, it didn't make me feel like I wanted to go home and be depressed or anything like that or particularly physically upset or emotionally upset or anything like that. It obviously had an
**Participant 03HM**

So, to give you an easy introduction into the conversation, tell me briefly about your role here and I suppose, why you first became interested in working within oncology.

I'm the, specialist oncology dietician; I'm the only dietician here that works for the private company. There are trust dieticians that I do liaise with but essentially I'm the only one that's based in, or covers the whole clinic.

Ok

Erm... I've been working in oncology for... think about seven years. Seven or eight years. So I started working within oncology back in New Zealand before I came over here.

Yes, I could tell by your accent!

Yeh, a little bit different. So...

Ok, so, that's for seven years and how many have you been working here specifically?

I've been working at the Christie Clinic, so, since it started, so coming up three years.

Erm, thank you very much for giving me that brief introduction. My next question, if you can answer it, is, give me a brief snapshot of your average day and I suppose I'm more interested in what your main feelings are when you walk through the door at the end of the day, if that makes sense.

Most days I feel... happy that when I walk out of the door that I've done everything I needed to do and... I wouldn't probably leave knowing that I hadn't finished something for a patient that was obviously directly related to their care, that there would be an implication that they would have to wait another day. I think that probably being the sole practitioner you can't palm it off to someone else and say, oh, can you do this. Yeh, I stay over time to get things done and obviously when I do leave, most of the times I am happy that I've done everything that I've needed to do to meet the patients needs.

And you've felt quite satisfied.

Yeh

Has there been occasions where you've left and you haven't felt as happy?

Yeh, I mean obviously there are days where you feel more stressed and when you've done what you need to do and you finally leave it's a bit of a... relief almost to leave. Well, I mean you obviously feel good that you've achieved everything but if you've had a really, really busy day like that, you feel quite a sense of achievement.
You mentioned stress there a couple of times, tell me a bit more about that and your experiences with stress, or lack thereof maybe.

Erm, well it's just probably more the time pressure, because I come in in the morning and we have a meeting and so identify patients which may need your input, then the nurses do a referral which is the formal process, so I mean you get an idea in the morning of what you need to do that day to sort of plan your day. It's when those unexpected patients come in that need things right there and then so it's probably the skewing of your time plan that creates the... I don't know but I think it's the thinking on your feet part of the job that I enjoy; never a dull moment.

And how do you deal with that, when that occurs?

Erm, just get on and do it really.

So, it sounds as though it's easy to you to do these sort of things...

Well, you prioritise them and then do the things which are most priority first and then make the assessment, does this need to be done today or can it wait to be done tomorrow.

And again, you find it easy to prioritise, get things in order and work through them?

Yeh

I suppose that leads into my next question of in working with oncology, in what ways do you think it affects you? Either positively or negatively.

Erm, some days I can feel really... well most days feel really, a sense of worthwhile that I've done something that has helped that patient on the bed to improve their overall quality of life and when you get feedback from patients as well when you've suggested something that they feel they can incorporate and carry on with then, that does make you feel good. Oncology, especially being based on the inpatient ward where I'm based, they are the sickest people and so I think over my years of dealing with it, you can get what's the word... tied down with that's what every oncology patient is like, like sick in the bed. But, you've also got to remember that you've got patients that come in an out of the day case or out patient clinic here who are lead reasonably normal lives it's just that they have treatment and it's successful and I think, it's kind of remembering that there is a continuum to the patient. Obviously the people I deal with are on the sicker end, erm, and it's... it does get you down a little bit, obviously when you go through the ward and everyone is dying, but you just got to think about, or the way I think about it is, what can I do to enhance their life and what they've got left.

So it sounds like really, the terrible and awful thing which is happening in that room, you turn it around almost to... facilitate you to work in a more productive way?
Participant 04LM

This first question is very easy, to easy you into the conversation slightly.

3 Good!

I'm just interested... tell me a little about your role here and why you decided to work within oncology.

Erm... I've worked in hospital pharmacy for 33 years, erm, always been involved in oncology and aseptic work and it's just been a natural progression really, erm, that in my previous role I was actually a septic services manager and got heavily involved because no one else was involved with oncology pharmacies as well, but, we had a few patients and it was something that I got interested in then and because the oncology treatments are evolving, erm, it was just a natural progression that when I left the Alexandra hospital, erm, this job, well became available so I just came here. And, although it's quite intense... erm... there's a lot to learn and I have learnt a lot since I've been here, which is interesting... sometimes a little bit scary but yes, erm.. I thought if I didn't do it now at my time of life I'd never do it, so it was leaping from the frying pan to fire really, so...

21 Ok, and how long have you been here specifically?

I started December 2010, so it's erm, almost two and a half years.

24 Ok

27 And how have you found those two and a half years?

Stressful.

30 Stressful?

33 Hmm.

In what way stressful?

36 Erm, a different company, a mixture of what we thought was going to be an NHS ventures, well, in a joint partnership with the NHS wasn't a joint partnership as they have very little to do with us and we were left to our own devices. We have had access to all their sort of... training modules on on the computer but, still, even so, when we're just thrown in dealing with patients we've never come across before, you know the different specialities in oncology. I was always, erm... we only dealt with solid tumours really. We did a bit of lymphoma work at the Alex, so I was always used to doing bowel, breast, lung, but of Hodgkin's and the occasional myeloma patient but, here, we're doing prostate massive haemo... you know really complicated haematology, stem cell transplants, so, you've got to have you wits about you because it's very very easy to make a mistake and also, we don't get fed the information I mean... it's much better than it was than when we first started but we weren't getting any information from anybody. It was all
assumed that we already knew it and that was quite difficult, so, it's been a
massive learning curve.

So it sounds like it's been relatively stressful because this is a new environment
and you were thrown in at the deep end.

Yes, thrown in at the deep end. It's a stressful job anyway pharmacy because
you've got to watch your back. You're trying to pick up any Doctors mistakes,
nurses mistakes, our mistakes, technicians mistakes, you know anything like that
so... you know, you've also got to provide a fast efficient service with this but,
when you're dealing with oncology, which is also very complicated, the regimes
are different, erm, there's all different parameters which affects the patients
treatment. You've got to liaise with the nurses; you've got to trust your team
completely. When you haven't got that trust, or if it's a new team... you feel quite
exposed, so... you've just got to... well I try to form those relationships with the
consultants to begin with just so we can speak to them. Like, I used to, when I
was at the Alex, I used to ring them up and ask them and say 'do you mean this'
at the risk of getting shouted at but it's far better to be sure and safe than... so
that's what I try and do and say 'Hi, I'm such and such, erm, I've not spoken to
you before but do you mind if I call you if there's any problems' which they tend
not to do if there is in the trust. There's a huge bank of pharmacists, which they
can all ask before they go to the consultants.

And how do you find cultivating those relationships, is it... it an easy task, are
they receptive to what you are trying to do?

One or two of them, I couldn't believe how rude they could be, but the vast
majority of consultants are fine. It's taken a little while with one or two but I
think we're on pretty good terms with all of them, but, like I said there are one or
two that even now I wouldn't.... I'd only last desperate attempt to speak to them
because they are so dismissive! But the vast majority of guys, we are all on the
same... you know.

It sounds like you've got a lot of, from what you said before, stresses from
different areas and different people really, of getting things right and you having
to get those things right really, as well...

Yeh, you have to get it right because at the end of the day you could... a patient
could die if you get the dose wrong or the... you know, wrong scheduling, wrong
number of intervals in between treatments. If the nurses give the go ahead but
they haven't checked with the perhaps the echocardiogram has been done, for
example, if they've got a rip roaring chest infection is not picked up and you
know it's things like that, so you've just got to be very tuned in to, you know,
what's going on, so it's quite hard.

No, no, I mean it sounds quite hard. So, if you could, if you could give me a
snapshot of your average day, what would that look like? And I suppose at the
end of the day what is your general feeling of what's happened? If that makes
sense.
Erm, so tell me briefly about your role and why you decided to work within oncology.

I started originally working with Christie hospital in about 2000, and I'm not overly sure how I got really into it. I'd gone to University as a mature student.

Mmhm.

And then after I'd left University I came working for a Psychiatrist over at Stanley house... she's now in Oxford. So I worked for her for about 18 months and then I kind of just got into it and then as the years have gone on I've worked in various different areas and at the moment I'm into my third year of working for HCA Christie Clinic which is the private sector.

Mhm.

Which I enjoy, it works slightly different in that I'm a secretary. There are five of us, we all have, erm, a dedicated number of consultants to look after.

Ok.

And then, when any of our colleagues are on holiday we have to look after them as well. So, the first ear for me was really bad because it was incredibly busy and sometimes it's hard to sort of... to be thinking on your feet because as soon as the phone went down you're having to do something else. I coped quite well I thought, but this year is much better I think because I'm learning to step back because I sometimes... sometimes get myself into the mind set that you know, you've got to do this, you've got to do this and you've got to do this and you're trying to do everything, for everyone. And in the first year when... at sometimes that caused me problems in that if I was to maybe '....' I might make an error because I'd been interrupted or something else had happened.

Mmhm.

So there was all this kind of, nothing was straight forward, you couldn't just sort of go, you know, work on one thing because always something else happened... something was more urgent.

Ok.

It's not as easy... it's easier said than done, you know, because we're all very busy because I suppose probably between about February to October, that's the time when people have holidays so you never really have a full compliment of staff.

Ok.

And then there might be the emergency when somebody goes off ill or something else happens and then at times it can be chaotic. But other times it can be totally fine.
Erm, so it's only recently you've developed this new, I suppose you could say coping....

Yeh, but I mean last year, well. I... I got myself into a bit of a problem in that I had a... I suppose you'd call it a haemorrhaging in my right... you can't tell by looking at me, in my right eye, which caused like a retinal vein... which was caused by blood pressure.

Right.

Which really frightened me to be honest, so I thought, probably rushing round, that's fine now, I'm doing very well, I take some meds and so, I think as a result of that, maybe I stepped back. Because maybe when I was younger I was always racing around, always wanting to do everything, you know.

So, you could say, maybe if there was a general theme running throughout the three years, maybe not as recently, but it's quite stressful...

It's a stressful environment because everybody wants things done, if you've got patients coming in etcetera, obviously the important thing is the patient and then your consultants, but when you've, when you've not got a full compliments of staff sometimes it can be... it's too much because sometimes, I do ridiculous things, like I'd work through my lunch hour or I'd stay after work or and sometimes I'd help other teams, I used to work weekends, not for the HCA, but on the NHS side as well which I've now given up. Because you just got into doing it, so you became a kind of, a bit like robotic, in a sense, because you did think as you were always doing it. I'm surprised I survived really when I think about it because it was a.... it's just the way it is I think. I do feel incredibly down about it all sometimes though, you know.

Mm, mm.

Whereas suppose sometimes, when you're really, really busy it's hard to think about, oh, lets step back, but I am consciously trying to do that. And in a sense, I think it's very good, it works, so sometimes if I'm on the phone and everything is going bad, I find myself thinking, ok, just stay cool I'm going to be fine, whereas before I wasn't uncool, I was just... I tended to just sort of take it all. You know, like, because it's kind of like, you're in work and you're kind of like on full speed and you don't actually step back you know. Some of it's my own fault when I think about it.

In what way your own fault?

In the sense that you always want to get everything done and keep everybody happy.

So that pressure was coming from yourself rather from elsewhere?
Right, so to ease you into the conversation slightly, we'll just begin with an easy question. Tell me a bit about your role here and why you decided to work within the oncology area.

Well, my role here, is that I basically schedule peoples chemo, maintain the day unit so it runs quite smoothly and assist the nurses, you know to make sure they're not stressed out about admin stuff really, so to make sure that's all good. I cam here, well, I worked in the health care industry before, in London, before moving to Spain and then when I came back from Spain this job opened up through an agency. So it wasn't like a chose to work in oncology, it just was a job that was available an I just... you know, I got the job and I really enjoy it in this environment.

And you've been working here since, this place opened.

Yeh, three years this year, so...

So getting into the routine of things here now.

Yeh, yeh.

So, that leads onto my next question of, can you give me a snapshot of your average day if possible

[laughs]

And I know it probably changes from day to day! General things.

Average day, you get there in the morning, make sure all the clinic's prepped for the people who are coming in etcetera, start greeting patients, start checking them in and dealing with day to day admin work, anything can change within the day. I mean one day you can have an SOS patients coming in, emergencies that happen on the day unit, erm, then you know re-book the patients before the leave etcetera.

Do you have a lot of contact with patients?

Yeh.

How do you find that, is that something you enjoy?

Yeh, I love it, you see them once every two to three weeks, so they become more like friends than patients so yeh, you build up a really good relationship with them, so, I do enjoy it.

An when you leave here at the en of the day, what if you could describe a general feeling that you might have, what might that be?

Knackered basically. Not physically but mentally drained because it's a really, you know, when you see people coming in who are really poorly and erm, you
know that kind of affects you a little bit when you see them go down hill a little bit and, yeh, so you just feel emotionally drained.
How does that specifically affect you?
I don't know you just feel a bit like... tired sometimes with it all, you know what I mean...
And what is it with a patient going down hill which sort of, evokes that tiredness in you.
Well, you're always having to be upbeat so it's quite draining. It's hard to take that mask off at the end of the day. It is hard to switch to [says name] the friend. I can't show my feelings because if I show my concern then how are the patients going to feel? Oh God they'll say, why is he worried about me? If he's worried about me then there must be seriously wrong. It's draining almost performing for the camera you know, when sometimes you do want to say 'shit', that is really bad I'm so sorry. In that sense and you know, when you do see people who you've known for like two years who start to look really ill and things. SO you just feel a bit sad in a way I guess. I don't know, you go home and you think about your own kind of mortality and things like that. It's hard listening to these people you know, it's constant. It's painful.
And you've just said there about going home and thinking about these people, is this something that happens regularly?
Oh yeh yeh....
...Something which you find hard to manage?
Oh no, no, you go home and think about people in a good way and a sad way you know because sometimes there's a lot of success stories as well and it's sometimes nice to hear people getting, you know, being well for a while and things, but you think about your patients and things like that.
You mentioned being upbeat as well, it's something you feel you have to be?
Well, no, no. I mean, it just happens naturally. It's not a forced thing at all, but I think it's more of, you can't not be upbeat. Because you can't obviously when someone does come in and they do look really poorly, you can't show you're kind of shocked even though you are so you've always got to be, you know, upbeat in front of them.
I mean, how do you manage that tension, because I suppose it can be in a way?
Erm, I don't know really, I just get on with it really.
So it doesn't really affect you in an explicit way when a patient comes in and there's a dramatic decrease in how they are.
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<td>Good day when things go right</td>
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<td>98</td>
<td>Angry</td>
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<td>99</td>
<td>Waiting to get upset</td>
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<td>100</td>
<td>Thinking about families</td>
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<td>101</td>
<td>Worrying about lack of knowledge</td>
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<td>102</td>
<td>Long day</td>
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<td>103</td>
<td>Try and form relationships</td>
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<td>104</td>
<td>Shocked by patients</td>
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<td>105</td>
<td>Learnt to be detached</td>
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<td>106</td>
<td>Not enough staff</td>
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<td>107</td>
<td>Not stepping back</td>
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<td>108</td>
<td>Too clinical</td>
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<td>109</td>
<td>Stress relief tactic</td>
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<td>110</td>
<td>Experience</td>
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<td>111</td>
<td>Take a step back</td>
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<td>112</td>
<td>Lack of trust</td>
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### Participant 01HM

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<thead>
<tr>
<th>Data Extract</th>
<th>Line Number(s)</th>
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<tbody>
<tr>
<td>Erm, when I walk out of the door from work to my home life my work stays in work (55)</td>
<td>41 - 42</td>
<td>55 - Able to contain work in work</td>
</tr>
<tr>
<td>I do enjoy coming to work. (16) I enjoy looking after the patients, I'll rephrase that. I enjoy looking after the patients and I enjoy the job I do. Erm, I enjoy, you know sitting and chatting to patients, you know about their sort of, their weeks since their last chemotherapy. (3) You know, about their side effects about their symptoms and just sort of generally... how their life is, you know. Certainly from patients that I've looked after in the past, erm, when they come in for their two or three week chemotherapy regimes, it's to them, it's a catch up. It's about, you know, how things, what their life is like and that type of thing, rather than them coming in, to sit in a chair, to receive chemotherapy and have that done to, you know sort of feeling really. It's about, you know, it's a catch up for them, just to see how everybody is and, you know, yeh. (56) (4)</td>
<td>56 - 66</td>
<td>16 - Job satisfaction</td>
</tr>
<tr>
<td>56 - Treat patients as humans</td>
<td></td>
<td>3 - Enjoy relationships with patients</td>
</tr>
<tr>
<td>4 - Developing close relationships</td>
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<tr>
<td>It's nice to know that they feel relaxed and sort of, and sort of within this sort of environment that they're coming in for their treatment for cancer they sort of lost within the... even though they're sat in a chair and receiving chemotherapy or whatever they maybe receiving. But they're sort of lost and they're still sort of able to talk about the nice things, you know, just about getting out and about and their families, what you've been doing and, it's nice to know that they feel sort of relaxed and comfortable talking to a complete stranger really when you think about. (57)</td>
<td>71 - 78</td>
<td>57 - Receiving something from the patient relationship</td>
</tr>
<tr>
<td>Getting their view on how they've</td>
<td>84 - 86</td>
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<tr>
<td>4 – Develop close</td>
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brought up their children and stuff like that, have you tried this and have you tired that and as I say it's just a sort of a general catch up and a chit chat for however long they're here for really.

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<th>Relationships</th>
<th>98 - 100</th>
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<tr>
<td>11 - Clinical-ness</td>
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I can't take on board because I'd never be able to do my job otherwise. If I got completely wrapped up in the patients, I'd ever be able to do my job, I'd be a complete and utter wreck. (11)

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I empathise with the patients. I sit and I listen and I listen and I listen. (58)

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if you're able to then, erm, help them through the end to make it as comfortable and to make it, erm... to ensure that their quality of life at the end is as... sustainable is the word to use then that, I feel re-assured to know that I've done my best for that patient. (59)

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<th>108 - 111</th>
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They're deteriorating week by week and that type of thing, and they're just sort of, come to a point when you think, if and when they die, you know it's the best thing for them. (60)

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<th>125 - 127</th>
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It is the best thing for them, yeh, they're in a better place, they've gone to a better place, out of their suffering, you know, however long they've been diagnosed, however long they've gone through, you know, treatment for, it's, it's a better sort of option really to die. (21)

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<th>135 - 138</th>
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Clinical. (11) It has to be, because you can't... maybe that's just me being hard, but after 13 years of looking after cancer patients, you can't... you know, you think about it. For instance, there was a patient we found out yesterday who passed away and he was literally here Wednesday, Thursday at his clinic appointment last week. And he'd been deteriorating week by week as he was coming in for treatment and clinic appointments and stuff and

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<th>143 - 151</th>
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11 - Clinical-ness

61 - Have that moment and move on
we found out yesterday he had passed away over the weekend, erm, so for a few maybe 10-15 minutes, you think about that patient, and then you think about well they're out of their suffering, you know (61)

| 158 – 163 |
| 105 – Learnt to be detached |
| 55 – Able to contain work in work |

As I say, when I look at people, certainly the newer qualified members of staff who you know, just starting out in their oncology career or their cancer, you know nursing career and to differentiate, it probably took me about two years, from when I first qualified, to be qualified for two years to sort of to learn to be able to do that. (105) To be able to sort of, when you walk out of work, you leave work at work; you know the emotional side of things. (55)

| 175-180 |
| 60 - Not affected by deterioration of patients |

Erm, I don't know. You've got nothing... there's nothing personal there with the patient. From a personal point of view my Dad died 13 years ago, I was 22, just had a massive heart attack and died, but when it's personal, when it's a family member, you look back and you talk about the good times to bring back those nice feelings and nice memories and stuff, but there's nothing... you're not emotionally attached to the patients. Again, it sounds hard, but you're there, we're here to do a job

| 184 - 186 |
| 60 - Not effected by deterioration of patient |

You know, I'm there to offer the patient advice, support and comfort while they're here having the treatment, but when they've gone, you then go onto the next patient and then the next patient and however many patients you have in a particular day. (60)

| 201 - 206 |
| 57 - Receiving something from patient care |

Positively, I know that I'm bringing something to the patient, you know, I'm there to treat them, you know with chemotherapy, psychological support, erm, refer them onto you know, necessary people if required.
Erm, whether that be counselling, whether that be palliative care for end of life, district nurses for support in the community and stuff like that. So that’s me doing a positive thing, it’s the whole package of what I’m there to do. (57)

It makes me feel... good I’m helping you know, because not everybody could do this job I don’t think. Like I said before, it gives me a sense of worthwhile and pride I suppose. (57)

I mean if you walked in and thought I’m going to save everybody today, you’d leave feeling very disappointed and sad because it just doesn’t happen like that (92)

Whereas for me, if I think, today I’m going to help the patient make one small improvement, whether that be diet or just to normalise something you gain a better perspective about the work you do (76)

Erm... but negative... I don’t feel it affects me in a negative way. (94)

everybody is going to die at some point but obviously these patients have got a disease that’s going to bring them closer to death and you or I, well, I could walk across the road and be knocked over by a bus on ym way home from work, you know, such is life really (9)

Yeh, it does yeh. Sorry, going back to my Dad dying, it does make your own family a little bit more precious and you do appreciate your home life and I do try and spend as much time with my kids and my own close family as much as possible, really. (9)

No, I would probably say I’m comfortable in my work. (63)

I certainly wouldn’t get anxious about anything, you know. (64) Ask. I’m quite open, I’ll ask
anybody whether that be the domestic that's cleaning, or you know the chief Exec if needs be. Consultants and stuff if I'm unsure about something.

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<tr>
<th>anybody whether that be the domestic that's cleaning, or you know the chief Exec if needs be. Consultants and stuff if I'm unsure about something (65)</th>
<th>communicate with colleagues</th>
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Well, no, I don't really get anxious if I'm honest.

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<tr>
<th>Well, no, I don't really get anxious if I'm honest (64)</th>
<th>257</th>
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Not at all no. I enjoy coming to work, (16) it doesn't depress me. (66) I enjoy coming into work to do what I'm doing, as in looking after the patients and looking after... sort of the political part of the work. That has an impact, in some way, but I don't let that affect how I look after the patients. (17)

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<th>263 - 266</th>
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I am enthusiastic about my job, again, to know that I'm sort of, you know, I'm here for the patients, it's nice that they get to know us as staff and get to come in all you by your name and ask how things are and stuff like that, so I certainly am enthusiastic to look after the patients and if you get to look after the same patients, even though the patients are allocated to different nurses, it's nice to be able to look after the same patients on a regular basis, for a general catch up if you like.

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<th>276 – 283</th>
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And, the job is varied in every way possible so I don't get particularly bored at work (1)

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Plus, you've got colleagues here to keep you chirpy and talk about other stuff, yeh. (65) So that's yeh... erm, I don't get tired, only when it's the end of the day and I'm on my way out of work, but it's that sort of, erm, sense of relief that when you do walk out of the door, you know, and it's almost as if, when you put your uniform on you turn into nurse mode, you turn into, you know Mum mode or that type of thing. (67)

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Certainly, from a different role perspective, when I did the chemotherapy course back in 2002,

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<th>301 - 304</th>
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we had to do an oral exam and one of the suggestions the lecturers gave was to, erm, if you want to be in that mind set of, erm, nurse, then you can wear the uniform, wear your nurses uniform for the oral exam and it worked (68)

You have to put a completely different head on and I'm sure everybody... because my husband or my kids, they haven't got a clue with the terms of whatever and that's probably one of the reasons I don't talk about my work because it doesn't, certainly my husband, he doesn't understand (69)

The only thing that I would say stresses me is when patients are allocated particular times to come in and there's a full day unit already and those patients have been given a time and for whatever reason, you know blood results, treatments being delayed, you know, consultants not seeing the patients, that type of thing, it's trying to fit the amount of patients in to those specific time slots without stressing the patient out. (42)

Satisfied as in looking after the patients I love that kind of thing. (16) (3) Satisfied as in my career, my job satisfaction as in I could do a lot more than what I'm doing for what my aspirations are as a nurse, it's far beyond what I'm doing. (87)

No no, because really, I am emotionally detached. (11) You can't take things home (69) with you can't take things to heart, you know, it's about giving the patient a better quality of life and listening to what they want to talk about. (58)

And I don't think that's a bad thing because it helps me and in 13 years of working so far I've never said oh

| 309 - 313 | 69 - Don't let work affect home life |
| 331 - 336 | 42 - Frustrations with environment |
| 356 - 358 | 16 - Job satisfaction |
| 356 - 358 | 3 - Enjoyment of interaction with patients |
| 401 - 403 | 11 - Clinical-ness |
| 401 - 403 | 69 - Don't let work affect home life |
| 412 - 416 | 60 - Not effected by deterioration of patient |
it's getting too much or anything like that. It's better being that way. If you took on board everything a patient said or every patient you looked after, then you'd be an emotional wreck, you wouldn't be able to do the job, which is why I'm here. (60)
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<tr>
<td>I love... I love being with patients, you know long term patients, because I'm in HTU, the transplant unit, so all of our patients are in for... when they come in for a transplant, they're in for three weeks so I like developing that rapport with people and you get to know they're family and... to me that's a better aspect of nursing to how I'd like to be a nurse rather than, you know, like an A&amp;E type nurse where they just see them, treat them and then go somewhere else, you know. (4)</td>
<td>25 - 31</td>
<td>3 - Enjoy relationships with patients 4 - Develop close relationships</td>
</tr>
<tr>
<td>Well, I don't get involved, I don't get personally involved (11)</td>
<td>41</td>
<td>11 - Clinical-ness</td>
</tr>
<tr>
<td>I suppose when you looking after somebody that may or may not be at the end of life, then it's bound to be a little upsetting, it's only normal isn't it. (61) But so far, I've not felt... upset yet. I genuinely haven't been upset, not that I mean to smile about it or anything. (60)</td>
<td>51 - 55</td>
<td>61 - Have that moment and move on 60 - Not effected by deterioration of patients</td>
</tr>
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<td>I don't know whether I'm getting hard in my old age or what [laughs], or whether it's something as a professional I might not do, you know. (60)</td>
<td>59 - 60</td>
<td>60 - Not affected by deterioration of patients</td>
</tr>
<tr>
<td>Well, I've not got, I haven't got upset, no. (60)</td>
<td>64</td>
<td>60 - Not affected by deterioration of patients</td>
</tr>
<tr>
<td>I think I probably... I thought I might do yeh because I've seen other girls get upset, you know, other nurses to get upset over different aspects of patients care and stuff like that.... I'm sort of like waiting for it to come if you know what I mean, I feel like it might be out there somewhere, but as of yet... (99)</td>
<td>68 - 71</td>
<td>99 - Waiting to get upset</td>
</tr>
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<td>The worst thing for I think is when someone actually reaches the end of life here on our unit and realistically it's dealing with the family afterwards, for me (88)</td>
<td>81 - 82</td>
<td>88 - Dealing with family after death</td>
</tr>
<tr>
<td>You know, when they're all very</td>
<td>82 - 87</td>
<td>88 - Dealing with</td>
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**Participant 02HM**
upset and they probably realise in their own minds that their family member is going to die, but when it actually happens, they're all upset on the other side of the room and that's the worst part for me. You know, seeing them upset and not necessarily the patient dying because it was expected, you know with the way in which the disease was going.

It's not a nice experience dealing with somebody whose just lost their Dad, or just lost somebody. I think I dealt with it alright, it didn't make me feel like I wanted to go home and be depressed or anything like that or particularly physically upset or emotionally upset or anything like that. It obviously had an impact on me, I'm not saying I'm hard or anything like that, it just... I think maybe I've got a tough exterior... a tough front a little bit, I don't know.

Well, it did happen toward the end of the shift, so, I was going home at the end anyway so... I think the next day is a new day, you come back and deal with things a different way, deal with different patients again.

I think about the family sometimes because they've come back and had a few chats with me and the ward sister, you know, about bits and pieces, but they haven't been back for a while now, but they're all fine. But you remember their faces you know, like you do.

Erm, knackered probably

I suppose it depends on what sort of day I've had really. Sometimes you feel quite high if you've treated someone really well and they're happy with the treatment, you go out on quite a high, you know. When it's an upsetting day, you know, you just go home and go to bed probably. It can be a bit
| No, no, I think I'm quite a different person when I go home because I've got teenage kids and stuff and I think I'm a normal Mother when I get back home. Or as normal as I ever am going to be! (67) | 134 - 136 | 67 - Able to adopt different roles |
| I just think I just do it. It's automatic. Take my uniform off and then I'm just a Mum again. (68) It doesn't seem to have any lasting effects on me, when I get out of this place. This is me and my profession here and when I leave here, I probably change into somebody else. (69) | 145 - 148 | 68 - Easily separate different roles 69 - Don't let work effect home life |
| I wanted to be one of those nurses that's not so involved that you're thinking about it every waking moment or anything like that, but you know, feel comfortable (63) talking to a patient and sort of things like that. (4) | 156 - 159 | 63 - Feel comfortable at work 4 - Develop Close relationships |
| No, my worry is, I suppose, lack of disease knowledge really about, because some of these people might have had. I mean obviously some cancers people have had are long term diseases aren't they? They probably have a lot of time to know what's going on and probably know more about the treatment their having than me as... a newly qualified nurse might have, so that... I do worry about that a little bit I think. (101) | 171 - 176 | 101 - Worrying about lack of knowledge |
| Yeh, I love it, (16) I mean, it's not busy enough for me sometimes but that's the private sector I think. (70) | 185 - 186 | 16 - Job satisfaction 70 - Not busy enough |
| Yeh, I like to be busy. On the haemotology side, on the side where I actually do work, it's not actually as busy as the oncology site. I'm not sure whether you've | 194 - 199 | 70 - Not busy enough 111 - Take a step back |
got any responses on that, who you might be interviewing, I don't know. I prefer to have a bit more work to be going on. Sometimes it's really busy an we have a lot going on, others it's quite quiet. I know my own limits and when to take a step back though.

I think I thrive more in a bit more of a stress like environment as apposed to being in a quiet environment, you know.

But occasionally we do sit down and have a little chat. Yeh, we do talk about things that have gone on an yeah we do talk about patients together. I like being around others, I couldn't do it on my own. You know, so, some patients have a difficult journey ahead of them, so we do empathise with them and try and... might talk to our colleagues a bit about bits an pieces without involving the patient, you know, everyone's has got a personal opinion about things, someone might not agree with certain things that they're doing, others do.

Yeh, I think we do. I mean we're in a small team, so we're probably quite a close team, I would say. We all feel comfortable an if something was bothering us we'd certainly be able to talk about it to another member of the team...

Yeh, I think, we were all a bit saddened by it really because he didn't have a very nice end to his life and it was all a bit distressing for the family, you know, so that's probably one of the reasons why I remember it more clearly than other ones. He was diagnosed quite late in the journey to the end of life, so, not so good for him an the family really. It was all a bit of a shock. not nice for them really as apposed to us trying to pick up the
pieces and help him, you know. working in oncology makes you think a lot of things, like I'm glad I don't have cancer or I hope I don't get cancer' because it's in your face everyday of your working life. (21) You're bound to think about your own mortality and what's going to happen to you. (9) But, I think I see it more of a positive thing, as in, look how lucky I am to be in good health and be in a position to help these people. (21) I think I've become desensitised to death now if I'm honest. When you are constantly around it or near it, it becomes... less of a stranger. (60)

Yeh, I'd say I'm satisfied, definitely, yeh. (16)

It's just, such an interesting and challenging environment for me as a nurse now. And it's a caring environment. (72) It's a good chance as an older nurse for me, to sort of like... well your personal skills are a bit different when you get older aren't they. You've gone through quite a lot in life and it's nice to be able to sit with the patient, have time with that patient and I just think here in the private sector it gives you that opportunity a bit more to do that. Just be able to spend a bit more time with them and you know, it's just a horrible journey that some of them have to face isn't it. I think think it's quite good we're able to support them and give them that bit more time sometimes (58) (4)

I mean, I suppose I still remain enthusiastic about my job. I do enjoy the job that I do here and... (16)

I suppose certain things do make me angry as well, but... (98)

I suppose that's more on the professional side really rather than working with patients really an working within a system really.
<table>
<thead>
<tr>
<th>Working with consultants and people in the network of the system really, more than anything else sometimes. (42)</th>
<th>351 - 357</th>
<th>42 - Frustrations with environment</th>
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<tbody>
<tr>
<td>That link between us and the outside world I suppose, is poor, sometimes it makes that journey from here into the next place quite a difficult thing, instead of doing it seamlessly like it should be it's traumatic and things get missed and medication gets missed off and it's all a bit... that makes me a bit cross. It's frustrating, when you look after someone to the best of your abilities here and it goes wrong when they go out the back door sort of thing. (42)</td>
<td>357 - 359</td>
<td>72 - Interesting and challenging environment</td>
</tr>
<tr>
<td>Certainly not bored here, (72) it can be tiring environment here, (6) obviously we do 12 and a half hour shifts here, that's quite difficult, especially when you get older like me [laughs].</td>
<td>364 - 366</td>
<td>6 - Tiredness</td>
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<td>I mean yeh, we all do long days here so, we start at like half past 7 and don't get out to quarter past 8, or 8 o clock, you know so it's quite a long day. (101) Which is fine when you're busy as it goes by quite quickly, but if you're clock watching it is a long day. (39)</td>
<td>370 - 375</td>
<td>73 - Enjoyment of work essential</td>
</tr>
<tr>
<td>Yeh, you need to enjoy it or you wouldn't be here otherwise for 12 and a half hours as if it's a depressing day or a traumatic day you wouldn't be able to cope with it would you. I don't think. (73) However... everyone is probably all a bit different so people cope with things a bit differently than others, you know. I think, I don't know we are quite a close team, so if things were bothering me or any of us, I'm sure we'd all be able to talk about it in our little unit. I think we're quite well supported by each other. (65) (85)</td>
<td>388 - 392</td>
<td>60 - Not effected by deterioration of</td>
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I don't know. It's a sort of... you get a little bit close to them, that patient, or any patient. I think sometimes it can be a little bit harder in our field because they come to our unit 3-4 weeks at a time so you'd have to be... I don't mean cold or anything like that, but, I can't think of the right word to say now, erm, it's normal to develop a bit of a relationship with them if you're going to be looking after them for 3-4 weeks. You can't just treat them just as.... it just wouldn't be quite right would it. (4)

| 400 - 406 | 4 - Develop close relationships |

| 413 | 64 - Not anxious |

| 413 - 415 | 69 - Don't let work effect home life |

| 420 - 421 | 66 - Not depressed |

| 432 - 434 | 94 - Not affected by work |

| 439 - 441 | 16 - Job satisfaction |

| 450 - 453 | 94 - Not affected by work |
is better things on offer now than there was a few years ago, better for patients and a better outlook now in that things can get treated more than they ever used to, for me, that's a positive feeling (21)

| But, I think because cancer can be so devastating, knowing that I'm helping in some small way, I think it makes everything worthwhile. What I get back from seeing a patient leave here, going back home makes everything worthwhile. You think, yeh, I know why I came into this profession, it's to help and when you know you have helped someone, however small, it makes me feel good. (57) | 469 - 474 | 57 - Receiving something from patient care |

21 - Positive philosophy
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<tr>
<td>Most days I feel... happy that when I walk out of the door that I've done everything I needed to do <em>(74)</em></td>
<td>30 - 31</td>
<td>74 - Happy</td>
</tr>
<tr>
<td>Yeh, I mean obviously there are days where you feel more stressed and when you've done what you need to do and you finally leave it's a bit of a... relief almost to leave. <em>(20)</em></td>
<td>45 - 47</td>
<td>20 - Stressed</td>
</tr>
<tr>
<td>Well, I mean you obviously feel good that you've achieved everything but if you've had a really, really busy day like that, you feel quite a sense of achievement <em>(13)</em></td>
<td>47 - 49</td>
<td>39 - Enjoy it being busy</td>
</tr>
<tr>
<td>Erm, just get on and do it really <em>(92)</em></td>
<td>65</td>
<td>92 - Not effected by stress</td>
</tr>
<tr>
<td>Erm, well it's just probably more the time pressure, because I come in in the morning and we have a meeting and so identify patients which may need your input, then the nurses do a referral which is the formal process, so I mean you get an idea in the morning of what you need to do that day to sort of plan your day. It's when those unexpected patients come in that need things right there and then so it's probably the skewing of your time plan that creates the... I don't know, but I think it's the thinking on your feet part of the job that I enjoy; never a dull moment <em>(75)</em> <em>(39)</em></td>
<td>54 - 61</td>
<td>75 - Time constraints</td>
</tr>
<tr>
<td>39 - Enjoy it being busy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erm, some days I can feel really... well most days feel really, a sense of worthwhile that I've done something that has helped that patient on the bed to improve their overall quality of life and when you get feedback from patients as well when you've suggested something that they feel they can incorporate and carry on with then, that does make you feel good. <em>(57)</em> <em>(39)</em></td>
<td>81 - 85</td>
<td>57 - Receiving something from patient care</td>
</tr>
<tr>
<td>Obviously the people I deal with are on the sicker end, erm, and it's... it does get you down a little bit, obviously when you go through the ward and everyone is dying, but you just got to think about, or the way I think about it is, what can I do to enhance their life and what they've got left. <em>(21)</em></td>
<td>92 - 96</td>
<td>21 - Positive philosophy</td>
</tr>
<tr>
<td>It's just sort of what you can offer to that</td>
<td>104 - 110</td>
<td>76 - Modifying</td>
</tr>
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</table>
patient. Like, I might have known them for quite some time and then they sort of start to deteriorate, then rather than saying, well you don't need my input anymore, they might not need, deictic input is not such a high priority anymore, obviously if someone is deteriorating and if they are going towards end of life, it's not such a consideration, but just because I've known that person as well (76).

> Sometimes it does make me emotional and cry, (77) but you've got to remember that these people have been through a lot and I think through the years, a lot of the time it's actually a relief. Like, for that person to have a sort of a... I mean liaison with a whole lot of health professionals, but they've come to the decision that no I don't want this treatment or this is the best place for me to be (21).

No I think, yeh, different moments or scenarios, I mean, I can have that moment. Most of the time I probably share it with my colleague who is the physio who is based where my desk is, and then sort of, move on. (61) (65)

> Yeh, yeh. I think, it's not a... it's just obviously a support thing that you know, someone else is having those feelings as well. (78)

We're not robots, we're all human, you have to chill out sometimes. (79)

Well, I love oncology. It's an area I moved into back home and when I came over here I did a bit of locum work, so it was a bit of everything, then sort of I, saw this job, which became available, then I saw it was oncology and it was the perfect scenario really. And I managed to get a position. And also because, erm, I've been able to build the service, you're the dietician, you're the sole dietician basically, do what you want. (16)

Well, yeh, I have a boss, but realistically kind of erm, being left with free sort of range an seeing the patients because it's private it's like charges you accumulate as well, but because of that, if you've got
<table>
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<tr>
<th>initiatives to broaden the capture area as well, then obviously it's a beneficial thing from higher up that you're trying to get more business really (92)</th>
<th>200</th>
<th>57 - Receiving something from patient care</th>
</tr>
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<tbody>
<tr>
<td>Yeh, the feeling that you've done something beneficial and worth while for them. (57)</td>
<td>219 - 224</td>
<td>80 - Empathy</td>
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<tr>
<td>Yeh I mean, it's not something I sing from the rafters or anything, but yeh, I think it maybe from the empathy side of it, all cancers are different and people journeys are different, I think probably maybe it's the... I obviously can't remember a lot of the things that I went though, I mean there's certain things, I think that it's from appreciating what my parents, my family went through when I was sick and trying to... and what I do trying to offer something, which is beneficial for that person. (80)</td>
<td>231 - 237</td>
<td>58 - Able to listen to patient</td>
</tr>
<tr>
<td>trying to empathise with the position that they are in or information that they've divulged to you because I think maybe the time I get to speak with patients, they don't just get to talk about food or what we were talking about that time, they do often bring up, erm, how they're feeling or anxieties and things, and I think it's important to at least address those, even though I may not be the person that deals with it. At least, kind of acknowledge them. (58)</td>
<td>247 - 249</td>
<td>57 - Receiving something from patient care 81 - Trust</td>
</tr>
<tr>
<td>if someone does identify something personal I actually feel quite honoured that they've trusted me enough, or comfortable in the situation that they can tell me that. (57) I think it's part of the trust thing. (81)</td>
<td>258 – 261</td>
<td>210 - Experience</td>
</tr>
<tr>
<td>And I think it's an experience thing as well, that, you may hear things rather than glossing over them and carrying on with what you're interested in, erm, is obviously identifying it and forming yes, this is the best person for that or at least addressing the issue so the person feels that whatever they've divulged has been addressed (110)</td>
<td>292 - 294</td>
<td>17 - Frustrations with management</td>
</tr>
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could have been better or certain things addressed. (17)

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<tr>
<th>I mean, you feel a bit annoyed, in that you can't go home when you wanted to go home, but I think that's a bit of a given, with the level of practitioner, which I am, a senior dietician, I think that with the job title and experience levels, it is a bit of give and take an it's not just get in at this time an walk out the door. And I think, yeh you do do overtime and you don't really get that time back. I don't try and stay longer than I need to. It is literally, what is the essential today and get that done. I try not to stay over though, I mean, I find that ridiculous'. (82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>324 - 330</td>
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<tr>
<td>82 - Not wanting to stay longer than necessary</td>
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. I used to be in walking distance and I thought that was quite good in the twenty minutes home, you've shaken things off and you can enjoy your evening. (69)

<table>
<thead>
<tr>
<th>it's not necessarily worrying because it's a positive thing. I mean sometimes I go home and think about if I have done something right and or something wrong, but, I think it's like normal I suppose, if I prescribed something right and acknowledging if an interaction went well or if it didn't what I did or what I could do again in the future to make it better (83)</th>
</tr>
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<tr>
<td>342 - 344</td>
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<tr>
<td>69 - Don't let work affect home life</td>
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</table>

My manager appreciated the input we have and the role of continuity as well, so that's good as well and makes you feel good as well. (84)

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<tr>
<th>Well, I think there are a lot of unhappy people here and don't enjoy working here, but I do, I'm really happy here and enjoy the work which I do. (16) I mean I came over here on a working holiday visa, and then when I got this job, they actually sponsored me, so I can stay in the country because I'm working for them, but it's not a big driver to think that, that's not my drive for work, but it's obviously a factor that if I quite I'd have to get a new visa, but I'm not in that position because I don't want to quit and I'm very happy here. I think being supported from my colleagues I feel supported that I'm doing a really good job, so that makes you happy too. (85)</th>
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<tbody>
<tr>
<td>360 - 362</td>
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<tr>
<td>84 - Recognition</td>
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</table>

| 16 - Job satisfaction |
| 85 - Supported by colleagues |
### Participant 04LM

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<tr>
<th>Data Extract</th>
<th>Line Number(s)</th>
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<tbody>
<tr>
<td><strong>Stressful.</strong>(20)</td>
<td></td>
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<tr>
<td>It's a stressful job anyway pharmacy because you've got to watch your back.</td>
<td>29</td>
<td>20 - Stressed</td>
</tr>
<tr>
<td>You're trying to pick up any Doctors mistakes, nurses mistakes, our mistakes,</td>
<td>56 - 59</td>
<td>38 - High pressured environment</td>
</tr>
<tr>
<td>technicians mistakes, you know anything like that so... <em>(38)</em></td>
<td></td>
<td></td>
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<tr>
<td>You've got to liaise with the nurses; you've got to trust your team</td>
<td>62 - 65</td>
<td>103 – Try and form relationships</td>
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<td>completely. When you haven't got that trust, or if it's a new team... you</td>
<td></td>
<td>112 – Lack of Trust</td>
</tr>
<tr>
<td>feel quite exposed, <em>(112)</em> so... you've just got to... well I try to form</td>
<td></td>
<td></td>
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<tr>
<td>those relationships with the consultants to begin with just so we can speak</td>
<td></td>
<td></td>
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<tr>
<td>to them. <em>(103)</em></td>
<td></td>
<td></td>
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<tr>
<td>Yeh, you have to get it right because at the end of the day you could... a</td>
<td>87 - 89</td>
<td>38 - High pressured environment</td>
</tr>
<tr>
<td>patient could die if you get the dose wrong or the... you know, wrong</td>
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<tr>
<td>scheduling, wrong number of intervals in between treatments. <em>(38)</em></td>
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<tr>
<td>I know it sounds really awful but you've got to be watching what people</td>
<td>128 – 134</td>
<td>38 – High pressured environment</td>
</tr>
<tr>
<td>are doing all the time and I know it sounds awful but there's certain people</td>
<td></td>
<td>112 - Lack of Trust</td>
</tr>
<tr>
<td>you can and some people you can't and <em>(112)</em>, erm, as a pharmacist you have</td>
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<td>to be very aware that you can fall foul of somebody else's mistake. Because</td>
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<td>in a court of law if you think 'well, I thought somebody else was going to do</td>
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<tr>
<td>it' doesn't defend you when somebody has died, you know, so it's quite</td>
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<td></td>
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<tr>
<td>stressful. <em>(38)</em></td>
<td></td>
<td></td>
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<tr>
<td>but if it's a bit more rushed or pressured to do it on time then... it sort</td>
<td>143 - 144</td>
<td>13 - Stressful environment</td>
</tr>
<tr>
<td>of can be a little bit stressful. <em>(13)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you've had a near miss or you know you haven't checked something properly</td>
<td>146 - 150</td>
<td>32 - Thinking about work at home</td>
</tr>
<tr>
<td>it's going round and round and round in your mind. I mean, I've woken up at</td>
<td></td>
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<tr>
<td>3 o clock in the morning and thought... having a mini panic attack thinking</td>
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<tr>
<td>have I... god I didn't check such and such. <em>(32)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because you know you're tired and because you know you're not focusing as</td>
<td>157 - 159</td>
<td>6 - Tiredness</td>
</tr>
<tr>
<td>you should be doing, that's when it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>start to happen and you start to spiral downwards (6)</td>
<td>I find the difficulty here is that it's a very young team and they're not very... well, the people I work with are not very appreciative of domestic pressures that you get because, well, two have just had babies, but that's as far as it's gone, so you haven't had school life and things like that you know, it is quite... (45)</td>
<td>171 - 175</td>
</tr>
<tr>
<td>People think I'm weird because you know, I work through my coffee breaks and just to sort of get it sorted and so I'm on top of things, you know. (29)</td>
<td>182 - 183</td>
<td>29 - Work overtime</td>
</tr>
<tr>
<td>I can't switch off, I'm one of those people, I don't even switch off when I get home, when, you know, which annoys my husband... (32)</td>
<td>191 - 192</td>
<td>32 - Thinking about work at home</td>
</tr>
<tr>
<td>I'm too tired, (6) but it's also that commitment to do those things and I feel like my job seems to take over my life, you know what I mean. It is important because it pays the you know, your wages but yeh... I don't have a very good balance (40) I'm afraid because when I am at home I'm usually helping out with Anna's homework or... doing other things.</td>
<td>195 - 198</td>
<td>6 - Tiredness 40 - Poor work/life balance</td>
</tr>
<tr>
<td>I'm always in that mind set that every time the phone goes there's an adrenaline rush (31) at home because you think that someone is going to be calling about something... (32) I am stressed; I know I'm stressed... (20)</td>
<td>200 - 202</td>
<td>31 - Constant adrenaline 32 - Thinking about work at home 20 - Stressed</td>
</tr>
<tr>
<td>Erm, I love doing what I do, (16) I don't think I'd want to at the moment, do anything because I feel you're in the thick of it and from an academic and stimulating environment it's all changing, it's all new, it's really revolutionary, you know what's happening at the minute (72)</td>
<td>208 - 211</td>
<td>16 - Job satisfaction 72 - Interesting and challenging environment</td>
</tr>
<tr>
<td>but negatively, yes, every single day you think there but for the grace of God (39)</td>
<td>211 - 212</td>
<td>39 - Negatively affected by work</td>
</tr>
<tr>
<td>I'm not used to seeing, erm, sort of young people coming in you know, I'm</td>
<td>212 - 215</td>
<td>104 – Shocked by patients</td>
</tr>
</tbody>
</table>
used to the breast and bowel and the lung, but generally, over the Alex they were slightly older. I mean, it's shocking at any age, but you know, some of the things you see here... (104)

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<tr>
<th>262</th>
<th>9 - Own mortality</th>
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</table>

Oh, god yeh. Well they must come in and... you just wonder why, you know (9)

| 223 | 10 - Thinking about patients outside of work |

Erm, sometimes, when it starts affecting your life at home, it does. You know, but, you seem to have that... you can't let go (10)

| 234 - 235 | 10 - Thinking of patients outside of work |

Well, thinking about people. (10) I suppose actually, you get to know them because you chat and to be truthful with you, I think this is why I prefer the day case unit because they're coming and they're having their treatment and everybody is positive, everybody is... it's a nice atmosphere because everybody is trying to... you know... (7) but you do listen to their problems constantly. They come in and you know, you're listening to them moaning constantly... sometimes if you're not feeling very well, you think, well, nobody ever bothers about me, (41)

| 239 - 245 | 10 - Thinking of patients outside of work |

| 7 - Not showing true emotion |

| 41 - Difficulty listening to patients |

I'm the one trotting around like a robot every single day (91)

| 245 - 246 | 91 - Robotic |

I think it's because I'm an aseptic pharmacist. If you put something in the wrong bag you're going to kill somebody so you have to be particularly, you've got to be right and this is how I do my work upstairs because you're going to end up giving the wrong bag to the wrong patient (38)

| 256 - 260 | 38 – High pressured environment |

| 42 - Frustrations with environment |

| 38 - High pressure environment |

you know it's like the scenario, they'll switch the rooms around without telling us, last week. I went in and I went 'oh mrs such and such and she said 'no', 'oh, I'm so sorry', you know that's how embarrassing it is because it looks as if you don't care, so you constantly check even though they put the patients in the rooms, you know, it's that sort of a scenario. (42) I'd rather be working like an idiot and

| 260 - 266 | 42 - Frustrations with environment |

| 38 - High pressure environment |
making sure it's right then you don't get complaints or offending people than be a little bit slap happy and, you know what I mean... (38)

<table>
<thead>
<tr>
<th>Erm, yes I am. I enjoy, like I said I love the, erm, (16)</th>
<th>272</th>
<th>16 - Job satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes I'm too tired (6) and I do have an irritable bowl and that sometimes kicks off when you try to do too much. (27)</td>
<td>279 - 280</td>
<td>6 - Tiredness, 27 - Physical problem</td>
</tr>
<tr>
<td>Yeh, I like to feel, I don't like to feel... I wouldn't like to do a boring job (43)</td>
<td>302</td>
<td>43 - Enjoy the variety</td>
</tr>
<tr>
<td>The biggest problem here is, I don't feel supported (19)</td>
<td>313-314</td>
<td>19 - Isolation</td>
</tr>
<tr>
<td>Here I feel as though I am on my own, which makes you feel absolutely terrible and down quite a lot of the time. (19)</td>
<td>317-318</td>
<td>19 - Isolation</td>
</tr>
<tr>
<td>because the consultants have been complaining about something, then they'd be on report for this, this and this and you know I think then for the grace of God. I think I've made a few mistakes (25), but you know it's not been noticed and I have had panic attacks since I've been working here (27) because I've thought ahhh god, and you've been awake all night and then you've got to come back and check something that it was ok, you know (32)</td>
<td>325 - 331</td>
<td>25 - Making mistakes, 27 - Physical problem, 32 - Thinking about work at home</td>
</tr>
<tr>
<td>There doesn't seem to be that buffering system here, (44) when they say, we know you've been doing a good job, we know that you're working as hard as you can, don't worry, but you know... and it's that... that doesn't exist here. (45)</td>
<td>330 - 333</td>
<td>44 - In the firing line, 45 - No recognition</td>
</tr>
<tr>
<td>..I'm not saying the consultants don't support you because they do, most of them... but, it's a very very strange set up here. (19)</td>
<td>339 - 341</td>
<td>19 - Isolation</td>
</tr>
</tbody>
</table>
| Erm... the anxiety, (46) depression (47) and tiredness (6) because that's what I am. Yeh, I'm in a constant state of anxiety. I've never felt comfortable, which is weird isn't it. (48) | 351 - 352 | 46 - Anxious, 47 - Depressed, 6 - Tiredness, 48 - Not feeling comfortable in the
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<th>Text</th>
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<td>I'm always on edge, I'm an edgy person anyway, I know I am and that's</td>
<td>356</td>
<td>93</td>
<td>Can't relax</td>
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<tr>
<td>probably why I can't relax (93)</td>
<td></td>
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<tr>
<td>and I think you miss that sort of rapport, so really it is very much up</td>
<td>364</td>
<td>49</td>
<td>No support team</td>
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<td>to you as an individual to get the work done (49)</td>
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<td></td>
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<tr>
<td>... you try and help people, but you don't want to seem domineering,</td>
<td>380</td>
<td>50</td>
<td>Difficulty forming relationships with colleagues</td>
</tr>
<tr>
<td>so whilst yeh, you do want to get on with people, I feel again there's</td>
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<td></td>
<td></td>
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<tr>
<td>nobody my own age that I can gel with, you know what I mean (50)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am depressed, I know I am. There are periods of time where I can't</td>
<td>392</td>
<td>47</td>
<td>Depressed</td>
</tr>
<tr>
<td>stop crying and sometimes it is work related sometimes it is at home.</td>
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<td></td>
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<tr>
<td>But something is going on that, erm, you just try and control it because I'm not one for this going to the GP or anything. (47)</td>
<td></td>
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<tr>
<td>when sometimes someone passes away here, you really got close with them,</td>
<td>400</td>
<td>5</td>
<td>Negative effects of deterioration of patients</td>
</tr>
<tr>
<td>you find that you're driving home and.. <em>sniffs</em>, but I mean, it's deeper than that, it drags you down (5)</td>
<td></td>
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<tr>
<td>it's a trust thing with the management and the company that I work for.</td>
<td>407</td>
<td>17</td>
<td>Difficulties with management</td>
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<tr>
<td>I actually said something last week and just exploded because I got a mouth full from a young lad when all I asked him to do was something quite menial, but I was doing it, erm and I just said I need to know where I stand. (17)</td>
<td></td>
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<tr>
<td>I need to know from you that we are getting supported, doing, you know giving the orders without any repercussions and I think that... makes me feel more depressed than dealing with the oncology side of things because (17)</td>
<td>411</td>
<td>17</td>
<td>Difficulties with management</td>
</tr>
<tr>
<td>Yes, because I know they're quite cut throat and ruthless. BMI was like that, very much so, that's why you just kept your head on the parapet, if you stuck it up, you'd get shot; like it or not shut up and get on with it (38)</td>
<td>440</td>
<td>38</td>
<td>High pressure environment</td>
</tr>
<tr>
<td>It's full on everyday, you're staying over to sort patients out to 7 o clock or whatever, (29) there's never a word of</td>
<td>448</td>
<td>29</td>
<td>Work over time</td>
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<p>| Code | Description |</p>
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<tr>
<td>thanks (45) but then you're getting picked for 'oh, there's such and such didn't do this' there's never any sort of supportive... I know sometimes I say oh it's a load of nonsense but people do want to feel wanted, you know. (44)</td>
<td>45 - No recognition 44 - Isolation</td>
<td></td>
</tr>
<tr>
<td>Yeh, tiredness is just what you're physically doing, you think, think, think, your brain never stops. (6)</td>
<td>470 - 471</td>
<td>6 - Tiredness</td>
</tr>
<tr>
<td>I can’t cope with it. (5) I'm not a nurse, I've always said I can't cope with that aspect of it. If I know them quite well and they're on the ward and they're not recognisable I just ten not to go in because I think 'oh god I'm going to start'. You know, you can't start crying your eyes out in front of people, (7)</td>
<td>481 - 484</td>
<td>5 - Negative effects of deterioration of patients 7 - Not showing true emotion</td>
</tr>
<tr>
<td>She had breast cancer for 20 odd years, but, what's his name... her son was the same age as my Chris.. Oh God, you know that is hard, when you put yourself in their circumstances...(89)</td>
<td>486 - 488</td>
<td>89 - Put yourself in their position</td>
</tr>
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<td>I don't cope with death (90)</td>
<td>492 - 493</td>
<td>90 - Can't cope with death</td>
</tr>
<tr>
<td>there's no point moping around and when thins really are going wrong then you really are in trouble. You know, you've got to, you're on the firing line here so you've just got to get it done (52) (95)</td>
<td>500 - 502</td>
<td>52 - No time to feel down 95 - In the firing line</td>
</tr>
<tr>
<td>I'm like, look, Andrew, at the end of the day I'm trying to do far too much and you know, it's difficult isn't it but I can't stop doing it (36)</td>
<td>525 - 527</td>
<td>36 - Can't focus on one job</td>
</tr>
<tr>
<td>Yeh and you've just got to cope with the lot that you've got and you shouldn't moan and this is what you say to yourself, you shouldn't moan because you could be in their situation. (21) So, you think, you know, life’s not that bad is it. You've got a good job a nice family, you got a nice house and everything and you just sort of... do it. (53)</td>
<td>537 - 540</td>
<td>21 - Positive philosophy 53 - Grin and bare it</td>
</tr>
<tr>
<td>I got angry last week (98)</td>
<td>550</td>
<td>98 – Angry</td>
</tr>
<tr>
<td>Oh yeh, you could choke the living day lights out of them [laughs]. (17)</td>
<td>570</td>
<td>17 - Difficulties with management</td>
</tr>
<tr>
<td>But, I thought, I know how exactly how you feel because you don't realise... you come out of here and</td>
<td>570 - 575</td>
<td>31 - Constant adrenaline</td>
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</tbody>
</table>
you're on this... *breathes in* (31) because you have to be, they used to call it the Alex smile, (7) and then you've got to be yourself again and because you've come down, you crash, you walk through the door home and whatever anyone says to you it's RARARA (40)

Yeh, you have to be all these different things to all these different people. (54) 583 - 584 54 - Being all things to all people

. But that's what I enjoy doing, but you think 'oh I should be doing this and I really should you know. But you are already committing your whole life and something to someone else for most of the week, you know. So it is, it's quite difficult (40) 590 - 593 40 - Poor work/life balance

Sometimes I have taken things home to [name of husband] and said 'you never guess what' and he's listened to me but other times he's gone mental and he said 'will you just stop talking about all these people who have died (33) 600 - 603 33 - Affecting home relationships

but sometimes you feel as though you've got to talk to somebody but there's nobody to talk to because... (19) 606 – 607 19 – Work isolation

but I don't really like that as you feel as though it's a weakness. I feel it's a weakness when you need not help sort of thing, but you know what I mean, because you know, just pull yourself together and you'll be damn fine (23) 611 - 614 23 - Don't talk to colleagues

You're not solving anyone else's problems or the patients’ problems by being morbid about things, which sometimes you do feel a bit morbid (86) don't you. (52) 616 - 618 52 - Talking doesn't help 86 - Morbid

It's because you're getting mixed messages from the hierarchy all the time about what's going on. (17) There's no stable influence there it's all moving and changing and people are leaving and people are going up and people are coming in there's no stability and people do need stability in their working lives. You spend a lot of time at work and you know, you need to feel comfortable there, you know. (48) 642 - 646 17 - Difficulties with management 48 - Not feeling comfortable in the environment
**Participant 05LM**

<table>
<thead>
<tr>
<th>Data Extract</th>
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<tbody>
<tr>
<td>So, the first year for me was really bad because it was incredibly busy and sometimes it's hard to sort of... to be thinking on your feet because as soon as the phone went down you're having to do something else (12)</td>
<td>23 - 25</td>
<td>12 - High work load</td>
</tr>
<tr>
<td>because I sometimes... sometimes get myself into the mind set that you know, you've got to do this, you've got to do this and you've got to do this and you're trying to do everything, for everyone. (24) And in the first year when... at sometimes that caused me problems in that if I was to maybe '....' I might make an error because I'd been interrupted or something else had happened (25)</td>
<td>27 - 31</td>
<td>24 - Wanting to do everything for everyone 25 - Making mistakes</td>
</tr>
<tr>
<td>So there was all this kind of, nothing was straight forward, you couldn't just sort of go, you know, work on one thing because always something else happened... something was more urgent (2)</td>
<td>35 - 37</td>
<td>2 - Flexible</td>
</tr>
<tr>
<td>It’s not as easy... it's easier said than done, you know, because we're all very busy because I suppose probably between about February to October, that's the time when people have holidays so you never really have a full complement of staff (107)</td>
<td>41 – 43</td>
<td>106 – Not enough staff</td>
</tr>
<tr>
<td>I... I got myself into a bit of a problem in that I had a... I suppose you'd call it a haemorrhaging in my right... you can't tell by looking at me, in my right eye, which caused like a retinal vein... which was caused by blood pressure. (27)</td>
<td>54 - 57</td>
<td>27 - Physical problem</td>
</tr>
<tr>
<td>It's a stressful environment (13) because everybody wants things done, if you've got patients coming in etcetera, obviously the important thing is the patient and then your consultants, but when you've, when you've not got a full compliments of staff sometimes it can be... it's too</td>
<td>69 - 72</td>
<td>13 - Stressful environment 24 - Wanting to do everything for everyone</td>
</tr>
</tbody>
</table>
much because sometimes (24)

I do ridiculous things, like I'd work through my lunch hour or I'd stay after work or and sometimes I'd help other teams, I used to work weekends, not for the HCA, but on the NHS side as well which I've now given up. (29) Because you just got into doing it, so you became a kind of, a bit like robotic, (91) in a sense, because you didn't think as you were always doing it (30)

72 - 77  29 - Work overtime
30 - Working on automatic pilot
91 - Robot

I do get incredibly down about it sometimes though, you know (47)

78 - 79  47 - Depressed

You know, like, because it's kind of like, you're in work and you're kind of like on full speed and you don't actually step back you know. Some of it's my own fault when I think about it. (107)

88 - 91  107 – Not stepping back

In the sense that you always want to get everything done and keep everybody happy. (24)

95 - 96  24 - Wanting to do everything for everyone

I know that's kind of a strange word to say hyped, but, so, when you get home, you're still in a sense, you know racing, you're still that... (31)

110 - 112  31 - Constant adrenaline

Buzzing. But that's really, it's good and bad because it's good to have that adrenaline rush but not on a permanent basis. It can't be healthy I suppose (31)

116 - 117  31 - Constant adrenaline

and I have been at home... still now but not to that greater degree and you think 'oh, I must speak to... and check that scans come through' because sometimes your work comes back with you. (32)

119 - 122  32 - Thinking about work at home

and you've been working with lots of different people and different names come into your head and you'll think to yourself, 'did I do that? (25)

128 - 129  25 - Making mistakes

Well, to be honest no (32)

149  32 - Thinking about work at home

the inevitability is that's what's would have happened anyway, (21) but I suppose, even though you know it's there you don't really think about it (26) until it's actually

156 - 159  21 - Positive philosophy
26 - Don't think about death
happened and then you sort of start to feel sad. (5)

You just have that moment because you can't help but feel sad, it's terrible (77)

I'd like to sort of think I can rise above it, you know. I mean, I'm trying to be philosophical in a sense in that I know we're all born to die and at some point... other people have got designated times than others and some people haven't and it's just one of those facts of life. (21)

But, I mean it's just a fact isn't it. I think that's me in my clinical approach. In some respects maybe it is good to think in a... I don't know in a clinical sense (11)

In some respects, yeh, because you have to have that kind of... be kind of like clear cut, I mean, you know, because it's easy to get involved with patients etc. (11)

No, but it's when you think about, when you're talking about emotions when you're having to think clinically and then you're having to be emotional then that could cause problems, do you know what I mean. (11)

Well, I think I have to and I do yeh, so I suppose I am, even though I think I am warm, sometimes I might come across a bit clinical because I don't want to get overly involved you know. I guess I'm worried that my personal side might come out a bit more, so perhaps I don't listen to the patient as much as I should. (108)

Oh yeh, they're very important, very very important because more often than not if the patient phones me up, sometimes it's things that they're not saying, you kind of like sense things.
or I can sometimes.  

<table>
<thead>
<tr>
<th>Text</th>
<th>238 - 240</th>
<th>4 - Develop close relationships with patients</th>
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</thead>
<tbody>
<tr>
<td>So, I've had situations where I've had conversations with patients like that, or relatives, so when you get to know them it tends to be come more personal in some respects (4)</td>
<td>240 - 242</td>
<td>16 - Job satisfaction</td>
</tr>
<tr>
<td>From that aspect, I do enjoy the job. Because there are a lot of patients that survive so that's really good... yeh... I must enjoy it to still be here, so... in that sense (16)</td>
<td>296 - 305</td>
<td>29 - Work over time</td>
</tr>
<tr>
<td>Well, I tend to come in earlier to work, a) to get a coffee and look at the email and then I sort of like break into the day. I might have a list of things that I already need to do that I've already got set in my mind that I tend to do. (29) Then you just sort of tend to like, go with it. Maybe in the past, in the first year I may have been a bit too mad really because I'd try and come in and do... 'cos I mean, you do... if you arrive early at work you do start to do work whatever happens, so you end up doing something but in some respects it's quite good because it kind of like paces you, the day, whereas if I came in on time it'll all go... slightly frantic, (12) so if I give myself that bit of time, which you're actually giving to the company but I mean, whatever. I mean, it works because it gives you time to organise. But I suppose if I ended up in a really comfortable role, I'd probably hate it because I wouldn't have that kind of... managed adrenaline rush (33)</td>
<td>321 - 322</td>
<td>33 - Enjoy it being busy</td>
</tr>
<tr>
<td>But that kind of... it makes you, erm, you have to think on your feet, whereas if you're in somewhere, it's the only way I can think of it, if you're doing something which is very like, straight forward or kind of like monotonous, it's kind of like, I don't know, something really simple, whereas if you're having to do a few things at once, you're having to go</td>
<td>333 - 338</td>
<td>1 - Different jobs in a day</td>
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‘tsh tsh tsh’ and that tends... that works, I like that kind of... (1)

| when I had the retinal vein inclision or.. that's kind of, I don't know, frightened me a little bit perhaps, well a lot. to be honest at the time (27) | 369 - 371 | 27 - Physical problem |

I don't know, it's sometimes difficult I think to talk about if there's something wrong with you in a cancer ward because, when it's not cancer it pales into insignificance really, doesn't it. And, I didn't want people to see me upset or worry about me, so I guess I just did what I always had done and try and get on with it. (23) Outside I was cool as a cucumber but inside all sorts was going on. (7) You know, you can't see a ducks legs or whatever it was, it's kind of like that. But, I think it was more of a shock than anything else

| I think maybe possiblly, yes, probably if I was going to be truthful. Yeh because, obviously I wasn't aware of whatever was going on inside of me, that was creating that situation and because something did had to happen to cause that situation, then... (34) | 419 - 421 | 34 - Not aware of feelings |

because at work I tend to be a bit of a joker or I tell jokes or just whatever, I make some like random statement (35)

| 435 - 436 | 35 - Make colleagues happy |

Well, if you're analysing I probably use that as a form of stress relief. (109) I like to feel that, let's say my colleague is going to stop and take a few minutes, because there is one, a situation this week where one of my colleagues was a bit stressed because she had a lot on so I just said, put your phone on, take ten minutes and go for a walk (35)

| 457 – 460 | 109 – Stress relief tactic |

35 – Make colleagues happy

By almost joking, it's easier to ignore isn't it. (28) Let's all forget about all this we have in front of us, because sometimes if you really think about what you have to do,

| 465 - 470 | 28 - Ignore emotion |

20 - Stressed
how much you have to and all that, it can become a bit overwhelming. (20)

<table>
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<tr>
<th>I was working for a consultant who was a fabulous guy and erm, there was a point where I'd made a few errors in letters and things, which I never normally do...</th>
<th>479 - 481</th>
<th>25 - Making mistakes</th>
</tr>
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<tbody>
<tr>
<td>Yes, when I had more to do. The stress was a result of having to work for lots of different people and then having so much to do (25)</td>
<td>487 - 488</td>
<td>25 - Making mistakes</td>
</tr>
<tr>
<td>If you could divide yourself up into three people it would be perfect because, physically, that's what you needed to do. You needed to be two people, if you were to do it to perfection. (36)</td>
<td>496 - 498</td>
<td>36 - Can't focus on one job</td>
</tr>
<tr>
<td>Yeh, you are. It's kind of like, I suppose, my thought processes are a bit stupid, maybe a bit old fashioned because it's like, let's just save the day, let's just get it done, almost superhuman, which you're not. (24)</td>
<td>505 - 507</td>
<td>24 - Wanting to do everything for everyone</td>
</tr>
<tr>
<td>I do enjoy what I'm doing (16)</td>
<td>519</td>
<td>16 - Job satisfaction</td>
</tr>
<tr>
<td>But when you're working for seven people or eight people depending on what their workload is, you can't be as... the role can't be that perfected because you're only doing a section of that role. (36)</td>
<td>522 - 525</td>
<td>36 - Can't focus on one job</td>
</tr>
<tr>
<td>Recently, I've got more involved with kind of like patient calls, which I quite enjoy (37)</td>
<td>529</td>
<td>37 - More involved with patients</td>
</tr>
<tr>
<td>I do like having a mix role because it's interesting and you don't get bored. Because quite a lot of jobs, you just come in and do it where working for.... what we're doing now, that's not the case. There is such a lot of variety (1)</td>
<td>536 - 539</td>
<td>1 - Different jobs in a day</td>
</tr>
<tr>
<td>Invariably I do start working, but it suits me and there's probably a sense of stupidity there in some senses because technically your supposed to do whatever you're going to do in your 7.5 hours but that's sometimes not possible (29)</td>
<td>546 - 550</td>
<td>29 - Work over time</td>
</tr>
<tr>
<td>And sometimes I can walk down the</td>
<td>564 - 566</td>
<td>32 - Thinking</td>
</tr>
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road and think 'oh'. It'll just come into my head, little things I've done. It doesn't halt me or anything like that. I sound totally work obsessed (32) about work at home
**Participant 06LM**

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<thead>
<tr>
<th>Data Extract</th>
<th>Line Number(s)</th>
<th>Code</th>
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<tbody>
<tr>
<td>Average day, you get there in the morning, make sure all the clinic's prepped for the people who are coming in etcetera, start greeting patients, start checking them in and dealing with day to day admin work, anything can change within the day (1) I mean one day you can have an SOS patients coming in, emergencies that happen on the day unit, etc, then you know re-book the patients before they leave etcetera (2)</td>
<td>29 - 34</td>
<td>1 - Different Jobs in a day</td>
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<td></td>
<td></td>
<td>2 - Flexible</td>
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<tr>
<td>Yeh, I love it, you see them once every two to three weeks, so they become more like friends than patients (3) so yeh, you build up a really good relationship with them, so, I do enjoy it (4)</td>
<td>42 - 44</td>
<td>3 - Enjoy relationships with patients</td>
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<td></td>
<td></td>
<td>4 - Develop close relationships</td>
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<tr>
<td>Knackered basically. Not physically but mentally drained because it's a really, you know, when you see people coming in who are really poorly and erm, you know that kind of affects you a little bit when you see them go down hill a little bit and, yeh, so you just feel emotionally drained (5)</td>
<td>49 - 52</td>
<td>5 - Negative effects of deterioration of patients</td>
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<td></td>
<td></td>
<td>6 - Tiredness</td>
</tr>
<tr>
<td>I don't know you just feel a bit like... tired sometimes with it all, you know what I mean... (6)</td>
<td>55 - 56</td>
<td>7 - Not showing true emotion</td>
</tr>
<tr>
<td>Well, you're always having to be upbeat so it's quite draining. It's hard to take that mask off at the end of the day. It is hard to switch to [says name] the friend (54) I can't show my feelings because if I show my concern then how are the patients going to feel? (7) Oh God they'll say, why is he worried about me? If he's worried about me then there must be seriously wrong. When sometimes you do want to say 'shit', that is really bad I'm so sorry (8)</td>
<td>61 - 67</td>
<td>8 - Unable to be honest</td>
</tr>
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<td></td>
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<td>54 - Being all things to all people</td>
</tr>
<tr>
<td>I don't know, you go home and you think about your own kind of mortality and things like that. (9) It's hard listening to these people you know, it's</td>
<td>69 - 71</td>
<td>9 - Own mortality</td>
</tr>
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<td></td>
<td></td>
<td>41 - Difficulty listening to</td>
</tr>
<tr>
<td>constant. It's painful. (41)</td>
<td>80 - 83</td>
<td>10 - Thinking about patients outside of work</td>
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<td>you go home and think about people in a good way and a sad way you know because sometimes there's a lot of success stories as well and it's sometimes nice to hear people getting, you know, being well for a while and things, but you think about your patients and things like that (10)</td>
<td>88 - 91</td>
<td>7 - Not showing true emotion</td>
</tr>
<tr>
<td>Because you can't obviously when someone does come in and they do look really poorly, you can't show you're kind of shocked even though you are so you've always got to be, you know, upbeat in front of them (7)</td>
<td></td>
<td></td>
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<td>you do try and detach yourself a little bit from it (11)</td>
<td>101</td>
<td>11 - Clinical-ness</td>
</tr>
<tr>
<td>If they come in quite regularly, you know you can't help but get to know them, a bit about their life and... the history of stuff I guess (4)</td>
<td>106 - 108</td>
<td>4 - Develop close relationships</td>
</tr>
<tr>
<td>Erm, I don't know, it's a bit of a balance really... 'cos it's erm... I don't know. I don't know really because like a say you know, you've got the good times and the bad times, so... and you just deal with each day depending on what's going on, on that day (96)</td>
<td>108 - 110</td>
<td>96 - Each day as it comes</td>
</tr>
<tr>
<td>Well, there's a lot of factors which come into consideration as well not just the patients but the work load is quite stressful at times, (12) and things like that then you don't get the chance to interact with the patients as much as you'd like (3)</td>
<td>120 - 120</td>
<td>12 - High work load</td>
</tr>
<tr>
<td>a good day can be like, I don't know... when everything goes right... there's no emergencies to deal with and things like that... (97)</td>
<td>122 - 124</td>
<td>3 - Enjoy relationships with patients</td>
</tr>
<tr>
<td>Yeh, it is really, it is really stressful (13) at times because the work load can be quite demanding, you know having to look after patients, consultants, nurses, do your admin work, answer the phones and when you're on your own having to deal with all that and I can stress myself out (1) (12)</td>
<td>128 - 131</td>
<td>13 - Stressful environment</td>
</tr>
<tr>
<td></td>
<td>12 - High work load</td>
<td></td>
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<td></td>
<td>1 - Different jobs in a day</td>
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Yeh, it's more of an emotional response thing really, negative emotion, you get a bit fed up with it at times really. Having so much to do, it's not fun. (12) Well, I mean, work isn't supposed to be fun but the stress sort of takes the enjoyment out of the work and you just always think, I can't wait to go home now because this is coming all a bit much. (14) When you become stressed, I sort of feel I lose interest in it an it's not that I can't cope with it, because I can, but it's difficult to remain, I suppose going back to what you were saying... erm, positive really. (15)

I mean I'm very satisfied with my role (16) and what I do and the interactions I have with the patients and things like that (3) but then obviously, when you're put under a lot of pressure from the management and things like that, it makes you a little dissatisfied with the role (17)

Oh yeh, I do, I love my job (18)

Well... it's like everywhere you just get more and more put on you don't you, so, you're expect to manage it all on your own, erm, because basically there's a team of us. There's a team of three in the outpatient department but there's only me on my own so I don't really get any support that way and you just get more and more things to do. (19) And... you just have to get on with it really. But obviously it's not ideal, because when you give yourself more and more work, it becomes more difficult to cope with it, you get frustrated and I don't know, it just becomes difficult sometimes. (12) (20) (42)

Well, the way I see it is that at the end of the day, I get to go home and you know and I'm ok, whereas these people are poorly, so I try to put it into perspective if you know what I
<table>
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<th>Topic</th>
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<tbody>
<tr>
<td>Working here obviously even though I am stressed and sometimes a bit unhappy with the way things are going. (20) things always could be worse you know (21)</td>
<td>177 - 179</td>
<td>20 - Stressed, 21 - Positive philosophy</td>
</tr>
<tr>
<td>You know, they just push you to the absolute limit but you never show it sort of thing. (7) No, at home it's different isn't it. You go home, you need to kick a cat when you walk through the door (22)</td>
<td>185 - 187</td>
<td>7 - Not showing true emotion, 22 - Letting frustration out at home</td>
</tr>
<tr>
<td>Well, mostly tiredness, like mentally tired at the end of the week, (6) but I'm also enthusiastic and I take pleasure in my work (16)</td>
<td>196 - 197</td>
<td>6 - Tiredness, 16 - Job satisfaction</td>
</tr>
<tr>
<td>You get angry sometimes at young people, when they're really ill, so I guess quite a lot of them really. (98)</td>
<td>199 - 202</td>
<td>98 - Angry</td>
</tr>
<tr>
<td>Well, I guess so, I don't know really, I just think because you're always on show and you're always dealing with people on a daily basis and things like that and then having to sort of... (7) see what they're going through, you do get tired, I don't know how to put it really... (6)</td>
<td>204 - 207</td>
<td>7 - Not showing true emotion, 6 - Tiredness</td>
</tr>
<tr>
<td>Well, I just sort of offload to my friends really, but I don't express it here if I can (23)</td>
<td>230</td>
<td>23 - Don't talk to colleagues</td>
</tr>
<tr>
<td>I mean I'm very satisfied with my role and the interactions I have with the patients and things like that but then obviously I would like something more, just, I don't know, I guess I'm alright for the time being. (16)</td>
<td>241 - 243</td>
<td>16 - Job satisfaction</td>
</tr>
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1. **Initial Grouping of Codes**

- Tiredness - 6
- Physical problem - 27
- Wanting to escape - 14
- Constant adrenaline - 31
- Angry - 98
- Making mistakes - 25
- Morbid - 86
- Sad - 77
- Happy - 74
- Depressed - 47
- Not aware of feelings - 34
- Can't relax - 93
- Not depressed - 66
- Not anxious - 64
- Own mortality - 9
- Not affected by work - 94
- Increased negativity - 15
- Can't relax - 93
- Can't stop thinking - 51
- Stressed - 20
- Anxious - 46
- Allowing to feel - 79

**General Perceptions of Work**
2. Refinement of Codes

**Physiological**
- Making mistakes - 25
- Physical problem - 27
- Tiredness - 6
- Constant adrenaline - 31
- Wanting to escape - 14

**Feelings**
- Depressed - 47
- Angry - 98
- Not aware of feelings - 34
- Happy - 74
- Sad - 77
- Anxious - 46
- Stressed - 20
- Morbid - 86
- Allowing to feel - 79
- Not depressed - 66
- Not anxious - 64

**Thoughts**
- Can’t stop thinking - 51
- Increased negativity - 15
- Not affected by work - 94
- Own mortality - 9
3. **Further Refinement and Deletion of Codes**

![Diagram]

- **Physiological**
  - Making mistakes - 25
  - Tiredness - 6
    - Physical problem - 27
    - Wanting to escape - 14

- **Feelings**
  - Depressed - 47
    - Happy - 74
    - Anxious - 46
    - Stressed - 20
  - Not aware of feelings - 34
  - Not depressed - 66
  - Not anxious - 64
  - Allowing to feel - 79

- **Thoughts**
  - Increased negativity - 15
  - Not affected by work - 94
4. **Naming of Theme**

- **Consequences of Oncology**
  - Tiredness - 6
  - Making mistakes - 25
  - Physical problem - 27
  - Increased negativity - 15
  - Not affected by work - 94
  - Wanting to escape - 14

- **Impacts of Working in Oncology**

- **Emotions**
  - Depressed - 47
  - Not aware of feelings - 34
  - Not depressed - 66
  - Happy - 74
  - Anxious - 46
  - Not anxious - 64
  - Stressed - 20
5. **Final Theme and Sub-Themes**

- **Individual Impact of Working in Oncology**
  - Personal Consequences
  - Emotions
1. Initial Grouping of Codes

Patients

- Can’t cope with death - 90
- Waiting to get upset - 99
- Difficult to listen to patients - 41
- Empathy - 80
- Treat patients as humans - 56
- Too clinical - 108
- Develop close relationships - 4
- More involved with patients - 37
- Dealing with family after death - 88
- Trust - 81
- Put yourself in their position - 89
- Able to listen to patient - 58
- Done the best you can - 59
- Positive philosophy - 21
- Not showing true emotion - 7
- Not able to be honest - 8
- Sad - 77
- Clinical-ness - 11
- Shocked by patient - 104
- Not affected by deterioration of patient - 60
- Changing perspective of success - 92
- Not able to be honest - 8
- Not affected by deterioration of patient - 60
- Negative effects of deterioration of patient - 5
- Enjoy relationships with patients - 3
- Receiving something from patient relationship - 57
- Have that moment and move on - 61
- Don’t think about death - 26
- Able to listen to patient - 58
- Done the best you can - 59
- Positive philosophy - 21
- Not showing true emotion - 7
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- Shocked by patient - 104
- Not affected by deterioration of patient - 60
- Changing perspective of success - 92
- Not able to be honest - 8
- Not affected by deterioration of patient - 60
- Negative effects of deterioration of patient - 5
- Enjoy relationsh
2. **Refinement of Codes**

**Interaction**
- Able to listen to patient - 58
- Empathy - 80
- Trust - 81
- Put yourself in their position - 89
- Develop close relationships - 4

**Aftermath of Death**
- Dealing with family after death - 88
- Can’t cope with death - 90
- Don’t think about death - 26

**Coping Strategies**
- Learnt to be detached - 105
- Done the best you can - 59
- Not showing true emotion - 7
- Not able to be honest - 8
- Changing perspective of success - 92
- Positive philosophy - 21
- Clinical-ness - 11

**Impact of Patient**
- Shocked by patient - 104
- Have that moment and move on - 61
- Receiving something from patient relationship - 57
- Enjoy relationships with patients - 3
- Not affected by deterioration of patient - 60
- Sad - 77
- Not affected by deterioration of patient - 5

- Waiting to get upset - 99
- Difficult to listen to patients - 41
- Treat patients as humans - 56
- Too clinical - 108
- More involved with patients - 37
- Able to listen to patient - 58
- Done the best you can - 59
- Positive philosophy - 21
- Enjoy relationships with patients - 3
- Treating patients as humans - 56
- Changing perspective of success - 92
- Positive philosophy - 21
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- Changing perspective of success - 92
- Positive philosophy - 21
- Enjoy relationships with patients - 3
- Treating patients as humans - 56
- Changing perspective of success - 92
- Positive philosophy - 21
- Enjoy relationships with patients - 3
3. **Further Refinement and Deletion of Codes**

**Interaction**
- Able to listen to patient - 58
- Empathy - 80
- Trust - 81
- Put yourself in their position - 89
- Develop close relationships - 4
- More involved with patients - 37
- Too clinical - 108
- Treat patients as humans - 56

**Coping Strategies**
- Not showing true emotion - 7
- Learnt to be detached - 105
- Positive philosophy - 21
- Clinical-ness - 11
- Not able to be honest - 8

**Impact of Patient**
- Sad - 77
- Can’t cope with death - 90
- Shocked by patient - 104
- Have that moment and move on - 61
- Receiving something from patient relationship - 57
- Enjoy relationships with patients - 3
- Not affected by deterioration of patient - 60
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- Too clinical - 108
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- Able to listen to patient - 58
- Empathy - 80
- Trust - 81
- Put yourself in their position - 89
- Develop close relationships - 4
- More involved with patients - 37
- Too clinical - 108
- Treat patients as humans - 56

---

285
4. Further Refinement, Naming Themes and Sub-Themes

**Closeness of Relationships**
- Able to listen to patient - 58
- Difficult to listen to patients - 41
- Develop close relationships - 4

**Empathy - 80**
- Trust - 81
- Too clinical - 108

**Patient Relationships**
- Not showing true emotion - 7
- Not able to be honest - 8
- Clinical-ness - 11
- Not affected by deterioration of patient - 60
- Have that moment and move on - 61
- Sad - 77
- Negative affects of deterioration of patient - 5

**Coping Strategy**
- Receiving something from patient relationship - 57
- Enjoy relationships with patients - 3

**Impact of Patient**
- Can’t cope with death - 90
- Have that moment and move on - 61
5. Final Theme and Sub-Themes

- Closeness of Relationships
- Impact of Patient
- Coping Strategy
- Importance of Relationship

Diagram: Patient Relationships

287
1. **Initial Grouping of Codes**

- Supported by colleagues - 85
- Try and form relationships - 103
- Difficulty forming relationships with colleagues - 50
- Lack of trust - 112
- Recognition - 84
- No support team - 49
- No recognition - 45
- Don’t talk to colleagues - 23
- In the firing line - 95
- Isolation - 19
- Talking doesn't help - 52
- Difficulty with management - 17
- Make colleagues happy - 35
- Share feelings with colleagues - 78
2. **Refinement and Deletion of Codes**

- **Communication**
  - Try and form relationships - 103
  - Difficulty forming relationships with colleagues - 50
  - Able to communicate with colleagues - 65
  - Make colleagues happy - 35
  - Share feelings with colleagues - 78
  - Don't talk to colleagues - 23
  - Lack of trust - 112
  - Talking doesn't help - 52

- **Support**
  - Supported by colleagues - 85
  - No support team - 49
  - Isolation - 19
3. Final Theme and Sub-Themes

Staff Relationships

- Ability to Communicate
- Feeling Supported
1. **Initial Grouping of Codes**

- Grin and bare it - 53
- Easily separate different roles - 68
- Able to adopt different roles - 67
- Thinking about work at home - 32
- Constant adrenaline - 31
- Poor work/life balance - 40
- Thinking about patients outside of work - 10
- Don’t let work affect home life - 69
- Affecting home relationships - 113
- Not concerned about thinking about work – learning - 83
- Letting frustrations out at home - 22
- Being all things to all people - 54
- Ignore emotion - 28
- Able to contain work in work - 55
2. Refinement and Deletion of Codes

- Ability to Contain
  - Being all things to all people - 54
  - Able to contain work in work - 55
  - Able to adopt different roles - 67
  - Easily separate different roles - 68
- Poor work/life balance - 40

- Impact on Home life
  - Thinking about work at home - 32
  - Don’t let work affect home life - 69
  - Affecting home relationships - 113
  - Not concerned about thinking about work - learning - 83
  - Thinking about patients outside of work - 10
  - Constant adrenaline - 31
  - Letting frustrations out at home - 22
3. Further Refinement and Naming of Themes and Sub-Themes

- **Ease of Transition**
  - Being all things to all people - 54
  - Able to contain work in work - 55
  - Able to adopt different roles - 67
  - Easily separate different roles - 68
  - Poor work/life balance - 40

- **Impact on Home life**
  - Thinking about work at home - 32
  - Affecting home relationships - 113
  - Constant adrenaline - 31
  - Don’t let work affect home life - 69
  - Not concerned about thinking about work – learning - 83
  - Letting frustrations out at home - 22
  - Thinking about patients outside of work - 10
4. Final Theme and Sub-Themes

- Transition to Home
  - Ease of Transition
  - Impact on Home life
2. Refinement of Themes and Deletion of Codes

PERCEPTION OF JOB
- Enjoyment of job - 73
- Enjoy the variety - 43
- Job satisfaction - 16
- Allowing to feel - 79

WORK ETHIC
- Work over time - 29
- Robotic - 90
- Wanting to do everything for everyone - 24
- Can’t focus on one job - 36
- Working on auto-pilot - 30
- Not wanting to stay longer than necessary - 82

Attitudes to Work
- Enjoy it being busy - 39
- Not busy enough - 70
- Self imposed high work load - 12
- Take a step back - 111
- Different jobs in a day - 1
- Thrive in stress - 71
- Comfortable at work - 63
- Long day - 102

Reactions to Environment
- Frustration with environment - 42
- Stressful environment - 13
- Not feeling comfortable in the environment - 43
- Interesting and challenging environment - 72
- Not affected by the environment - 62
- Not stepping back - 107
3. Further Refinement and Naming of Theme

**Work Drive**
- Can’t focus on one job - 36
- Work over time - 29
- Not wanting to stay longer than necessary - 82

**Job Satisfaction**
- Enjoyment of job - 73
- Job satisfaction - 16
- Allowing to feel - 79

**Environmental Perceptions**
- Self imposed high work load - 12
- Wanting to do everything for everyone - 24
- Different jobs in a day - 1
- Enjoy it being busy - 39
- Not busy enough - 70
- Thrive in stress - 71
- Not stepping back - 107

**Reactions to Environment**
- Enjoy the variety - 43
- Robotic - 90
- Working on auto-pilot - 30
- Comfortable at work - 63
- Not feeling comfortable in the environment - 48
- Not affected by the environment - 62
- Take a step back - 111
- Stressful environment - 13
4. Further Refinement

**Self Imposed Work**
- Can’t focus on one job - 36
- Work over time - 29
- Not wanting to stay longer than necessary - 82
- Self imposed high work load - 12

**Environmental Perceptions**
- Enjoyment of job - 73
- Job satisfaction - 16
- Different jobs in a day - 1
- Enjoy it being busy - 39
- Thrive in stress - 71
- Not busy enough - 70
- Allowing to feel - 79
- Wanting to do everything for everyone - 24
- Take a step back - 111
- Not stepping back - 107

**Reaction to the Environment**
- Job satisfaction - 16
- Enjoy the variety - 43
- Robotic - 90
- Working on auto-pilot - 30
- Comfortable at work - 63
- Not feeling comfortable in the environment - 48
- Not affected by the environment - 62
- Stressful environment - 13
- Not stepping back - 107
- Take a step back - 111
- Allowing to feel - 79
- Wanting to do everything for everyone - 24
- Not busy enough - 70
- Thrive in stress - 71
- Enjoy it being busy - 39
- Self imposed high work load - 12
- Work over time - 29
- Not wanting to stay longer than necessary - 82
- Enjoyment of job - 73
5. Final Theme and Sub-Themes

- **Environmental Perceptions**
  - **Job Satisfaction**
  - **Self Imposed Work**
  - **Reaction to the Environment**
1. Grouping of Miscellaneous Codes

- Worrying about lack of knowledge - 101
- Not enough staff - 106
- Experience - 110
- Thinking about families - 100
- Stress relief tactic - 109
- Good day when things go right - 97
- Each day as it comes - 96
Appendix p

**Impacts of Working within Oncology**

**Tiredness**
Wanting to escape
Increased negativity
Stressed
Making mistakes
Physical problems
Not aware of feelings
Anxious
Depressed
Not anxious
Not depressed
Happy
Not affected by work

**Staff Relationships**

Isolation
Don't talk to colleagues
Make colleagues happy
No support team
Difficult forming relationships with colleagues
**Able to communicate with colleagues**
Share feelings with colleagues
Supported by colleagues
Talking doesn't help
Lack of trust
Try and form relationships

**Patient relationships**

Enjoy relationships with patients
Develop close relationships
Negative effects on deterioration of patients
Not showing true emotion
Not able to be honest
**Clinical-ness**
Too clinical
Can't cope with death
More involved with patients
Difficult listening to patients
**Receiving something from patient care**
Able to listen to the patient
Not affected by deterioration of patient
Have that moment and move on
Empathy
Sad

**KEY:**

HIGHER
MINDFUL
PARTICIPANTS

LOWER
MINDFUL
PARTICIPANTS

HIGHER AND
LOWER
PARTICIPANTS
Transition from work to home

Thinking about patients outside of work
Letting frustration out at home
Thinking about work at home
Poor work/life balance
Able to contain work in work
Able to adopt different roles
Easily separate different roles
Don't let work effect home life
Not concerned about thinking about work – learning
Constant adrenaline
Being all things to all people
Affecting home relationships

Environmental Perceptions

Can't focus on one job
Work over time
Not wanting to stay longer than necessary
Self imposed high work load
Enjoyment of job
Job satisfaction
Different jobs in a day
Enjoy the variety
Robotic
Working on auto-pilot
Comfortable at work
Not feeling comfortable in the environment
Not affected by the environment
Stressful environment
Not stepping back
Take a step back
Wanting to do everything for everyone
Allowing to feel
Thrive in stress
Not busy enough
Enjoy it being busy
Biases and Assumptions

I have collated a list of the main biases and assumptions which I held about the research and the topic of study, which became apparent through the process of writing in my research diary. I present them to inform the reader and add to the trustworthiness of the research (Elliott et al., 1999).

1. On a personal level, I practice and appreciate the effectiveness of mindfulness and use it with clients within a therapeutic context.

2. I assumed that participants would not be very forthcoming and explicit about different concepts of well-being; therefore I was pessimistic about what concepts may have been formed and that they would have very vague answers such as ‘I’m ok’ and ‘not bad’. It was incredibly hard not to pick up on concepts of which I had previously read about and remain out of the inductive analysis process.

3. I was pessimistic about dispositional mindfulness and its potential usefulness in everyday settings because of the number of variants potentially having an effect on well-being.

4. However, I do have the assumption that dispositional mindfulness can be reliably assessed and measured and that it can have an impact in certain areas.

5. I have concerns about the impact of dispositional mindfulness and what it might mean. For example, because of my disillusionment with the popular franchise of mindfulness, I feel that dispositional mindfulness is important and would potentially underline who we are as people. Self-awareness of our own state is important if people are interested in acknowledging what that state is.
SCR UK R&D Trial Proposal Form

This form applies to all research conducted in a HCA (UK) owned or controlled facility (the below HCA sites are not final – there may be more additions in the future):

- Harley Street Clinic
- The Lister Hospital
- The London Bridge Hospital
- Satellite Units Docklands
- The Portland Hospital
- The Princess Grace Hospital
- The Wellington Hospital
- Sarah Cannon Research (UK) Drug Development Unit
- Harley Street at UCH
- Harley Street at Queens, The Christie Clinic

[PLEASE COMPLETE ELECTRONICALLY]

PLEASE NOTE HCA WILL NOT ACT AS A SPONSOR FOR ANY RESEARCH

PART A – FOR APPLICANT USE

Please complete the following sections accurately and to the best of your ability. If you need clarification on the forms, feel free to contact UshaDevi.Annadurai@SarahCannonResearch.co.uk.

Submissions will not be scheduled for review until the application is deemed complete by the R&D office staff

1. STUDY INFORMATION:

<table>
<thead>
<tr>
<th>Full Study Title:</th>
<th>The Mindfulness Characteristic of Professionals Working Within Oncology and their Experience of Well Being at Work</th>
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<tbody>
<tr>
<td>Short Study Title:</td>
<td>Mindfulness and Oncology Well Being</td>
</tr>
<tr>
<td>Principal Investigator:</td>
<td>Andrew Greaves</td>
</tr>
<tr>
<td>Employed by HCA International</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Name(s) of other Investigators involved at HCA site:</td>
<td>N/A</td>
</tr>
<tr>
<td>Address</td>
<td>2 Upper Lees Drive, Westhoughton, Bolton</td>
</tr>
<tr>
<td>Post code</td>
<td>BL5 3UE</td>
</tr>
<tr>
<td>Telephone</td>
<td>07850 470512</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:andrewjgreaves@hotmail.co.uk">andrewjgreaves@hotmail.co.uk</a></td>
</tr>
<tr>
<td>Study Coordinator Name:</td>
<td>Dr Clare Lennie</td>
</tr>
<tr>
<td>(will act as the main contact with R&amp;D)</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
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</table>
What do you propose to do at the intended HCA site? *(please provide a brief summary of study activities to be conducted at HCA site)*

At the proposed HCA site, an email from myself will be sent to all employees at the Christie Clinic. This email will contain a link to an initial assessment questionnaire to assess levels of mindfulness. The mindfulness questionnaire will then be scored, and participants who fall under certain brackets, i.e. particularly high or low levels of mindfulness will be contacted and asked if they would be willing to attend an informal interview. A date and time will be agreed, in correspondence, for the interview to take place. The interview should last no longer than half an hour, and will centre around the participants perception of their personal well being at work. The qualitative data collected will then inform the results as to whether mindfulness as a characteristic can be used by staff working within oncology to aid well being.

Please provide details of non clinical interventions or procedures that will be received by patients as part of the research protocol *(i.e. seeking informed consent, interviews, use of questionnaires)*

Mindfulness Attention Awareness Scale (MAAS), (see appendix C), is a short, 15 item trait assessment of one's tendency to pay attention to everyday experiences in everyday moments. The scale should only take approximately 5 minutes to complete. The MAAS is only used to obtain my target sample; high and low mindfulness. Informed consent (appendix D) will be needed to complete this assessment as participants need to be aware that they may be contacted for the second phase of the study. Study information (appendix F), the consent form and MAAS will be provided and completed online.

To assess the experience of well-being a face-to-face interview will be utilised which will last about 30 minutes. Before the interview takes place, the participant will receive a second information sheet so they are clear as to why they have been chosen for an interview (see appendix A) Refer to appendix ‘B’ for the interview structure and ‘E’ for the informed consent.
Please provide details of clinical interventions or procedures that will be received by patients as part of the research protocol (i.e. assessments, use of medicinal products or devices, imaging interventions, taking samples of human biological material)

NONE

2. STUDY DETAILS

<table>
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<th>Study Type / Study Design</th>
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<tr>
<td>Clinical Investigation or other study of a medical device</td>
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<tr>
<td>Combined trial of an investigational medicinal product and an investigational medical device</td>
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<tr>
<td>Other clinical trial or clinical investigation</td>
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<tr>
<td>Use of questionnaire/interviews for quantitative and/or quantitative/qualitative methodology</td>
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<td>Use qualitative methods only</td>
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<td>Use human tissue sample</td>
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<td>Retrospective study</td>
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<tr>
<td>Sponsored (non commercial)</td>
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<td>Grant Agency/Government</td>
<td></td>
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<tr>
<td>Other (please specify):</td>
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<tr>
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<th>Name of the Sponsor (HCA does not act as the sponsor)</th>
<th>N/A</th>
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<tr>
<td>Proposed start date at HCA site</td>
<td>May 2013</td>
</tr>
<tr>
<td>Proposed end date at HCA site</td>
<td>July 2013</td>
</tr>
<tr>
<td>Total duration of the study</td>
<td>0 Years 2 Months</td>
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</table>

Location(s) where research is to be conducted (select all that apply):

SUBJECTS EXPECTED TO BE ENROLLED AT HCA SITE

<table>
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<tr>
<th>Expected number of patients:</th>
<th>12</th>
</tr>
</thead>
<tbody>
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<td>Will the study be advertised at HCA site?</td>
<td>Yes</td>
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3. PHARMACY

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<th>Do you require HCA Pharmacy service?</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td><em>(If yes please complete the below questions)</em></td>
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### 4. LABORATORY

Do you require HCA Laboratory service?

- [ ] Yes
- [x] No
- [ ] N/A

### 15. HUMAN TISSUE

Do you plan to use human tissue sample(s)?

- [ ] Yes
- [x] No

*If yes please complete the out-going material transfer form*

### 6. ARCHIVING

**HCA DOES NOT CURRENTLY HAVE FACILITIES TO PROVIDE ARCHIVING SERVICES TO MEET UK STATUTORY INSTRUMENTS**

<table>
<thead>
<tr>
<th>Who is responsible for archiving?</th>
<th>University of Manchester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide details of facility to be used</td>
<td></td>
</tr>
</tbody>
</table>

**Applicant’s Declaration**

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I understand that information about me and my collaborators as researchers will be held by the R&D Office and where necessary disclosed to the MHRA inspectorate.

<table>
<thead>
<tr>
<th>Signature</th>
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<tbody>
<tr>
<td>Print Name</td>
<td>Andrew Greaves</td>
</tr>
<tr>
<td>Date</td>
<td>24/7/2012</td>
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