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**Resilience of Nurses who work in Community  
Mental Health workplaces in West Bank-Palestine**

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**Doctor of Philosophy**

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## Summary

Nurses in Palestine work in a significantly challenging environment within and outside their workplaces. Mental health services in Palestine are underdeveloped and under-resourced. For example, the total number of community mental health nurses (CMHNs) in the West Bank is seventeen, clearly insufficient in a total population of approximately 3 million. This thesis is concerned with the resilience of nurses who work in community mental health workplaces in Palestine. This research explored sources of resilience and daily challenges that Palestinian CMHNs face within and outside their demanding workplaces. The up to date understanding of resilience is drawn from the social ecological perspective. Within Arabic culture, resilience has traditionally been conceptualised as a prerequisite to understanding and achieving 'Sumud', meaning that the individual has to be resilient in order to remain steadfast in the face of daily challenges and not to leave their place or position.

An interpretive qualitative design was chosen to explore resilience and the daily challenges. Fifteen face-to-face interviews were completed with participants. Thirty-two hours of observations of the day-to-day working environment and workplace routines were conducted in two communities' mental health centres. Written documents relating to practical job-related policies were also collected from various workplaces. Thematic analysis was used across all data sources resulting in four main themes, which describe the challenges faced by CMHNs and their sources of resilience. These themes consist of the context of unrest, societal challenges, lack of resources and organisational challenges. These sources are Sumud and Islamic cultures, supportive relationships, making use of the available resources, and personal capacity. The study concludes with a better understanding of resilience in nursing which draws on wider cultural contexts and responses. The outcome of this thesis will be used to develop the resilience of CMHNs in Palestine.

## Declaration

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is it being submitted concurrently in candidature for any degree or other award.

Signed ..... (Candidate) Date .....

### STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of PhD

Signed ..... (Candidate) Date .....

### STATEMENT 2

This thesis is the result of my own independent work/investigation, except where otherwise stated.

Other sources are acknowledged by explicit references. The views expressed are my own.

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### STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available online in the University's Open Access repository and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed ..... (Candidate) Date .....

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## **The Author**

The author graduated from Ibn Sina Nursing College, Ramallah- West Bank as a registered nurse in 1998. I worked across a wide range of specialisms within demanding workplaces. For example, I worked as a staff nurse in different departments in Rafedia Hospital and the Arabic speciality Hospital in Nablus city. I completed a Bachelor's degree in Nursing from AL-Quds University - Jerusalem in 2005. I moved to work in Ramallah city in various hospitals; these included Ramallah Hospital, Red Crescent Hospital and Arab Care Hospital. In 2006-2008, I completed a full time Master degree (MSc.) course in Community Mental Health from ALQuds University. It was intensive and the first specialist course of its kind in Palestine; it included various modules in research. In 2006, I started to work at the Modern Community College as clinical instructor specialising in the mental health field. In addition to this practice background, I was elected a member of the Nursing Association in Palestine. Then, I took up my current education and research post in the School of Medicine and Health Sciences -Nursing and Midwifery Department at Annajah National University. The academic profession enabled me to develop my experiences in research and the mental health nursing field. I also completed an intensive training course in Karolinska institute in Stockholm, Sweden about the reproductive health and sexual rights of adolescents.

In January 2011, I commenced my doctoral study at the School of Healthcare Sciences at Cardiff University. The PhD covered different modules to develop my personal and professional skills such as academic writing, and research skills. I have also had the opportunity, while in the UK, to gain clinical experience in various mental health and social care settings. In addition, I gained experience in teaching and training health professionals across the UK including nurses, and physicians. In coordination with other colleagues, we established the first oncology-nursing society in Palestine. We successfully joined the European Oncology Nursing Society EONS. Eventually, while I was in Cardiff-UK, I became a member of the Health Committee at Dar UL Isra Educational and Welfare centre.

The above-mentioned experiences motivated me to think about the available supportive resources and infrastructure for nurses in Palestine. My personal and professional experiences played a crucial role in the development of this study (Maxwell, 2013 p24). Particularly important were my background in the nursing field and in teaching and research, and my motivation to make a significant practical difference. In some parts of this thesis, due to the absence of adequate supportive literature in some sections, I have written from my experiences. The title of the project was chosen after reading the edited book of Hannigan and Coffey (2003), accompanied by in depth discussions with supervisors and other local researchers. Finally, my thesis was nominated as an outstanding project by Cardiff University, and as a result, I won a prize from the University President.

## **Conference presentations, abstract publications and events arising from the thesis**

- In 2014, Methodological innovations in mental health and well-being research  
<http://blogs.cardiff.ac.uk/imgame/2014/09/29/event-methodological-innovation-in-mental-health-and-wellbeing-research>
- In 2014, Conference on promoting resilience among community mental health nurses in Edinburgh Napier University.  
<http://www.napier.ac.uk/faculties/health-life-social-sciences/nursing-midwifery-social-care/mhn-conference/Pages/Conference-themes.aspx>
- In 2013, Conference of the personal and politics of Mental Health Nursing organised by international network for psychiatric Nursing Research Conference. Published abstract in  
[https://www.rcn.org.uk/\\_\\_data/assets/pdf\\_file/0004/538897/NPNR\\_2013\\_-\\_Book\\_of\\_Abstracts\\_6.09.13\\_.pdf](https://www.rcn.org.uk/__data/assets/pdf_file/0004/538897/NPNR_2013_-_Book_of_Abstracts_6.09.13_.pdf)
- In 2013, Spot light on social sciences conference.  
[http://ugc.subsite.cf.ac.uk/wp-content/uploads/Spotlight\\_2013\\_Report.pdf](http://ugc.subsite.cf.ac.uk/wp-content/uploads/Spotlight_2013_Report.pdf)
- In 2013, Voices of Humanities conference.  
<http://www.cardiff.ac.uk/ugc/archives/2480>
- In 2012, Annual PGR Symposium of SONMS shared in presentation.
- In 2012, research visit to the resilience centre at Brighton University.  
<http://www.boingboing.org.uk>
- In 2011, Annual PGR Symposium of SONMS shared in poster. In April 2011, shared in the international conference our resilience Why bother? At Brighton University.  
<http://www.boingboing.org.uk/index.php/training/resilience-conference>

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## **Chapter one:**

### **Introduction and context of the study**

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# 1. Chapter one: Introduction and context of the study

## **1.1 Thesis organisation**

This thesis consists of six chapters and the outline of the subsequent chapters is as follows.

### **Chapter one: Introduction and context of the study**

This chapter provides an introduction to the context of the study outside and within the community mental health workplaces in Palestine. This includes the contexts of the study within its geo-political and historical context and its relation with the general wellbeing of civilians. Then, the chapter presents the development and challenges on mental health services and the work of the nurses in a context of unrest. Finally, the chapter discusses the development of the nursing profession in Palestine, challenges faced by Palestinian nurses in general and the local future challenges for mental health services.

### **Chapter two: Literature review of resilience**

This literature review chapter presents an overall view of theoretical perspectives and practical research knowledge in relation to 'resilience', the resilience of Palestinians in particular, and the related concept of 'Sumud'. The chapter presents definitions of resilience, and studies outside and inside the nursing field from a social ecological perspective. It also discusses resilience in the Arabic and Islamic context, and the relationships between resilience, 'Sumud' and nursing.

### **Chapter three: Methodology**

This chapter presents the research process. It includes justification of this study followed by aims and objectives, research design and methods, plus sampling. The chapter discusses the gaining of ethical approval from Cardiff University and research

permissions from Palestine. Multiple methods (interviews, observation, and collecting documents) are discussed. The approaches to data management and analyses are presented in addition to strategies to enhance the quality, objectivity, and reflexivity of qualitative research.

#### **Chapter four: Findings, challenges of CMHNs**

This chapter presents the findings related to the challenges faced by CMHNs inside the workplace, set in the context of surrounding unrest. These challenges were embedded in a context of turmoil and oppression. The chapter discusses the following themes in detail, the context of turmoil and unrest challenges, societal challenges, lack of resources and organisational challenges.

#### **Chapter five: Findings, sources of resilience among CMHNs**

This chapter presents the findings related to the sources of resilience among CMHNs within and outside their workplaces. These sources are discussed as being embedded in the Islamic and Sumud local culture. The chapter presents themes such as Sumud and Islamic cultures, supportive relationships, making use of the available resources, and personal capacity.

#### **Chapter six: Discussion chapter**

This chapter presents the contribution and main findings of this thesis. It also presents implications for future research, nursing education and policy makers and managers. Finally, the chapter discusses the strengths and limitations, and ends the thesis with conclusions.

## 1.2 Introduction

This thesis is concerned with the study of resilience among nurses who work in community mental health workplaces in Palestine. As will be described in the literature review chapter, there is an absence of studies which investigate resilience among Palestinian nurses. The outcome of this thesis will be used to develop the capacity and resilience of community mental health nurses (CMHNs) in Palestine. It will also be of benefit to the wider understanding of community mental health nursing. The definition of resilience in this thesis is drawn from the up to date understanding of resilience, in particular from “social ecological” ideas, as will be discussed in the literature review chapter. Resilience seems to be present only when there is a risk; it is like two sides of the same coin. Therefore, we need to clarify what we mean by risks before proceeding to a discussion of resilience (Ungar, 2004b). According to Liebenberg & Ungar (2009 p.03) *“Ironically we cannot study resilience without studying risks”*. This introductory chapter provides a background to the challenges in the Palestinian context.

This chapter discusses the background of challenges or risks outside and inside the community mental health workplaces in the occupied territories. For example, it explains the complex geo-political and historical context in Palestine. This includes the historical overview and its relation with the general wellbeing of civilians, then an overview of the mental health of Palestinians. This includes the history and development of mental health care in the Arabic and Muslim area, where Palestinian nurses practise within the Arab/Muslim context. It explains the development of the cross-cultural context of mental health services and the development of mental health services and the work of the nurses in a context of unrest. Finally, the chapter discusses the development of the nursing profession in Palestine, challenges of Palestinian nurses in general and the local future challenges of mental health services.

### 1.3 Context of the study

The following sections discuss the challenging and complex context in which the study exists. For example, contexts within which community mental health nursing exists include geo-political, historical, workplace, domestic, and international settings.

According to Parker et al. (2003 p206) context is *“to interpret the subjective meaning which actors give their action and situations, we must locate these within a wider social and historical context. This requires a skilful widening and deepening of the background context which may include highly influential factors which help us to make better sense of what is happening”*.

Therefore, discussing the context of the study will help the reader to understand some of the nurses’ actions and interactions which occur within their culture. Culture can be defined as *“the humanly invented realm of producing artefacts and meaningful interpretations of experience and their symbolic representation”* (Parker et al., 2003 p207). This might also help to understand or interpret the challenges and resilient responses of Palestinian community mental health nursing within local and a wider context.

This chapter was written in the knowledge that there are very few studies in Palestine due to a lack of funding to support an effective system of research. I had two choices to produce this chapter, either not to write at all due to a lack of high quality studies or to write in spite of the poor level of quality in the studies I found. The decision was taken to therefore write this chapter based on what was available within the resources available, in spite of the lack of high quality studies (CRD, 2009). Palestine has been described as *“uncharted territories”* due to a lack of accurate data resources or records (Snow, 2010). It is a state that is seeking independence with scarce resources, therefore health research is under-developed and there is a significant lack of health research infrastructure and funding (Sweileh et al., 2013). As a result, there is a lack of detailed data or national surveys of health needs, services or of nurses (Mataria et al., 2009). In the absence of a mature programme of research, I have had to rely instead on small-scale, fragmented studies completed by academics or by nongovernmental organisations with little or no funding. There are probably some practical pressures on researchers to do quantitative studies more than qualitative. For example, from

personal experience: some of the academic researchers are required to complete about 200 published papers to develop their rank from university lecturer to professor in a specific period of time, so their focus is mostly on doing easier and quicker studies.

In addition, I chose consciously to maintain an objective position as much as possible; the study was conducted in a highly politically sensitive zone and I chose carefully the words I used in order to enhance objectivity. This chapter does not represent the personal opinion of the researcher toward the complexity of the political conflict. The study focused on the Palestinian part of the conflict, and the Israeli health system is not included; this approach was chosen because this study is about Palestinian nurses only. The Israeli nurses have a separate health system management which bears little resemblance to Palestinian services and it may not have been possible for me to have access to the setting or data system due to my ethnicity.

## **1.4 Palestine: Geo-political and historical perspectives**

The study has been conducted in the West Bank, Palestine. In 2012, the United Nations voted to recognise Palestine as a non-member observer state (UN, 2012a). Because of that, I will use the term 'Palestine' instead of the alternative historical term 'Occupied Palestinian Territories' and I will try to adopt a neutral political opinion towards the conflict in this study. According to United Nations resolutions, Palestine currently includes the entire West Bank, East Jerusalem and the Gaza Strip area totalling 6, 220 sq. km. The total population of Palestinians in Palestine (include Gaza and West Bank) is around 4 million. The Palestinians outside Historical Palestine (Occupied Palestinian Territories and Israel), defined by the United Nations (UN) as refugees, number around 7 million (PCBS, 2010). According to United Nations resolutions, the capital of Palestine is East Jerusalem. The major religions in Palestine are Islam, Christianity and Judaism (UN, 2012b). The official language is Arabic, and English is widely understood. The nationality of the population (the noun) is Palestinian (s) and the adjective is Palestinian. The Palestinian National Flag is as we see below:



The first map (below) shows the location of Historical Palestine after the 1967 war. This shows that historical Palestine is situated on the eastern coast of the Mediterranean Sea in the Middle East. Lebanon borders it to the north, Syria and Jordan to the east, and Egypt and the Mediterranean Sea to the west. It also illustrates the Palestinian territories occupied by Israel since June 1967 which include the West Bank Cities, Gaza Strip and East Jerusalem. The second map shows the lands after the peace agreements which are managed by the Palestinian Authority, in zones A and B, while zone C is managed and controlled by Israel. It also highlights the movement restrictions and the distributions of access to health in the West Bank. However, several conflicts about the existence and borders of Palestine have occurred over the last five decades which will be discussed in the next sections.

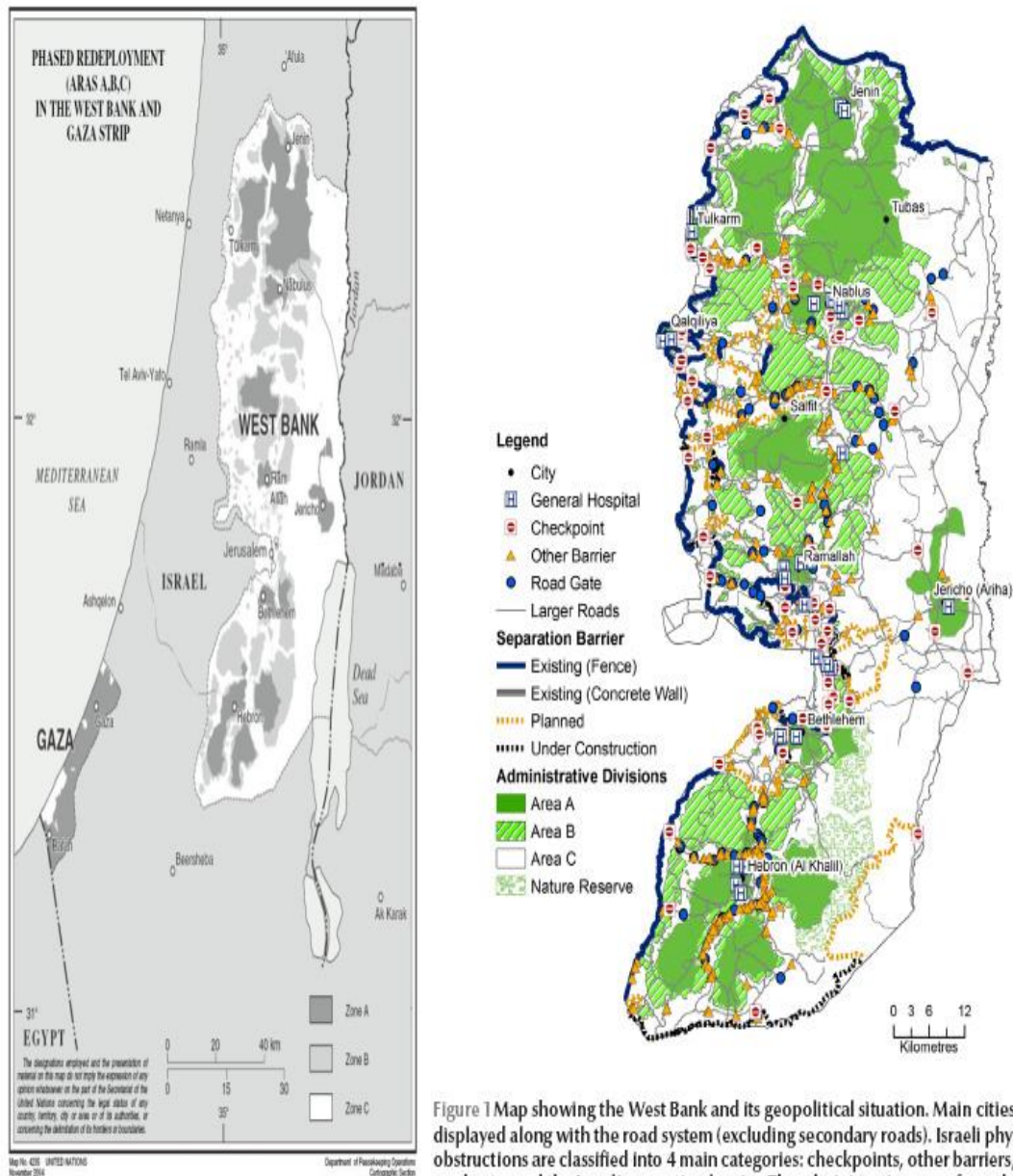


Figure 1 Map showing the West Bank and its geopolitical situation. Main cities are displayed along with the road system (excluding secondary roads). Israeli physical obstructions are classified into 4 main categories: checkpoints, other barriers, road gates and the Israeli separation barrier. The administrative areas from the Oslo Peace Accords are shown in the background

Source: First map (UN, 2004) second map (Eklund and Mårtensson, 2012).

## 1.5 Overview of Palestine within its historical context

This following section clarifies significant events that have led to several conflicts in this region and in Palestine specifically. It also discusses the challenging political context and its effect on Palestinian mental wellbeing and lifestyles. It is probable that the

following historical events have greatly influenced the Palestinian people, although the extent to which these have influenced the nurses' ability to create their own resilience is currently unknown.

Between "1517-1917" Palestine was part of an Ottoman (Turkish) empire. Then between 1917 and 1947 Palestine was part of the British Management. In 1917 the British government issued the Balfour Declaration which led later to the creation of Israel (UN, 2012b).

The 1948 War was considered, by the Palestinians, as the beginning of the 'Catastrophe', known in the Arabic language as 'Nakba'. As a result of the war, the State of Israel was established on 82% of the historical land of Palestine. The other part of Palestine (East Jerusalem, the West Bank) was annexed by Jordan and the Gaza Strip was placed under Egyptian management. Around three quarters of the Palestinian people were displaced or fled due to the conflict and were then considered refugees by the United Nations (UN, 2012b).

As a result of the 1967 War more land came under Israel's control including the West Bank, Gaza Strip and East Jerusalem; according to the UN, these areas are considered to be 'occupied territories'. Since then, the United Nations Security Council, the international community and the United Nations have affirmed many solutions to end the conflict. However, new numbers of Palestinians fled to the surrounding countries and they too were considered refugees by the United Nations (UN, 2012b). This war had a negative effect on Palestinian wellbeing and on people's daily lifestyles. In addition, more Palestinians ended up living in an unstable environment or facing dramatic changes (El Sarraj and Qouta, 2005).

In 1987, the First uprising, known as the Intifada, started in the Gaza Strip and the West Bank. The unstable environment had increased collective distress and lifestyle disturbances for Palestinians. Significant measures were used to curtail the Intifada. For example, many more people experienced detention without trial, collective retribution, discharge from jobs, and disruption in schools and universities. More people

experienced lack of freedom to travel, give political speeches or attend meetings; and there was a lack of opportunity to express national identity (El Sarraj and Qouta, 2005).

In 1993, a peace process started between Israel and the Palestine Liberation Organization (PLO), later renamed the Palestinian Authority. The Oslo agreement of 1993 was signed as a result of the peace process in order to gradually create a Palestinian state within five years and to implement the UN resolutions especially 194 and 242 (UN, 2012b). The Palestinian Authority started to manage many Palestinian services in the occupied Gaza Strip and West Bank. The health service was one of the services that came to be managed by the Palestinian Authority (Giacaman et al., 2009). During this period, there was significant development and growth of a peaceful environment. However, some new experiences of displacement for Palestinians were reported during the peace period (Teeffelen et al., 2005).

In 2000, peace negotiations between Israel and the Palestinian Authority collapsed after the failure to establish a Palestinian state within the suggested five years (UN, 2012b). Other events caused the second uprising, or Intifada, known as the Al-aqsa Intifada. There were measures and practices put in place to discontinue demonstrations or protests. According to Israel human rights reports B'Tselem (2010), movement restrictions became tighter, collective punishments were carried out, and many more Palestinians, health and wellbeing were affected in a negative way. Significant numbers of Palestinians complained of mental illness or disorder as a result of the conflict (El Sarraj and Qouta, 2005).

In 2002, Israel started to build a physical barrier and part of it was built between the Palestinians' cities and villages. Israel called it a 'fence' (Amnesty, 2009) and Palestinians called it a 'Separation Wall'. Currently nearly 300 miles long and 8 metres (25 feet) in height the fence/wall has had a negative impact on the daily activities of most of the Palestinian people. According to Abu ziada (2005) in his study of the psychosocial needs of Palestinians in the North District area of Palestine, 24% of Palestinians have had their land beside the 'Wall' affected negatively. Eighty percent of the families living behind the physical barrier have trouble accessing basic health

services. Moreover, the study explained that the physical barrier had caused mental disturbance to 90.7% of the families living beside it. Thirty percent of these families started to think about changing their home's locations. In addition, the new changes increased the poverty percentage to 67% especially amongst Palestinian farmers. The 'Wall' or 'fence' has increased the percentages of landless people. All in all, these new changes to the land have had a negative effect on the mental health of the people (Abu ziada, 2005).

In 2006, national elections were conducted in the Palestinian territories (West Bank, Gaza and east Jerusalem). One of the local parties (Hamas) won the elections and it formed the Palestinian government to run basic services for civilians. Due to political differences the Hamas government experienced a boycott by most of the world's influential countries, including Israel. This led to a significant lack of economic support and international aid. This had a negative effect on the running of services for civilians; health services were one of those areas most affected (Giacaman et al., 2009).

In 2007, internal division between the two major Palestinian parties affected the unity and cohesiveness of society in a negative way. Internal political violence increased which caused unpleasant, problematic lifestyle changes to the civilians and more political separation between the Gaza Strip and the West Bank (Giacaman et al., 2009).

In 2008, according to Amnesty International, a new wave of conflict started particularly in the Gaza Strip. Israel called it the 'Case Lead' military operation. As a result, more Palestinians experienced loss of life, injuries and home demolition. More people had experience of displacement and unpleasant lifestyle changes (Amnesty, 2009). Most of the people in the West Bank were gravely concerned about their relatives in the Gaza Strip during the military operation (de Val D'Espaux et al., 2011).

In summary, the above history of conflict caused major challenges to the Palestinian people including the nurses who are the focus of this thesis. According to Afana et al. (2004) historical events have made around one third of Palestinians in need of mental health interventions which makes mental ill-health, whilst least acknowledged, constitute one of the largest of all health problems. These events imprinted this conflict

on the collective consciousness of the Palestinian state in a negative way (Giacaman et al., 2009). This raises questions about the mental health needs of Palestinians who live in these chronic conditions as well as questions about the increased demands on the mental health nurses who carry responsibilities to offer care to their local society. The following sections explain the developmental challenges on the mental health services in the surrounding countries or region.

## **1.6 Development of mental health care in the Arabic region**

This section is concerned with the history and development of mental health care in the Arabic and Muslim area. This section will explain the developmental challenges of the cross-cultural context of mental health services. The mental health professionals including nurses, face challenges in offering the level of care they wish based on the cross-cultural context or the available resources.

In the Arab states, religion has played a key role in many aspects of people's lifestyles and in political issues (Dubovsky, 1983, Halligan, 2006). The Islamic psyche is based on the human being consisting of body, mind and soul was developed through a cultural paradigm of holistic health and mental health care (Mohamed, 2008). The Islamic model of nursing care has been influenced by the cultural context, and is seen as inseparable from Islamic values (Lovering, 2008).

The history of nursing in the Arabic region goes back to the beginning of Islamic civilisation. In comparison to Florence Nightingale, who is the most significant nurse in European and arguably Western culture, the most significant nurse in the Islamic history and Arabic culture was Rufaidah Al-Asalmiya (570-632 AD). She was a local community leader, who helped needy people in addition to her hospital duties especially orphan and the handicapped and tried to solve social problems that led to diseases. In this way, she was both a public health nurse and a social carer. In addition, she created a nursing school and she taught other females how to offer care to patients. Consequently, she laid the foundations for the philosophy of the Muslim nurse based

on the Arabic cultural context. Nurses gain rewards from Allah for their work and effort. Therefore, nurses are portrayed as being like “Angels of mercy”, considered as praying or worship. Medicine and nursing grew up side by side in the Islamic civilization based on this philosophy (Rassool, 2014).

In addition, the longest history of mental health services in the Arab countries goes back to the “golden” periods of Islamic civilization. For example, Baghdad in Iraq had many mental hospitals established in the year 705 AD, whilst in Cairo, Egypt, a city mental hospital opened during 800 AD and in Syria in Damascus City a hospital opened during 1270 AD (Gordon and Murad, 2005). Muslim scientists established during the 10th century some of the basics which are practised nowadays. For example, ALrazi in paediatrics (932-854 AD) and Avicenna or Ibin Sina in modern medicine (1038 – 980 AD). AL-Farabi (870-950AD) and AL- kindi, in what would now be termed social psychology, used dream interpretation and music therapy. Al-Zahrawi was a neuropsychiatrist and Ibn al-Haytham worked in the equivalent of what is now regarded as experimental psychology, Al-Bīrūnī (973-1048) was an anthropologist and studied ideology, IbnKhaldun studied cultural history, sociology, and social sciences. Some of the Muslim scientists understood mental illness and gave them definitions such as hallucinations, delusions, schizophrenia, mania, melancholia. These are terms or mental disorders classifications we still use today (Mohamed, 2008).

Mental health services in the Arabic region nowadays does not command such a leading position in science as it previously did. There is a near absence of effective nursing research, and the mental health services are grossly underdeveloped with stigma attached to those experiencing mental illness. However, the developmental challenges of mental health nursing vary from country to country influenced by their income. In addition, many factors have determined the efficacy of the mental health services including political decisions, social factors and the specific diversity of cultures. The Arab countries have tried to develop their model of care and mental health services. They are trying to improve research in the mental health field and to train higher numbers of qualified professionals. They are also moving toward deinstitutionalization models and are trying to become independent and autonomous

by suggesting more suitable models of care for the modern Muslim culture (Okasha and Karam, 1998).

There are cultural context influences on the health care or nursing care plan in Palestine. For example family cohesion and support are important aspects in the life of patients and the family needs to be included in significant decisions (Saca-Hazboun and Glennon, 2011). The care plans created by the Palestinian nurses were affected by their cultural context and their environment (Abushaikha and Saca-Hazboun, 2009). From my personal experience, as a university lecturer in nursing, there was an absence of Arabic text books in nursing that fit with the local model of care. Nurses are trying to find a compromise between the care plans revealed in the “English” language text books and the local cross-cultural context.

The following sections will discuss the epidemiology of mental health among Palestinians. In addition, it will further discuss the effect of these historical events on the mental health of Palestinians, and nurses who number amongst them.

## **1.7 Mental health of Palestinians**

This following section presents a review of English and Arabic language papers regarding the mental health of Palestinians. The aim of this section is to gain an overall view of the mental wellbeing of Palestinians. I read the full text articles carefully many times and I summarized what I think is important to serve my study in general. The articles located from the databases were reviewed with critique of qualitative and quantitative studies. Papers were reviewed based on whether or not the article related to mental illness or disorders among Palestinians. This section was written based on what was available from the data resources in spite of a lack of high quality, evidence-based knowledge. These findings need to be considered with caution due to weaknesses in study design, such as the use of self-developed and unverified questionnaires and that measurement tools are in need of further validation. To avoid repetition and to maintain the focus of this section, I chose one or two examples from the studies which were found that included adults, women, and children.

For the search strategy, I scanned databases broadly prior to refining my searches. CINAHL (Cumulative Index to Nursing and Allied Health Literature); Science Direct, Pub med, PsycINFO and Google scholar were searched for a review of current literature. Key words included, 'Palestin\*AND mental health AND surveys OR screening'. These words were also used to search in the Arabic language to identify articles indexed in Annajah University Journal for Research, and Islamic University Gaza Journal of Research. Moreover, additional papers, which did not come to light in the electronic data base search, were obtained via an examination of reference lists of published papers. For the critical analysis of empirical articles, the following aspects were considered: instrument, aim, sample, data collection criteria, limitations or bias, key findings, ethical and procedural rigour. Moreover, for the empirical studies with statistical methods the reliability and validity were taken into consideration and the framework of Rees (2003) was consulted to help with these appraisals and critiques.

The first study discussed in the review is from Madianos et al. (2012) who undertook a cross sectional quantitative study designed to investigate the lifetime and one-month prevalence of a major depression episode (MDE) in a multi-stage. The sample consisted of 916 adult Palestinians in the West Bank drawn from the Al-Aqsa Intifada. The clinical examination used DSM-IV criteria for the detection of MDE. Data on socio-demographic, suicidal behaviour, previous help seeking, medication use and exposure to trauma were also collected. The study found that the lifetime and one-month prevalence of MDE was 24.3% and 10.6%, respectively. The vast majority of males in this sample (85%) and 69% of females confirmed that they had experienced a serious traumatic event.

Another survey was conducted in five towns in the West Bank area, all of which had been major conflict zones. The sample consisted of 153 households in Ramallah city, 154 in Nablus city, 148 in Bethlehem, 151 in Jenin and 155 in Tulkarim. Each town was divided into five strata then stratified random sampling of houses was undertaken and survey interviews conducted, mostly equally divided between both genders of the household. The researchers used a self-developed questionnaire that consisted of 10 items measuring housing, financial and health related issues. Responders reported high

psychological distress at home such as: uncontrollable fear, hopelessness, fatigue, depression, sleeplessness, shaking episodes, and uncontrolled crying episodes or enuresis in children. This distress had the highest percentage in Ramallah city (93%), then Tulkarim (91%), Jenin 89%, Bethlehem (87%), and Nablus city (71%). Also, this study showed that the psychological distress was associated with witnessing unpleasant events (Giacaman et al., 2004).

A quantitative and descriptive analytic study was carried out to determine the most significant psychological problems that affected Annajah National University students during the Alaqsa Intifada. The random stratified study sample consisted of 586 students, of whom 566 responded. The researcher used a self-developed questionnaire that consisted of three parts. The first part included a section to gather demographic data. The second part consisted of a psychological problems questionnaire that contained 73 items. The third part contained open questions that asked the student to write three positive things resulting from the Intifada. The students' psychological problems were 60.1%, indicating that most of the university students complained of psychological problems. Moreover the study showed that participants experienced different psychological problems such as: anxiety, fear, frustration, lack of feelings of security, psychological stress, hopelessness, helplessness, and fatigue (Assaf, 2005). These findings should be considered with caution as it is not advisable to generalize about all Palestinian students due to this being a self-developed questionnaire. This measuring tool was used for the first time and further investigation on reliability and validity may be needed.

To investigate the mental health of women, a quantitative study was undertaken in North Palestine Districts to determine the effects of measures on Palestinian women's stress during the Alaqsa Intifada. Women are considered the core of Palestinian society so if there is any pressure on society then that pressure will be exerted on the most important person in the family, which is the mother. This random sample study included 900 women from different education levels, social classes and districts. The researcher used a self-developed questionnaire that consisted of 77 items. The study found that the average degree of psychological, economic, and social pressure among

the participants was high (69%). This meant that most of the women experienced a high degree of suffering and complained of collective distress due to the conflict. The participants also reported that the sense of solidarity between Palestinians was increased during adversities (Assaf and sha'th, 2002). These findings should be considered with care and not be generalised to all Palestinian women. The sample included the north districts where the Gaza Strip and other district were not included. This measuring tool was used for the first time and further investigation on reliability and validity might be needed.

Finally, the mental health of Palestinian children may be affected even more than the mental health of adults. Arafat and Boothby (2003) carried out a study in which they found that 93% of children had experienced being threatened, feeling threatened, a loss or a lack of security, and fear. The fear was not about themselves alone, but also about their families and friends. In addition, parents reported many psychological problems in their children such as nightmares, enuresis, and high levels of aggressive behaviours, hyperactivity, low attention and concentration.

There was a lack of qualitative studies and one shared limitation for the above quantitative studies is that they need more strategies to enhance the credibility and validity of the findings. For example, one-off self-questionnaires were used and reviewed by the local experts. Alpha Cronbach Equation tested most of the reliability of the studies for internal consistency which was found to be more than good. From the above studies, it seems quantitative studies are more common in Palestine as they are less time consuming or costly. It seems that Palestinian researchers are not working together to develop a Palestinian measure by building/developing on each other's work. All in all, these studies give us insight, albeit limited at times, about the mental health of Palestinian people in the absence of more accurately representative surveys in this field (Mataria et al., 2009). It seems that there is a lack of accumulation of knowledge across multiple studies especially in the area of mental health screening. The studies were conducted during the Intifada period, so are more representative of mental health status when there are high levels of violence in the surrounding environment. These quantitative studies may explain the extent to which Palestinians

live under chronic intense pressures, but qualitative studies are still needed to be able to develop these findings further.

In summary, from the above studies it is clear to see that Palestinians have increasing needs for mental health interventions especially during times of conflict. Nurses face these collective experiences in their daily lives but they have additional tensions due to increasing demands on their roles as part of the nursing profession. There was an absence of studies which investigated the work and life experiences of CMHNs specifically. The history of collective challenges might motivate Palestinians to respond in a resilient way. For example, in the absence of a comprehensive health network the Palestinian survivors depended on their extended families and social networks to bear the brunt of medical payments (Giacaman et al., 2009). The next section discusses, in more detail, the developmental challenges facing mental health services in Palestine.

## **1.8 Development of mental health services in Palestine**

This section briefly discusses the history of developmental challenges inside the health organisations within the challenging Palestinian context. As discussed in the section earlier, the political historical events (1922, 1967, 1987, 1993, 2002 and 2006) caused national challenges for mental health services. The health system in Palestine is in a “transitional stage” and facing specific contextual challenges linked with political conflict (Hamdan and Defever, 2002). The health care system is complex and fragmented; basic public health and primary care are offered by four main facilities: the Palestinian Authority (Governmental), the United Nations (United Nation Relief and Work Agency for Palestinians), non-governmental Organization, and the private health care services such as pharmacies or clinics (WHO, 2006).

Before the British management of Palestine, the main responsibility for mentally ill clients rested with their families (characterized by families and community ties or cohesiveness). Non-violent, mentally ill clients could walk freely on the streets with only violent mentally ill clients confined at home (Keller, 2001).

In 1922, during the British management of Palestine, mental health services were influenced by the British model and started to focus on the individual's mind and its supposed deficits. The British government established a system "to admit lunatics to asylums" and opened a psychiatric hospital in Bethlehem city. Mental health care did not focus on preventative care (Government of Palestine, 1922).

After 1967, mental health services for the Palestinians in West Bank and Gaza were managed by the Israeli government and were underdeveloped. The services needed to be prioritised, there was a lack of resources and trained professionals. Multiple frameworks for care plans were used from the Ottoman Turkish, British, and the Israeli legislations. There were underdeveloped Palestinian mental health legislative frameworks which were unsuitable for the local cultural context. For example: there were no Palestinian parliament mental health rules suitable for professional use (Gordon and Murad, 2005). Mental health services needed more development in Palestine. There was a significant lack of effective primary mental health care or community mental health services such as individual or in-patient facilities. There was a need for effective secondary prevention, and a lack of infrastructures and the necessary qualified teams (Giacaman et al., 2005).

In 1987, after the First Palestinian Intifada, there was an increasing need for mental health services in the Palestinian community due to the conflict. Due to a significant lack of effective government services, some of the Palestinian nongovernmental organizations, with professional volunteers, started to work in the field. These NGOs have tried to help the Palestinians as much as possible and fill the gap of governmental services (Giacaman et al., 2005).

In 1993, after the Oslo peace agreement, the Palestinian Authority started to manage Palestinian basic services including mental health care. They took over responsibility for an underdeveloped mental health system. For example, the Palestinian Authority management inherited one psychiatric hospital in Bethlehem, with some of the psychiatric clinics in primary care. The Palestinian Authority tried to develop and manage the mental health system in spite of many challenges such as taking over an

ineffective health system, having a persistent lack of funds, having a lack of trained professionals, lack of infrastructure, an underdeveloped primary mental health care system and disadvantaged health teams (Mataria et al., 2009, Giacaman et al., 2009). In 1996, community mental health services became an independent part of primary care and separated from psychiatric hospital management (Giacaman et al., 2011, Giacaman et al., 2009).

In 2004, the need for mental health care among Palestinians became greater than before, especially during the Al-aqsa Intifada. Many health services and clinics were affected negatively due to the period of conflict. For example, the only Palestinian psychiatric hospital in the West Bank (in Bethlehem city) was affected by direct violence in April 2004. There were increasing numbers of Palestinians who developed mental health difficulties during the last decade (Murthy and Lakshminarayana, 2006). In addition, during the Al-aqsa Intifada, more patients became unable to reach the psychiatric hospital in Bethlehem due to movement restrictions on roads. A few governmental and nongovernmental institutions delivered psychosocial and community mental health services, but most of them were limited services and depended on externally funded programmes. Moreover, the number of mental health professionals was still seriously limited. For example, in 2005, the number of all Palestinian psychiatrists in Palestine numbered only nine; the number of all clinical psychologists now is no more than 15 and the nurses who work in the mental health field, not more than 100. These numbers are regarded as insufficient given that they serve about 2.7 million people in the West Bank (Giacaman and Mikki, 2003). In addition, the Ministry of Education that serves one million children, employed for the first time in Palestinian history, 382 counsellors in the West Bank, 150 counsellors in the Gaza Strip. The United Nation Relief and Works Agency for Palestinian refugees employed 55 school counsellors in the West Bank and 85 counsellors in Gaza (Giacaman et al., 2005).

The World Health Organization (WHO) has been trying to develop the Palestinian health system. Consequently, WHO, in cooperation with the Palestinian Ministry of Health, has implemented a plan to develop a mental health system in the West Bank and the Gaza strip (Snow, 2010). This plan is based on moving away from hospital

based in- patient services to a community provision of care. As a result, WHO is building new community mental health centres in each city. They have also trained significant numbers of the mental health professional teams, although the total number of mental health nurses continues to be very low. The WHO, in cooperation with Annajah National University in the West Bank and with the Islamic University in Gaza, has established the first Master's Degree in community mental health nursing in Palestine. This Master's programme aims to prepare highly qualified mental health nurse graduates who can work in the community mental health centres (Giacaman et al., 2011, Giacaman et al., 2009). A PhD in mental health nursing is very rare in Palestine, and Annajah National University is very much in need of this type of specialist. This PhD project was partially supported as a part of this process of development because of the need for lecturers to run the Masters programme. As will be further discussed later, the outcomes of this study will be used to develop the capacity of the working CMHNs and to increase the capacity of a new generation of CMHNs students.

In 2006, the Palestinian government experienced an acute lack of international funds and financial support. As a result, the health system was affected negatively; for example: access to medicines was reduced, and money was not available to pay salaries. Therefore, nurses and doctors had no money, even for transportation to the community mental health centres. In addition, many nurses have themselves required interventions where they have complained of psychological problems such as anxiety, apathy, depression, psychosomatic symptoms, feelings of isolation (Asalia and Al-Talaá, 2007).

According to the WHO and Ministry of Health reports (2006) community mental health has not been a priority in the financial budget of the Ministry of Health and is under resourced. For example, the budget for mental health services consisted of 2% of the whole budget of the Ministry of Health; and 73% of the 2% is spent on the psychiatric hospital. A lack of financial, management structure and human resources inhibited the quality of mental health services (WHO and MOH, 2006). There is a significant need to

train new numbers of professionals and to strengthen the mental health workplace (WHO, 2010).

In summary, there is a significant lack of studies that investigate the challenges inside the local health organizations. Mental health services have been mostly underdeveloped and under supported (Okasha et al., 2012). The mental health system was affected by the political conflict and this is thought to increase the challenges facing nurses in the daily routine. There was an absence of effective community mental health nursing care in the field with a lack of tangible protective factors for nurses in their workplaces. According to Hart et al.(2012 p05) *“Challenging workplaces that are constantly changing and very demanding on nurses affect their ability to be resilient in academic and healthcare environments”*. The next section will discuss the challenges in the workplaces of Palestinian nurses. It will be demonstrated that some studies explain percentages of nurses who are satisfied in their workplace or others who have experienced ‘burnout’ in their work. The following section also discusses the daily challenges for nurses in their clinical workplaces.

## **1.9 Development of mental health nursing in Palestine**

As discussed in the section earlier, the political historical events affected the development of nursing, and mental health nursing specifically. This section explains the development of the mental health nursing profession in Palestine, a task made difficult by the lack of literature or studies in this field. The few available sources were used in spite of significant lack of peer reviewed articles (CRD, 2009). For instance, in 1987 after the First Intifada, there was only one published book in Arabic related to health care, about the realities of the nursing and midwifery professions in Palestine. A group of teachers at the Nursing School of Alquds University wrote the book (Aghabkian et al., 1990).

Before the British management period, nursing was primitive, with some nurses trained by doctors rather than in Schools or Colleges of nursing. During the English government period, some training programmes for nurses were started. Then, after the

1948 war, the need for nurses increased in the hospitals to treat wounded people. More schools of nursing were established to meet the tremendous need for nursing services in refugee camps and hospitals. Nurses shared in treating wounded civilians and the profession became 'more respected' and 'more in demand'. In addition, the living costs of the Palestinian families increased, and more women started to work beside men. The nursing profession was a good field to provide a minimum stable source of income. During that period, degree schemes in nursing were first delivered (Aghabkian et al., 1990).

The last two chapters of the above mentioned book were about the realities and the main challenges of mental health nursing in Palestine. For example, Manasra (1990) explained that mental health nursing was a significantly underdeveloped profession. Seventy one percent of Palestinian students of nursing in 1988 were not interested in studying mental health nursing. The low number of students interested in mental health nursing is explained, somewhat, by the fact that there was a lack of supportive resources, lack of infrastructure, lack of reflective supervision, low status of nurses, experiences of malpractice, and an absence of community mental health centres.

Manasra (1990) also wrote that the nurses working in the psychiatric hospital experienced low wages, stigma, and staff shortages. They delivered a sub-standard quality of care, and maltreated patients. There was an absence of home visits, motivation, continuing education opportunities or professional development. They experienced violence inside the workplaces. There were no highly-qualified community mental health nurses in Palestine and an absence of any mental health research centres or postgraduate educational workplaces, and nurses did not offer counselling services. The nurses, who worked in the mental health field, after a period, were considered as mental health or psychiatric nurses through gaining experience or receiving short training courses. There was no clear definition or identity of mental health nurses; their independent professional development was considered to be at the neonatal stage.

In addition, I found through my search strategy only one recent publication about the community mental health workplaces in the West Bank (McAuley et al., 2005). The

recent publication was prepared by UK mental health experts and NHS practitioners following their visits and conducting training with local mental health teams in three workplaces; Bethlehem, Hebron and Ramallah. The publication was a part of the WHO strategic plan to develop mental health services in Palestine. It focused on the area of development of the work environment inside the mental health workplaces. The published work contained a section on the challenges for the nurses who worked in the psychiatric hospital and two community mental health centres. The NHS experts reported similar challenges and realities to those mentioned above by Manasra (1990), but they added some challenges related to the community mental health centres that had been established since 2000. They explained that there were an overload of cases; lack of up to date medications and a lack of effective management structure inside the community centres (McAuley et al., 2005). The methodology of producing the publication was not clearly explained. It also discussed observation of three sites of the workplaces. As previously explained I include these findings as the only available source of information (CRD, 2009).

The total number of nurses in Palestine in the West Bank today is 4,038, and midwives 415. The number of nurses in Gaza is 1,895 and midwives 119 (Ministry of Health, 2009). There are nurses and midwives with different types of qualifications. These numbers include: firstly, registered staff nurses or midwives who have a master's degree, higher diploma, bachelor degree, or have completed three years of study; secondly, practical nurses or midwives who have studied for two years, or more than 18 months (Amro, 2006). Thirdly, a few nurses and midwives who have studied for less than 18 months. This degree is very old, and was stopped many years ago (Aghabkian et al., 1990).

The nurses will have graduated from the universities or colleges as general nurses. They can work in many health fields including mental health services. Midwives who graduate from university or college commonly work in the maternity field. However, all nurses and midwives, before starting work, must pass The Nursing Comprehensive Exam (PNNA, 2010). All the nurses must succeed in passing theoretical and clinical courses in the mental health field. These courses are similar in most universities and

colleges and enable nurses to deal with differing needs of mental health clients. For example: the student nurses at Annajah National University study courses in their curriculum such as mental health nursing which is a combined theoretical and clinical course. In addition, they study other courses related to the mental health field such as medical sociology, clinical psychology, communication, health promotion, and anatomy (Annajah National University, 2006).

In summary, there was an absence of high quality studies that investigated CMHNs workplace environments and the main challenges they faced. There was also an absence of studies discussing the resilient responses of CMHNs inside and outside their workplaces. However, the mental health nursing profession was significantly underdeveloped in terms of resources, policies and procedures before and during the Palestinian Authority period. Mental health nursing was, and still is, considered part of the nursing profession in general. Therefore, there might be shared challenges between the general nursing and the nurses who work in the mental health field. The following section discusses the challenges of nurses in general inside and outside the workplace.

## **1.10 Challenges for Palestinian nurses**

For synthesis of this section, the following databases were searched: METLIB, CINAHL, Science Direct, Pub med, PsycINFO and Google.ps, Google scholar. Key words included "Palestin\* (Palestine and Palestinian) AND nurses, Palestin\* AND mental health nurses". To be as comprehensive in my review as possible, I also searched these words in the Arabic language in Arabic databases such as the Annajah National University journal and the Islamic Gaza University. These are reasonable sources of data given the general lack of literature in this area. Few full text published works in the Arabic language were found and few full text published Masters' theses via the Palestinian universities' websites. References in the Arabic language were translated to the English language and I chose literature related to nurses' stressors or challenges and left out unrelated details. Moreover, additional papers which did not come to light in the electronic database search were obtained via an examination of reference lists of

published papers. The first paragraphs below will discuss the findings of the reports found, and the following paragraphs discuss the studies found (see appendix 1).

The Palestinian nurses offered nursing care within environments in conflict in spite of a marked lack of safety and in the face of personal threats (Gold, 2009). According to the WHO reports, Palestinian patients and health staff (including nurses) faced difficulties in accessing the health care workplaces especially in East Jerusalem (Vitullo et al., 2012). The road restrictions created problems for the health services and disrupted the education of medical staff. For example, restrictions on travel often prevented nurses and doctors arriving to duty on time which affected negatively the routine and the quality of care in the health workplaces. Moreover, health teams experienced disruptions when attending in-service training or conducting research; difficulties in travelling and access disadvantaged them continuing their education and updating their skills (B'Tselem, 2010). The United Nations recorded 528 checkpoint and physical obstacles, set up for security reasons, in 2006 which limited freedom of travel and increased the isolation of Palestinian lands, cities and villages. These measures inhibited access to services to meet basic needs such as health and education (UN, 2004). In addition, the organisation Human Right Watch stated that there was a need to protect health staff in the conflict zone. They pointed out that some health staff had lost their lives or been injured (HRW, 2004). According to Amnesty International reports, health teams had trouble in offering care. They suffered from a lack of hospital food, lack of medical supplies, inconsistency of electricity supply in hospitals, and deficient supply of water especially in the Gaza strip (Amnesty, 2008). According to Castledine, (2003) who visited Palestinian nursing schools, nurses need help and support to reach educational aims and provide quality of care. He also reported that there was a lack of up to date journals and text books in the nursing field.

Through my search strategy, I found only 12 studies about non mental health Palestinian nurses. Not one of these studies was about the resilience of nurses, but they did discuss issues such as the challenges faced by nurses, stressors, and burnout and job satisfaction (see the table in appendix 1). The first nine studies in the table in appendix 1 were quantitative and the last three were qualitative. A few of the

quantitative studies used self-developed questionnaires. The researchers also used questionnaires for the first time in the Palestinian culture those were originally based on other populations. One shared limitation was the lack of strategies to enhance validity and reliability of the findings when using these surveys in the Palestinian context. In addition, there was a lack of accumulation of the knowledge related to the studied themes. The studies found through the search strategy were the only source of knowledge that been published about the Palestinian nurses. There was an absence of studies which explored the resilience of the Palestinian nurses. The next paragraph summarises the studies detailed in appendix 1.

These studies discussed the nurses or midwives in general who work in significantly challenging environments inside and outside the workplace (Hassan and Wick, 2007, Wick, 2008, Shawawra and Khleif, 2011, Ashour, 2003). Various studies also highlighted that a remarkable number of nurses experienced moderate levels of mental distress (Jaradat et al., 2012), and moderate levels of job satisfaction (Abushaikha and Saca-Hazboun, 2009, Abu Ajamieh et al., 1996). There are a remarkable number of nurses who have moderate levels of burnout (Abushaikha and Saca-Hazboun, 2009, Elamassi, 2007), high rates of mental health disorders (Alhajjar, 2013), and high levels of stress (Elamassi, 2007, Joudeh, 2003, Saadeh et al., 2003, Umro, 2013). However, none of the above studies investigated nurses who work in community mental health workplaces. This might be due to lack of interest in mental health nurses as it is clearly an ignored area of research.

There was an absence of qualitative studies in particular that investigated the resilience of CMHNs and observed their workplace environment. There remains a significant need for qualitative studies to hear the voices of the voiceless and to explore the CMHNs' perspectives. The next section will discuss the main future challenges that Palestinian nurses may need to consider; the priorities of mental health services in the future; and supportive factors that may need to be focused on.

## **1.11 Future challenges for mental health services in Palestine**

The previous sections discussed the past and present political unrest which has created an environment in which challenges to the mental health services have arisen. The following sections draw attention to the future challenges or opportunities for the mental health services in Palestine. The meaning of adversities and risks may vary across cultures. For example the Chinese symbol for 'crisis' is danger and opportunity (Walsh, 1998). There is an importance attached to developing capacity among nurses, who are working and living within significantly challenging environments. There was a significant need to develop the mental health services by strengthening and empowering the mental health staff's capabilities and resilience (de Val D'Espaux et al., 2011).

There is an increasing need to develop mental health nursing for many reasons. For example, many areas need to be developed in mental health services in Palestine such as: raising awareness toward stigma of mental health, integration of mental health with primary care, supervision systems, capacity of mental health teams, and increasing the availability and quality of care (WHO, 2013). There is a lack of awareness of mental illness and there is a need to tackle the misperceptions and stigmatising attitudes of nurses and other health professionals (Afana et al., 2000). Many of the mental health funded programmes have been linked with the political environment (More, 2004) and, therefore, only existed for short-term periods only. For example, during the Alaqsa Intifada, many projects were set up but were stopped after the Intifada finished. In addition, there is no effective collaboration between governmental and nongovernmental institutions, with contradictions in some roles or funded programmes. Moreover, there is a lack of effective long-term strategic planning for mental health services, which can be implemented by all the institutions (governmental and nongovernmental) working in the mental health service field (Giacaman et al., 2007). The above mentioned challenges might be responsible for a high turnover

and/or limited numbers of CMHNs who find it difficult to remain or survive in the workplace.

There is also a priority to listen to the CMHNs' needs, and support them in order to enable their resilience and cope with the daily challenges. Many of the international funders connect their biomedical approach to mental health treatment and their funding. For example, they focus on PTSD as an individual problem but without a focus on its social, political and cultural context. The Palestinian community has cohesiveness and most of the community is exposed to violence. The depressive-like effect will be found in individuals as part of cumulative collective exposure. In other words, in the Palestinian collective culture, trauma is mostly interpreted according to specific collective meaning more than individual experiences. In addition, some of the international funders spend funds without basing these on need assessments related to the Palestinian context. For example, they advertise in the newspapers that their project will achieve some goals such as women's civilian rights then the mental health agencies try to follow and work on these themes which are not necessarily the most urgent or most suitable priority for the whole population (Giacaman et al., 2009). In addition, after the Gaza wave of conflict in 2008, a study undertaken by UNFPA and FAFO (2009) showed that just 1% of civilians would look for individual counselling, whereas most of them preferred to talk to close friends or to their family members. This study gives us an opportunity to focus on social support group models or improve the capacity of the whole community more than focusing on the other approaches based on individual treatments. This includes developing the capacity or resiliency of nurses who work in underprivileged workplaces with the addition of increasing life demands.

Nurses who are part of the Palestinian population need to fulfil their basic needs as human beings such as maintaining their feelings of well-being. For example, bringing an end to the surrounding violence promises to improve the mental health of civilians (Hobfoll et al., 2011). Overall, some international countries are dealing with chronic conflict in a superficial way, giving only urgent humanitarian food or aid. Furthermore, the most important priority need for civilians is to be protected during the conflict. The continuous chronic, unstable environment is also producing new mental health

problems for the civilians. The priority is to create an effective and supportive mental health system and break the cycle of the conflict as a primary prevention (Giacaman et al., 2005). Palestinians who live in occupied territories are mostly living in unbearable circumstances due to a lack of their basic human needs being met (Amnesty, 2009).

To summarise, there is a significant need to minimise the challenges and develop the resiliency or capacity among civilians including nurses. Civilians also need to focus on their own available resilient resources and protective factors in order to survive. This study will explore the challenges of CMHNs as part of the Palestinian community living in a significantly challenging context. The outcomes might help decision makers to focus on how to develop resiliency, support the Palestinian population and the CMHNs in particular.

## **1.12 Conclusion**

This chapter has discussed the background of challenges inside and outside the health organizations. It has also included a brief historical overview and an analysis of the effects of the present situation on the mental health of the population. The mental health problems among civilians were addressed. The cross-cultural developmental challenges of mental health care in the Arabic region were included. In addition, the history of the developmental challenges of the Palestinian mental health services was discussed in detail. This was interwoven with the challenges for the nursing profession within the historically unstable context. Finally, the chapter discussed the future challenges for mental health services in Palestine.

This chapter has contained an overview of the background to the Palestinian political, historical and cultural context. It was obvious that there was a significant need to explore the difficulties for CMHNs who work in a significantly demanding context both inside and outside the workplace. Very few studies have provided data related to the challenges faced by nurses inside and outside workplaces and this has been very limited. There is an absence of studies which discuss the challenges facing community mental health nurses. The challenging context might motivate nurses or Palestinians to

respond in a resilient way. Bob Marley tells us *“you never know how strong you are until being strong is the only choice you have”*. There is a significant need to explore the resilient resources of the Palestinians and the CMHNs specifically. There was also an absence of studies which observed the workplaces or listened to the experiences of community mental health nurses (CMHNs).

This project will provide data about nurses and civilians who live in a conflict zone. They have limited ability to change the chronic conflict but they created strategies to survive. According to Kabat-Zinn (2009) *“You cannot stop the wave but you can learn to surf”*. Therefore, the outcomes of this study will be used to develop the capacity of CMHNs. This thesis was completed in an under researched culture and the outcomes might be used to minimise the challenges among the Palestinians. This might help to develop resilience among the Palestinians where nurses are considered a part of the vulnerable civilians who are living in a politically fragile zone. This chapter discussed the background to a challenging context where the CMHNs live and work. The next chapter will explain resilience from the social ecological perspective. It will discuss the resilient resources and responses within the Palestinian cultural context.

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## **Chapter Two:**

### **Literature review of resilience**

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## 2. Chapter Two: Literature review of resilience

### **2.1 Introduction**

This literature review chapter presents a review of English and Arabic language literature regarding resilience. The aim of this chapter is to gain an overall view of theoretical perspectives and practical research knowledge in relation to 'resilience', the resilience of Palestinians in particular, and the related concept of 'Sumud'. The chapter consists of several sections: the history of the concept of resilience, conceptual definitions of resilience, social ecology of resilience, social ecological studies of resiliency in various fields, and resilience of nurses. It also consists of resilience in the Arabic and Islamic context, and resilience among Palestinians, and 'Sumud' as a social ecological idea. Finally, the relationship between resilience, 'Sumud' and nursing is discussed.

### **2.2 Search strategy**

The search procedure was based on three main steps: In the first step, I put the term in the search database engine as explained in the sections below. The second step I read the title, and I read the abstract of the relevant title, and I saved the relevant full text articles in electronic folders. In the third step, the full text articles located from the database were reviewed and analysed. For the analysis of empirical articles, the following aspects were considered: instrument, aim, sample, data collection, limitations or bias, key findings, ethical and procedural rigour. For the empirical studies with statistical methods the reliability and validity were taken into consideration. The framework of Rees (2003) was consulted to help with these appraisals and critiques.

For this literature review, the following electronic databases were used: CINAHL, British Nursing Index, ASSIA, Medline, PsycINFO, and EMBASE. I also used the data resources at the resilience centre at Brighton University, and I shared in their resilience international conference. I set an alert in 2012 through "Zetoc" for up-to date resilience articles. The additional papers, which were not revealed in the electronic database

search, were obtained via an examination of reference lists of published papers and books. Furthermore, I made contact with several local and international researchers who had studied resilience or relevant Palestinian concepts and requested them to forward their articles or books via email. For example, Tony Teeffelen forwarded his, under publication, book "Living Sumud" (2011), and Kårtveit (2010) forwarded his PhD thesis (Sumud is a Palestinian concept its meaning is close to steadfastness and resilience).

The search strategy was limited to English and Arabic languages; books about resilience and relevant concepts were included. Keywords in English consisted of nurs\* AND resili\* (translated as nurses or nurse or nursing; resiliency or resilience or resilient), resili\* AND Arab\* OR Muslim\*, resili\* AND Palestin\*, Sumud, Palestin\* AND coping, Palestin\*AND Hardiness. These words also were searched in the Arabic language to identify articles indexed in Google Palestine, Annajah University Journal for Research, and Islamic University Gaza Journal of Research. However, few references were found about nursing resilience and no studies were found about resilience among Palestinian, Arab or Muslim nurses. Two librarian technicians from Cardiff University and Annajah National University were consulted in this search strategy. The resilience search strategy also focused on academic papers or research mostly rather than opinions and suggestions. The above searched terms produced considerable numbers of full text Arabic and English references. For example, 235 articles related to the terms 'resilience' AND 'nurses' terms were reviewed, the duplicated articles were removed, and 25 studies were included based on the above-mentioned eligibility criteria (See the appendix 2 table which contains examples of the databases and keywords search in English language). The table (2.1) below explains the inclusion and exclusion criteria.

## 2.3 Resilience Literature: Inclusion and exclusion criteria

table 2.1

TABLE 2.1: Resilience Literature: INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> <li>➤ English and Arabic references</li> <li>➤ Research 'resilience'</li> <li>➤ Articles related to Arab and Muslim resilience.</li> <li>➤ Studies about Palestinian resilience</li> <li>➤ Reference focussing on Palestinian 'Sumud'</li> <li>➤ Research involving Palestinian coping and hardiness among adults</li> <li>➤ References focusing on resilience among nurses</li> </ul>	<ul style="list-style-type: none"> <li>➤ Articles that focus on burnout and stress among other health workers such as student nurses and midwives</li> <li>➤ Coping and hardiness among Palestinian children</li> </ul>

## **2.4 Resilience**

### **2.4.1 History of the concept of resilience**

Researchers in parts of Europe started to use the concept of resilience, extending back to the 1800s (Jackson et al., 2007). The word itself comes from the Latin 'rescindere', which means cancelling or terminating (Phaneuf, 2008). The origin of resilience stems from psychiatric writing to describe children whose parents have a mental illness, live in adverse conditions, and yet are invulnerable to mental illness. Later on this word, invulnerable, was replaced by the term 'resiliency' (Earvolino-Ramirez, 2007). The last 30 years of investigating resilience focus on examining the psychological and psychosocial dimensions, correlations or constructs, and includes the biophysical (Curtis and Cicchetti, 2003).

### **2.4.2 Conceptual Definitions of Resiliency**

There is a complexity in defining the concept 'resilience', according to Masten and Obradovic (2006). There are a number of issues to consider when we carry out resilience research. Firstly, resilience is a challenging concept to define and is linked with a wide range of other concepts. Secondly, there are multiple pathways of resilience. This means that resilience can vary from one individual to another within the same context or culture. Thirdly, resilience can be embedded in the cultural context. As such, resilience experiences can be associated with the cultural context or traditional sources. Finally, there is a need to know about resilience research in non-Western cultures.

Through the search strategy described above, the following studies were found which discuss the used definitions and understanding of resilience in general. The table below (2.2) contains various interpretations of resilience among different groups such as nurses, adults, the elderly, families, youths and children. This section was limited to the development of human resilience, and resilience in other fields, such as physics, was excluded. It also includes a mixture of periods (ancient until modern day), countries, cultures and contexts. The aim was not to solve the dilemma of defining the concept but

to explain the lack of consensus between scholars on how to define resilience. As a qualitative researcher, it is less important to find one specific definition or meaning but instead it is important to be generally aware of how the concept may be differently understood. The following table definitions were themed according to Ungar (2012, 2011), Ungar et al. (2007), Masten (2007), and others, with suggestions of four overlapping research waves of resilience:

- 1) Individual traits
- 2) Protective mechanisms
- 3) Developmental assets individual and community
- 4) Social ecological: culturally embedded understanding of resilience and “new voices”.

The table below (2.2) contains examples of the first three waves, followed by discussion of each wave. The fourth wave also will be presented and discussed at the end of three wave’s discussions.

TABLE 2.2: RESILIENCE DEFINITIONS

No	Author (s)	Definition or description (s)
1	ALBalakhi (850- 934 AD)	The ability of the individual to be aware to himself and his surrounding supportive resources; to use his internal defence mechanisms [AlhealAlnafsia] or the external resources of coping mechanisms to preserve his wellbeing. Then do training to cope with small stressors to become more mentally flexible, tolerant, resist hardship and gain experiences [AltamaronAlnafsi in the Arabic language].

2	Wu et al. (2013 p1)	<i>“The ability to adapt successfully in the face of stress and adversity”.</i>
3	Rutter (1985)	rebound or overcome in spite of substantial difficulties
4	Rutter (2006 p1)	<i>“An interactive concept that refers to a relative resistance to environmental risk experiences, or the overcoming of stress or adversity”.</i>
5	Masten (2001 p228)	<i>“Class of phenomena characterized by good outcome in spite of serious threats to adaptation or development”.</i>
6	Turner (2001 p441)	<i>“The capacity to bounce back in the face of adversity and to go on to lives with a sense of well-being”.</i>
7	Jacelon (1997 p123)	<i>“The ability of people to spring back in face of adversity”.</i>
8	Grafton et al. (2010 p1)	<i>“An innate energy or motivating life force present to varying degrees in every individual, exemplified by the presence of particular traits or characteristics that, through application of dynamic processes, enable an individual to cope with, recover from, and grow as a result of stress or adversity”.</i>
9	Atkinson et al. (2009 p137)	<i>“The capacity to recover from extremes of trauma and stress”.</i>

10	Felton and Hall (2001 p46)	<i>“The ability to achieve retain and regain a level of physical or emotional health after devastating illness or loss”.</i>
11	Lamond et al. (2009 p148)	<i>“The ability to adapt positively to adversity, may be an important factor in successful aging”.</i>
12	Grafton et al. (2010 p698)	<i>“An innate energy or motivating life force present to varying degrees in every individual, exemplified by the presence of particular traits or characteristics that, through application of dynamic processes, enable an individual to cope with, recover from, and grow as a result of stress or adversity”.</i>
13	Hart et al. (2012 p1)	<i>“The ability to bounce back or cope successfully despite adverse circumstances”.</i>
14	Hodges et al. (2008 p81)	<i>“A dynamic capacity to modulate and monitor one’s interactions with ever changing disruptions in the practice environment that results in higher levels of self-efficacy, wisdom, transformational energy, and expertise”.</i>
15	Jackson et al. (2007 p1)	<i>“The ability of an individual to positively adjust to adversity”.</i>
16	Dyer and McGuiness (1996 p1)	<i>“Process whereby people bounce back from adversity and go on with their lives”.</i>

17	Luthar et al. (2000 p543)	<i>“A dynamic process encompassing positive adaptation within the context of significant adversity”.</i>
18	Garcia-Dia et al. (2013 p267)	<i>“Is one's ability to bounce back or recover from adversity. It is a dynamic process that can be influenced by the environment, external factors, and/or the individual and the outcome”.</i>
19	Ungar (2005)	<i>“Adequate provision of health resources necessary to achieve good outcomes in spite of serious threats to adaptation or development” or is the outcome of negotiation between individuals and their environments to maintain a self-definition as healthy.</i>
20	Van Kessel (2013 p122)	<i>“The ability to bounce back from adversity and regain health”.</i>
21	Cameron and Brownie (2010 p67)	<i>“The ability to rebound from adversity and overcome difficult circumstances in one's life’.</i>
22	Windle (2011 p163)	<i>“It is the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and ‘bouncing back’ in the face of adversity. Across the life course, the experience of resilience will vary”.</i>

23	Humphreys (2001)	The capability to positively and quickly bounce back to equilibrium after trauma
24	Bosworth and Earthman (2002 p229)	<i>“Resiliency describes the ability of children to overcome adversity and become successful adults”.</i>

The above table contains examples of research that largely can be linked with the first three suggested waves of resilience. The beginning of the above definitions focused on the individual factors to understanding resilience (see the above table studies from 1-15). In the first wave, the initial conceptualisation of resilience was focused on individual traits, in the beginning associated with positive outcomes (Garcia-Dia et al. 2013 p267; Anthony, 1987). According to the British paediatrician and psychoanalyst Bowlby (1969) the concept of resilience is based on attachment theory. He argued that the mother gives the infant a sense of security and self-confidence when she fulfils his basic needs. This will protect the infant later on from life crises and help him to cope with separation and adversity. However, it has also been noted that some individuals have the ability to become resilient in spite of lack of support from their families and communities (Turner, 2001).

In contrast to the first wave, Rutter and others argued, in the second phase of resilience conceptualisation, that resilience is a dynamic process and the interaction between genetic and environmental factors were considered (Rutter, 2012). The integration of genetic and other factors play a role in developing resilience (Wu et al., 2013). The healthy individual uses some of his internal defence mechanisms to cope (Phaneuf, 2008). Therefore, resilience can be a process of using internal and external protective factors to adapt to a situation (Garcia-Dia et al., 2013). Some researchers focused on resilience as a dynamic process of recovery or a protective mechanism (see table 2.2 studies from 16-18 (Dyer and McGuiness, 1996, Luthar et al., 2000, Garcia-Dia et al., 2013).

Other scholars mentioned the interaction between the environment and individual factors in determining the resilience variables (see table 2.2 studies from 19-24 (Ungar, 2005, van Kessel, 2013, Cameron and Brownie, 2010, Windle, 2011, Humphreys, 2001, Bosworth and Earthman, 2002)). The third wave of resilience conceptualisation is the shift to developmental assets, both individual and community. These scholars introduced a more ecological interpretation of resilience; they argued that resilience can be an outcome of interactions between individuals and their environments, and the progression which leads to these outcomes (Ungar, 2008). For example, resilience of the daughters of battered women can be affected by individual and environmental factors (Humphreys, 2001). In addition, children's resiliency in schools can be enhanced by focusing on individual and environmental factors (Bosworth and Earthman, 2002, Masten, 2001). As discussed below, there are some limitations related to this understanding of resilience constructs (Windle, 2011).

There is a critique and debate of the above three waves of understanding the concept within different groups and purposes. For example, culture also needs to be taken into consideration when we discuss resilience (Tusaie and Dyer, 2004). There are complex multidimensional interactions depending on the cultural context (Ungar, 2011). For instance, the resilient individual might be unable to stay in high resiliency every day in each stage of his life. Other individuals may be resilient in spite of lack of community or environmental supportive resources. The individual who grew up with mentally ill parents or family will be considered vulnerable according to some of the above definitions. However, this is not always the case; these factors depend on the context and culture within which supportive factors interact. The child might live in a collective society where the extended family, neighbours and other supportive community resources buffer the challenges. In some situations, the surrounding culture supports the individual and helps him or her to use the available resources to their utmost (Ungar, 2011). Each individual has protective factors and risk factors in his surroundings, sometimes these factors can be converted from risky to protective and vice versa. It can vary from time to time and from person to person. For example, an individual can consider his parents as a protective factor that can be called on when

needing to face adversity. Sometimes these same parents can become the risk factor and cause the adversity faced by the individual (Ungar, 2008). Therefore, there are cultural and contextual factors which might affect the complex dynamic interaction of the sources of resiliency (Ungar, 2011). However, most of the definitions in the table were constructed within the developed countries and none of them were developed in a chronic, politically adverse context such as Palestine.

Following on from the above discussion and critiques of the three waves of resilience, the fourth wave of understanding resilience focused on the cultural context and other social ecological sources. For example, cultural values play a crucial role in the collective resilience of the individual and community within a politically violent context (Sousa et al., 2013). According to Ungar (2008 p225), resilience can be *“in the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual’s family, community and culture to provide these health resources and experiences in culturally meaningful ways”*. I think, this definition closely relates to my general understanding of the Palestinian context, based on my lived experience. This understanding of resilience focused on the cultural and social ecological aspects of resilience. The next section will discuss the fourth wave of resilience in detail.

## **2.5 The Social Ecology of Resilience**

There is a new direction for the future to investigate resilience and develop social ecological interventions (Ungar, 2011). There are scholars who are the ‘new voices’ of resilience interpretation such as Ungar (2012, 2011), Ungar et al. (2007), Masten (2007) and others. For example, Kent (2012 p111) clarified that *“resilience does not occur in isolation. It is an interactive process that requires something or someone to interact with. It is dependent upon context or environment, including our relationships”*. The individual brain is a responsive organ operating within a social context especially during adversities. Supkoff et al. (2012) reported that children at risk sometimes did surprisingly well. This was due to contextual factors which affected the developmental history of these

resilient children. According to Murray and Zautra (2012) community resilience is necessary for individual resilience in different cultures and contexts. They also reported that shared identity, community collaboration, increased social ties has a promise to enhance the well-being of individuals under stress. Berliner et al. (2012) argued that individuals who are struggling with their personal challenges can support each other and become resilient. This will happen by strengthening community resilience, revitalisation of the culture through social networks and locally formulated values and resources. This also offers options of creativity and encourages shared activities.

The fourth and up-to-date wave of resilience conceptualisation is the social ecological, where understanding of resilience is culturally embedded. There are new voices of scholars who suggest that there are possible individual differences of resilience in the same context or culture. Some of them argue that resiliency sources may be different from culture to culture and it is difficult to nominate fixed, ordered, global sources of resiliency. What determines protective and risk factors differ significantly from culture to culture. We can find some shared sources of resiliency but their relative priorities and their origins differ significantly from one culture to another. Each culture might provide meaning to a person living through adversity. For example, the effect of some risk factors on youths, such as political violence, depends on how they experience or deal with these risks within their cultural context (Ungar et al., 2007). Finally, Schoon (2012) argued that the adaptive response of the individual to adverse circumstances is determined through interaction between the individual and the context. This interaction happens over time ranging from micro to the macro level context.

A number of the scholars came to similar conclusions after conducting various studies in non-Western cultures which included Palestine. For example, Scheper-Hughes (2008) conducted various studies and worked in zones of political unrest such as South Africa during the apartheid period, and also in Brazil. He tells us that the Western understanding of resilience is insufficient in other cultural contexts especially in politically conflicted areas. In these areas of conflict, there is an everyday form of resilience in the oppressed and politically excluded communities. In such overwhelming contexts, the ability to survive and exist is an important focus of

resiliency. Therefore, resilience understanding might be dissimilar from culture to culture, and the environment possibly linked with the resilience. The social cultural context, family unity and sense of coherence play crucial roles in understanding the resilience of people (Panter-Brick and Eggerman, 2012).

According to Barber (2013) in responses to adversity, there are specific cultural differences variables which might play crucial roles. Contrary to the dominant expectation, the majority of Palestinian youths function effectively in spite of the surrounding risks. Due to the specific nature of the conflict, the youths have their own interpretation, exposure, participation and means of processing. There is a need to understand their ideology, their way of thinking, and their created meaning regarding adversity. Finally, Gren (2009) carried out a study in the West Bank- Palestine to explore ways of maintaining everyday life in spite of adversity during the second Intifada. The author used interviews and field note observations for over one year in one of the Palestinian camps. The study showed that the people used tactics and practices of resilience to survive in a significant conflict zone. These tactics included positive attitudes and strategies which were upheld by the surrounding cultural context. Therefore, the resilience of the individual was discussed within a collective political resistance context.

The previous section explained the waves of resilience research. It also included the development of the fourth up to date resilience understanding. As we notice from the above discussion, resilience might be culturally embedded. It is a complex multidimensional interaction between the individual's capacity and his or her physical and social ecologies. There is a need to focus on how the cultural context can influence the resilient individuals (Ungar, 2012). There are few studies which investigate resilience based on the up to date understanding of resilience. There is a near absence of studies which investigate resilience within conflict zones and in underdeveloped countries. There is also a lack of studies that investigate resilience within an Arabic or Muslim cultural context. Therefore, this study will investigate resilience among community mental health nurses in Palestine. The next section will discuss some social ecological studies relating to resilience in fields outside nursing. This will be followed

by the nurses' resilience and resilience studies which have been carried out in the Palestinian cultural context.

## **2.6 Social ecological studies of Resiliency in various fields**

There are increasing numbers of studies conducted to highlight the significance of the social ecological view of resilience (see *The Social Ecology of Resilience: A handbook of Theory and Practice* (Ungar, 2012)). It is not possible to present all of these studies; therefore, I chose the studies below which are relevant to resilience amongst Palestinians.

One of the studies investigated resilience in chronic political war zones such as Afghanistan (Panter-Brick and Eggerman, 2012). This example can be relevant to Palestine; both countries experience chronic political conflict within an Islamic cultural background. The study showed the significance of the social cultural context toward resilience. For example, the family unity in the Muslims' community, sense of coherence and hope for the society were foundations of resilience. There were also specific cultural and faith meanings as a means of responding to crises, such as death and loss, within the local community. Therefore, the development interventions to support people's resilience needs to be culturally and contextually sensitive. These conclusions can be used as evidence for the new voices of understanding resilience where social ecologies play a crucial role.

There is another example that can be used as an example of the social ecology of resilience. Kirmayer et al. (2012) studied the resilience among the aboriginal community in Canada (indigenous people). The findings of the study may relate to the resilience of the indigenous people in Palestine. For the aboriginal people, resilience was significant to their connectedness to the land, cultural continuity, political activities, community solidarity, and collective identity. They have also family and community connectedness and spirituality. The language, history, traditions and storytelling are also considered to be sources of resilience. The dominant mental health approach focuses on individuals but there is also a need to develop resilience features for the whole community. The

resilience is deeply embedded in the indigenous people's cultural context and their environment. These findings revealed the social ecological sources, such as collective solidarity and identity, in developing resilience.

The above sections discussed the social ecological sources in developing resilience. The first section investigated resilience among Afghanistan Muslim culture within a chronic conflict context. However, Afghanistan might have differences in culture and language, also the nature or context of the conflict might be different to that of Palestine. The second study discussed resilience among the heterogeneous community and native people in Canada. There are differences in culture, language, lifestyles and contexts between Palestine and Canada. As a result of these differences, there is a need to focus on exploring resilience within the Palestinian cultural context. However, this project is investigating resilience of Palestinian adults, in particular, who work as nurses. The next section will be more specific and discuss studies into nurses' resilience.

## **2.7 Resilience of nurses**

These sections discuss studies that investigated resiliency in various nursing fields and countries. The studies below were themed according to the four waves of resilience mentioned earlier (Ungar et al., 2007, Ungar, 2012, Ungar, 2011).

### **2.7.1 Resilience as an individual trait of nurses**

This subdivision discusses the first wave of understanding resilience among nurses. The following studies were reviewed and can be largely associated with the individual trait wave of resilience. For example, Hart et al. (2012) suggested intrapersonal strategies to build resilience among nurses within individual, group, and organisational level. Larrabee et al. (2010) carried out quantitative studies to evaluate the level of interpretive style of stress resiliency (deficiency focusing, necessitating (meaning demanding or 'you have to do'), and skill recognition) on psychological empowerment, job stress, job satisfaction and intention to remain in nursing. The interpretive style will affect psychological empowerment; reduce stress, and increase satisfaction which will encourage the motivation to continue in the role of nurse. Similarly, Simoni et al. (2004)

completed a quantitative study to describe the effect of three interpretive styles of stress resiliency on psychological empowerment. The study showed that feelings of empowerment could reduce stress, enhance job satisfaction and improve resilience among the sample.

There are three studies which discuss experimental suggestions to promote resilience among nurses. It seems that these suggestions largely focus on resilience traits to cope with stress and challenges. The first study used teaching programmes based on increasing the individual's coping strategies to develop nurses' resilience (McDonald et al., 2012). As a consequence, participants became more assertive, creative, more self-expressive, and developed a better understanding of self-care practices (McDonald et al., 2013). The second one also suggested teaching the nurses effective coping mechanisms to enhance their resiliency (Pipe et al., 2011). The final one suggested teaching nurses how to practise "stress reduction" through mindfulness techniques in order to promote resilience (Foureur et al., 2013). These studies seemed to narrow the understanding of resilience and ignore other critical social ecological factors. It can be difficult to enhance resilience by teaching stress reduction and coping strategies only. This ignores other variables that affect nurses' resilience such as the local culture and context.

The following studies also can be largely linked with the individual trait of understanding resilience: Kornhaber and Wilson (2011), Ablett and Jones (2007), Birchenall (1997), Gillespie (2007), Edward (2005), Gito et al. (2013), Matos et al. (2010), Othman and Nasurdin (2011), Hodges et al. (2008). After reviewing all the above quantitative and qualitative studies that were conducted to explore resilience amongst nurses in various fields, some themes were identified within the literature which can be largely linked to the individual traits perspective. For example, the need to "cope" was identified in several papers (Pipe et al. 2011, Hodges et al. 2008, Gillespie 2007, Ablett and Jones 2007, Kornhaber and Wilson 2011). Hope or positive attitude was identified in others (Othman and Nasurdin 2011, Edward 2005, Gillespie 2007, McDonald et al., 2012, Hart et al. 2012). Other themes included hardiness (Ablett and Jones 2007, Gito et al. 2013, McDonald et al. 2012), job satisfaction (Ablett and Jones 2007, Matos et al. 2010,

Larrabee et al. 2010) empowerment (Simoni et al.2004, Larrabee et al. 2010) and commitment (Ablett and Jones 2007, Birchenall 1997).

However, this literature review discusses resilience from a social ecological perspective. This means that these individual traits need to be discussed within their cultural context. For example, it would be impractical if the National Health Service (NHS) enhanced hope or commitment among nurses, only to then cut by half the level of resources available. It might be a good idea to enhance commitment amongst nurses, but this should be in parallel with development of the NHS system. Developing individual traits only without also developing the system of health services can be challenging to nurses.

It is of note from the above-mentioned investigation of nurses' resilience that the nurses used various individual resources. These resources might vary from one person to another and from one workplace cultural context to another. There is a need to explore in which cultural context these individual traits influence resilience, what make them work in specific situations and have limited influence in others (Ungar, 2012). The above studies also did not focus other factors, such as social ecological, which might enhance resilience (Ungar, 2011). However, the nurses are unlikely to be able to be resilient every single moment in their work or daily life. There is a need to investigate resilience in the nursing field from a social ecological perspective.

### **2.7.2 Resilience as a protective mechanism**

This subdivision discusses the second wave of understanding resilience among nurses. The following studies were reviewed and can be largely associated with the nurses' resilience as a protective mechanism. Resilience can be a protective mechanism against mental disorders. For example, Manzano Garcia and Ayala Calvo (2012) investigated the influence of resilience on the emotional exhaustion level of nursing staff in Spain. The findings revealed that resilience was a protective factor against emotional exhaustion of the hospital nurses. Moreover, Mealer et al. (2012a) undertook a study to explore resilience among the ICU (intensive care unit) nurses in the USA. The study showed that the highly resilient nurses showed low level of anxiety, depression, burn

out and PTSD compared with nurses who had low resilience. The resilient nurses had better insight related to their workplace environment and life outside the job. Mealer et al. (2012b) conducted a follow up study to explore the mechanisms used by the highly resilient ICU nurses to prevent PTSD symptoms. The worldview of participants, social networks and cognitive abilities were considered the main protective mechanisms. However, what was considered a protective factor might vary from nurse to nurse and from one workplace to another. The workplace cultural context within and outside the organisation needs to be taken into consideration when investigating resilience (Ungar, 2011). There is a need to explore nurses' resilience focusing on cultural contexts or social ecological influences.

### **2.7.3 Resilience as developmental assets within individuals and communities**

This subdivision discusses the third wave of understanding resilience among nurses. The following studies were reviewed and can be mostly connected with the nurses' resilience as developmental assets within both individuals and communities. For example, Glass (2009) observed the nurses in school settings and clinical practice in the USA, UK, Australia and New Zealand. The author used the ethnographic approach from feminist perspectives to explore the unique socio-political experiences for each participant. He found the social-psychological construct of adaptability and flexibility is one of the sources that foster resilience. In addition, positive relationships with the environment and friends can also build nurses resilience.

Zander et al. (2013) completed a study to explore resilience among five paediatric oncology nurses in one of the cancer units in Australia. The study revealed that all the nurses believed that resilience can be developed by work experience within the organisation and some of them mentioned that resilience was a personality trait. The interviewees reported that they each preferred to use different individual strategies to deal with challenges in order to enhance their resilience. The nurses mentioned that they each valued receiving support from various resources such as colleagues, family, spouse, and organisations. A holistic environment to foster resilience can also be linked

with this wave of resilience (Cameron and Brownie, 2010). It seems that the above studies focused on resilience as developmental assets within both individual and community resources. However, the dynamic interaction between the nurses and their surrounding community or ecologies needs to be taken into consideration. For example, it is difficult to ignore the cultural context where the nurses use developmental assets. There is a need to explore what helps the nurses to use the available resources in their surroundings (Ungar, 2011). The cultural context here needs to be addressed and resilience investigated from social ecological perspectives.

#### **2.7.4 Social ecological approaches: resilience as culturally embedded**

Throughout the review findings there was an almost total absence of studies that adopted the social ecological fourth wave in investigating nurses' resilience. It was obvious that there is a knowledge gap in investigating resilience as a social ecological wave. This subdivision discusses resilience findings among South African nurses, where some of the findings are notable as they can, on the whole, be matched with the social ecological wave of resilience. For example, Koen et al. (2011b) clarified that resilience might vary across different workplace contexts. Nurses' resilience is interrelated to the culture with respect to the multicultural group differences. The sources of resilience among the nurses were social and spiritual, contextual and personal (Koen et al., 2011b). They suggested broad guidelines in order to enhance resilience and well-being among the nurses in South African (Koen et al., 2011a). These guidelines were formulated after previous studies undertaken to investigate resilience among nurses in South Africa (Koen et al., 2011b, 2011c). The social/ behavioural nursing environment and psychosocial dimensions were taken into consideration. Therefore, some of these findings can be consistent with the social ecological wave of resilience.

## 2.8 Summary

The above section discussed resilience studies grouped under Ungar (2012) and Masten (2007) and suggested four waves of resilience. It was of note that most of the studies discussed resilience as an individual trait, a protective mechanism or as a developmental asset within both individuals and communities. There was a significant lack of studies which discussed nurses' resilience from a social ecological viewpoint. There is a need to focus on how the cultural context can influence the individual traits, protective mechanisms, and community assets of resilience (Ungar, 2012). "Cultural context" can include CMHNS workplaces (e.g. team culture), professions (nursing culture), countries (Palestinian culture), communities (West Bank Culture), ethnic cultures, religious cultures and so forth.

There is a need to investigate whether cultural and contextual factors play a role in understanding nurses' resilience. Most of the above were studies conducted in developed countries, and nurses across other cultures such as Islamic or Palestinian culture were not included. The nurses' resiliency research is still in its early stages; more studies are needed to clarify resilience particularly within mental health workplace cultures. None of the above studies discussed the nurses' resilience in an Arabic or Muslim cultural context. None examined resiliency among CMHNS living and working within an overwhelming context, at times characterised by intense pressure from the political situation and with significant lack of supportive resources within Palestine (see chapter one). Most of the above studies used a quantitative approach to measure resilience by using questionnaires. These measuring tools were designed and tested in developed countries which raise questions about validity when these are copied or used to measure resilience in developing countries. There is a need to investigate resilience by using qualitative studies in underdeveloped and under researched countries.

The above sections discussed the resilience studies in the nursing field and investigated resilience in general. This project was conducted within the Palestinian culture, which has similarities with Arabic and Islamic culture (has same language and religion). The

next section will discuss the investigation of resilience within the wide umbrella of Arabic and Islamic backgrounds.

## **2.9 Resilience in Islamic history**

It seems that the concept of resilience is quite under-researched in the Arabic and Islamic regions. There was a lack of articles which discussed resilience in the Arabic or Islamic states. However, the studies below examined the concept within different groups' contexts and countries. These studies were reviewed in the light of the social ecology of resilience and Ungar's four typology mentioned earlier (Ungar et al., 2007, Ungar, 2012). For example, the prophet Mohammad's 'PBUH' (in Islamic culture reference to Mohammad must be followed by the phrase "peace be upon him" or 'PBUH') life story, with other examples of prophets in the Holy Qur'an, affected the way of thinking of believers in Islam. His life story (Seerah) was recognised as a good pathway or role model of resilience. Muslims try to follow Mohammad's 'PBUH' Sunnah (Sunnah means all his behaviours and sayings in different life situations). It inspired them as to how they can thrive or survive in difficult conditions. Their main teacher is the prophet Mohammad 'PBUH' who was considered a successful example (Ramadan, 2007).

I read the below reference in the light of resilience and the use of coping strategies. Resilience was discussed when ALBalakhi suggested strategies to cope with life's adversities during the 10th century. For example, he suggested that the individual must be aware of himself and his surrounding supportive resources. The human being can use his internal defence mechanisms known in Arabic as [AlhealAlnafsia] to cope with adversity in a positive manner. The individual can practice exercises or training to cope with small stressors but, when he fails to cope, he could use external coping resources. This kind of training will help the individual to become more mentally flexible, gain experience, gain psychological strength and become more tolerant. This training, called at that time in Arabic [AltamaronAlnafsi], meant that if the individual knows himself to be vulnerable he must try to avoid engaging in risks as much as possible to protect his

mental health (ALBalakhi, 850- 934 AD). The next section will discuss the resilience studies, which were conducted in the last decades.

## **2.10 Resilience among Arab and Muslims**

It seems that the concept of resilience is under-researched in the Arabic and Islamic regions. However, the studies below examined the concept within different groups' context and countries. These studies were reviewed in the light of social ecology of resilience and Ungar's typology mentioned earlier (Ungar et al., 2007).

For example, the two studies below can be linked with the first wave of resilience research that is based on establishing individual traits. Both studies examined the level of individual resilience among university students. The first study was from the United Arab Emirates (Mehzabin et al., 2011) and the second from Kuwait (ALnaser and Sandman, 2000). The author used self-administered questionnaires to measure the intrinsic resilience, which was high among students in the U.A.E. In the second study, in Kuwait, the ego resilience scale (ER89) was translated into Arabic and used. The students in general also had high ego resilience scores. Both scales were applied in Kuwait and the U.A.E for the first time. This might need strategies to enhance more the validity and reliability of the used scales. The articles also need to clarify the details of the items used in the questionnaire. This will help to recognise the relevant sources of resilience and promote better understanding of the concept. Moreover, the cultural context factor needs to be discussed or at least taken into consideration.

However, the studies below can be largely linked with the up to date wave of resilience that focuses on the social ecological idea of resilience. For example, Abu zahra (2004) carried out a qualitative study in the U.S.A to explore the sources of resiliency among immigrant Muslim women facing adversity after the events of 9/11. The mass media was distorting the realities of Islam and trying to alter the public image of Muslim identity who lived as heterogeneous minorities. The women struggled with unique context challenges or faced common risks e.g. dealing with intolerance, discrimination, stereotyped images, adjusting to a non-collectivist society, raising their children in a

minority faith. The researcher used interviews with the sample, which consisted of nine women, to reveal the sources of resiliency. The women had arrived in the U.S. as adults and resided in America between 6 and 35 years. The sample reported that the main contributory sources of their resiliency were their Islamic religion. Faith uniquely emerged as central, an underlying and broad support for these women. Their direct, close, and positive relationship with Allah (God) was a significant source of support. In addition, the sample reported that collective supportive relationships inside and outside their families cultivated their resilience. Moreover, they emphasised the importance of the familial, gender, spiritual and personal protective process in Muslims' cultural context as resilient dynamic growth processes in their life journey. The immigrant Muslim women had grown up with adversity during their different stages of life events. Therefore, it seems that resilience can be discussed within specific cultural contexts of heterogeneous minorities.

Beitin (2003) and Beitin and Allen (2005) carried out studies to explore the resources of resiliency among Arab American couples following the events of 9/11. The study was conducted in the U.S.A where the mass media was misrepresenting the realities of Arabic culture. The sample consisted of 18 immigrant Arab American couples; three of them were Muslim couples and 15 of them were Christian who were American citizens. One Palestinian Christian family was part of the sample and took part in the study. Semi-structured interviews were conducted with heterogeneous minority samples. The study showed that the main themes related to the sources of resiliency were spiritual beliefs, resilient marriages and spouse support, and their process of identity which involved their religion and nationalities. The sample referred to their wider system, which included their children, relatives, worship practices and their relationship with the U.S.A. Government and their governments back home. The participants had political/religious awareness which may have helped them to overcome the crisis. The study suggests sources of resiliency among Arabic couples but this study included only three couples who had an Islamic background. Moreover, this study mentioned the resilience sources within a specific cultural context. These findings of heterogeneous minorities might be linked with the social ecological idea of resilience.

Milliano (2010) explored sources of resilience among 582 youths after a flooding disaster in Burkina Faso. The researcher used mixed methods, which included interviews, focus groups and questionnaires. The objective was to explore what sources made them resilient during the disaster period. The findings suggest that males have more access to tangible resources, such as food, than females due to male domination culture and traditions. The findings also showed the importance of tangible resources for youths such as subsistence farming and material resources. The following intangible resources were ranked according to degree of importance - social resources, support from external aid organisations, Allah/God, parents, and then the elderly people, ranked as most helpful. This study showed that these resources strengthen or inhibit the resilience among the youths who were influenced by their age, culture, context, gender and ethnicity. It seems that there are cultural context considerations related to the dynamic interaction between the participants and the material resources. For example, male youths were more able to use the aid resources than females due to the surrounding culture and traditions. This meant the resources were available in the community but females were unable to use the resources as much as the males. This can be seen to be consistent with the up to date social ecological idea of resilience.

In summary, cultural or contextual sources can contribute to resiliency. The social ecological influences play a significant role in resilience among Arabic or Muslim people. For example, the male youths used the available resources more than the females due to cultural context factors (Milliano, 2010). Moreover, the immigrant women considered the gender and personal protection process in their cultural context as significant to their resiliency (Abu zahra, 2004). However, none of the above studies discussed resilience within the context of military conflict. None of the above studies investigating resilience interviewed people inside the Arabic countries where there is severe lack of resources and infrastructures, such as Palestine (see chapter one). The previous sections discussed resiliency in the Islamic and Arabic context but this PhD project is investigating resilience specifically in the Palestinian cultural context. Consequently, the next section considers research that investigated resilience in Palestine.

## 2.11 Resiliency among Palestinians

Through the search, only a few relevant studies on the resiliency of Palestinians were found. There is very limited government funding for health research (Mataria et al., 2009). In the absence of a mature programme of research, there were instead small, fragmented studies often using self-developed scales. The following studies will be discussed according to the typology of Ungar et al. (2007) and Masten (2007).

There were two quantitative studies examining resilience among Palestinian children. Their findings can be linked with the third wave of resilience research mentioned earlier, in which studies focus on the developmental assets of both individuals and the community (Ungar et al., 2007). In their study Punamäki et al. (2001) found that children who responded actively to the Intifada had lower levels of posttraumatic stress disorder (PTSD). They also found sources of resilience among children. Family support and creativity were important individual characteristics as well as active responses to the political violence. Punamäki et al.'s (2011) study showed that resilient children had a good school performance, benefited from supportive parenting practice, and good physical and mental health. There might also be common cultural features to foster resilience in the Palestinian culture. In addition, the authors criticised the study which had not included other possible variables such as the social process in a conflict zone.

Palestinian youth were included in an international resilience project led by Ungar concentrating on youth resilience. This study is in consistent with the social ecological wave of resilience. This study's sample consisted of 1500 youths from 14 different countries. Mixed methods were used, quantitative through questionnaires, and qualitative through face-to-face interviews, to investigate resilience. The sample included 114 Palestinian youths from both genders. Their ages ranged from 16 to 21 years, and the Palestinian youths were from Palestine. They were considered to be "coping well" according to their behaviour in their cultural context. The youths explained that their experiences included facing adversity which made them resilient, especially when witnessing the clashes between Palestinians and soldiers e.g. when children threw stones in street protests.

The study also reported that they used resilience when faced with martyrdom, death, and abuse and drug addiction. The young people used resiliency responses such as expressing emotion, family support, involvement in youth clubs, and sharing in building their local community. Moreover, the study found the sources of resilience among youths may be similar but, significantly, the effort to promote resilience must always take into account that there are special considerations of each community's cultural context. For example, the Islamic faith or spirituality is a more important factor among Palestinian youths than for young people in many other countries. Another finding is the Palestinian youths were significantly different from other youths, as they did not use "I" when they mentioned their identity. They referred to the whole community when they tried to represent their identity. Thus, these factors can be seen to be different from cultural context-to- cultural context e.g. Palestinian children sharing with their local community in collective resistance and seeking freedom activities, which improved their resilience. This may not be the case in Western countries where children rarely share in political activities (Ungar, 2008).

The findings of AL Ajarma's (2010) study can largely be related to the up to date social ecological fourth wave of resilience. AL Ajarma completed a PhD-level qualitative study to explore the role of the arts in building resiliency among Palestinian adults who experienced the first Intifada. His sample consisted of seven postgraduate students from both genders who were studying in U.S. universities. Semi-structured interviews were used and the data was analysed thematically. The study found the following sources in resiliency: education, family support, community network and social support and the arts. In addition, political awareness and activity were helping the individuals to find meaning in their life and make sense of their struggles. The above sources were discussed within the specific cultural context of the Palestinians who lived under occupation practices, political oppression, lack of security and lack of human rights. In his literature review, the researcher described suggested sources of resiliency among Palestinians, which are - education, religion, family support and strong ties, belief systems, community networks and social support, arts and sports activities. It seems that some of the above sources are associated with social ecological sources

which contribute to resilience. The culture and conflict context played a significant role in fostering resilience among the sample. The sample talked about their previous experiences and there is a need to investigate resilience based on the current experiences of Palestinian adults who are not all highly educated.

Another example can be linked with the social ecologies wave of understanding resilience. Makkawi (2012) undertook qualitative research to explore resilience among academic female students in the West Bank. Tape recorded interviews were conducted with 15 participants and the data was analysed thematically. The female participants were newly graduated from high school in the 2005/2006 academic year, which was considered a significant academic challenge. The sample reported a number of sources which enabled them to gain academic achievement and was considered as resilient. Family support and a supportive female teacher were two reported sources from the participants. In addition, the environment within the school helped them to succeed and overcome challenges. They felt the female only environmental context was safer than co- educational and this enabled them to be involved in various activities inside the schools. The High schools in the West Bank generally were segregated by gender due to the local culture. Educational success was also mentioned as a strategy to share the public space. Finally, students explained that specific personal characteristics such as self-esteem, self-confidence, internal locus of control, persistence and motivation to complete the academic goals enabled them to succeed. This study showed that there was a need to support the students in a culturally sensitive strategic way inside and outside the school. The above findings mentioned gender segregation as a factor of resilience; this might be an unwelcome idea in other cultures. Their willingness to prove themselves and share in the public space was significant sources within their cultural context. Therefore, it would appear that resilience is culturally embedded and is influenced by the social ecological environment. However, the sample involved females only and there is a need to investigate the resilience of males and females from various age groups.

Nguyen- Gillham et al. (2008) carried out a qualitative study to explore the resiliency of Palestinian youth. This study can be discussed in the light of the social ecological wave

of resilience. The sample consisted of 321 Palestinian youths in the 15 Ramallah areas, aged from 15 to 18 years old. The sample was taken randomly from different schools in the Ramallah district. In this study the researchers look at how the adolescents themselves interpret and give meaning to the concept of resilience in abnormal conditions. This study explored the sources of resiliency through separate focus groups conducted with both genders; the themes and subthemes emerged from the focus group's conversations. Sources of resiliency among boys were their friends, families and sports activities. Sources of resiliency among the girls were found to be: reading, writing, and drawing, in addition to the pursuit of education. Some of the participants mentioned that living in their villages and cities was like living in a big prison. They tried to do specific or limited activities to promote their resilience based on what was possible or available in the context of political conflict.

To summarise, for the Palestinian youth, resiliency is embedded in their capacity to make their lives as normal as they can in the face of the challenging context and lack of infrastructure resources. In this study there are differences between sources of resiliency among boys and girls; most of girls develop their sources of resiliency inside the homes. These findings might be due to the dominant conservative culture in Palestine. Most of people believed that home is the most secure environment for girls due to the lack of security within the conflict context. The focus groups were conducted separately due to the conservative culture in the belief that the participants might feel freer and more relaxed to talk. The researcher mentioned that he used note taking instead of tape recording due to personal preference of the interviewees; local people in general feel discomfort towards tape recording. The findings of normalising the abnormal study are largely related to the Sumud cultural context. How the sample shaped their pathway of resilience in an overwhelming context depended on what was culturally and contextually suitable and available. There were also differences between sources of resilience among males and females due to cultural context influences. Therefore, these findings largely can be matched with the social ecological fourth wave of resilience. However, this study investigated resilience among youth only; and there is a need to investigate resilience among adults from different cities or areas.

Finally, Hobfoll et al. (2011) carried out a quantitative study to predict the Palestinians' resiliency factors using PTSD and depression symptoms scales in Palestine. The aim of the study was to identify psychologically resilient individuals and the factors that predict resilience. Questionnaires were distributed to 1196 adult participants to measure the level of PTSD and depression among them. The researchers consider that a resilient individual is one who has the ability to recover quickly from PTSD and depressive symptoms. The study showed that there was a high level of PTSD and depression among the sample. After six months, the survey was repeated and it showed some positive recovery from PTSD and relief from symptoms of depression. The study suggested that this capability to cope or recover was due to greater social support from their local surroundings. The study also mentioned that there was less political violence and less of an absence of resources between the two periods. The resources considered were interventions such as financial, material, open borders, job availability, and better transportation access. Furthermore, intervention targeting social, family, and personal resources could help the recovery process of Palestinian people who are exposed to severe chronic traumatic events. These basic need resources will benefit all the Palestinians who are vulnerable and resilient.

However, the author mentioned that there are contextual factors due to the political conflict that influence resilience. There are also cultural factors related to the collective culture, which foster resilience. These suggestions can be sensitive to the cultural context; these might be largely matched with the social ecological idea of resilience. It seems that the surrounding environmental context contributes to the above mentioned sources of resilience. I think the limitations of this study are that the researchers used PTSD and depressive symptoms scales to measure resiliency but they did not use any resiliency scale. However, PTSD and depressive scales might be developed in another population; further strategies are needed to enhance the validity and reliability of the scales and its findings. As a final point, the definition of the resilient individual needed to be clearer in the article.

In addition, the above studies revealed that resilience among undergraduate university students was not the same as with postgraduates. This might lead us to think that there

are possible contextual and cultural consequences (Tusaie and Dyer, 2004). It was of note that there is cultural context sensitivity related to resilience in the above-mentioned studies (Ungar, 2008, Hobfoll et al., 2011, Makkawi, 2012, Nguyen-Gillham et al., 2008, AL Ajarma, 2010). These studies can largely be linked with the up to date social ecological wave of resilience. However, some of Punamäki et al.'s (2001, 2011) findings can largely link with the third wave of resilience research which takes into consideration developmental assets, both individual and in the community. Therefore, it seems that there is a significant lack of studies relating to adults within the Palestinian cultural context. This inspired me to undertake this study in the Palestinian context.

Resilience was also discussed in relation to the Sumud culture within the Palestinian context by authors such as (Taraki, 2008, Kårtveit, 2010, Isaac, 2011, Gren, 2009). The unique cultural values and meanings play a significant role in the social ecological understanding of resilience (Ungar, 2013). However, the resilience concept is still under explored and none of the studies clarified the exact meaning of the concept in the Palestinian context. For a better understanding of Palestinian resilience, there is a need to clarify Sumud cultural concepts, which significantly link with resilience. The next section discusses the concepts related to the Palestinian resiliency.

### **2.11.1 'Sumud' culture as a social ecological idea**

In 1978, the PLO (Palestinian Liberation Organisation) recommended Sumud as a way of helping people to remain steadfast in Palestine. Thus, Sumud became a basic national concept and strategy for Palestinians in order to preserve identity and restore dignity and in the struggle for national liberty. In addition, Palestinians are deeply connected to their home land, which is an integral part of their life (Teeffelen, 2011). "Sumud" is a very distinct, Palestinian, idea. It is the art of living to survive and thrive on their homeland in spite of hardship and under occupation practices. These skills of how to live are used in different aspects of life such as economic, political and social. They can also be used at many levels: individual, family and within the Palestinian community. Moreover, Sumud has been divided into two types: tangible resources

such as the infrastructure supporting basic needs (for example, schools and hospitals) which enable the existence of the Palestinians on their land and help them to be more resilient. In addition intangible sources of Sumud also exist, which include: belief systems, religion and social and family support which help the Palestinians to cope with their chronic daily collective suffering (Teeffelen, 2011, Teeffelen et al., 2005). Tangible and intangible resources may help people to cope with life's challenges and be more resilient (Hobfoll et al., 2011).

According to Taraki (2008, p17) *“Resilience and steadfastness (Sumud) have been staples of the Palestinian ethos for generations now. Sumud’s incarnations have been many, but the dominant motif has been Palestinians’ determination to continue under adversity, fortified by their roots in their land, the strength of their traditions, and family and kin solidarity... A new conception of resilience has been taking root, one that is not based on an ascetic denial of frivolity, joy, or entertainment, but rather renders the very pursuit of happiness a manifestation of resilience and of resistance at the same time. The legendary resilience of Beirut’s, who are perceived as living life to its fullest despite the turmoil of war and strife is certainly an inspiration here”*. The mentioned Beirut is the capital of Lebanon where Palestinian refugees demonstrated resistance to the Israeli occupation during the 1980s.

In his published book, *The Third Way*, Raja Shehadeh (1982: vii, cited by Wick, 2008 p336) who is a Palestinian author and human rights lawyer, writes of the everyday practices of Sumud. *“Long before Arab politicians outside defined Sumud as a pan-Arab objective, it had been practiced by every man, woman and child here struggling on his or her own to learn to cope with, and resist, the pressures of living as a member of a conquered people. Sumud is watching your home turned into a prison. You, Samid, choose to stay in that prison, because it is your home, and because you fear that if you leave, your jailer will not allow you to return. Living like this, you must constantly resist the twin temptations of either acquiescing in the jailer’s plan in numb despair, or becoming crazed by consuming hatred for your jailer and yourself, the prisoner. It is from this personal basis that Sumud for us, in contrast with politicians outside, is developing from an all-encompassing form of life into a form of resistance that unites the Palestinians living under Israeli occupation”*. (The singular of Sumud in Arabic language is Samid).

Therefore, it would seem that Sumud translates as the social ecological idea of resilience. Tony Teeffelen tried to explain the concept of Palestinian Sumud in his book. He undertook face-to-face interviews with many key persons in the Palestinian society and he asked them, 'What is the meaning of the Sumud concept?' There was a lack of consensus in defining this complex concept. Each one tried to explain the concept from their own personal experience or perception. Each interviewee had struggled to survive and thrive on the land, overcome adversities and cope in their own way with the daily chronic challenges (Teeffelen, 2011). Concerning the Arabic idea of Sumud, famous Palestinian artists have tried to explain the wide-ranging definitions of the Sumud concept, which are close to the ideas of resiliency, a peaceful way of resistance and steadfastness. He drew an old olive tree with deep roots; its branches try to be flexible in facing adverse conditions and strong winds. The tree is a symbol of peace, reward, and their history over thousands of years and the roots are a symbol of steadfastness on holy land. The branches are a symbol of Palestinians' resiliency and the wind is a symbol of occupiers (Teeffelen et al., 2005).

The Palestinian culture is considered part of Islamic and Arabic culture; but the Sumud concept is more significant to Palestinian culture alone. The Palestinian idea of 'Sumud' (the meaning of which is close to resiliency and steadfastness) is rooted deeply in their historical and religious contexts (Schiocchet, 2011). As a result of continuous adversities inflicted on the Palestinians during their Sumud in the occupied territories, around one third of them have needed mental health interventions (Afana et al., 2009). Leaving the homeland may be accompanied by even graver physical and mental health disorders. There are a wide range of coping mechanisms (Thabet et al., 2009) or adaptation strategies (Abu Elrub, 2005) embedded deeply in their Sumud political cultural context. These studies were discussed within the Sumud context, which linked with the Palestinian resiliency.

Palestinians have significant degrees of coping which are deeply rooted or inspired by their religious, political, cultural, and historical Sumud context (ALbarawi, 2010). The Palestinians have individual traits, such as hardiness, which are discussed within Sumud culture (Hijazi and Abu Ghali, 2009, Dokhan and Hajjar, 2006). The history of a

chronically unstable environment motivated the Palestinians to develop their coping strategies and gain more experiences in how to survive (El-Smairi, 2010). The above section discussed the Sumud concept which is interwoven with the social ecological idea of resilience. There was a near absence of studies that investigated resilience from a social ecological perspective within a Palestinian Sumud cultural context. Consequently, this project will be the first study specifically about the resilience of Palestinian nurses. There is, therefore, a need to discuss the interwoven relationship between relevant resilience concepts and Palestinian nurses, which the next section will address.

### **2.11.2 Palestinian nurse studies**

None of the studies mentioned below examined the resiliency of nurses who work in Palestine. The meaning of the concept of resilience is still under explored and none of the studies found in this review have clarified the meaning of the concept in the Palestinian context. This is a significant gap in the literature which this study will address. In addition, there were few articles that investigated other concepts that are related to or interwoven with the idea of resilience.

Alhajjar (2013) carried out PhD research at Manchester University – UK regarding occupational stress among Palestinian nurses in the Gaza strip. The author used questionnaires to examine the levels of stress among hospital nurses and he used open-ended questionnaires to explore the experiences of the nurses related to work stress. The nurses responded that they used the following coping strategies: exercises, faith, seeking social support from their surroundings, in addition to seeking counselling. The nurses reported that experience in the field was a protective factor from the surrounding distress. In addition, overtime work helped nurses to cope with financial difficulties and low salaries. The above findings were discussed within the conflict context and the local culture.

One descriptive correlation study indicated that, despite turmoil, there are some nurses able to benefit from the positive aspect of their profession such as, finding strength in their moral values, having good relationships with peers and superiors, being content

with the amount of responsibility they assume on a daily basis and their salary meeting their living expenses and needs. In addition, nurses expressed positive attitudes toward their relationships with their clients which nurtured mutual care and concern especially during unstable political and social situations (Abushaikha and Saca-Hazboun, 2009). Another study showed that the nurses had more of a sense of coherence than medics, social workers, psychologists and counsellors. Sense of coherence was used to evaluate the ability of health workers to make sense of traumatic experiences within the surrounding unrest and unstable political environment. The researchers also did not claim generalisation of the findings due to limitations such as the definitions of well-being in a conflict zone which might differ (Veronese et al., 2012).

According to my literature review, it is obvious that there is no study about the resilience of Palestinian community mental health nurses. This PhD study was conducted to fill this gap and explore what sources of resilience exist among Palestinian community mental health nurses. As a teacher of CMHNs, I chose CMHNs as a sample because we have very few numbers of them working in the West Bank (see justification of the study in methodology chapter). The previous section discussed resilience and Sumud, and nursing studies in Palestine. There is a need to discuss the relationship between Sumud resilience and nursing. The next section will discuss the relationships between these factors.

### **2.11.3 Relationship between Sumud, resilience and nursing**

From the previous sections, it seems that Sumud as a social ecological idea contributes to resilience. There are interwoven relationships between resilience and Sumud; therefore, he who leaves the land may be quite resilient, but he is definitely not Samid (has no Sumud status) (Teeffelen, 2011, Teeffelen et al., 2005). Therefore, resilience might be the prerequisite to Sumud. The section below discusses the concept of Sumud in the health care system and nursing in particular.

Livia Wick (2008) completed an ethnographic study to explore the interaction between national politics and the professional politics of medicine during the second intifada. She clarified that health workers try to live and apply Sumud in their own individual

way. For example, the director of Almakassed hospital in East Jerusalem, Palestine, believes Sumud is “practised” in everyday life: Dr. Rami’s clarification of Almakassed hospital as a Sumud health workplace not only categorised it as a PLO-related organisation, but also described practices of everyday life in health workplaces. For example, coping with restrictions of movement on the roads and at health workplaces are considered as living the politics of Sumud. In addition, the hospital services depend on the ability of health workers to deal with significant shortages of resources and human resources. Health professionals also struggle to provide services to the best of their ability in spite of adversities such as military barriers, curfews and other practical obstacles.

Wick (2008) also explained the midwives’ and nurses narratives about their work revolved about ideas of daily struggle contained in the concept of Sumud. For example, she described how Samia, who was a midwife, freely admitted that half of her work of birthing assistance was completed on the telephone. This happened when most of the pregnant women were unable to reach the hospital due to curfews and barriers. She described how a quarter of the nurses left their families and stayed at the hospital during the week to prevent and cover nurse shortages.

During the literature review, I have not come across any practical example relating to Sumud or resilience specific to mental health nurses nor to mental health workers in general. Therefore, I need to fill the gap in this study. Because of the negative cultural attitude in Palestine towards community mental health, nurses face a multifaceted difficulty. They face significantly high workloads and receive low levels of support. For example, community mental health has not been a priority in the financial budget of the Ministry of Health and is under resourced. The budget for mental health services consists of 2% of the whole budget of the Ministry of Health. A lack of financial, management structure and human resources inhibited the quality of mental health services (WHO and MOH, 2006) (see chapter one). For example, I trained nursing students in a community mental health centre in the city of Nablus. A single CMHN served the whole of the Nablus district that has a population of a quarter of a million people. At the same time, this CMHN received very limited support in the form of

supervision, training or human resources. In spite of these challenging and overwhelming conditions, this nurse is steadfast in her position. She is willing to do her best and serve the community as much as she is able. There is a need to listen to the CMHNs experiences within their cultural context and explore their resources of resiliency.

Through my search, I found a very limited number of studies which investigate nurses' resiliency, and only one study included community mental health nursing - in Australia (Edward, 2005). I did not find any study which discussed the resiliency of Arabic or Palestinian nurses. As was explained earlier in chapter one; it was obvious that there is increasing demand on mental health nurses. The researcher believes that the development of mental health care in Palestine needs to include an increase in the number of community mental health nurses and enhance their resiliency. Mental health nurses offer care for all Palestinians, a good model of coping for clients; and offers teaching and support. According to McGee (2006 p43) *"There is a pressing need to cultivate and foster personal growth in nurses because we cannot give our patients what we do not possess ourselves"*. Therefore, this thesis focuses on resilience of the community mental health nurses specifically. At present, resilience of the Palestinian CMHNs is still an underexplored and under-researched area.

## **2.12 Conclusion**

This chapter has clarified the historical development of the concept of resilience. Since then the resilience concept has become more defined or described according to its use and in which context. The current, final, wave of resilience research is the social ecological and focuses on the contribution of cultural contextualisation. There might be unique pathways of resilience across cultures. Various studies were then introduced explaining resiliency and its examination inside and outside the nursing field. The chapter also discusses studies that have investigated resilience within Arabic and Muslim culture. The literature review contains few resiliency research studies conducted within the Palestinian cultural context. Other articles were found which

linked to the resiliency concept, such as those discussing Sumud. Finally, the relationship between, resilience, Sumud and nursing were discussed.

It was noticeable from the literature review that there was a significant lack of studies which investigated the new resilience phenomena in the nursing field. The nursing resiliency research is still in its very early stages and most of what has been carried out is quantitative in nature. Qualitative studies can be used to hear the voices of the voiceless and to explore the nurses' resilience experiences, including those who work and live in underdeveloped countries. None of the articles found investigated the resiliency of CMHNs in Palestine or in Arabic or Muslim cultures. In this study, I have located my research in the last wave of resilience research, termed the "social ecological"; I will try to continue what other scholars have started. I will also build my methodology based on these recommendations.

Organising this literature review about resilience inspired me to map the design of the project. It was clear from the previous literature about resilience that there is a need to explore in depth the perspectives of nurses or people in under-researched cultural contexts or countries. Additionally, most of the questionnaires used in existing studies were developed in European countries or cultural contexts; very few were developed in underdeveloped nations. There was also an absence of qualitative studies investigating resilience among nurses in Palestine. There was an absence of studies in which researchers interviewed or observed the workplaces specifically among CMHNs in Palestine. After these first two chapters (introduction and literature review) which have discussed the challenging contexts of the study and resilience, the next chapter will discuss the adopted methodology including sample selection, how the data was collected and analysed.

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## **Chapter Three:**

### **Methodology**

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## 3. Chapter Three: Methodology

### **3.1 Introduction**

This chapter will address research process issues in detail. It consists of several sections: justification of this study, aim and objectives, research design and methods, sampling strategy, and types of generated data. The chapter contains a discussion on applying for formal scientific and ethical approval from the School of Healthcare Sciences at Cardiff University. This includes securing approval from the Research Review and Ethics Screening Committee (RRESC), and from the School's Research Ethics Committee (REC). It also includes a discussion on securing permission from the Palestinian Ministry of Health and NGO Centre. It contains an account of negotiating access to community mental health workplaces. The use of multiple methods (interviews, observation, and collecting documents) is presented in detail. Data management, analytic processes, and strategies to enhance the quality and objectivity of qualitative research are discussed. Finally, the importance of reflexivity is discussed.

### **3.2 Justification for the study**

As described in the previous literature review chapter, there is a gap in the literature investigating resilience especially in underdeveloped countries such as Palestine. Nurses, like soldiers and prisoners of war, are exposed to stressful situations e.g. traumatic events and emergencies. There is a need to explore sources of resiliency among nurses in the workplace and to focus on, and develop, the capacity of nurses to be resilient (Jackson et al., 2007). Resilient nurses are able to deal with stress in adverse workplaces. Nurses' resilience is used in various nursing fields but it is still 'unrecognised' (McGee, 2006). There is an increasing need for resilient practices by mental health nurses to meet the needs of service users during the 21st century (Warelow and Edward, 2007). Finally, there is also a significant gap related to studies conducted in the new social ecological tradition of resilience research (Ungar, 2012), especially in the mental health nursing field.

As described in the previous literature review, research on resiliency among nurses is still at a neonatal stage, and there is a remarkable deficiency of studies related to community mental health nurses' (CMHNs') resilience. As described in the introduction chapter, Palestinian CMHNs face challenging circumstances within and outside their workplaces (McAuley et al., 2005). It is crucial "to foster resilience" among the Palestinian mental health professionals who are working within an overwhelming and challenging context. There is also a need to develop mental health services by strengthening and empowering staff members' capabilities including those of nurses (de Val D'Espaux et al., 2011). It is essential to improve understanding of the extent to which developing nurses' resilience minimises staff shortages and increases retention (Hart et al., 2012), especially the retention of CMHNs (Edward, 2005) who are very few in Palestine. According to Owen (2009 p141) *"the best way to prepare for crisis is to develop resilience early... leaders of the future need to take risks and learn about adversity and resilience early in their careers"*. There is a need to develop nurses' resilience in the workplace (Jackson et al., 2007).

### **3.3 Aim and objectives of the study**

In this context the aim of the study was:

- To explore resiliency among Palestinian nurses who are working in the West Bank community mental health workplaces.

The objectives of the study were:

- 1) To observe and describe the environment within community mental health workplaces.
- 2) To explore challenges facing CMHNs inside and outside the workplace.
- 3) To explore sources of resiliency among Palestinian CMHNs' lives in general.
- 4) To explore sources of resiliency in Palestinian CMHNs' practical work.

- 5) To explore the sources of resiliency shared between CMHNs' general lives and their workplaces.
- 6) To complete this project, return to Palestine and share in the process of mental health service and research development.

### **3.4 Study design and methods**

Quantitative or qualitative design and methods can be used depending on the aim of the study. Qualitative design was selected to achieve the aim and objectives in this thesis. Qualitative research attempts to make sense of, or understand, phenomena in terms of the meaning participants bring to them (Denzin and Lincoln, 1998). Qualitative design is focused on words, how we collect the data, the context, behaviour, beliefs and cultural values. It has interactions in social settings that help to produce deep and rich data and formulate new type of knowledge or concepts (Bryman, 2012). The qualitative design is not based on numbers or measurements for collecting data. Flexible methods can be used in qualitative design to study small numbers of people in their natural settings (Hammersley, 2013).

Qualitative design can be used in health workplace investigations to explore feelings, attitudes, perceptions and thoughts. The qualitative design is sensitive to the culture, context, traditions and customs or strategies of living. The researcher needs to immerse himself in the setting to explore the participants' perspective, meaning and interpretation of their surrounding environment. The nature of the relationship between the researcher and participants might affect the generated data. This relationship must be based on trust and respect, and should treat the participants as sensitive human beings not just objects under investigation. This design also gives the opportunity to produce detailed description, rigorous analyses and interpretation of the studied field (Holloway and Wheeler, 2010).

The interpretive approach is one of the multiple frameworks or paradigms that have been used in qualitative research. Interpretivism can be a philosophical approach to interpret or make sense of the social life, culture, values, attitudes and beliefs. This

means there is a need to explore, learn, and observe participants experiences and perspectives within their cultural context (Hammersley, 2013). An interpretive approach in social science can be used when the purpose of the research aim is to understand and describe meaningful social action. It can be utilised when there is a need to explore the evidence embedded in the context of social interactions (Neuman, 2011). Interpretivism can shape the methodology used in the qualitative studies. It can include more than one method to achieve the goal of the study and to describe or interpret the studied phenomena. For example, analysing what people say can be accompanied with observing what people do, to explore the interactions within their cultural context (Hammersley, 2013). Consequently, an interpretive approach in qualitative research can include an array of experiential methods including interviews, observations, and collecting of written documents. These multiple methods (interviews, observation and collecting documents) offer the opportunity to be actively involved in the selected setting during data generation. These multiple methods also offer an opportunity to describe/interpret the environment of workplaces and the wider social setting in order to better understand participants' whole life experiences. It helps to understand the day-to-day cultural or environmental context.

Although observational methods were utilised along with interviews and the analysis of written document to explore resilience, I do not consider this to be an ethnography because of the limited time spent undertaking observation in the field and the study's focus on sources of resilience rather than participants' use of resilient strategies. This study investigated resilience by using multiple methods underpinned by a social ecological perspective. I was aware that I was the instrument to explore and observe in a reflexive style. I considered this project as 'qualitative' not as 'ethnographic'; however, I used multiple methods that can be used in ethnographic studies. The research objectives focused on sources of resilience and challenges among CMHNS. The objectives did not focus on how they apply resilient strategies but did focus on what helps participants to be resilient. Ethnographers may need to spend more time in the setting to describe the way of living or action (Bryman, 2012). Therefore, observational methods were utilised with interviews and written document to explore resilience.

I was aware that there are critiques of both qualitative and quantitative research. For example, the qualitative studies might be too subjective and there may be a lack of transparency. I might be influenced by my experience to decide what is significant and important in data generation. Therefore, I employed strategies to enhance the quality and validity in this research (see quality in qualitative study section in this chapter). It is also difficult to reproduce the same study, it might vary from one researcher to another based on the relationship, gender, background, and access to the data. It might be a problem to generalise the findings if the study focused only on one organisation or group of people (Bryman, 2012). There was a challenge to see or interpret the data from the point of view of participants (Bryman, 1988).

### **3.5 Rationale for choosing a qualitative study**

There are two basic approaches or choices to deal with the challenge and difficulty of investigating or defining resilience (Ungar and Liebenberg, 2009). The first choice is based on quantitative studies; specific resilience questionnaires have been developed and used, to measure resiliency in specific cultures or countries. It seems that most of the resilience scales for all age groups need more validation (Windle, 2011). It will be also difficult to find one resilience measure that is appropriate for various cultural contexts and in all places and all times (Ungar, 2013).

The second approach is based on qualitative study, which offers more opportunities to explore resilience within different cultures or contexts (Ungar, 2004a). As described in the previous literature review chapter, there is an up to date wave of 'new voices' investigating resilience while resilience is embedded in the cultural context. According to Ungar (2003) the qualitative design provides a significant contribution to understanding resilience in unique cultural contexts. Ungar (2004a) also suggested qualitative research design, with the aim of understanding the contextual cultural differences and how individuals build their resilience strategies. In each cultural context, people are able to decide what are considered protective factors and what are considered dangerous. The relationship between risk and protective factors of resiliency may be different from one context or culture to another, so the researcher

should not impose previous judgments or his/her perception. There are unique pathways of resilience in each cultural context (Ungar et al., 2007).

As described in the previous introduction chapter, Palestinian CMHNs face challenging contexts inside and outside their workplaces due to the chronic conflict. Palestinian nurses were working in under researched workplaces. I chose a qualitative design to study resilience in its natural situation, attempting to be aware of experiences in terms of the meaning people bring to them (Denzin and Lincoln, 1998). Qualitative design has been described as being more flexible than quantitative research design as it allows interaction between the researcher and the sample within the studied environment (Maxwell, 2013). This interaction needs to be non-judgmental in order to explore and interpret the world of the participants from their own point of view (Ungar and Liebenberg, 2009). Using multiple methods in qualitative studies (such as interviews, observation and collecting documents) helps to interpret the findings of the area under investigation. These methods will give room to explore the coping strategies employed in order to manage daily challenges. It will help to describe and interpret in depth the human beings' life experiences based on the interpretive philosophical approach (Denzin and Lincoln, 1998).

The qualitative design and multiple methods were thought suitable to explore nurses' resilience within an under-researched, war-like, zone. As described in the previous literature review chapter, there were few studies having previously discussed resilience as an area of study. In the qualitative studies none have explored this area of interest directly, although some have used similar methods e.g. interviews and thematic analysis (AL Ajarma, 2010, Nguyen-Gillham et al., 2008, Makkawi, 2012, Ungar, 2008). Multiple methods (interviews, observation, and collecting written documents) were utilised to explore resilience of nurses in the study of Gillespie (2007). The above researchers' experiences inspired the design and methods of this study.

### 3.6 Sampling strategy

The study was focused on the nurses who were working in community mental health workplaces in Palestine. Choices were taken about who to interview and how and what to observe, and what documents should be collected. Then the decision was made to interview CMHNs in Palestine from settings and documents that I had the ability to access. Non probability sampling was used, purposeful samples were chosen based on accessibility to the sites and documents. The total population of the sample members was 17 CMHNs 15 of whom agreed to take part in interviews. Multiple documents relating to local workplace policy and other operational policies were collected (Bryman, 2012). Purposeful sampling was used to choose two different sites to answer the research questions. Observation of two different community mental health centres was made to understand the day-to-day work place environment of CMHNs. The choice to conduct fieldwork in two separate, institutionally distinct workplaces was made to enable comparison and difference. Operationally, in the context of this research, one site was distinguished from the other by having two centres - governmental and non-governmental settings (Burgess, 1984) (see also type of data section in this chapter).

The data was generated from 12 mental health settings in the West Bank. It included the following cities and towns: Hebron, Halhul, Bethlehem, Jericho, Ramallah, Nablus, Salphit, Qalqelia, Jenin, East Jerusalem, Tulkarim and Azoon town beside Qalqelia city. In each site, there are only one or two community mental health nurses at the most. The Ministry of Health employed all the interviewed CMHNs apart from the one nurse who was working in a nongovernmental organisation. Therefore, the purposeful sample included all community mental health nurses, which was 17 working in community mental health workplaces in the West Bank. Two CMHNs did not show an interest in taking part therefore fifteen interviews were conducted. All interviews were audio-recorded except one which was not recorded due to the participant's preference. Other settings were excluded from the sample due to the impossibility of access because of the lack of freedom to travel to places such as Jerusalem.

### **3.7 Ethical, Access and Political consideration**

I constantly considered, in each stage of the study, ethical and political issues. I believe that this study caused no recognisable physical or psychological harm to the participants. I tried to protect their right of autonomy, privacy and confidentiality in each period of the research (Bryman, 2012). Participants were free to decide on whether or not they wished to take part; there was no pressure in any way to join the study (Watson II and Clement, 2008). Pseudonyms were used to protect the details of the interviewees, people observed in the work setting and the collected documents. The recorded audio-interviews were saved in password-protected computers and other collected resources were kept in my locked office drawer. Access to the collected data was limited to those who worked in the project. Politics also can be an issue in the context of the work setting or organisation during data generation and negotiating access. For example, to access documents, I dealt with several layers of gatekeepers. I remained aware of my position related to the participants and studied field as much as possible (Bryman, 2012). The next sections will address the above ethical concerns in detail such as ethical approval, obtaining permission and negotiating access.

Theoretically, there was a possible risk that the results of this study could be used in order to target the Palestinian population more efficiently for political reasons. For example, the findings might be used against people's willingness to be resilient or have Sumud. However, I had reason to believe that this was highly unlikely. There have already been several published studies about resilience involving other representative samples of the Palestinian populations. I had previous experiences in research in this context and local researcher experts were also consulted. The discussions concluded that there were no possible practical risks for the researcher personally, for clients or for nurses participating in this particular social, political, cultural context. In the course of the study, care was taken that nothing was done which could bring additional risk to the participants, and the researcher believed that the project would bring no heightened risks in the future (Burgess, 1984). Moreover, written permission and support to complete this study from the relevant gatekeepers and stakeholders in Palestine had

already been secured. The Palestinian Ministry of Health and NGO Centres will not approve any study that may bring additional or heightened risks to their employees or service users. The official approvals confirmed that there were no additional legal or ethical requirements related to the process of data collection. Due to unrest in the political environment, I formalised a plan with my supervisors to keep in touch during data generation, once a week, via email (Fahie, 2014).

### **3.7.1 Ethical approval**

This study reflected what Bailey (1996) discussed related to the ethics of qualitative studies. It should be ethically acceptable research. In the case of the ethics of interviews, the researcher should have consent forms and permission to access the workplaces. The individuals should be shown respect before, during and after the interview. The interviewer should show commitment to the organisation and people. For example, the data needs to be confidential and saved in a secure way (Myers and Newman, 2007).

In June 2012, approval from the Research Review and Ethics Screening Committee (RRESC) of School of Nursing Midwifery Studies at Cardiff University was secured. They raised very few concerns which were then discussed in detail and the necessary amendments were submitted to the Research Ethics Committee (REC). On 24th June 2012, conditional ethical approval from the REC was secured. Finally, I received approval from REC of School of Nursing and Midwifery studies at Cardiff University on 4th of September 2012 (see appendix 6).

### **3.7.2 Obtaining official permission**

On 1st March 2012, I went home to Palestine to secure support and necessary cooperation from local managers of the CMH Centres. It was also necessary for the progress of the project to collect some Arabic references related to Sumud culture as these were unavailable on UK library shelves. Initial contact was made with the Ministry of Health and local managers of nurses in West Bank districts. Then, a negotiation process was started with the Palestinian Ministry of Health and one of the Nongovernmental Mental Health centres to secure official permission before starting

collecting my data. Most of the stakeholders in Palestine showed interest in the study. In June 2012, the official permission from the Palestinian Ministry of Health and NGO Centre to start collecting data was secured (see the appendix 3).

Regular contact and discussions with local managers were conducted, and focused on collecting the data successfully (see the appendix 3). I also made contact with the CMHNs in West Bank districts who showed an interest in taking part in the study (Burgess, 1984). Generating the data process finished before the end of 2012 as was planned.

### **3.7.3 Access to workplaces**

Negotiations to gain access to the community mental health nurses varied from site to site. I secured official permission from the Ministry of Health in June 2012. Due to lack of communication and resources in the Ministry of Health, I had to follow up and intervene to sort out the practical challenges. For example, I made phone calls and sent a copy of the official permission by fax again to all workplace sites. I had to renegotiate and make further arrangements with the local directors at the workplaces.

It was also necessary to re- build trust and re-negotiate access to one of the centres. I visited the head of the Governmental Community Mental Health Centre before starting data generation. The head of the centre explained that two MSc students had collected blood samples from service users who had schizophrenia, for research reasons. The students had not sent the results yet, as they had promised to do. The Head of the centre claimed that this event had damaged the trust relationship between the psychiatric clients and the centre. She also stated that she would not cooperate with Annajah National University research teams any more. I had to take action in order to gain access and rebuild trust and collaboration. I promised the Head of the Centre to do my best to sort out these concerns as soon as possible. I went to Annajah University and explained the problem to the supervisor of the project who was my colleague. The student supervisor responded immediately and phoned the students requesting them to send the results urgently to the centre. Later, I visited the centre to double check that the results were received and if they were now happy to take part. I was delighted that

these efforts were successful in rebuilding the trust and opening the opportunity again for doing my research.

### **3.7.4 Inviting participants to take part**

Before my participation in the field, staff and patients knew in advance of my project plans; individuals had a chance to discuss the purpose of fieldwork. Regular contact and suitable arrangements with the local managers of the centres were made.

Concerning the observation part, people had a chance to read a poster situated in advance in the receptions of the two observed centres. Then people were invited to get in touch to discuss the study, all of the staff in the two selected centres agreed to take part. Concerning interviews with CMHNs, nurses were invited to get in touch if they were interested in taking part having already had a chance to read the information sheets, distributed via my contacts who are the managers of the services where the nurses worked. Then, visits were arranged with potential participants interested in taking part in the study. These were arranged according to the CMHNs' preferred time schedules.

Written informed consent was obtained before conducting interviews, while written consent forms were not obtained for observation purposes (see the appendix 5). The observation method was used to describe the work environment in two workplaces (see observation section in this chapter later on). It was impractical to obtain consent from everyone in the clinics, or everyone who passed through the centres/clinics where observations were being conducted. Most of the community mental health centres were integrated with other primary care clinics to minimise mental health stigma. The centres were semi-public, non-private and crowded places. Therefore, many people were based in or passed through the centres such as doctors, cleaners, other patients, visitors, and clients' relatives, staff, who were making one-off visits, in addition to clients who visited other primary care clinics, or who visited the centre to obtain medication from the pharmacy. It was impractical and time consuming to stop each one and ask him or her to sign a consent form having explained the study. Anyone reading the findings of the study will not see the real names of people or places in the field

notes (Murphy et al., 1998). Four hours were spent at each centre on each visit, and the focus was on what to observe in each specific period rather than to pursue people to sign forms.

Finally, community mental health nurses participating in the study were fully informed of the reasons for their participation and there were no recognised costs, risks or benefits involved. Participants were informed that there were no direct benefits for them participating in the study and what they said would be used for academic purposes only. However, sharing experiences may indirectly bring healing and strength to the narrator and may help develop resilience (East et al., 2010). A further immediate benefit may be the knowledge that they have contributed to a study that may lead to the improvement of nurses' well-being in the future. The data generated was kept from participants' managers, so that what people said could not affect their job status. Any personally identifying patient or staff details were not used.

Pseudonyms were used for the names of all people and places, and these were inserted into the dataset at the earliest opportunity and before data was analysed. It was explained to the participants if any one decided to withdraw before results from the study were reported; the data would be destroyed and not used at all. If a participant withdrew after the thesis was completed, or after data was used in journal articles or presentations, then it would not be used in any further articles or presentations (see the appendix 4).

### **3.8 Data generation methods**

As discussed earlier data generation from the workplaces was managed using multiple methods. It included conducting interviews, observation of key features of two community mental health centres and interaction with mental health teams, and the collection of written documents. The aim of these was not just to be involved but it was more about how to answer the research questions and to explore the routine and day-to-day work. I was integrated in to the workplaces as much as possible in order to gain a picture of the workplace; curiosity about what was going on was a common thing

(Hammersley and Atkinson, 1995). Therefore, the term “data generation” was used rather than data collection in this project (Mason, 2002).

### **3.8.1 Interviews**

Qualitative researchers often rely extensively on in-depth interviews; it is one of the strongest and most effective methods in generating qualitative data (McCracken, 1988). Interviews were chosen as a means of generating data for many reasons, including that they offer clarification of under-described experiences. They also achieve high response rates, give more understanding, enable deep conversation and allow for depth of answers in response to research objectives (Polit and Hungler, 1999). Narrating experiences can be the basis for research through promoting understanding of human experiences in context and can provide insight into peoples’ backgrounds (Banks-Wallace, 1999). An interview, as a research method, is an effective way of gaining insight, knowledge and understanding of life experiences. Verbal and nonverbal expressions during the interviews offer opportunities to discover deeper meaning of participants’ culture through the process of reflecting feeling when talking about the experiences of adversity. Interviews are also a tool to transfer experiences from old to new generations in spite of time differences. They give room for new generations to learn values or lessons, which can be used to deal with similar situations or adversities (Atkinson, 1997).

Interviews give a chance to explore the resilient experiences of participants. They offer an opportunity to investigate how they developed their coping strategies within an external cultural context (Atkinson, 2002). As a result, this method was chosen to investigate resilience. The choice of using interviews in investigating resilience was taken to replicate or copy other studies that studied resilience. There is a wide range of examples of using interviews as a tool of generating data in resilience research. For example, Edward (2005) used face to face interviews to explore resilience in crisis care mental health clinicians in Australia. Other scholars also used interviewing as a tool to investigate nurses’ resilience in various fields other than in Palestinian CMHNs; (Kornhaber and Wilson, 2011, Hodges et al., 2008, Cameron and Brownie, 2010, Glass,

2009, Ablett and Jones, 2007, Broussard and Myers, 2010, Gillespie, 2007, Zander et al., 2013, Koen et al., 2011b). According to UNFPA and FAFO (2009) most Palestinians chose to talk about experiences of adversity. Palestinians preferred to recount experiences; how much success they have had and how they have been able to find alternatives to cope with adversities (Teeffelen, 2011, Teeffelen et al., 2005). Interviews have been used as a tool to investigate resilience in the Palestinian cultural context outside the health field (AL Ajarma, 2010, Nguyen-Gillham et al., 2008, Makkawi, 2012, Ungar, 2008). The above researchers' experiences inspired the design of this study.

There are three main styles of interviews: unstructured, semi-structured, and structured. The unstructured style is based on listening to the interviewee's story with no or minimal interruption or direction of the flow. The semi-structured style is mainly based on interaction or conversation between the interviewee and interviewer to answer the research questions. The structured style is usually used in quantitative studies to answer specific lists of questions. The semi-structured style is more flexible and offers the opportunity to gain rich and in-depth answers to research questions. Interviews of this type need to be recorded in quiet places with minimal noise, and be transcribed and analysed (Bryman, 2012).

The face to face interviews are based on what people decide to talk about and there is a need to steer the focus of the interviews (Creswell, 2009). In this study a semi-structured style was adopted and the duration of each interview was approximately 30-90 minutes. In this study, as in most in-depth inquiries into complex social phenomena, decisions about interviewing style and approach were taken before the fieldwork (Burgess, 1984). According to Edward and Hercelinskyj (2007 p242) "*Resilience can be learned and interwoven with related work and life experiences*" and, as a result, my interview schedule encouraged participants to reflect upon and discuss work and life experiences. Respondents might not give full details of the story; therefore it is important to be aware of what, when and how to ask questions (Maxwell, 2013).

### **3.8.1.1 Interview process**

The prompt sheet helped to keep the interviews on track to answer the research questions (McCracken, 1988). The interview guide was prepared before the interviews and it focused on challenges and resiliency in the workplaces and in life. The open-ended questions were derived and developed by drawing on the resilience concepts discussed in the literature review chapter. These pre-planned questions were reviewed, rephrased and reorganised to be better understood by the participants. The researcher's experiences of investigating Palestinian resilience inspired the design of these prompt questions such as AL Ajarma (2010). These guide interviews were prepared after in-depth discussions with the two supervisors. As the interviews were conducted in the Arabic language, below pre-planned questions or prompts were translated to Arabic:

1. Tell me about your work challenges.
2. Tell me about the resources enabling you to keep going.
3. Tell me about the resources supporting you to cope with work adversities.
4. Tell me about your life challenges.
5. Tell me about the resources enabling you to keep going.
6. Tell me about the resources supporting you to cope with life adversities.

I was constantly thinking that interviews are an interaction or a "conversation with purpose" that focuses on the research interest. This meant that the data was constructed or generated rather than "excavated" or collected (Mason, 2002). Interviews were an active and meaningful communication to explore the participant's perspective based on what I needed to know through interviewing. The interview was promoting or stimulating the respondents to talk about their opinions, emotions, and experiences. For example, the interviewed nurses were playing more than one role such as "Palestinian adults" and "CMHNS" at the same time. Through conversation, I tried to help them to

express or formulate their answers when responding to the research questions (Silverman, 2011).

The interview, as a dynamic process, needs to be sensitive to the other influencing factors that can lead to building knowledge. The interviews were conducted in the workplaces, within limited time and specific environmental context. My background, gender, profession and appearance were taken into consideration. For example, my skin colour does not look like that of a Palestinian; I tried to be consistent with my appearance. I kept my beard unshaved and wore the same kind of clothes that were acceptable socially. In the workplaces, I tried to talk with anyone who knew me in front of the interviewee to increase the trust and rapport, before we started the interview. I talked Arabic colloquial language with a Palestinian accent to encourage them to feel comfortable and as relaxed as possible. The time and place were agreed, the instruments, such as a recorder and note paper were prepared. I introduced myself and the study briefly, the participants had the opportunity to ask questions. The interviewee had received basic information about his or her rights, and the subject of the interview. I asked the participants what they preferred to be called during the conversation, some of them chose their name and others preferred their nick name. As an insider researcher I knew that some people preferred to be known by the name of their oldest son; for example, the mother of Bilal (Um Bilal). This step showed my respect and helped to increase trust and rapport according to the local culture. In order to break the ice, I talked about general issues and interests in the beginning. Then, I started the interviews with the prompt sheet questions; tell me about your work? Tell me about work challenges? My main role was as a facilitator, I also asked follow up or probing questions when necessary and encouraged the interviewees to talk freely. I listened patiently and interacted based on the flow of the conversation and the concern of the study. I did my best to represent the interviewee's experience by using their own words or colloquial language. I wrote notes during the interviews and I organised in advance the way to exit or end the interview, and I offered the opportunity for them to add any points (Myers and Newman, 2007).

This interview event was sensitive to the cultural context especially when I interviewed nurses in Arabic regions. I used to use some colloquial words such as yes; ok to show that I was listening and what they said made sense within a sensitive context and collective society. I was aware of the conservative culture when I interviewed the female nurses (Hawamdeh and Raigangar, 2013). For example, the female nurses decided the preferable time and place of the interviews. Sometimes, I also kept the door open when interviewing females based on their preference and with regard to the conservative culture. I maintained enough space with interviewees to encourage the interaction more freely. In order to increase the trust and rapport I shook my hands with men and I avoided doing this with females interviewees. I respected, totally, the context where there was no relief for interviewees, and as a result the interviews were interrupted sometimes to meet the service users' needs. I was also aware of the local meaning of non-verbal gestures or communication before and during the interviews (Holloway and Wheeler, 2010). I used my skills in eye contact with respect to the social context of the local culture gender sensitivity.

I was aware that the interview could go wrong if there was lack of trust and rapport, the use of ambiguous words, and bias in asking questions. There were factors which could affect the generated data such as ways of access to the organisation or gatekeeper contact; also the interviewee might give answers under the pressure of time (Myers and Newman, 2007). I was aware that it is a time consuming process and there is a risk of subjectivity when using the investigator as an instrument to generate the data. The transcription took time and it could be boring some of the time (Bryman, 2012).

### **3.8.2 Observations**

Social scientists and scholars, who conduct qualitative studies, have a tradition of observing people's activities taking place in everyday settings. I chose to use observation as a method for the following reasons, "*Observation has been characterised as the fundamental base of all research methods in social and behavioural sciences*" (Denzin and Lincoln, 1998 p729). It is a helpful and authentic method to collect detailed relevant data about the work environment in the workplaces (Polit and Hungler, 1999). It

enables substantial descriptions to be made of the work environment (Marshall and Rossman, 2006). Observation as a data generation tool is helpful for exploring previously under-described cultures or experiences (Emerson et al., 1995).

The observation as a method can provide a better understanding of the studied field. The relationship between the researcher and participants requires trust and rapport. The interpretation is essential in understanding the participants' actions in the settings. Observational methods give the opportunity to distinguish between the interviewee's words during conversation and the observed actions. The researcher's interpretations, through the experience of observation, will help to analyse and make sense of the observed health setting (Holloway and Wheeler, 2010). The researcher needs to "immerse" him/herself in the studied setting for an extended period of time, while using observation as a research method. The researcher's eyes will be used to observe the behaviours of the participants, asking questions, listening and conducting conversations will also be necessary to explore the perception of the studied people toward their surroundings. This gives room to describe social life or specific cultural settings in a reflexive style (Bryman, 2012).

There are scholars who used observation as a method to investigate nurses' resilience such as Glass (2009) and Gillespie (2007). The choice of using observation in investigating resilience was taken to replicate or copy other studies that studied the field. Therefore, I started with the interviews with nurses, and then moved to the second section of the study which involved observation and collecting written documents. The choice to conduct fieldwork in two separate, institutionally distinct workplaces was taken to enable comparison and difference. One site was distinguished from the other by having two centres, governmental and non-governmental settings (see type of data section).

There are six types of participation during observation of workplaces as discussed in Bryman (2012). The first type is to participate in all activities as a full member but not known as a researcher in the setting. Second, participate in all activities as a full member and being known as a researcher. Third, participate in main activities only but

not as a full member. Fourth, observe and participate partially in core activities specifically. Fifth, participate minimally or (at least) in main activities. Sixth, as a non-participating observer who interacts with the team, conduct observation without participation in activities. The sixth type of observation can be used when observation is not the only source of data. Interviews or collecting documents is significant as an observation method. Each observation type carries advantages and risks and the researcher often moves between these roles during the data generation period. I adopted the sixth type, non-participation role during my involvement in the setting in order to generate data.

### **3.8.2.1 Choices of observational approach**

The non-participant observation role was conducted except during emergencies such as saving lives. This role included conversations with the mental health nurses and team in the work setting (Bryman, 2012). Non-participant observation role gave me room for more objectivity rather than act, as in my previous job, as a teacher or a nurse. If I immersed myself in the workload, this might draw my attention away from observing the key features or daily routine. Consequently, the non-participant role was more suitable to answer the research question and to achieve the research objectives. There were also further choices to make in conducting observations to generate data, such as whether to stay all day in the selected setting or visit the place over several days. I chose to observe the two communities mental health centres, one governmental and one non-governmental centre. The centres were observed over four different days; four hours were spent on each visit, and 32 hours in observation were undertaken in total. Visiting places on different days had many advantages such as there was enough time to transcribe what had been observed during each previous visit (Emerson et al., 1995). Visiting various places on different days also opens up the possibility of seeing different things occurring (Burgess, 1984). Field notes were recorded on papers during each visit; after each visit, I returned home and wrote up the field notes in full.

With regards to the position or plans of observation; I was unable to generate data about all detailed events happening in the workplaces (Wolcott, 2009). Initial

impressions toward the observed setting were addressed, drawing on those things available to the senses such as sounds, physical environment, feel of the location and people. These were included when observing and describing impressions about the workplaces and the people in the health workplaces such as: colours, noise, size, space, equipment, and movement. I wrote down key features about the observed people and their characteristics in the setting such as race, number, gender, dress, movement, appearance and comportment. Then, I went home and wrote down in more detail what I had observed and heard. The used strategy during data generation was to deal with familiar things as unfamiliar or strange. This meant that I observed things with fresh eyes as much as possible without prejudgments. I ignored my perception about the observed setting and considered myself as a researcher who visited these sites for the first time (Burgess, 1984). I was aware of the need to focus on what I heard as well as focusing on what I observed in the setting (Silverman, 2000).

I observed the governmental nurse inside the centre only, due to absence of home visits in his routine. I shadowed the NGO nurse during the home visits to observe different days of his routine inside and outside the centre (Gilliat-Ray, 2011). This study was designed to investigate the resilience of the nurses, and I was interested to observe the daily routine and the various work challenges of the nurses. The CMHT employed one nurse, one psychologist and one receptionist. The nurse and psychologist went to work outside the main building and the receptionist stayed in the main building. The nurse and the psychologist did field work three days per week outside the centre; therefore, I decided to follow them and I conducted the observation outside the centre (see table 3.3). Moreover, I carried out observations during my visits when conducting the interviews with the other 13 CMHNs in 10 workplaces. In addition, observations during the interview were used as sources of data against the objectives of the project, and to answer the research questions (Bryman, 2012). Observations during conducting the interviews or during the visits to 10 different workplaces settings enriched the generated data. However, I found the daily routine was quite different from site to site according to the available resources or infrastructures. I was focused on these differences during the conversations with the community mental health team (CMHT).

### **3.8.2.2 Ethical considerations for the home visits**

The researchers had to deal with unexpected practical events in the field sometimes when conducting the research particularly in a challenging context (Asia et al., 2010). For example, I had permission from the REC at Cardiff University to conduct the study but home visits had not been negotiated. I was planning to conduct the observation inside the NGO centre premises. I had believed that the nurses were not conducting home visits. I secured official permission from the manager of the Non-governmental organisation to conduct the study. Without previous expectations, the Community mental health team invited me to conduct the observation during the home visits. They had already secured the necessary permission from the service users and local managers. It was impractical to refuse their invitation as that might affect negatively the process of building trust. The programme was going to close down. The nurse was going to depart from the programme one week after the observation period. There was not enough time to negotiate with Cardiff University for extra permission for the home visits. I was interested to observe the nurse but not the patients. Therefore, I did the home visits and managed successfully the unexpected practical challenges within the time limitations.

### **3.8.3 Collecting documents**

I collected written documents as part of the investigation for the workplaces or settings under examination. These documents may play an important role in understanding and analysing the context of the key figures or organisation being studied. The written documents sometimes describe the workplaces in details that may not be available from other resources such as interviews and field notes. Collected documents also may validate and challenge the collected data from other used methods such as observation or interviews. They can draw attention to more important details that can be used in integral features of everyday life of specific cultures. Finally, documents can play an important role in facilitating comparative analysis or interpretation of collected data from other methods (Hammersley and Atkinson, 1995).

A wide range of documentary data on the operation of these two centres was collected (e.g. local or practical policies). The collected documents in this study included written papers about the work policies, booklets explaining the workplace in detail, pamphlets, relevant online resources, and other practical sheets (see type of data section table 3.1). I assessed the position recommended to write those accounts and the environment in which they were collected, and with respect to the gathering of documents to be accessed and subjected to analysis (Hammersley and Atkinson, 1995).

There were factors taken into consideration to evaluate or assess the written documents, such as who wrote the information, for what purposes, at what time and whether it was related to research questions or not. Written documents were excluded when they were outside of the research objectives. The documents were analysed against the observed data or what nurses talked about in the interviews. This helped to understand the workplace environment and to enhance ideas about the findings. Those written documents were important resources of data of examinations taking place in the workplace's cultural setting (Burgess, 1984). The names of people or places in these documents were not included in the final report (Wiles et al., 2005).

### **3.9 A summary of using “multiple methods”**

Wolcott (2009) compares the earlier used three methods, ‘enquiring’ (interviewing), and documentary analysis to ‘examining’, in dissimilarity to ‘experiencing’ (observing). As a qualitative research, interviews, observation methods were used; and multiple written documents related to the workplace environment were collected. The main source of the generated data was the semi structured interviews with 15 CMHNs from all West Bank districts. Thirty two hours of observation only were conducted of two community mental health workplaces. The collected documents might not depict exactly what was going on in the workplaces (see organisational challenges, inter-professional subtheme in chapter four). These three methods strengthened the rigour of the data generation but each one may have weaknesses in some aspects of the study. Therefore, the use of a combination of methods enhances the opportunity to obtain rich and rigorous data. It gives multiple interpretations and better understanding of the

studied phenomena within the described complex cultural context. This also gives room to compare the written official documents against the observed or extracted data from the interviews. Finally, I was aware that meeting objectivity is a challenge in qualitative studies and I adopted strategies to minimise subjectivity (Bryman, 1988). The previous three methods were used in a reflexive style to investigate the workplace setting and to explore under explored work environments.

### 3.10 Type of data

Data was generated by multiple methods such as interviews with the nurses, observation, and collection of written documents. The total number of interviewed nurses who were working in community mental health settings in the West Bank was 15. All of the interviewee nurses were working in the governmental Community Mental Health settings, except one who was working in a Non-governmental institution (the NGO Centre). The sample consisted of seven male and eight female nurses. Thirteen were married; one of the females was divorced with one daughter and one of them was single. The ages of the participants were between 24-60 years old. They had qualifications in general nursing from diploma to bachelor's degree level except one of them who had a secondary school degree in nursing. One of the nurses had a master's degree outside the health field but none of the sample had a master's degree in nursing or mental health nursing. However, the interviewees had received brief lessons in the mental health field during the undergraduate period or had undergone short training courses after their graduation. The generated data also included conversations with the service users and the CMHT. The table below (3.1) explains the characteristics of the interview sample.

TABLE 3.1: CHARACTERISTICS OF THE INTERVIEW SAMPLE

Type of centres, nurses and interviews	Numbers

Total Number of CMHNs in all West Bank (NGO and governmental)	17
Total Number of nurses who work in the NGO centre	1
Total Number of nurses who work in Governmental workplaces	16
Number of nurses who refused to take part in the study	2
Number of audio-recorded interviews	14
Number of non-audio -recorded interviews	1

The observations were conducted in one of the Governmental Community Mental Health Centres and in the NGO centre. I spent a maximum of four hours on eight days on the observation in both centres. In addition, I visited ten community mental health settings and conducted fifteen interviews. I recorded observation notes during the visits to those workplaces. The observed NGO programme started in 2006, but there was a risk of it closing down due to lack of funding. The observation was an opportunity to study the experience of the nurse who worked in this Non-governmental organisation. The table below (3.2) explains the characteristics of the observation sample.

TABLE 3.2: CHARACTERISTICS OF THE OBSERVATION SAMPLE

Type of observation	Amount observation	Number of days of observation
Non participant observation	2 centres	8 days
Hours of observation in the NGO centre	16 hours	4 days
Hour of observation in the selected Governmental Centre	16 hours	4 days
Observation in the Governmental workplaces in general (during my visits for interviews only)	10 visits conducted for 10 workplaces	One visit each for each workplace to conduct interview with the nurse

The NGO centre was one which belonged to one of the non-governmental workplaces based on the international fund. It contained the first rehabilitation programme for mentally ill patients and was managed totally separately from governmental services. All the mental health services in governmental workplaces followed the management of the primary health care according to the hierarchy of the Ministry of Health. This included the primary mental health care, secondary and rehabilitation services. All governmental community mental health workplaces were in a transitional stage and had dissimilarities from site to site. Eight worked in community mental health centres, three sites worked in community mental health clinics. The CMHNs were able to

conduct home visit in two centres only and the rest of the participants were unable to conduct home visits.

Some clinics will move to a new community mental health centre when the building process has finished. In other sites the community mental health centres have gradually lost rooms and have been converted to work as clinics due to a shortage of mental health staff. Therefore, observation was focused on CMHNS' daily routines within the workplaces, and the kind of care or services which were provided in general. People's interactions and key events or incidents that enriched the generated data were addressed during the observational periods. Alongside my observations, informal discussions with staff were designed to establish knowledge of daily routines and work organisation.

The table below (3.3) explains the characteristics of the collected written documents sample. This includes the work policy documents in (NGO and governmental centres) such as pamphlets, booklets about the workplaces (pamphlets about the centres). Written manuscripts to explain the work policy; other written work practical sheets (various papers or sheets used by nurses to organise their practical tasks).

TABLE 3.3: CHARACTERISTICS OF THE COLLECTED WRITTEN DOCUMENTS SAMPLE

	Number of the collected booklets from the workplaces	Number of the collected Written manuscript from the workplaces	Number of the collected Pamphlets from the workplaces	Number of the used Online resources from the relevant workplaces	Number of the collected Other practical sheets from the workplaces

Collected written documents from the NGO Centre	One booklet = 53 page	13 page of the Written manuscript	2 pamphlets	website of the NGO centre	21page of the practical sheets
Collected written documents from the Governmental Centres	2 booklets = (123 page in total)	28 page of the Written manuscript  (about the work policy)	4 Pamphlets (about centre services)	web site of the Ministry of Health relevant to the mental health services	9 page of the practical sheets

### 3.11 Data Management and Analysis

Braun and Clarke's thematic analysis method (2006) was chosen to analyse the data. It is a suitable and good fit with the adopted interpretive qualitative approach to achieve the purpose of this study for many reasons. It enables detailed and rigorous description of sources of resilience for participants within their culture. It is also flexible; and allows for psychosocial interpretation of findings (Braun and Clarke, 2006). It is an effective approach for searching themes in the generated data (Bryman, 2012). I focused on identifying themes/patterns of living experiences and behaviour among participants. Themes are formed by data which are grouped around a central idea or thought that achieve the research objectives (DeSantis and Noel Ugarriza, 2000). The above analytic approach can be *"a method for identifying, analysing, and reporting patterns (themes) within data"* (Braun and Clarke, 2006 p 6).

### **3.11.1 Data analysis process**

The contents of the audio-recorded interviews were transcribed, and observational field notes in full were written up. The generated data (transcribed interviews, field notes, and collected written documents) were coded. The data was coded with the aim of rearranging the data into categories which facilitated comparisons, connections, grouping and analysis later on (Maxwell, 2013). These codes and data were collated with a view to producing an initial set of sub-themes. These codes are relevant and gave meaning to the research objectives. There were two types of codes used. The first type was to highlight interesting extracts from interviewees. The second type was to interpret the meaning of these extracts and to try to understand what participants meant (Saldana, 1987). The sub themes meant that I gathered the relevant codes together into potential themes. Further revision of these initial sub-themes led to a final set of more well defined themes. The produced theme is a category recognised by the analyst in the raw data and built by codes and subthemes. Themes provide basic understanding of the data that can contribute to the findings (Bryman, 2012). Finally, a detailed thematic report was produced selecting compelling extract examples, analysing these examples, and relating this final analysis to the research objectives.

The paragraphs below explain in detail the data analysis process. The data included field notes from observations, collected written documents and transcribed interviews with nurses. The interviews were transcribed on word programme software, field notes and written documents were analysed as hardcopy. The data was analysed to answer the research objectives related to the challenges faced by nurses. I wrote the report and produced the challenges chapter. Then, the steps below were repeated to answer the research objectives related to the sources of resilience among nurses. At the end, I wrote the report and produced the resilience chapter.

- 1) In step one, I read and reread the generated data (transcriptions of interviews on software, field notes and written documents on hard copies) line by line to familiarise myself with the material.

- 2) In step two, the initial codes were generated: I noted anything important and related to the research objectives. I highlighted interesting features and I wrote down initial notes of what might possibly have meaning I also highlighted the relevant extracts which gave meaning related to the research objectives and I named them (codes). These codes explained the resilience sources and environmental challenges among nurses. I highlighted the software text data of the transcribed interviews by using different colours on word programme. I highlighted the hardcopy of the written documents and field notes manually by using coloured pencils.
- 3) In step three, I searched for possible sub-themes: I extracted the relevant codes from each data source (interviews, field notes and written documents) and I put them in software tables on my computer. I gathered and grouped these codes together into potential features called (sub-themes).
- 4) In step four, the suggested sub-themes were reviewed: I checked and reviewed if the gathered codes were relevant to the suggested sub-themes. Some codes fitted together and other sub-themes were recoded and reviewed again. I refined the possible sub-themes and decided if the collated extracts had formed a logical meaning. I gathered and grouped the relevant sub-themes together to inform the main themes.
- 5) In step five, the sub-themes/themes were refined and named: I have renamed and redefined the sub-themes/themes, to make sense of the whole story of the data.
- 6) In step six, the sub-themes/themes were translated from Arabic into English.
- 7) In step seven, the final report of analysis is presented to make sense of the overall findings.
- 8) At the end I reread the data to capture any data related to the suggested main themes.

### 3.12 Quality in Qualitative research

There is an ongoing discussion or debate between researchers about the best way to evaluate the quality of qualitative research (Murphy et al., 1998, Bryman, 2012). There are criteria for evaluating qualitative studies such as the worthiness of topics (see justification for the study section in this chapter), richness and rigour (see summary of using multiple methods and validity of the data sections in this chapter), sincerity or reflexivity (see reflexivity section in this chapter), defensibility (for example, see rational for choosing a qualitative study in this chapter) (Wolcott, 2009). The project has also made a significant contribution to the knowledge (see original contribution of the study in chapter six: discussion), ethical dimensions were discussed (see ethical approval section in this chapter), and it has meaningful coherence (Bryman, 2012 p394). The above mentioned criteria to evaluate the quality of quantitative research were taken into consideration during synthesis of this study. The data was not all the same and there were 'deviant cases' or significant differences between various data sets or cases. The data was generated from all community mental health centres in the West Bank; the findings were compared between various workplace contexts. This offers the opportunity to the reader to generalise the data with respect to dissimilarity between settings and individuals. The ability to compare and generalise the data conclusions or findings promises to enhance the quality of the findings (Silverman, 2000).

Adequate discussion was utilised to clarify the analysis process, selecting appropriate samples and making connections between data and interpretation (Silverman, 2000). I tried to make every effort to explain or interpret the findings. Reliability and validity were taken into consideration to increase the quality of this research (see validity and reliability section below). Triangulation has not been used to promote validity in this project. I used each method with its weaknesses and strengths to generate various types of data (Silverman, 2001). For example, the published documents about the community mental health centres on the official web site of the Ministry of Health did not depict an accurate representation of what was actually going on. Finally, I did my best to be aware of my background during data generation most of the time (Maxwell, 2013). I

played insider and outsider roles to increase the chance of exploring the reality and truth of the data. Reflexivity and self-criticism techniques are discussed in the following sections later to enhance the quality and validity of this qualitative study (Seale, 1999).

### **3.12.1 Validity of the data**

Validity means, in other words, 'the truth' (Silverman, 2000). This can be selective representation of the truth in a scientific way rather than reproduction of the events or reality. There are many strategies to increase the validity of the data and increase the intensity of analysis. For example, more than one coder can carry out the analysis of the data to promote validity and make rigorous interpretation of the data. This strategy will minimise conscious and unconscious background bias of interpretation (Denzin and Lincoln, 2002). This strategy was used to meet the quality and validity of the data. Five people shared their insights or viewpoints in the analysis process. My self and the first independent co-coder who is Palestinian did the coding for all the generated data (interviews, field notes and the collected documents). The second co-coder was British from Cardiff who did the coding for the two translated interviews in English. Both co-coders have backgrounds outside the nursing field and each carried out separate codes and sub thematic analysis, in addition to the researcher of the study. Co-coders had no contact with each other during the data analysis process. All used the same method of analysis which is based on induction to ensure reliability. After we finished the coding process, the three of us matched the sub themes. We had in depth discussions, and then we agreed sub themes. The field notes were written in English hour by hour and the supervisors have had an opportunity to read in detail what I observed during the visits to the centres. My two supervisors also had the opportunity to read the two translated interviews, discuss the method of analysis and share their viewpoints on the data analysis process. The mentioned strategies or steps might enhance the objectivity, minimise the subjectivity, and minimise conscious and unconscious bias (Trickett and Trafton, 2009).

Multiple coding (Barbour, 2001) is based on its ability to provide alternative interpretations and rigorous analysis. It can be useful to have another individual

examine the segments of data or emergent coding frameworks (Carey et al., 1996). The focus of our discussion was on disagreement on codes; this will provide a wealth of useful information in defining and refining code schemes. Consequently, Trickett and Trafton (2009 p342) suggested the following related to the coding scheme:

*There are two equally important goals to keep in mind in developing a coding scheme. First, the scheme must be reliable; that is, it should be sufficiently precisely delineated that different coders will agree on the codes applied to any given utterance. Second, the scheme must be useful; that is, it must be at the right "level" to answer the question of interest.*

The co-coder strategy was used in similar studies to enhance validity and trustworthiness of the data related to nurses' or midwives resilience. For example, in the Hunter and Warren (2013 p24) study about investigating resilience in midwifery, two researchers undertook independent "blind" coding. This means both undertook coding separately, followed by a meeting or discussion to form the final themes through agreement. External experts shared their feedback related to themes to enhance the analysis process. In addition, Koen et al. (2011b) carried out a study to explore resilience among hospital nurses in South Africa. The researchers asked independent co-coders to analyse the data separately in the same way, then to offer the theme via agreement with the research team. This co-coder strategy was used to enhance the consistency of the findings and trustworthiness of the analysis. This inspired me to use the independent co-coder analysis in my research. Some researchers suggested participants' validation, which includes returning findings to research interviewees in order to refine the analysis. This has not been attempted in this project for the following reasons. First, requesting participants' responses to the analysis may be considered as giving privileged status to the nurses. This also may have opened the possibility of gathering new sets of data (Silverman, 2001). A further rationale was the practical difficulties in revisiting the participants within the time and fund limitations, especially considering the unstable environment related to the study context (Bryman, 1988).

### **3.12.2 Reliability**

Reliability means the consistency used in the research stages by the researcher on different times or occasions. For example, during the data analysis, five co-coders used the same thematic approach to analyse or look at the data (Silverman, 2001). When we used the same method of analysis, it gave us further confidence about agreed themes (Ryan and Bernard, 2003). Using multiple points of view and recoding of the data was practised to enhance reliability (Seale, 1999).

### **3.12.3 Recording**

To also enhance the reliability, two audio recorders were used to record all interviews. A native Palestinian carried out transcriptions in the colloquial language (local Palestinian dialect), and she made comparisons between the two recorders to confirm accuracy and reliability. The transcription was done for the first recorder then compared with the second recorder. Then, I checked and reviewed every single word and, line by line, the transcription in the first recorder. Then, I compared every single word with the second recorder to confirm the accuracy and reliability. Recording and transcribing interviews has some advantages such as, it gives the opportunity to examine participants answers via repeated listening. Also, it minimises the researcher's limitations that might, for example, place a different meaning on what an interviewee said after the interview. It helps in the analysis process by revisiting the audio-records of the researcher or other researchers. Transcribing and checking transcription was a time consuming process (Bryman, 2012).

### **3.12.4 Translation**

As a native Arabic speaking researcher, I conducted the interviews in the same language as the participants with local Palestinian dialect (urban and rural). The audio interviews were transcribed and data was analysed in the same language. The project had very limited funding for three years without covering the costs of translations or data collection expenses. Translation for all the data to English was impossible because of limitations of the study such as time restrictions and limited funding. An external

translator translated two interviews into English thus enabling the two supervisors to look at them. I reviewed and compared the two translated interviews with the original transcriptions to ensure accuracy. The field notes were transcribed into English hour by hour and the supervisors had an opportunity to read in detail what I had observed. Finally, the quotes were translated into English by an official translator. Then, quotes were reviewed by the researcher to ensure the accuracy of the translation.

The strategy used in this project was to minimise risks of translation errors as much as possible. The translation from Arabic to English language might differ in meanings especially in the Palestinian culture and expressed emotions (Kayyal and Russell, 2013). There might be differences in translation of narrated text or stories from Arabic to English (Mohamed and Omer, 2010). In qualitative research, there was the risk of losing the meaning after translation from one language to another. It is recommended to conduct the interviews, transcribe and analyse the data in the same language (Van Nes et al., 2010). There was a PhD qualitative study that interviewed nurses, transcribed and analysed the data in the Arabic language at Nottingham University- UK Gazzaz (2009). These recommendations were followed in this research to ensure reliability and the quality of the findings.

### **3.12.5 Reflexivity**

Reflexivity is self-critical examination of researcher beliefs and assumptions and it contains self-criticism during each research stage and writing style. This enables the researcher to be more self-conscious regarding his relationship with those whom he studies, the data and with the study itself (Bryman, 2012). Reflexivity of the researcher who plays insider and outsider roles enriches the data. Reflexive comments of thoughts and feelings during the data generation process were addressed in the thesis to meet objectivity. In addition, reflexivity helps the researcher to be more self-aware of his or her feelings, background, beliefs, attitudes and behaviours during the data generation and writing up process (Daly, 1992, Atkinson, 2002). The importance of reflexivity and self-awareness is explained by Hammersley and Atkinson (1995 p236):

*The principle of reflexivity, which we have emphasized, underlines the fact that ethnographers themselves are part of the social world, and must work within whatever cultural perspectives are available to them. At the same time, this principle also insists that we can always learn to understand the world in new ways, and thereby come to better understandings of it. While we cannot prove in some absolute sense what is true and what false, and while there will sometimes be accounts amongst which it is hard to adjudicate with any confidence, this does not mean that just any account is as valid as any other.*

I believe that I was aware of my position toward the generated data within the study context. I employed strategies to minimise, as much as possible, conscious and unconscious bias or subjectivity. For example, qualitative design was chosen; this gave more room for exploring resilience within the investigated culture. Using quantitative questionnaires may be subjective toward under described phenomena (Ungar, 2004a). The choice of playing both roles of insider and outsider was taken, this gave room to increase the advantages and minimise the disadvantages of each role (Breen, 2007). I might be known before to some of the participants of the study as a university lecturer. According to the collective culture and community, the lecturer viewpoint may be followed and respected. I reminded myself to be aware of my professional status; thus limiting any possibility of influencing the participants about resilience. I gave more room to listen and explore the nurses' viewpoints during conversation on every single point. I was also aware of the possibility of slipping into a teaching role during generating data. For that reason, I always reminded myself that I was in the workplace as a researcher not as a teacher or a nurse. No judgments were used, and nothing was identified as being right or wrong during data generation.

Strategies to make the familiar unfamiliar were used during data generation. This tactic gave room to explore the view points of the people inside workplaces and to be more objective. For example, when discussing things related to the conflict I listened respectfully to nurses' experiences, to increase their trust. I used to ask exploring or probing questions regarding the everyday things of the local people. This made the nurses or community mental health teams express surprise, by facial or verbal

expression (see the first quotes in chapter five: sources of resilience, theme I sub-theme 1: Sumud culture). For instance, some participants replied to the researcher, 'it seems that you are not living in this country?' Alternatively, 'what happened to you? You couldn't remember anything about how things have been going here?' I used to smile some times and replied I was interested to hear from the participants (Burgess, 1984). The same language during data generation and analysis was used; this might offer the opportunity for more objectivity, increased trust and help prevent mistranslation errors.

Other co-coders analysed the data and final themes were written after in-depth discussions. This management technique was used to increase the objectivity. This gave room for more than one eye to look at the data and express multiple viewpoints or feedbacks toward the data. Also, as the study was conducted in a politically hot zone; few local researchers were consulted during the research project to minimise possibilities of bias toward the generated data or the project. I was also aware of the challenge that every single word or position toward the context may cause debate. Consequently, my beliefs, profession, background, experiences, race, ethnicity and even skills had an implicit impact on the investigation of the studied subject and were discussed during stages of the study.

In addition, I was aware of academic and non-academic challenges that may affect the project in a direct or indirect way. For instance, the Palestinian Authority employees and nurses had received only half of their salaries for months. Many medications were unavailable at the Ministry of Health due to the unprecedented financial crisis. This was accompanied by strikes affecting public transport, schools, universities and mental health workplaces. I collected the data as soon as possible and returned to the UK as there may have been risks to the project, such as data generation might be disturbed because of movement restrictions between cities that might have become tighter. This unstable and challenging context was a strong motivator to collect the data within a limited period before the whole situation became more complex. Finally, the data generation period was completed successfully within this challenging environment

before a new wave of conflict rose up again immediately after I finished data collections.

### **3.12.5.1 Self-management and insider/outsider research roles**

In any study the researcher needs to be aware of his or her position toward the study and how to deal with possible bias, in order to enhance the validity of findings (Maxwell, 2013). There is a debate about being an insider or an outsider researcher; both positions have benefits and risks. I was aware of these benefits and risks and tried to minimise the limitations of each position (Breen, 2007). Bonner and Tolhurst (2002) outline three key advantages of being an insider researcher: a superior understanding of the culture of a sample, greater intimacy with the group and more ability to interact naturally with members of the sample. There is one possible threat, which is lack of objectivity. In order to avoid that, the data was generated and managed in an open-minded way, and without any prejudgments or prejudice. Any predisposition towards assumptions and influences from my background was eliminated as much as possible, this included customs, habits, beliefs and experiences (Burgess, 1984). My background as a mental health practitioner helped me to be a good listener, non-judgemental, see things as they are and describe participants' experiences without conscious bias (Moustakas, 1994).

I was quite familiar with the cultural context of the study. This helped me to manage, successfully, the practical challenges during the data generation process and to conduct more fruitful interviews. As an insider researcher, this familiarity offered the opportunity to connect, analyse, describe and interpret the data successfully. I was able to notice what was suggested between sentences, words and the local meaning of non-verbal clues. I was aware of the cultural sensitivity while dealing with females, political (including factional) security and social complexities (Daly, 1992, Atkinson, 2002). This firm foundation of familiarity also helped me to access the written documents, and gain permission to enter the settings (Bailey, 1996).

However, I consider myself as an outsider researcher because I have never worked as a community mental health nurse in the new centres where the data was generated. I

have never visited most of these centres, or trained the students inside them. This gave me a chance to look at the data with fresh eyes and to analyse it in a more balanced way. I have no specific knowledge of how CMHNS feel or suffer, particularly in their work and daily lives, such as female nurses who face challenges inside and outside their homes. I have patience, and participants were given the chance to talk at length. The voices of participants were heard and I listened carefully to their life experiences. In this study, I played both roles of insider and outsider to enrich the data through maximising the advantages of each while minimising the potential for disadvantages (Breen, 2007). Therefore, the research strategy was based on making the “familiar as unfamiliar” (Burgess, 1984). I played a native or an insider role and at times an outsider or a non-native role. For example, I played an insider role sometimes to enrich the data, and I interpreted the observed behaviours according to the local culture. At the practical level, I moved between insider and outsider roles when I visited the workplaces for the first time. Thereby, I focused on the details of the observed environment. I wrote notes about the main features in the field, and then, I made detailed transcriptions with interpretations later on (Bonner and Tolhurst, 2002).

There follows a practical example of playing insider and outsider roles by the researcher during the data generation. I was invited to share with the community mental health team their break time. It was a great chance to build up trust, rapport and observe different kinds of data. I entered the kitchen, and one of the social workers looked at me with her eyebrows raised. As an insider researcher, it was understood that she might be unhappy to give this space to a male person outside the team. I said: ‘Sorry, I have been invited to have my sandwich at the table? If anyone is unhappy, I can leave!’ The social worker said: ‘You are welcome; I was looking for something else’. Then, I played insider role to rebuild the trust; I consciously provided some self-disclosure about my experiences as a Palestinian nurse in the UK. Then the trust environment was recovered and the team started to talk about themselves and their life experiences. I consciously switched to play outsider role; shared in conversation and interaction with the team with a focus on answering research questions.

### **3.12.5.2 Self-management of playing researcher/nurse roles**

It was a challenge to be a researcher and practitioner while playing a non-participant observation role (Arber, 2006). I kept in mind to observe the situation but not change it. I was in the field as a researcher but not as a mental health nurse. For example, one of the clients was interested in discussing his health condition when he knew that I was doing a PhD degree in the U.K. I explained to the client in as pleasant way as possible that he should continue with the care plan with the local community mental health team (CMHT). According to the local culture, the public tend to respect or follow the opinions of educated individuals. Another female client tried to discuss her health condition, and she asked for a consultation, she was a nurse with depression and she spoke using English language. I was aware that the client might use her shared background to obtain empathy and a consultation. I explained to her, in a pleasant and polite way, that I was doing research only and not in a position to offer a consultation. I clarified that she could discuss her health concerns with the local CMHT.

Sometimes the nurse will be in a position in which actions have to be taken in spite of previous decisions not to intervene. It was a challenge to keep a balance between the ethical conduct as a nurse and the position of the researcher who works in a context where there is a significant lack of resources (Arber, 2006). Therefore, the possible need for actions to save lives was taken into consideration during synthesis of this research especially during data generation. Health and safety was a priority when I was playing two roles as insider - outsider researcher. I conducted a non-participating observation strategy during data generation without undertaking nursing roles inside the workplaces.

However, using the example below during participation in the field, I will explain the exception of undertaking nursing roles during emergencies. During observation periods in the governmental community mental health centre, a nurse accompanied one of the elderly clients who came to the centre from a care home. The client was in the doctor's office, and then she became semiconscious due to hypoglycaemia. My aim at the beginning was to watch how the work environment would be conducted during the

emergency case. There was no one from the team in the doctor's office; the nurse who accompanied the clients was unable to handle emergencies properly. There was no emergency trolley inside the centre or written emergency protocol. The doctor started shouting "we need sugar"; I rushed to the kitchen; I brought the sugar and helped the doctor to save the life of the client. I used my background as a nurse who has wide experiences in similar situations. I played insider role at that moment who knew where the sugar was to be found inside the kitchen. I was quite familiar with the place as I used to train at the Annajah Student University in the centre before. My decision was to make the health and safety of the participants the priority in spite of research strategy and goals. Then, after we saved the client, I returned to play outsider role in observation and interaction of the team. As such, the consequences of the emergency event were discussed as an outsider, unfamiliar to the workplace.

There were culturally sensitive issues related to female clients - female nurses meetings. My experiences of more than 12 years in the nursing field helped me to handle local gender and cultural issues with sensitivity. During the observation process, the opportunity was given for the nurses, the team and service users, to discuss alone any private female issues. This did not affect the aim of the observation which focused on background data relating to the day-to-day context within which CMHNs work more than interaction with service users. None of these participants were past or current students of the researcher. It is possible that some will in the future follow an MSc course at Annajah National University where the researcher teaches. This possible area of tension was addressed on the written information sheet and during interactions with participants.

### **3.13 Conclusion**

This chapter has focused on the research process. It started with a rationale for the study, followed by the presentation of a general aim and specific research objectives. It has also contained a discussion on using qualitative design and multiple methods to generate data. The chapter has contained a justification for using interviews, observation and collecting documents in investigation. The particular strength of each

of these methods was discussed and the use of qualitative methods to study resilience was presented. The chapter has also presented the process of ethical approval and access to the community mental health centres to generate data. There were also discussions related to sampling, data management and analysis. The chapter has ended with sections on reflexivity and how to promote quality, validity and reliability in qualitative research.

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## **Chapter Four:**

### **Challenges of Community Mental Health Nurses (CMHNS)**

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# Chapter Four: Challenges of Community

## Mental Health Nurses (CMHNS)

### **4.1 Introduction**

This chapter discusses the challenges faced by CMHNS inside the workplace, set in the context of surrounding unrest. The data were generated, firstly, to investigate the challenges of the day-to-day environment of the CMHNS. Secondly; these data will help to explore resilience of the nurses inside and outside the workplace context. The chapter contains direct quotes or extracts from participant interviews. This will help to hear their voices and explore their experiences or perspective. Participants reported that they live or have grown up in a challenging environment. None of the interviewees felt there were no challenges to face in workplaces or life in general. However, it seems that some of the nurses reported that they faced more challenges than others.

The chapter consists of the shared challenges faced by participants in their workplaces and in their lives in general. I merged the themes/subthemes related to these challenges together. For example, the data revealed that there are similar challenges related to the context of unrest and turmoil inside and outside the workplace. Therefore, the below sections present challenges in the day-to-day environment of the CMHNS. The next findings chapter will consider sources of resilience.

### **4.2 CMHNS' Challenges**

Four main themes are presented that describe the challenges faced by CMHNS. These themes consist of the context of turmoil and unrest challenges, societal challenges, lack of resources, and organisational challenges. The following challenges explain that each main theme is made up of subthemes:

1. The context of turmoil and unrest which includes lack of safety and freedom, lack of support, and inconsistency of care services.

2. Societal challenges that included stigma toward mental illness, plus bias and favouritism.
3. Lack of resources challenges that included lack of funding, lack of rewards and motivators plus managing psychiatric symptoms.
4. Organisational challenges that included the gap between theory and practice, professional status of nursing, and inter-professional challenges.

### **4.3 Theme 1: The context of turmoil and unrest**

One of the four themes generated from my data related to the context of turmoil and unrest. As a result of turmoil and unrest, challenges presented themselves to the nurses on a daily basis. These included lack of safety and freedom, lack of support, and inconsistency of care services. The following sections present an analysis of each sub theme in detail.

#### **4.3.1 Theme 1 sub-theme 1: Lack of safety and freedom**

The participants experienced a lack of feeling of safety and a sense of real injustice inside and outside the health workplaces. In the following extract, one of the nurses told me her story when she was discharged from her nursing job. She clarified during the interview that she was innocent and had done nothing amiss, but because her husband was politically active, she lost her job. This exposed her family and children to risks of poverty due to the absence of an effective social welfare system.

*F: All our income was used to repay lenders. Because my husband is a patriotic Palestinian, this affects him negatively; he studied\*\*\*\* (his major name) at \*\*\*\* (the name of the university). When he came to the West Bank in order to take the comprehensive exam, he was arrested by the Israeli military forces. Consequently, he was prevented from taking the final exam, travelling abroad, and working in a government job. Before the Palestinian Authority came, he was working here and there. Then he worked in the Buses Company, so he improved his financial position*

*and after that Al- intifada started, and his condition worsened again. My heart bleeds for him, because he is an educated man and deserved better than that.*

*Mohammad: That's right.*

*F: Life wasn't fair to my husband...And my husband and I stayed in the same standard of living, as refugees.*

*Mohammad: Refugees, you mean...*

*F: Yes, I feel as poor as a refugee. Today I don't care when I compare myself to my peers; how they were in the school, what are they doing now, because everything in life is fate and as we say "Our fates are as registered by heaven". However, this affects me in some ways especially when I see a girl in the town, one day I taught her how to write her name, and now she is driving a car of 2012 model, like the proverb - " Throw a lucky man into the sea, and he will come up with a fish in his mouth".*

*...*

*F: You know I was discharged from my job because of my husband's political activity; I managed to return because I worked hard to get back to my work and put my trust in Allah...*

*...*

*F: In my home, for example, as a Palestinian living on her land, and having an occupation trying to banish her, to deprive her of her rights; I have to resist in order protecting my homeland, otherwise I'm the one who is going to be exiled. Imagine that Palestinians accept the saying that Palestine will remain occupied by the Israelis until the Day of Judgment, what will happen? Palestinians will stay helpless waiting for the liberation day of Palestine. Instead of that they keep fighting, since they believe they are defending their fair case.*

*[F.N. interview, Governmental centre]*

In the extract below with one of the interviewees, we were discussing his life challenges. He mentioned that he has no time to take a vacation due to increasing work demands. He used to visit his uncle daily and administer his injection, and he worked in two jobs to survive. He also talked about other challenges such as financial, economical, transportation and the effect of the separation Wall in his village.

*Mohammad: Let's move to another subject. What are the challenges you have faced in life?*

*M: Do you mean in the daily life?*

*Mohammad: Yes.*

*M: As a young Palestinian, I consider the financial challenge as the biggest one.*

*Mohammad: Challenge in what way?*

*M: Financial challenge, it's the first and the difficult one, followed by living and social challenges. My relationships, as a person working two jobs, have decreased though I was a sociable person before. In my village, my work took most of my time and took me away from my relatives and those close to me whom I liked to sit and go out with -- especially---- my wife. Once my wife and I planned to go somewhere, but my wife got sick, so we stayed at home. We consider this kind of night out as a way of discharging all the negative energies, so when I can't get such opportunities, this caused a serious problem on most days--- and also the time.*

*Mohammad: What do you mean by "time"?*

*M: I mean that I don't have time for reading a book, skimming internet, and chatting with family and the outside world. Another challenge is that all my immediate family is outside Palestine except my uncle who lives near me; it's a challenge because I used to see them every day, but now I don't.*

*Mohammad: Don't you have other relatives here?*

*M: Yes I have relatives, uncles, cousins, we all live in the same neighbourhood. When I finished my work, I used to visit my cousin for five minutes and then another for five minutes and so on until it became 12 midnight. What I want to say is that in the past I used my free-time for social matters, but now everything has changed especially after marriage and working two jobs.*

*Mohammad: Mention other challenges?*

*M: Transportation.*

*Mohammad: What about transportation?*

*M: Every morning I have to walk a long distance; about 15 to 30 minutes or one km, because my house is far from the village and cars aren't allowed to come there. Moreover the Apartheid Wall forms a basic barrier in our life; it changed our life upside down.*

*Mohammad: How has it changed your life?*

*M: My village was economically prosperous. People worked 24/7, but now my village has become isolated; there is neither transportation nor commercial movement--nothing-- And this has an effect on the current conditions.*

*[M.A. Interview, NGO nurse]*

As we see from the above, nurses faced multiple demands and responsibilities outside work. They had to cope with the hardships of chronic living costs and lack of economic stability. The interviewees were struggling to secure the basic needs for their dependants such as food, shelter, water, electricity, and education. They tried to fulfil their family and local society needs within a demanding context. For example, they offered voluntary nursing care services to the local community other than when on duty and from their homes. This limited their opportunity to have a break when off duty. Sometimes the needy patients had limited choices and knocked on the door of the nurses' houses to ask for health care or consultations. This often happened when the

access to the health services was nearly impossible due to the lack of freedom to travel or imposed curfews. They also had limited opportunities to go for holidays outside their cities due to lack of safety and restrictions on travel. There was little or no provision of recreational infrastructures or leisure activities near their homes. Therefore, many of the interviewees faced a challenge to strike a balance between their social commitments and their needs to have a rest.

All participants talked about the restrictions on their movement especially during the periods of "Intifada". In the interview extract below we were talking about the main challenges the nurse faces in her life as a Palestinian working woman. She explained her regular difficulties on the roads and her exposure to life threatening conditions.

*Mohammad: What were the most important challenges that you faced?*

*S: We used to cross very large distances, climb soil piles that block roads.*

*Mohammad: You used to come on foot?*

*S: Yes. We used to walk for long distances, and we did not worry whether we arrived late or not. That was not the problem, but --*

*Mohammad: Yes?*

*S: During that period of time, we sometimes ran into soldiers who threw gas canisters at us. We had to run and run. The distance was too long. We rarely found a car to take us I remember that I had walked 20 Km on my feet many times.*

*Mohammad: What made you go to work? You could return home if you weren't allowed to cross the checkpoint.*

*S: No, no. There were patients who were waiting for us.*

*Mohammad: What could you do for the patients? Your life was in danger!*

*S: Suppose that my mother, sister, or any relative is a patient and waiting for me? I had to go no matter how the road was. I had to go.*

*[S.S. Interview, Governmental centre]*

As we see above, participants experienced lack of freedom to travel, and they talked about having been exposed to risks while travelling on the roads. For example, nearly all of the nurses reported their experiences when Israeli forces or settlers threatened them personally. The movement restrictions limited the travelling of nurses between districts to workplaces, to conduct meetings or attend workshops. One of the nurses used alternative ways to come to his workplaces when he was prohibited from passing the physical barrier.

*T: Sometimes, I used to come to my job through one of the sewage canals there!*

*[T.H. Interview, Governmental centre].*

Some of the female nurses complained about the long hours of being away from their homes. They had to spend hours at military check points or finding alternative roads, in addition to their working hours. This affected their ability to create a balance between work and family responsibilities. Another example emerged during an interview with one of the nurses. She reported that her house was about 15 minutes from the work place, but she had to spend around four hours daily on the road to get to work.

The participants also experienced lack of hope for a better future for their children. All of these factors increased the demand on the nurses inside and outside their workplaces. The following extract with one of the female nurses, is a common example. The quotes illustrate the distress that affected her while she was on duty. Sometimes she was concerned when her children travelled to school because of the threats and dangers in the lack of a peaceful environment. She was concerned about their future and if they did well in the school exams.

*Mohammad: Mention more challenges other than the financial challenges?*

*F: Yes, what I can tell you is about social challenges.*

*Mohammad: Tell me about the pressures that you have experienced as a working female nurse.*

*F: The nature of work is difficult; I leave house at 7 o'clock, and return at 3 or 3.30-4.00 o'clock. And when I arrive I should feed my children, clean and arrange the house, pay visits for this and those, do---, receive guests, and teach my fifth grade daughter. So you feel there is no time for taking rest, or doing something else. And what makes things worse is that both my husband and I are quick tempered, these really influence us negatively.*

*F: Because I worry if my son decides one day to join either of these parties, I advised him that if he really wants to serve his home, he can do that through his education. In fact, I no longer trust anybody, since I think this one ---- might kill that one and so on; there is no longer security in the world. You definitely know about the military barriers and the difficulties that we face if we decide to go to Jerusalem, for example. Also the economic conditions and the high costs of living; we have to pre-set our budget before deciding to buy anything...*

*F: Similarly, if I went to work, and left my son sick at home, or if my daughter or son had exams, I will be worried all the time until I call them and ask how they did, whether they have eaten or not, whether they have arrived home safely.... Therefore, this surely will influence me...*

*[F.N. interview, Governmental centre]*

It seems that the significant lack of safety influenced negatively the level of health care. There was a lack of effective practical measures in the occupied territories to protect the local people including nurses. The nurses had to make compromises between the limited health services; local job policies and the service users' needs. In the quote below, I asked what the main challenges in workplaces were. The interviewee summarised that nurses were being abused and received little or no support.

*M: 1) in the private hospitals or centres there is no job security. 2) The nurses who work in governmental workplaces are abused; I'm not talking about the nongovernmental community mental health centre. 3) Also there are no other supportive centres for the patients.*

*[M.A. Interview, NGO nurse]*

There was little or no feeling of job security for the employees who work in private workplaces. Nurses had to adopt the internal policy of the organisation, and they needed to protect themselves at the same time. The nurses faced the risk of sanctions from the local managers, which included transfer to a more difficult work environment such as the rural villages or to the hospitals, if they were seen to have failed the organisation. The participants also experienced verbal and physical violence inside and outside the workplaces. Service users sometimes expressed their anger or frustration toward the health team due to the inconsistent care or lack of medication. The following extract illustrates how nurses are exposed to violence when they are unable to meet the needs of the service users. I observed one of the service users threaten the team to force them to transfer his patient to the psychiatric hospital. The psychiatric patient was agitated in his home; the patient's family was unable to deal with the psychotic symptoms. There was no outreach emergency service in the country services to deal with these cases. The Ministry of Health policy was not to transfer any patient to the psychiatric hospital before being assessed in the centre.

*I saw a gunman had started shouting at the CMHT, he had an agitated psychiatric client and he needed to transfer him to the psychiatric hospital. The team was explaining that the client should be assessed in the centre before they carried out the transfer process; the man had started shouting and threatened them personally. At the end, the doctor wrote the transfer letter for him. The nurse said "Nobody protects us from personal threat and the police officers mostly do nothing. Any confrontation with the service users might cost us personally".*

*[Field notes, Governmental Centre]*

As can be seen from the above discussion, the nurses worked within a zone of political conflict and in a demanding or overwhelming context. They experienced violation to their basic human rights especially when they went to work during times of curfew or clashes. They also experienced a lack of freedom to speak about or show their political interest within a politically fragile environment. CMHNs were concerned by unrest in the whole of their lives not just while on duty. The next section will discuss the lack of support within this context of turmoil.

#### **4.3.2 Theme 1 sub-theme 2: Lack of support**

The participants reported that there was a significantly low level of formal support especially from their employer and nursing association. In the following extract with one of the interviewees, the nurse expressed her feelings when we talked about the available supportive facilities or rights for nurses. She was talking about the nurses who were marginalised by the Ministry of Health.

*Mohammad: What else does marginalisation of nursing mean? How do you feel that you are marginalised here at the Centre?*

*S: Nobody here supports us. There are things that I do not know enough about in nursing*

*Mohammad: In what aspects do you need support?*

*S: For example, the Ministry should send us to attend courses so that we could know more...Here at all of our ministries, nobody supports or motivates us.*

*[S.S. interview, Governmental centre]*

In the extract below one of the nurses told her story when she collapsed due to her diabetes. She was disappointed with the health officers who did not show sympathy or respect regarding her health condition.

*Mohammad: Could you choose a very, really very difficult situation?*

*L: I faced several difficult situations while working at a specialisation clinic. While working..., I felt dizzy and fell to the ground. I was carried by the nurses and placed on a bed. They did not know whether I had hypertension or diabetes. Thanks God, my colleagues were supportive of me. Whereas they (health officers) told the management that I was pretending so that I would not work. I had been transferred to Al-Maqased Hospital where they found out that I was suffering from (very high glucose) diabetes. That was the most difficult situation that I have faced.*

*[L.E.J. interview, Governmental centre]*

As in the above example, some of the participants had chronic diseases such as diabetes or cardiac diseases that limited their ability to work. Their ability to be given their rights was very limited on the personal level and the nursing union was unable to defend their rights properly. In the next extract, we were discussing the available support and respect shown to nurses. The nurse expressed her dissatisfaction from the level of respect or available opportunities to be listened to. She talked about the frustrating environment inside the Ministry of Health.

*Mohammad: Do you feel that opportunities are available for you here as a nurse?*

*L: No, no, no. Not even one in a thousand, neither financial, nor the chance to express ourselves, we are always frustrated...*

*[L.E.J. Interview, Governmental centre]*

Looking at the field notes, I saw that the CMHNs worked with significantly needy people who were unable to feed or look after themselves. Some families had lost their main source of income due to the conflict. This was beyond the remit of the Ministry of Health policies which tried to focus on treating health problems. There was an ineffective social care system to support these families and protect them from hunger. Some of these families received a small amount of money every three months from the Ministry of Social Affairs but it did not cover their food or basic needs. Some nurses carried out responsibilities outside their duty tasks and tried to help as much as they

could. The lack of other supportive organisations increased the demand on nurses. The following field notes describe the additional responsibilities toward their service users in two governmental centres.

*During the interview, a family came to the mental health centre and asked about the nurse; the man had three children and his wife. We stopped the interview; and the man explained – “someone in the town told me that the nurse could give financial help”. The nurse explained: “sorry I did this for the clients of the centres only”, but she referred him to one of the institutions that might be able to help... In another centre, the nurse collected some donations from health workplace employees to help the neediest service users’ especially during the fasting month (Ramadan).*

*[Field notes, Governmental centre]*

Most of the interviewees expressed their dissatisfaction with the status of nursing and the general work environment. The data showed me that the nursing association activities or protests were limited. Before the Palestinian Authority came to power, union activities were prohibited. Nowadays, the employees’ strikes are sensitive in a politically conflicted zone and fragile environment. Any activities may cause personal threat to the members of the nursing association. The nurses reported their dissatisfaction towards inefficient and underdeveloped actions of the nursing association. There were two nursing associations, one in the Gaza strip and the other one in the West Bank. Both were influenced by the political agenda of the two local authorities. The two associations were separated physically due to the inability to travel freely between both sites.

The above section discussed the challenge of lack of formal support within the context of turmoil and unrest. This challenge included lack of support from their employer, the nursing union, and other mental health institutions. The next section will discuss the inconsistency of health care and lack of support within this unsettled context.

### 4.3.3 Theme 1 sub-theme 3: Inconsistency of care services

There was inconsistency of care services due to lack of medical supplies and instability of health care services. In this extract from an interview, we were discussing the main challenges in work. The nurse was concerned about the basic human rights of the Palestinian people. The interviewee discusses the lack of medication, in this case Largactil (chlorpromazine hydrochloride), which is one of the prescriptions used for psychiatric problems.

*M: If there is lack of Largactil nobody cares, the clients are expected to find their own solution and buy the medication. These are people who are deprived of their basic rights.*

*[M.A. Interview, NGO nurse]*

This extended field note goes on to provide examples of the lack of basic medical supplies and medications experienced in two governmental health centres. The first example illustrates the lack of medication where I observed the nurse (F.N) explaining to one of the service users that the medication was not available that period. The second example describes the lack of medical supplies in one of the centres, namely that there were no syringes and needles in the governmental centre.

*One of the service users entered the nurses' room in the first observed governmental centre. The service user asked the nurse (F.N) "if the prescribed medication is available in the centre these days or not". The nurse (F.N) replied: "the medication was unavailable; it might be expensive at private pharmacies, but we (mental health team) might find some available alternatives"...I also observed in the second governmental centre that the nurse (T.H) was unable to give the intramuscular injections to the patients in the mental health centre; I asked the nurse (T.H) why? He replied: "we (mental health team) have had no syringes and needles in our centre for two months".*

*[Field notes, Governmental centre]*

I found, during my observation period, that what happens in one workplace (governmental centre) influences what happens in another (non-governmental NGO centre). Most of the mentally ill clients collected their monthly psychiatric medications from the Governmental centre. If this was not available they then could not move on to the NGO rehabilitation centre. The instability of the care service in the governmental community mental health centre limited the care services in the non-governmental centre. For example, the CMHT in the NGO explained that the clients in the programme were chosen carefully. Most of them had recovered from mental illness before they joined the programme. If anyone relapsed, she/he would be dropped from the programme. The following field notes provide examples of the inconsistency of care services in both centres due to employees' strikes. The employees had not received regular salaries for a few months. The strike affected the availability of medication and mental health care services in general.

*During the observation period the Governmental Mental Health Centre closed due to the employees' strikes. The governmental health employees had not received regular salaries for months. This meant that the availability of medications was sporadic and this might cause relapses in the patients. The CMHT discussed with the clients and their families how to monitor the days of the strikes. The CMHT also stressed that patients collect their medications in advance from the governmental health centres.*

*[Field notes, Governmental centre]*

The inconsistency of care was because of limited financial abilities of the Palestinian Authority. The chronic economic hardship of the local authorities limited the expenses available to pay the nurses and meet the needs of service users. The financial situation was also affected by sanctions imposed by Israel, and the lack of international funds. The availability of the care services or medication was also due to other practical difficulties such as movement restrictions that were imposed as part of the conflict with Israel. This caused relapses or delayed the progress of treatment plans.

## **4.4 Summary**

From the above discussions, the chronic context of turmoil and unrest is a main challenge. It includes the following challenges such as lack of safety and freedom, lack of support, and inconsistency of care services. The above sub themes have spelled out or described the interwoven complex challenges for the CMHNs. For example, inconsistency of care services influenced by the lack of funding and movement restrictions. The nurses also reported feeling humiliated that their human rights were not respected, and a lack of personal safety due to the fear generated by the lack of a peaceful environment. There was a lack of justice, and effective legislations to protect them. The participants needed more support from the health managers and the nursing association. There was no effective parliament legislation to determine, control and follow up the rights of the nursing employees.

The nurses are working in a zone fraught with tension and unrest. This increases the demand on them socially and their feelings of responsibility toward the local community. For example, all the interviewed nurses talked about their work in their home and the help they extend to people who are unable to access the health services. Poor patients sometimes have no money for transportation to seek treatment. The nurses have to try and find a balance between their need to relax when off duty and the pressure to help local people who have limited choices. The next sections explain other challenges that were influenced or created by the context of turmoil and unrest.

## **4.5 Theme 2: Societal challenges**

The nurses have to deal with several challenges linked to the local society such as stigma toward mental illness, and bias and nepotism. The following sections explain each one of these relevant sub themes.

### **4.5.1 Theme 2 sub-theme 1: Stigma toward mental illness**

The data led me to understand that there was a significant lack of awareness, plus considerable social stigma toward mental illness. For example, in the extended quotes

with one of the nurses, we were discussing the challenges related to the local community. She reported that she was working in the governmental centre and explained how she had encountered the stigma of mental health.

*F: When I was employed here \*\*\*\* (name of the centre) they, including nurses in the primary health department, ridiculed and laughed at me, they said that I am crazy to work here in the clinic. For your information, when this job was offered to several nurses no one accepted it but me...We face difficulties when we try to integrate mentally ill people in society, and to remove barriers between them and the normal people. Our patients have creative abilities when they get the opportunity to work and innovate. However, when they are treated as mad, their condition will worsen.*

*[F.N. interview, Governmental centre]*

There were negative attitudes towards psychiatric diseases in general and also towards mental health professionals. The next story, extracted from the field notes, reveals this challenge of stigma. One of the family members refused to open the door or meet the nurse face to face during the home visit.

*The nurse explained: the father of the client was a kind man and known in the town; the nurse could understand the father's behaviour. He might feel ashamed of his son who was mentally ill. Therefore, he tried to escape from face to face meetings with the mental health nurse.*

*[Field notes, NGO Centre]*

I also found that most of the patients went to the traditional healers before they sought medical treatment for mental illness and that this led to profound symptoms of mental illness. The nurses were working with a lack of awareness and a misunderstanding in the community related to mental illness. Sometimes people dealt with the CMHT with a lack of respect; the centre was not well known in the surrounding area. The NGO nurse reported that many people were afraid to join the programme in the centre. The families and clients refused to join the programme in the main because of the social

stigmas of mental diseases. Their neighbours might learn that the family have a mentally ill member. Some of the people did not value the importance of the centre's activities.

The above section discussed lack of awareness toward mental illness and stigma. This was partly due to lack of 'raising awareness' programmes as a result of lack of funding. The next sections describe favouritism or nepotism by the local society that created challenges for the interviewees.

#### **4.5.2 Theme 2 sub-theme 2: Bias and favouritism**

Bias and favouritism was another challenge inside and outside the workplaces caused by the attitude of the local community. In the extended extract, bias and favouritism were another societal challenge reported by one participant. We were talking about the challenges caused by the local society to the nurses within and outside the workplaces. He explained that to get a job or a top position in your work was based on who were your relatives or your political party.

*M: The opportunities that are given to a man, even from a personal aspect; there is a difference ,for instance, between one who finds a job after graduation and his rights are preserved, and another one who is unemployed and his rights are violated, this is the first point. The other point is that what has made the institution (employer) accept you; your achievements or favouritism? And unfortunately the second "cronyism" i.e. social or political favouritism is the more pervasive in our society.*

*[M.A. Interview, NGO nurse]*

The individuals are mostly protected by their families, friends and political parties. Social and political favouritism, or nepotism, is shown towards people who have significant influence or are leaders in the society. The CMHNs were underprivileged as regards fairness of opportunity in the working environment. This underdeveloped attitude affected the nurses negatively inside and outside the health workplaces. The dominant culture of the society was to distribute the limited resources based on bias or

social political favouritism. In the following quotes, one of the nurses narrated her story when the Ministry of Health sent a psychologist to attend training for the mental health nurses instead of sending her. The psychologist has a close relative working in one of the leading position in the Ministry of Health.

*F: ...As I told you, when the psychologist went to Lebanon in order to participate in the training course, she was surprised that this course was originally made for the mental health nurses. Consequently, they changed the programme because she is a psychologist. And for your information, they were taught and trained by a mental health nurse in Beirut.*

*Mohammad: oh! Ok.*

*[F.N. interview, Governmental centre]*

There was also an unfair distribution of the limited training opportunities due to partiality and favouritism. For example, other health professionals were given most of the opportunities whereas some of the mental health nurses might never share in any workshops or training. Most of the nurses had not had these opportunities for many years. They reported that they need to do special training to fulfil their needs as mental health nurses. One of the female nurses talked about her feelings toward status and respect in nursing. We were talking about the challenges for females inside the workplaces. She replied that the physicians who were male deal with female nurses in a superior way and show lack of respect.

*Mohammad: Do you feel that there is respect for nursing?*

*L: Rarely, perhaps in some departments. But here the physicians, especially the older ones, deal with us by looking down on us. I do not know why.*

*[L.E.J. Interview, Governmental centre]*

There were significant numbers of nurses employed in the Ministry of Health who were female. Yet most of the top positions, such as general managers in the Ministry of

Health, were filled by men. I found that most of the female nurses were working in a patriarchal society. The local society mostly consists of extended families where the leaders of the tribes and political parties are men. Women are subservient to men mostly and are dominated within their society and in the organisations. The nurses' rights were not met and they had to do what the Ministry of Health leaders (most of them physicians) wanted them to accomplish. Some of the nurses used the term 'we' when they talked about themselves. This indicated that the nurses shared similar challenges and had solidarity with each other. In the quotes below, one of the nurses expressed her dissatisfaction with bias and lack of equality.

*S: When the doctors went on strike, they got a hundred percent bonuses. But when we went on strike, they gave us nothing.*

*[S.S. Interview, Governmental centre]*

The above section discussed bias and favouritism against mental health nurses and female nurses in particular. This happened due to lack of transparency and fairness as a result of a near absence of political accountability. The lack of an effective nursing union to lobby for more resources is also a factor. The nurses and psychiatric patients were not a priority in a community which is based on decisions made through social favouritism rather than justice.

## **4.6 Summary**

The above theme described some of the cultural attitudes of the local society challenges such as the stigma of mental illness and bias and favouritism. These challenges are interrelated and are connected to the attitude of the local people. The revealed data show there was a significant need to improve the attitude of the local community toward mental illness, nurses, and service users. Moreover, there was a need to raise awareness toward those seeking treatment and joining the rehabilitation programmes. There was lack of recognition that mental illness can be a curable disease. There were many inter related factors which affected the commitment of the service users; but there was a need also to improve the attitude itself. I think this links to the lack of political

decisions on health to change the negative attitudes and misperceptions about mental illness. There were misperceptions of other health professionals about psychiatric diseases and disorders.

There were remarkably negative attitudes toward the female nurses' capabilities in the patriarchal society and also a lack of transparency and equality. There was misunderstanding in the public toward women's leadership. The female nurses faced the challenge of working within male dominated workplaces. One of the nurses was divorced and she reported her experience within the local society which dealt with divorced women by showing a lack of respect in the main. There was a lack of political will to improve attitudes inside public organisations. However, the Ministry of Health struggles to secure the basic medical supplies and means of meeting health needs. Therefore, mental health awareness, enhanced transparency or issues of justice, and gender issues might not be a top or urgent priority.

The nurses encountered social and political partiality inside and outside the workplaces. This challenge needs to be discussed in the context of the social ecologies of the participants. There was an absence of effective legislations, transparency, and parliamentary guidance. The cohesiveness and strong ties inside the local community can be used incorrectly at times. For example, the job and the available resources were distributed based on social or political affiliation instead of individual needs and capabilities. The next theme will be about the lack of resources.

### **4.7 Theme 3: Lack of resources**

There are several sub themes related to the lack of resources challenges within the context of turmoil. These are lack of funding, lack of rewards and motivators, and the difficulties in managing psychiatric symptoms. The following sections will describe each sub themes in details.

#### 4.7.1 Theme 3 sub-theme 1: Lack of funding

There was a lack of human resources, learning opportunities, and supervision or guidance, plus poor facilities or infrastructures and a lack of financial resources. For example, it was obvious that the ratio of human resources (nurses) was considered very low in comparison with the total population. The total number of CMHNs who are working in the West Bank is 17 and the population is about three million. I found only one or two nurses at the most who covered each district which might consist of a quarter or half a million population. There was rarely any replacement of employees who retired or took leave. The interview below describes the shortage of nurses.

*Ab: But you can say that since three or four years ago, no nurses have been employed. If a nurse retires, there is no replacement for him. This means that there is a shortage in the nursing staff.*

*[Ab. J. interview, Governmental centre]*

Most of the nurses worked without having any other nurses to hand over to inside the health organisation. For example, if a nurse took maternity or sick leave, no one was likely to cover the nurse's tasks. The nurses also needed to convince the local managers in advance if they wished to take their leave. The example clarifies how nurses feel due to this lack of other nurses to hand over to.

*F: I could not pay visits to patients at home because there is not another nurse to cover me. Similarly, I could not engage in any activity within the centre since I have to spend time registering patients in the psychiatrist's files, so I feel constrained...*

*[F.N. interview, Governmental centre]*

The participants also had a near absence of teaching, effective guidance or supervision, and very limited up to date training to manage the challenging psychiatric symptoms. The below quotes from one of the interviews describes this challenge.

*F: ... Definitely. I need someone to guide me in my working; to tell me whether my performance is good or not, whether I do certain things correctly or not. For example, if I have someone to train and teach me new methods to deal with the mentally ill, and correct my mistakes, then my skills and knowledge will be improved, and I will base my work on scientific grounds when dealing with patients; whereas if I work alone without supervision or learning new tactics, I will never enhance my skills and they will stay dead.*

*[F.N. interview, Governmental centre]*

Most of the CMHNs had a significant need to express their negative emotions. There was very little help or guidance in how to deal with daily stressors or practical challenges. This might expose them to specific psychological risks such as distress and feeling overwhelmed. Some of them showed limited willingness to listen carefully to the concerns of the service users. For example, I saw some nurses close the door of the nursing office to minimise the contact or communication with service users. It seems that some of the nurses used isolation from service users as a defence mechanism to protect themselves from additional workload or stressors. The nurses reported that they have very limited opportunities to update their knowledge due to many interwoven reasons such as, lack of budgets, shortage of staff, and being marginalised. The nurses have to cope with lack of training and to work within a very limited learning environment. Many of them working in the centres had not completed any special courses or training. They worked using their experience gained during the undergraduate training of the psychiatric module. The module included theory and practice but was for four months only. For example, the non-governmental nurse was newly graduated and he worked in the centre alone; there was, therefore, no opportunity to learn from any previous nurse colleagues, as he stated:

*M: I did not have training in mental health nursing. I had to remember some of the courses that I had during the undergraduate period.*

*[M.A. Interview, NGO nurse]*

There was also a significant lack of recovery or rehabilitation activities that supported the practical therapeutic plans. The following field note from the governmental centre describes this sub theme.

*I talked to the occupational therapist who expressed his intention to leave the centre; he was unable to apply his rehabilitation plans due to an absence of running costs. He mentioned that the rehabilitation services were not a priority for the Ministry of Health. Few patients came to the department, the CMHT were dissatisfied with the level or quality of rehabilitation for services users.*

*[Field notes, Governmental centre]*

The rehabilitation programme in the NGO centre was going to close down due to lack of finances. The NGO centre included various programmes and worked on a variety of projects in order to improve the mental health of Palestinians. There were some short and long-term projects depending on the availability of funds. The rehabilitation programme for mentally ill clients was one of these projects. The programme started in 2006 and it was the first non-governmental rehabilitation programme for mentally ill clients in Palestine. The main aim of the project was to engage the clients with the local community and with their families after hospital treatment. The programme was challenged by a lack of funding to keep going and to cover the running costs. The extract from the field notes mentions the lack of funding and other resources.

*One of the clients asked the nurse if there were any projects to offer jobs for the psychiatric clients. The nurse explained that the centre might be the only institution which targeted the psychiatric patients but it was going to close down due to lack of funding.*

*[Field notes, NGO Centre]*

Most of the CMHNs who worked in the Governmental mental health services faced difficulties working within poor facilities or lack of infrastructure. The field note below describes these difficulties in one of the governmental centres.

*I visited one of the governmental community mental health centres that were built by one of the international funders two years ago. I found the centre was converted to primary health care clinics. The Ministry of Health was unable to employ a new CMHT, and the local managers had displaced the nurse into the public corridor and they had used her office. Two offices were left, one for the psychiatrist and one for the psychologist. The nurse was sitting in the corridor and behind her sat the clients' files with a concerning lack of privacy. She had also health problems -a deformity in her right hand due to past cerebral vascular accident - from two years ago. I asked the nurse: "How do you give the intramuscular injection to the clients?" She replied, "I search for any private place in the building to carry out nursing procedures". She explained that she was working as a nurse, clerk and receptionist at the same time. She mentioned that the health managers did not consider mental health as a priority.*

*[Field notes, Governmental centre]*

The CMHNS worked within a low budget for the daily requirements or expenses. This lack of funds affected the quality and efficacy of care in a negative way. Financial difficulties were revealed in both NGO and governmental health workplaces. For example, the governmental centres had a significant shortage of funds of daily expenses for toilets, kitchens or offices. The nurse who worked in the Non-governmental Community Mental Health Centre worked within very limited and poor physical resources. For example, the Community Mental Health Centre did not own a building in one of the cities. The centre branch used, temporarily, two rooms only inside one of the buildings. The field notes below reveal that there was a need for basic infrastructure facilities in the NGO workplace.

*The association consisted of two rooms and two offices, a bathroom and a kitchen. Neither met health and safety criteria and offered a poor and tiny physical environment. The non-governmental centre used the two rooms twice weekly. The rooms were not designed for the rehabilitation programme...There was not enough space to move freely inside the room. The weather was hot, it was about 37-Celsius, there was only one fan inside the room. The volunteer turned the fan toward the clients who were drawing; but their papers started to move. The volunteer turned it*

*to her side; the clients then were sweating... The CMHT had a small safe that contained the patients' files and other properties. The CMHT squeezed all their equipment inside the safe after each use.*

*[Field notes, NGO workplace]*

The above discussions revealed that the nurses faced a significant lack of resources. This included a lack of human resources, training, supervision or guidance, as well as a lack of financial resources and infrastructure. These shortages of resources were associated with the military/political conflict and a lack of funding from the Ministry of Health. The fact that the nursing association did not take any serious action for more resources is also a factor. There were low status of "mental health" generally and prejudice towards the nursing work.

#### **4.7.2 Theme 3 sub-theme 2: Lack of rewards and motivation**

I found during my observations and conversations with CMHNs that they had very limited financial rewards (wages) and motivators. In the next quotes from interviews with one of the female nurses we were talking about the challenges for the nurses. She reported her dissatisfaction regarding the financial rewards.

*Mohammad: Do you feel that, as an employee, you receive your rights as an employee?*

*L: No.*

*Mohammad: How is that?*

*L: I have been in service for 20 years but I haven't reached one tenth of a decent salary.*

*Mohammad: Is the salary sufficient?*

*L: No. I have got the degree for two years, but just in writing. It hasn't been confirmed. The travel expenses were sufficient but they have cut them by 50 NIS every month, so I now pay for travel from my salary.*

*[L.E.J. interview, Governmental centre]*

In the interview quotes below, we were discussing the rewards for the nurses. The nurse stated that there were no motivators, rewards or bonuses offered by their employer.

*S: Now I attend work at the Health centre but the salary -- there are no rewards, no bonuses -- no motivators -- you work hard, but you do not receive even a thankful word, even if you work more than your capacity. When I worked at the Central Health Department, I used to go out on vaccination campaigns and other kinds of campaigns and visits and so on, but you would not receive a thankful word. Nevertheless, if you make a mistake or an error, the world will turn upside down. This means that your work is not appreciated, no motivators, nobody appreciates your work. Frankly, neither the place, nor the crew, nor the management motivates you. There are neither financial nor moral motivations.*

*[S.S. interview, Governmental centre]*

They reported that their achievements were undervalued by the Ministry of Health. They had excessive workloads and were treated as unskilled workers, and their rewards did not meet their expectations. The nurses reported that they received low wages below their expectations. Moreover, I noticed that the CMHNs who were working with the Ministry of Health had to deal with irregular monthly salaries. The nurses were receiving inconsistent wages and very limited rewards or appreciation from their employer. During the data collection period, I found there was a national crisis for all the public employees. The government employees received only half of their salaries for many months. All the interviewed nurses talked about their lack of rights and fair policy of rewards. The nurse who worked in NGO workplace had similar challenge to the governmental nurses who received low monthly wages. The

nurse was working in two jobs at the same time to cope with his personal financial challenges. The following field notes reveal the significantly very low income of the NGO nurse. His monthly salary was \$300 which had to cover everything including his transportations costs!

*The nurse received a low salary of \$300 monthly. This was below the level of profound poverty. I asked the psychologist (the team leader) what time the nurse finished his work. The psychologist replied that the nurse came from another district and spent much time on the roads due to movement restrictions. However, the nurses' salary might not cover his transportation costs!*

*[Field notes, NGO Centre]*

The above discussions revealed that the nurses faced a significant lack of rewards and motivators from their employer. These shortages of rewards were associated with the military/ political conflict and a lack of funding from the employer. They were also associated with the lack of an effective parliament to determine or control the rights of the employees. They were associated with the lowly status of “mental health” generally and bias against nursing work. The lack of an effective nursing association to lobby for more rewards, bonuses, and motivators is also a challenge.

#### **4.7.3 Theme 3 sub-theme 3: Managing psychiatric symptoms**

Nurses have challenges related to managing the psychiatric symptoms of their patients. As one of the interviewees described most of the psychiatric patients' relapsed.

*F: The majority of the cases that were coming to us were relapses...*

*[F.N. interview, Governmental centre]*

The next quote from one of the interviewees confirms the recurrent relapses of patients due to lack of financial resources and commitment on their part. We were talking about the difficulties encountered by the nurse in the NGO centre.

*M: Patients numbers declined; those who were coming from \*\*\*\* (city) stopped because of the long distance and lack of transportation. Therefore, we try to bring them in. As regards the patients from \*\*\*\*\* (city) and its villages, we offered the transport but at their expense. Some of them were able to stay with the programme, others were not. When they relapse, they ask for help from us. I myself supervised them, took them to the mental health centre of Ministry of Health. They usually stay for a while, one week for example, stay in the programme. The moment they feel better they go home. As the patient needs help he comes to us, this is the wonderful thing in the programme. Indeed, it is a perfect achievement when they no longer go to a healer or someone else.*

*Mohammad: Does this mean that patients do not adhere to the programme?*

*M: Some of them do and some do not. We have their files, they come for a while then they stop.*

*[M.A. Interview, NGO nurse]*

As mentioned in above, the NGO nurse faced a lack of commitment from the clients, this caused symptom relapses. Most of patients stopped their commitment to the programme after their health conditions improved. Most of the clients relapsed because they were unable to cover the costs of transportations and come to the centre two days weekly. Some of them were unable to attend due to movement restrictions on the roads. Therefore, most of the service users ceased to be involved in the programme and their health condition became worse. Then, they came to the centre and asked to join the programme again, but they did not show commitment again. Moreover, the centre was unable to cover half of transportation costs, as they had done before, due to lack of funding. This was interwoven with the lack of the funding and lack of awareness toward mental health in general. CMHNs sometimes had to deal with people with very challenging psychiatric symptoms. This exposed them to the risk of feeling personally distressed especially when they had insufficient knowledge. They received very limited up to date teaching and training to manage the challenging psychiatric symptoms. The

quote below from one of the interviewees describes her frustration due to the lack of knowledge on the part of some of the nurses.

*S: Look, nursing here at the Ministry is marginalised. We have no training courses; there are some topics that we do not know.*

*[S.S. interview, Governmental centre]*

The female patients were at risk of relapse due to lack of female human resources. The male nurse who worked in a non-governmental workplace organisation had challenges on a practical level. He explained that two CMHT members, one male and one female, should conduct a home visit. This policy was conducted for health and safety reasons and to respect the needs of the local conservative culture. The nurse stopped the home visits to the female patients due to a lack of female staff. The extracted conversation with the nurse reveals this gender sensitivity:

*The nurse said: It was unacceptable culturally for a male staff member to visit a female client in her house; she might be alone and this might cause social embarrassment to the service users. The nurse also told a story where they went to visit one of the clients and he opened the door undressed. The nurse asked his female colleague to stay outside until the client put on his clothes.*

*[Field notes, NGO Centre]*

From the above section, the lack of resources increases the problem of patient relapses. The lack of resources include the inconsistency of care services, lack of medication, lack of teaching, and lack of commitment of service users toward the treatment plans. Usually the service users stop taking medication when they are unable to manage side effects, and this leads to relapses. This occurred due to lack of teaching for the families and patients about the side effects of the medication. Lack of home visits by the CMHNS to follow up the cases at home increased the risk of relapses and deterioration of mental illness. The lack of home visits occurred due to severe shortages of staff and misconceptions about nurses' roles. . The nurses had to deal with recurrent chronic or

hopeless cases with lack of supportive facilities. The data led me to conclude that this might create feelings of being overwhelmed.

## **4.8 Summary**

From the above discussions, it appears that lack of resources again emerges as the root cause of many of the challenges experienced by nurses. Lack of resources includes lack of funding, lack of rewards and motivators, and the difficulty of managing psychiatric symptoms. The lack of resources caused patients to experience worsening of psychiatric symptoms. Mental illness is a chronic disease and needs consistent interventions based on continuity of care. I think it is one of the basic human rights for patients to receive regular mental health services. The Palestinian Authority which runs the health system has based services mainly on Israeli practices and international funding. The funding was unpredictable and depended on the political conditions or environment. For example, the NGO rehabilitation programme was running during the Second intifada period and it was designed to engage the clients in their local communities. It was the first non-governmental experience in community rehabilitation of the psychiatric patients. The programme funding was also affected by unrest and the political environment. When the conflict increased, the international aid funding increased to try and calm down the situation. When the level of conflict decreased, the funding diminished or stopped. This was a challenge for the nurses and CMHT who worked on the recovery or care plans.

The significant deficit of running costs caused other challenges such as lack of supportive infrastructure or facilities resources. The data reveals that the centres needed to expand and needed other buildings in other districts. The nurses struggled to carry out the care plans within these poor resources. The irregular funding and severe nursing shortages also affected the lack of staff training. The nurses needed to be trained and to update their limited knowledge in the mental health field. The continuous education process needed a budget and this budget was unavailable or insufficient. This affected, negatively, the level of the mental health nursing care plans. The CMHNS had other challenges related to the economic hardship and low,

inconsistent salaries which fell below what was needed to meet their needs. The monthly wages or financial rewards were also dependent on the political environment.

Most of the CMHNs were unable to conduct home visits and follow up cases which increased the possibility of relapse for clients. There was a significant lack of treatment-seeking by service users. Moreover, there were very few home visits by nurses to educate the service users about psychiatric diseases. Most of the patients stopped their medication when they were unable to manage the side effects. There was a need to teach the clients and families how to handle these side effects. The nurses were overloaded and unable to spend enough time teaching the service users. There was a lack of funded programmes to improve the attitude of the health leaders toward the importance of the nursing profession. The lack of resources possibly is associated with the lack of awareness toward mental illness and neglect of this field by health leaders and society. The next section will discuss further the challenges related to the nursing profession within the organisation.

## **4.9 Theme 4: Organisational**

There are numerous sub thematic challenges related to the internal health management policy of the health organisations. There are gaps between theory and practise, professional status of nursing, and inter-professional challenges. The following sections present an analysis of each sub theme in detail.

### **4.9.1 Theme 4 sub-theme 1: Gap between theory and practice**

There was a gap between what nurses had been taught in text books and what they were able to offer in practise, as is described in the following interview with one of the participants who was the only CMHNs in a district with around half a million population. We were talking about the main challenges he was faced with in the workplace. He reported the workload and pressure as a main challenge in the workplace. He also showed me the documents of the monthly records to prove what he said.

*Mohammad: Now what are the challenges or difficulties that you face in your work?*

*T: Work remains work. Work pressure remains work pressure--- The most difficult problem we face is work pressure at the peak of work...*

*T: You know these psychiatric patients. Every one of them wants to take their medication quickly. They would not be patient enough just to wait for 10 or 15 minutes. When he holds the prescription, he wants to take his medication at once. He would not wait. This is the biggest problem. How can a nurse dispense medications, give injections, deal with patients, and fill in the records at the same time? ...*

*Mohammad: In general, how many patients do you deal with every month?*

*T: I told you, about 750 – 800 patients.*

*Mohammad: 800 patients? Really?*

*T: Approximately. In addition to injections. I have here documented monthly reports. Here is for example the report of June 2012. I personally dealt with 789 cases that I gave medication to and 234 injections.*

*Mohammad: How many injections? 200 and*

*T: and 34. This is for June. But for May, I dealt with 870 cases and 304 injections. You know, give or take 50, or they increase by 100, that depend on the circumstances. I document all cases that I deal with directly, as you see.*

*[T.H. interview, Governmental centre]*

Due to the above mentioned workload, in the extended quotes the above nurse (T.H) explained that he is unable to provide what he has been taught to offer.

*T: You know that there should be psychiatric nursing as a specialty. You should have an understanding of medication to see what patients take, the effects of medication, right?*

*Mohammad: Yes.*

*T: You should not give the patient medication and ask him to leave. You should have enough time for each patient to take care of him. You should have a private room so that the patient can come and you should know how he takes the medication, what side effects are there. In this way, you may know if he takes an overdose so that you can reduce the dose. This is how nursing should be, but nursing is something and the reality is another.*

*[T.H. interview, Governmental centre]*

As we see in the above quotes, the nurses were challenged to practise what they had learned during their undergraduate training. They had to deal with patients with psychiatric symptoms who were often volatile. This was associated with the increasing numbers of service users and excessive workloads or demands. The interviewees also carried out additional work due to a severe shortage of mental health staff. The above mentioned nurse (T.H) was working as a clerk and a receptionist and he was unable to apply his nursing skills properly. Most of the nurses were unable to find time to write on patients' files, and although a few of them did, their notes were neglected or unappreciated. Nurses reported that they needed to share more effectively in the treatment plans. They also had insufficient time to spend with service users and this affected negatively the level of care they hoped to give. As discussed in the above quotes, they needed more time to explain how to use and the side effects of medications. Most of the nurses were working alone with the clients with very limited supportive resources. The nurses also explained that they needed other nurses to do other nursing care or tasks. These disadvantaged the nurses in applying nursing care properly.

The above discussions revealed that there was gap between reality and what nurses learned in the schools or universities. This challenge was linked to the increasing demands on nurses. It is possibly also associated with the lack of awareness toward mental illness and neglect of this field by health leaders and society.

#### **4.9.2 Theme 4 sub-theme 1: Professional status of nursing**

The data led me to understand that there were challenges related to the professional status of nursing within the organisation. For example, the next conversation with one of the interviewees who was working in the governmental centre clarified challenges faced by mental health nurses.

*F: There is no concentration on the nursing (mental health nursing). And what I really need to know is what I should do as a mental health nurse. Am I right or what?*

*Mohammad: You are absolutely right.*

*F: Right.*

*F: Unfortunately, there is no special training for the mental health nurses. I haven't received such training since the day I started working.*

*F: Here in the department, (I hope no one hears) the mental health nurse is completely ignored; they rarely engage us in workshops, courses or any other activity they do, the priority is always given to the social workers and psychologists to deal with patients and problems. Consequently, you feel there is no importance of your role.*

*[F.N. interview, Governmental centre]*

The entire sample expressed their significant dissatisfaction with the low status of the nursing profession within the Ministry of Health. One of the nurses stated during the interview when we discussed how some of the managers treat nurses.

*S: The management style is very bad. They deal with us in a dictatorial way...*

*[S.S. interview, Governmental centre]*

In the following interview related to transition from clinic to centre, one of the female nurses reported that she needs to feel involved and share effectively in the development plans.

*F: As I told you, I am ready to fight hard for anything related to mental health nursing. In fact, the mental health nurses are entirely neglected, the Department of Health has never nominated us in meetings or on courses or any other activity. I have been working here more than three years, and they never invited me to participate in a meeting or discussion.*

*[F.N. interview, Governmental centre]*

Nearly all nurses during the interviews used this term 'being marginalised or neglected'. This happened on a practical level and in the decision-making process. For example, they were not involved effectively in decision-making and they were not consulted in the transforming or development process. The international funders had recently built the community mental health centres. The work policy had shifted from being community clinics to being community mental health centres. The nurses had not been allowed to share effectively in the transition process. Therefore, their constructive viewpoints, concerns and needs were not addressed. Their nursing status was undermined and the nurses were unable to advocate for themselves properly. The mental health services followed the management policy of the primary health care services in the Ministry of Health. Interviewees had struggled to swap their workplace from the hospitals to primary health care which they would have preferred. The hospital work was more demanding for nurses due to excessive work pressure and night shifts. Nurses usually kept silent about their complaints and concerns, because if they complained they might be punished and transferred back to the hospitals. They were mostly controlled by the health leaders (mostly physicians) and they had to implement the managers' orders. The extract below reveals the conversation with one of the nurses about the professional difficulties. She emphasised that mental health nursing is not well recognised in the West Bank and is without a clear job description.

*F: There is no job description to identify tasks and duties for you; for example, the nurse who works in the town clinic that is related to the Health Directorate of \*\*\*\* (Palestinian city) is working independently, and similarly for those who are working in Jenin and in Hebron. In other words, we do not have specific generalised orders such as; you, as a mental health nurse, should work like this--; your duties are---, in order to achieve your work correctly, you should train on --- We do not have such thing unfortunately -- Ministry of Health ignored us as usual -- Mental health nursing is not recognised here in the West Bank...*

*Mohammad: But how do they consider you?*

*F: I don't know. We have a nurse, but we don't have a mental health nurse working in the mental health unit...*

*[F.N. interview, Governmental centre]*

The data led me to understand that the nurses have to create their own space and to manage their professional boundaries with other health workers. The CMHNs had to struggle in order to define themselves in a positive way. There were vague definitions of nurses' roles who were working in the mental health centres. Some official documents called them "nurse", others called them "psychiatric nurse or mental health nurse". This confusion from the Ministry of Health or NGO centre affected perceptions about the CMHNs in an unconstructive way. As a result, the CMHNs were struggling to seek recognition from their employers, colleagues and the public. For instance, during my observation, the nurse who worked in the NGO introduced himself to one of the client's family as a nurse who was working in the general hospital. This might reflect the challenge of identity among the nurses and he might also have used this term to gain trust. The general hospital might be better known as a respected place rather than the mental health centre. These challenges might reflect the need to create a committee or association for community mental health nurses. There was no specific committee or network for the community mental health nurses in Palestine.

One of the nurses explained that she needed to contact or please three different managers at the same time in order to be allowed annual leave. The extracted quotes from the interviewee describe the multiple officers who give orders to the nurse employee. I have a feeling that the nurse was sending a message that he was frustrated and that he mentioned "20 officers" as a way to over-emphasise and make his point more vividly.

*Ab: In the past, you would deal with one health officer, but now you have to deal with 20 officers and every one of them dictates what you have to do. How much can you tolerate?*

*M. What helps you to put up with the work environment in which you have 20 officers and every one of them dictates what you have to do?*

*Ab: This is not completely new. Just for 2 or 3 years. Before that, there was only one manager who was the only responsible officer. When he retired, those who came after him are not like him. At present, there are new appointments .... Several managers, various officers ....*

*[A.J. interview, Governmental centre]*

The data led me to recognise that there was a lack of nursing autonomy inside the health organisations. The nurses' managers worked in a health ministry dominated by physicians; this disadvantaged the nurses in their desire to be an independent body. The lack of autonomy in the nursing profession created opportunities for other health professionals to control nurses. It seems that the health leaders' concern was to meet the service users' needs disregarding the status or needs of nurses. This might affect negatively the enthusiasm, motivation and satisfaction of the nurses. I also found that the hierarchy of the nurses within the Ministry of Health was blurred and there were overlaps on a practical level. The nursing manager of the primary care in the district should be their line manager. However, the nurses explained they were expected to implement the orders of more than one manager at the same time. For example, they receive orders from the head of the centre, the manager of the primary care and other

local managers. This vague management policy increased the stressors and work pressures for the CMHNs.

There was a lack of appreciation from top executives, as to how nurses felt they were an underprivileged profession and their roles were undervalued. The data led me to conclude that nurses carried out unwanted tasks and covered the roles of other health team. In the Ministry of Health, not one of the top leading positions (such as general manager of a hospitals or a directorate in the primary health care workplace) was held by a nurse. The nurses faced a lack of opportunity to share effectively in the strategic plans or general management policy of the available resources. Some of the nurses reported that some of their managers were supportive and considered this a source of their resilience - which is discussed in the next chapter. Some of the nurses indicated that some of their managers added to the challenges they faced.

The above section discussed the professional status of nursing within the health organisation. This resulted in CMHNs being disempowered, feeling marginalised, experiencing a lack of professional identity and autonomy. These challenges were mostly linked with lack of support and resources. This challenge is also possibly associated with the stigma toward “mental health” generally and the low status of nursing inside and outside the health organisation. The next section will address the inter-professional challenges inside the health organisation.

#### **4.9.3 Theme 4 sub-theme 3: Inter-professional challenges**

Building on some of my findings discussed in the previous section relating to blurred boundaries, there were inter-professional challenges. These challenges included lack of clear job descriptions, multiple responsibilities and overlap of roles, plus lack of coordination and communication. These challenges will be discussed in the following paragraphs. For example, the nurses need clear and agreed job descriptions which reflect what is going on in the workplaces. This can be seen in the following conversation with one of the interviewees which describes the lack of a common job description.

*F: As a mental health nurse I took a course in a psychiatric clinic, and now work there, unfortunately, I do not have a job description to base my work on.*

*[F.N. interview, Governmental centre]*

The published documents about the community mental health centres on the official website of the Ministry of Health did not depict an accurate representation of what was actually going on. There were variations between the CMHNs tasks in reality and the published online job descriptions. Nurses' home visits to the service users were published online as one of the job descriptions, but most of the nurses explained they are unable to conduct home visits in their job. Another example, in the NGO health workplaces, showed how the CMHNs have to adapt to include undertaking tasks and roles they have little or no training for and which are beyond a recognised nursing role. The job tasks were shaped by local circumstances in the workplaces such as where nurses covered the roles of other members who had recently left the workplace. The job description below was written by the local CMHT to organise their tasks. This challenge made the nurse do what was expected on the written job description, in addition to the newly emerging tasks in the field. The two extracts below explain the differences between written documents and reality. The following were all tasks expected of the nurse who worked in the NGO:

- 1) Individual counselling.*
- 2) Recording nurses notes on files and follow up plans for the clients.*
- 3) Recording nurses notes on the computer files.*
- 4) Following up care plans and assessments forms online.*
- 5) Following up the family assessment form every six months online.*
- 6) Sharing in weekly supervision meetings and other management meetings.*
- 7) Evaluating the care plans of the clients continuously.*
- 8) Following up the side effects of the medications and health care plan of the clients.*
- 9) Filling out the attendance forms of the clients.*

10) *Recording the six-month and yearly evaluations forms.*

11) *Cooperating with the CMHT in case management work load.*

*[Written documents, NGO centre]*

The above list did not reflect what was going on in the field. The following section describes how roles were shaped by the emerging needs in the workplace and community. This was part of the daily routine for the non-governmental nurse. The nurse covered the occupational therapist and social worker tasks. He said these roles were carried out by the occupational therapist but after she left the work place, he covered her roles.

*I saw the nurse sitting with six clients in the television room. The nurse was leading the group in reading the newspaper, discussing general concerns on the TV. Then, the nurse led the service users in some exercises inside the room for 15 minutes. The group had a break for 20 minutes. The nurse asked a volunteer to prepare the tea for all of us. The group moved to the occupational therapy room to do the hand activities. The nurse asked one of the clients to write down the names of service users on the board and to distribute the activities related to the preference of each client. Finally, the nurse recorded notes on patients' files and he prepared with another clerk the stock list for the centre needs.*

*[Field notes, NGO Centre]*

I found that the nurses who covered the mental health clinic worked in other clinics at the same time, or they carried out extra tasks such as giving vaccinations, for example (see the second quote in lack of rewards and motivation subtheme, lack of resources challenge). One of the nurses reported that he used to work as a clerk, pharmacist and cleaner at the same time due to staff shortages.

*Mohammad: What other pressures do you have as an employee at the Ministry of Health? For example, salary and other things?*

*Ab: I carry out tasks in addition to my duties. For example, I am here a nurse, a registrar, a pharmacist, offer care and vaccinations, and all other kinds of work. I also clean the clinic.*

*[Ab. J. interview, Governmental centre]*

The work tasks of staff in the CMHT overlapped due to organisational ambiguity and staff shortage. I had arranged to interview the community mental health nurse and was surprised, when I found him working as a pharmacist in addition to nursing.

*I met the nurse as previously arranged, over the phone; He was an elderly man around 60 years of age. He was sitting in the pharmacy beside the entrance to the centre. The first question I asked: "What you were doing in the pharmacy?" He smiled and replied: "I have worked as a pharmacist for two years since the centre was opened and we still wait for the Ministry of Health to employ a pharmacist".*

*[Field notes, Governmental centre]*

The CMHT in the NGO workplace preferred to work in a 'cooperative way' and have loose job descriptions to cope with staff shortages. The non-governmental nurse told me during conversation:

*We (the CMHT) preferred to carry out tasks in a cooperative way to meet the needs of the service users. Sometimes we divided the files between both of us randomly to complete the records on the paper files. Sometime one of us did the tasks instead of the other.*

*[Field notes, NGO Centre]*

The CMHT in workplaces consisted of, in the main: a psychiatrist, social worker, a psychologist and the nurse. Each one of the CMHT needed to focus on specific concerns to achieve the holistic care for the service users. The managers were mostly interested in meeting the needs of the service users to the detriment of inter- professional relationships. Therefore, there were differences between tasks expected of the nurses

from one district to another. There was also an absence of regular communication between the nurses in the psychiatric hospital and nurses in the community mental health centres. The next field notes illustrate this challenge among participants.

*There was a lack of communication or coordination with other community mental health centres in other cities. There was a need to connect the mental health system electronically together through the electronic filing network with the other primary health care clinics. The centre was connected with the internet when it opened but the managers of the directorate stopped it. The team needed to be connected with the psychiatric hospital and to update the files of the service users for the transfer process.*

*[Field notes, Governmental centre]*

The CMHNs did not hold regular meetings or have effective communications or coordination to develop the level of care. For example, the NGO nurse also struggled to find new cases to join the rehabilitation programme. The governmental workplaces have almost none of such activities. The nurse in the non-governmental centre described these difficulties, as shown in the following field notes.

*Of course, there are challenges and difficulties, but the greatest difficulties I face are in reaching the patients...The nurse said "the manager of the primary care in the Ministry of Health visited the Non-governmental centre but I decided not to cooperate with the centre in an official way". This was his way of protesting.*

*[Field notes, NGO Centre]*

The above section discussed the inter-professional challenges. These challenges include lack of clear job descriptions, multiple responsibilities and role overlaps, plus lack of coordination and communication. It also explained how work tasks were shaped by the local circumstances in the workplaces, where there was not enough training.

## 4.10 Summary

The above discussion explained that there are major challenges related to the health organisation. It included other interwoven challenges such as the gap between theory and practice, professional status of nursing, and inter-professional problems. The professional and inter-professional challenges within the workplace caused tensions and distress to the nurses. Nurses were put in positions where they had to defend themselves and to justify or explain their actions. It was notable that the status of nursing was undermined and nurses felt disempowered and marginalised. This low professional status might expose nurses to the risk of self-doubt and low self-esteem.

Nurses also faced difficulties in expressing their identity within the local society due to a lack of job description and the stigma associated with mental health issues. As a result, it was a challenge for the nurses to introduce themselves inside and outside the centre properly. There was a lack of understanding toward the mental health nursing roles and the capabilities of nurses. The inter-professional relationships could affect the nurses' identity in unconstructive ways. The CMHT is still not oriented to what tasks the nurses are able to do. A cooperative way of working might change perceptions towards the CMHNs. The nurses mostly have to take on the undesirable tasks from the mental health team. The nurses' capabilities were still vague or unclear due to the multiple roles they performed. This way of working with the CMHT might be good from a cooperative point of view; but it might not improve attitudes towards the mental health nurse. It was also obvious that not one of the nurses held a role in one of the top leading positions inside the Ministry of Health or one of the roles of manager.

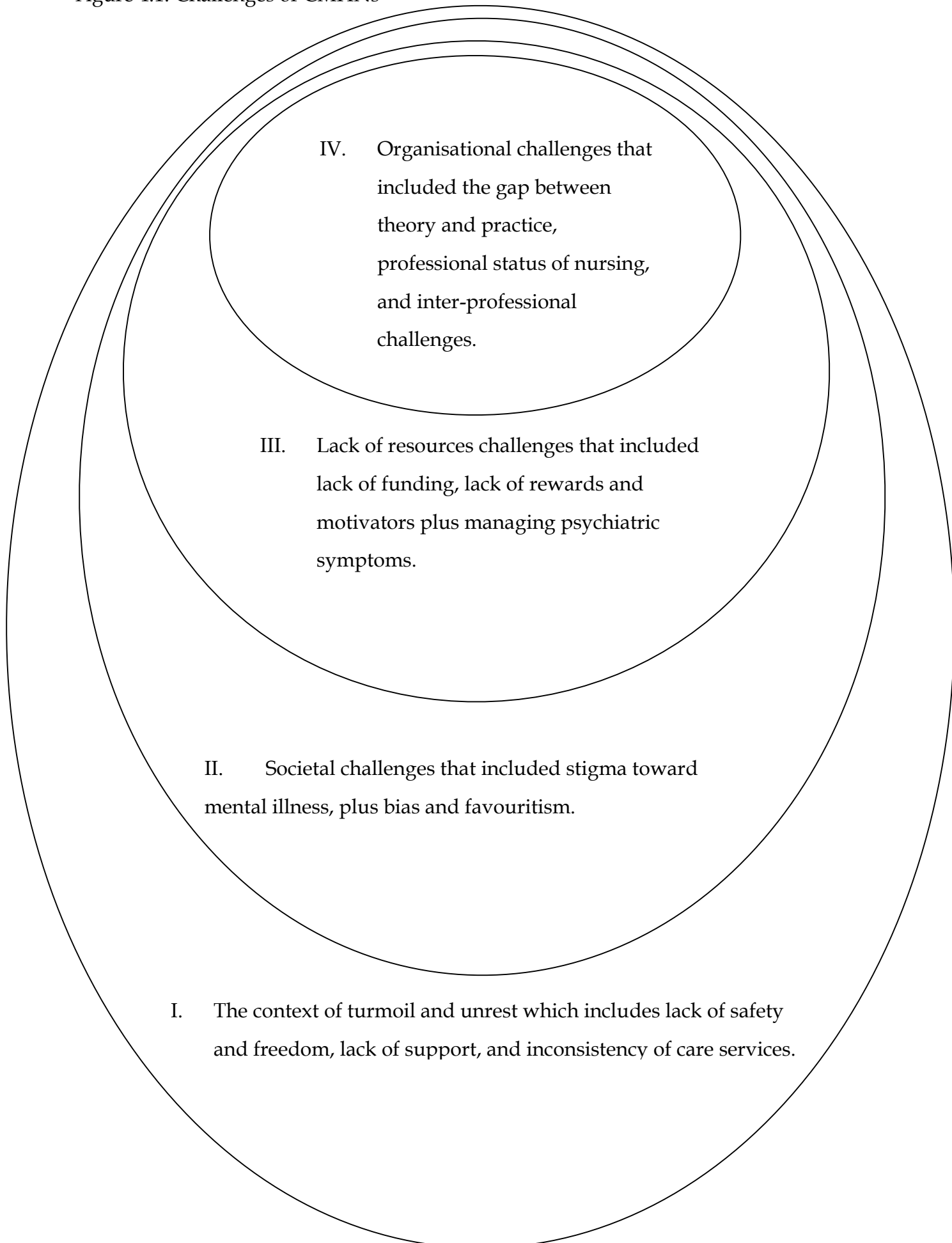
The organisational challenges were associated with lack of resources such as severe shortage of nurses. This can be linked with negligence or lack of awareness toward mental health. The above sub themes related to the health organisation; need to be discussed within the challenging context of unrest and turmoil.

## 4.11 Conclusion

The above chapter explained the challenges that CMHNs are faced with inside and outside the workplace. The chapter presented interwoven challenges and each one consists of many interwoven sub themes. The most relevant sub themes were grouped together to form main themes. These main themes are - a context of turmoil and unrest, challenges related to the society, lack of resources, and organisational challenges. These themes were embedded in the context of unrest and turmoil. Contextual challenges were interwoven with other practical difficulties such as societal attitudes, lack of resources, and organisational challenges.

The figure below (4.1) illustrates the theme of “challenges to the CMHNs”. The figure explains the most related sub themes, which together make up the theme. The challenges were embedded within the context of turmoil and unrest overall.

Figure 4.1: Challenges of CMHNs



The above figure (4.1) consisted of circles within the large circle of the context of turmoil and unrest. This means other challenges need to be discussed within the context of turmoil and unrest. Challenges were embedded in this context and there are interwoven relationships with other challenges. This means it is difficult to discuss one challenge without mentioning the other challenges for participants. For example, in order to understand the organisational challenges we need to discuss this challenge within its relationships with other challenges such as the lack of resources. The lack of resources needs to be discussed within the societal challenges. The societal challenges need to be discussed within the context of turmoil and unrest. This will offer better understanding of these challenges (see the discussion chapter, challenges faced by CMHNS section).

This study was the first one to discuss the challenges faced by the mental health nurses. The findings were significant in an under described and under explored experience. This helps to hear the voice of the voiceless and the points of view of under privileged participants. It also helps to explore the resilience of the nurses on a practical level and on a daily basis. This chapter includes the interaction between the nurses and the surrounding environment. It explains in detail the challenges the nurses have to respond to or cope with inside and outside their work places. It was notable that the above challenges linked with the context of unrest. It was obvious that some of the challenges were caused by the conflict context and others can be linked with the local society. The challenges can also be linked with the social ecology of the participants. Finally, the challenges in this chapter are consistent with other studies worldwide. The following section links these findings with the existing literature.

## **4.12 Reading the above findings in light of the existing literature**

This section considers relevant findings from previous work outside Palestine with the findings in this chapter. The generated themes in this chapter will be discussed in relation to the existing literature.

#### **4.12.1 Theme 1: The context of turmoil and unrest:**

The context of turmoil and unrest is one of the challenges in work and in life in general which face CMHNs. As presented earlier in this chapter, the theme of the context of turmoil and unrest consists of lack of support, safety and freedom, and inconsistency of care services. This section considers the relevant findings from previous work carried out outside of Palestine alongside the findings presented in this chapter.

Murphy (2004) reported that CMHNs are sometimes exposed to violence from service users within their workplaces. Coffey and Hewitt (2008) reported that CMHNs have challenges related to some of the psychiatric symptoms experienced by people, such as hearing voices. They are working in a multifaceted health system which contains “wicked problems” in a mental health context (Hannigan and Coffey, 2011). CMHNs sometimes deal with mentally disordered offenders who have a history of violence or assaults (Coffey, 2003b). In a study of community psychiatric nurses (CPNs) in the UK, Hopkinson et al. (1998) found that CPNs have challenges such as limited support and challenges in balancing work and home responsibilities. Edwards et al. (2001) found lack of support contributes to stress among CMHNs in Wales, UK. Finally, Hannigan (2003) mentioned that politics can influence the context CMHNs work in on a daily basis.

There are scholars who have discussed lack of safety and freedom among nurses in their workplaces. For example, Birchenall (1997) completed a study which focused on the resilience of British nurses under German occupation in the Channel Islands between 1940-1945. Thirteen semi-structured audiotaped interviews were conducted with former nurses who strove to provide emergency hospital services at that time. Official hospital records, news reports and other published literature were analysed as supporting data. The nurses reported that they experienced challenges such as lack of, or inconsistency in, medical supplies, foods, and fuel. British nurses worked in a violent environment while oppression and curfews were common. They carried out their nursing care in spite of surrounding challenges, such as some of the nurses being

arrested or killed by German occupying forces. These findings can be linked with the context of turmoil and unrest facing CMHNs, in spite of time differences.

From the above studies, there is evidence that other nurses may at times experience contextual challenges. Studies of nurses working in conflict zones are few, but also indicate that these findings point to the significance of context, consistent with the findings of this research, where there were contextual challenges facing the Palestinian CMHNs.

#### **4.12.2 Theme 2: Societal challenges**

As presented earlier in this chapter, the theme of societal challenges consists of stigma toward mental illness, plus bias and favouritism. This study produced findings which can be linked to findings from previous work outside Palestine. For example, according to a WHO report (2007) the stigma toward mental illness is considered one of the most significant challenges in low and middle income countries. There is a lack of funding and resources, which deters nurses from remaining in or joining the mental health field. According to Okasha et al. (2012), there is misunderstanding of mental illness in the Arabic cultural context. Some people believe that mental illness happens due to the influence of magic or the evil eye. In addition, Pinto-Foltz and Logsdon (2009) reported that stigma is an important barrier to recovery from mental illness in the U.S.A. These findings can be linked with the outcomes of this study where stigma is one of the challenges Palestinian CMHNs face. This means that CMHNs experience stigma because their client group is stigmatised.

According to Gazzaz (2009) nurses face societal challenges in Saudi Arabian culture due to tradition and tribal society. Nursing is an underprivileged career and is attached with negative stereotypes in Saudi society. Lovering (2008) also argued that nursing has a low status, especially amongst female nurses, in Middle Eastern societies. This means that there is bias and favouritism against nurses and female nurses in particular. These findings can be linked with the outcomes of this study where Palestinian CMHNs face bias and favouritism in their society.

From the above studies, there are stigma and bias challenges. These studies are consistent with the findings of this research, where there are social challenges facing the CMHNs in Palestine.

### **4.12.3 Theme 3: Lack of resources**

The challenge of a lack of resources faces CMHNs in work and in their lives in general. As presented earlier in this chapter, the theme of lack of resources consists of lack of funding, lack of rewards and motivators plus managing psychiatric symptoms. This study produced findings which can be linked to findings from previous work outside Palestine.

Jenkins et al. (2004) found UK mental health nurses experience a lack of human resources and face high workloads. Edwards et al. (2001) found a lack of resources contributes to stress amongst CMHNs in Wales, UK. In a study of community psychiatric nurses (CPNs) in the UK, Hopkinson et al. (1998) found that staff face many resources challenges. These findings echo the lack of resources reported by Palestinian CMHNs in this study. CMHNs also need to expect relapses of service users, especially those who have psychosis (Coffey, 2003a). This can be linked with the challenge of managing psychiatric symptoms among Palestinian CMHNs.

Other nurses faced similar challenges in health workplaces. For example, according to Birchenall (1997) the British nurses under German occupation during 1940-1945 reported that they worked within an environment lacking training and resources. This study found that nurses were innovative and created new ways of coping. For example, in preparing food they cooked the bone more than once due to a lack of meat supplies. Finally, according to Okasha et al. (2012) the mental health services in the Arabic countries are underdeveloped and under-resourced. There is a lack of support, and a lack of human resources including nurses, in the Arabic region.

From the above studies, it is evident that many nurses are challenged by a lack of resources. Findings from these studies are consistent with the findings from this current research, which reveal how lack of resources challenge Palestinian CMHNs.

#### **4.12.4 Theme 4: Organisational challenges**

Organisational challenges face CMHNs in work and in life in general. As presented earlier in this chapter, the theme of organisational challenges consists of the gap between theory and practice, professional status of nursing, and inter-professional challenges. This study produced findings which can be linked to the findings of previous work outside Palestine.

Scholars have discussed the organisational challenges facing CMHNs in their workplaces. Coffey and Hannigan (2013) show how CMHNs in England and Wales face professional and inter-professional challenges. In a study of community psychiatric nurses (CPNs) in the UK, Hopkinson et al. (1998) found that CPNs have challenges such as low status, lack of control, limited autonomy, lack of clear job descriptions, and roles which overlap. According to Jackson et al. (2007) workplace adversity in nursing is associated with excessive workloads, lack of autonomy, bullying and violence and other organizational challenges.

Other nurses are facing similar challenges in health workplaces. For example, Hodges et al. (2008) completed a study to explore the nature of resilience amongst new baccalaureate-prepared nurses in an acute care setting in the USA. A qualitative design was used, and semi-structured interviews were conducted with 10 hospital nurses. The data were analysed thematically which revealed that there were challenges for nurses in compromising between what they have studied and what they faced in the field. The nurses struggled to fit their personal values with the professional job within the organisational culture. This can be linked with the gap identified in the current study between theory and practice. Zander et al. (2013) completed a study to explore resilience amongst five paediatric oncology nurses in a cancer unit in Australia. The participants' perceptions were explored of the concept of resilience. In addition, nurses used coping mechanisms, and these and their day-to-day work experiences were also explored. Interviews were conducted with the sample and thematic analysis was used to analyse the data. The nurses reported the following challenges they face in their day-to-day work environment: policy inside the organisation, maintaining professionalism,

skill mix, witnessing of relapse or bad progress, work shift rota, staffing, and work job development. This can be linked with the organisational challenges that face Palestinian CMHNs as identified in this thesis.

Other health professionals are facing challenges in health workplaces. For example, Hunter and Warren (2013) reported that midwives face challenges related to work conditions, quality of care and professional issues. The significance of the findings in this work is the severity or level of challenges faced by the CMHNs in Palestine. In particular, the level and severity of the challenges were associated with the context of unrest and turmoil (see the discussion chapter, 'Challenges faced by CMHNs' section). The next chapter will discuss the resources which help nurses to respond in a resilient way and enable them to survive in this challenging context.

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## **Chapter Five:**

### **Sources of Resilience**

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## **5 Chapter Five: Sources of Resilience**

### **5.1 Introduction**

The previous chapter discussed the challenges among Palestinian community mental health nurses in their workplaces and lives in general. This chapter presents the sources of, or sources associated with, resilience among Palestinian community mental health nurses in their workplaces and lives in general. Multiple types of collected data were analysed thematically to synthesise the information as discussed in the methodology chapter. The deviant cases and their voices or points of view were presented; and these cases were discussed and compared with the majority of other contributions. However, all the participants reported that they saw themselves as resilient at some level when faced with work and life challenges. None of the interviewees described themselves as defeated or unable to cope. Finally, some of the mentioned sub themes discussed in the previous chapter were seen as certain challenges. This chapter will explain when the participants considered issues as a challenge and when they considered them as a source of resilience.

The chapter consists of the shared sources of resilience among participants in their workplaces and their lives in general. I merged the themes/subthemes related to these resilience resources together. For example, the data revealed that there are similar sources related to Sumud and Islamic culture inside and outside of workplaces. The sections below present these resilience resources found among CMHNs in detail.

### **5.2 Sources of resilience**

Four main themes are presented which describe sources of resilience among CMHNs. The themes are the Sumud and the Islamic culture, supportive relationships, making use of available resources, and personal capacity. Each main theme is made up of subthemes, which are:

1. Sumud and Islamic cultures include Sumud culture, Islamic culture, and love of nursing and nursing values.

2. Supportive relationships consisting of the community, family, plus colleagues and local manager's support.
3. Making use of available resources includes education, rewards, and available infrastructure and facilities.
4. Personal capacity includes experience, individual characteristics, and coping skills.

## 5.3 Theme 1: Sumud and Islamic cultures

There was consensus amongst the participants that the Sumud and the Islamic culture were considered the main sources which contribute to resilience. The theme of Sumud and Islamic cultures consists of Sumud, and Islamic culture, love of nursing and nursing values. The interview data led me to understand that Sumud and Islamic cultures influence or shape the other sources of resilience. The following sections present an analysis of each theme in more detail.

### 5.3.1 Theme 1 sub-theme 1: Sumud culture (الصمود)

Sumud culture was discussed during the interview as a basic resource which contributed to the resilience of CMHNs in their work and life. As in the following extract, one of the nurses defined Sumud in his own words when I asked him 'what does Sumud mean to you? He seemed surprised when I asked him this question, because he knew that I am Palestinian and it is a renowned and well-known concept for the native people.

*M: The Sumud of the Palestinian people*

*Mohammad: But what does it mean?*

*M: The Sumud of!!*

*Mohammad: But what does this mean? Assume that I'm a foreigner, and I want to know the meaning of this term.*

*M: It means facing the external challenges whether at the personal or at the general level; and being steadfast all the time. Another thing, one should decide on and commit to a plan in order to succeed and achieve the required aims.*

*[M.A. Interview, NGO nurse]*

Sumud is a transferable source of resilience in their workplaces and life in general. In the extended quotes below, one of the nurses described her experience of Sumud in her workplace and life. She had two choices in the community mental health centre either to stay or to leave. She chose to stay and face challenges in order to prove herself. She talked about the patriotic role of nursing within the Sumud culture. She felt her nursing care would enable other civilians to remain steadfast in their homeland and not to flee or breakdown.

*Mohammad: Do you feel that "Sumud" in Palestine affects you whether in your home or in your work?*

*F: Of course, we hold steady despite the Israeli occupation, difficulties, homelessness, deprivation because we believe that this land is ours and we have the right to live here similarly, in work with all pressures, tiredness, concerns, and infringements of our rights and dignities, we stay and tolerate since we have to prove ourselves. Though we are talking about two different situations, they have the same content.*

*Mohammad: They have the same meaning?*

*F: The same meaning*

*Mohammad: What are the things that helped you to tolerate all the pressures both in work and at home?*

*F: May be my faith that I am on the right path concerning the issue I am involved in...*

*Mohammad: Oh! Ok.*

*F: So we are suffering a lot in the mental health centre. I am trying as much as possible to prove my competence, and to learn new things through whatever courses are available then I put my trust in Allah.*

*Mohammad: You have said that working here can be considered as a patriotic role. Could you explain how you can represent your nation by working here?*

*F: If you work in any institution this--*

*Mohammad: Go on.*

*F: If one works honestly and correctly, and provides services for people, he is considered as a patriot. For example, if a teacher teaches his students morals, good values, we consider him patriotic. Similarly, if I do my work excellently, and serve poor ignored people honestly, I have served my homeland at the same time.*

*Mohammad: do you think that your presence in the centre is important and helps people?*

*F: yeaaaaaaa, sure (laughing)*

*[F.N. Interview, Governmental centre]*

The example of shared backgrounds and experiences increased the sense of cohesiveness among the people and created a culture of unity. In the extract below we were talking about the collective suffering of the people. One of the nurses said that all nurses were suffering and he realised he might be better off than some other people in his surroundings.

*Mohammad: Do you feel that when other people suffer like you that you are not the only nurse that suffers in your town?*

*M: Yes. All nurses suffer. When you feel you are not alone, you may make comparisons with others and so you may find that your conditions are better than others.*

[M.B. T. Interview, Governmental centre]

As in the above extract, the nurses talked about the collective suffering of employees who worked in the nursing profession. These feelings motivated the interviewees to construct their own ways to survive. Nurses had shared difficulties and they faced similar challenges, which helped them to create resilient responses as a group. Most of the challenges and difficulties were common issues and were not specific toward any of them in particular. For example, in the quotes below, one of the female interviewees draws attention to her story of Sumud in life in general. She narrated her story when we talked about challenges among Palestinians and how people responded at the start of their suffering when first occupied.

*F: My father and grandfather were rich and they had big farms. The Israelis dismissed us by force and controlled all what we had owned, our life was turned upside down...Then, the story of suffering and Sumud started, we lived in one of the refugee camps in a tent.....the life was different and very difficult, there was no electricity, no sewage system and no clean water... I remember I studied nursing by candle light and my primary school was a big tent. Refugees' survival was based on United Nations food aids; poverty, feeling of oppression and daily suffering were the shared common things. Then, we bounced back, like someone who gets back on his feet, from the destruction; my parents denied themselves food sometimes to save money and allow me to study nursing. I was the hope of my family, I finished my studies then I helped my family and we built a small house in the camp.... I am a single woman in my 60s who offered her life to my people in the camp and to support my parents and eleven brothers and sisters. I am not leaving my camp again in spite of everything; I have had many good opportunities to work outside the country but I am like a fish that would die if lived outside water. We hope to return to our original home and big farms one day.*

[F.T. Interview, Governmental centre]

As we see from the example above, the nurses had grown up within unstable conflict zones, which helped them learn how to create their own way of living in spite of

chronic adversities. The people might have limited control of the political situation but they crucially remained in control over their resilient responses. They perceived the occupation practices as a threat to their existence. They considered themselves as native people and the 'stranger' was trying to eject them from their homes. They developed their own way of surviving and as a consequence they became more attached to their homeland. The nurses pointed out that they struggled to protect themselves and not collapse or break down when confronted by occupation forces and practices. They built their ideology and coping strategies in the face of the life challenges. For example, they employed Sumud strategies when faced with chronic daily life hardship. This included the need to have extra patience or endurance and not to be defeated or leave their homeland. Sumud culture helped the nurses to create other sources of resilience. For example, Sumud culture motivated people to support each other during crises and strengthen their family or social relationships.

Sumud also revealed how abnormal events can become normal. As we see in the above mentioned story of Sumud, the life, including reading by candlelight and suffering, became part of the accepted daily routine. In the following extract, when talking about Palestinian Sumud with one of the nurses, he described how the abnormal things such as stress become regarded as normal after constant repetition.

*H: You become used to stress, stressors, and so you see that stressors are trivial and normal.*

*Mohammad: Abnormal but normal?*

*H: Abnormal turns into normal by repetition... The first time we were attacked was in 1948, then in 1967, followed by 1988, and then in 2000, a group of crises.*

*[H.H. Interview, Governmental centre]*

The occupation practices and conflicts may be viewed as abnormal for people who live in other countries. However, Palestine has a long history of occupation and conflicts, which have been experienced by many generations. The participants' parents and

grandparents had experienced similar difficulties and they, in turn, taught their families how to survive. The chronic challenges taught them to treat the chronic daily life adversities as “normal” life styles.

From the above discussion, Sumud culture was a main source of resilience which was embedded in their political and cultural context. Sumud included their political awareness of the chronic conflict, and their sense of collective suffering. Sumud is displayed in the nurses’ feelings of collective suffering and how they converted the abnormal to normal by the repetition of experiences. Nurses also applied Sumud culture in work and life in general in order to face challenges.

### **5.3.2 Theme 1 sub-theme 2: Islamic culture**

The Islamic culture was the basic source which contributed to interviewees’ resilience in work and life. In the next quotes one of the participants talked about his belief in rewards in the afterlife. He also described the rewards if the individual remains steadfast in the Holy land (Palestine) in spite of the significant challenges.

*Ab: From a religious perspective, religion is the most important aspect in our lives. You, for example, why are you living in this life? Allah says that He has not created man and jinn for anything else except to worship Him. This means that the most important thing in this life is worshipping Allah. All things in life are created to serve humankind. We have to do good things. The Prophet Muhammad (PBUH) tells you that our land (Palestine) is the land of steadfastness. Therefore, you have the heavenly reward of steadfastness in this land. You have to work hard and struggle so that you would receive the heavenly rewards. Nevertheless, many people do not look at this from this perspective. They usually say, "What am I doing in this country? How can I live with a salary of 2,000 NIS? I must emigrate to Mexico ...."*

*[Ab. J. Interview, Government centre]*

Practising Islamic faith in the daily life helps nurses to face challenges, gain success in life, and achieve their goals. In the quotes below, the NGO nurse reported that all his success is due to Allah. He used the term 'password' which means the secret of his

success. He believes that Allah helped him to overcome challenges whether at home or in the workplace. He also believed that his mother's supplications for him helped to find a job.

*Mohammad: What else helped you in your life as a young man lives alone at home, then studying, getting married and now working and you succeeding in your job, so that you were able to build a home and marry. We all know that there are young men who could not, excuse me, have achieved what you did. So what are the sources that helped you to overcome the challenges? And could you tell us the secrets behind your success?*

*B: Password: Allah Lord of the worlds and my mom's prayers. (Both laughed during the interview).*

*Mohammad: How could Allah be a reason for your success?*

*B: Yes, it was my mother's prayers; when I graduated I neither expected to find job, nor to work in a mental health centre. From the beginning, I suggested they give this job to a male nurse who has a diploma or to a female nurse because both were poor, or even to any other nurse who has a BA; however they insisted I took the job.*

*Mohammad: You didn't answer my question?*

*M: You can say that Allah in some way helped me...*

*[M.A. Interview, NGO nurse]*

As an insider researcher I recognise in the above extract the underlying principle that people have to satisfy their parents in order to worship Allah properly. Allah usually accepts the supplication of their parents if they asked Allah to support and help their children. The participants felt that belief in acceptance encouraged them to restructure the perception of a crisis. In the extract below we were talking about the importance of faith in relieving stress. One of the interviewees described the importance of following

instructions in his religion in order to respond to anxiety; performing ablution or praying offered a means of finding calm.

*Ab: Something makes you irritated. What makes you agitated?*

*Mohammad: For example, any reason. What do you do when you are irritated?*

*Ab: From a religious perspective, if you become irritated, you must sit down if you are standing up. The Prophet Muhammad (PBUH) says this, if you are standing up, you must sit down.*

*Mohammad: This means that you do this when you are agitated or irritated?*

*Ab: Of course, one hundred percent. For example, go and wash your hands and face, seek refuge from Satan, there is not anyone who would not ever be agitated. You see, a person is agitated a little, and then he calms down.*

*[Ab. J. Interview, Government centre]*

The above discussion shows how the Islamic faith helped the participants to survive in their workplaces and cope within the overwhelming, challenging context. Muslim belief was a main source of resilience that was deeply embedded in their culture. For example, they talked about their great rewards from Allah if they tolerate, remain steadfast and do good deeds in the Holy land (Palestine). They also mentioned aspects of religious practice, such as praying and ablutions, helped them to feel happy and relaxed when faced with challenges. Strong faith and religious practices helped the nurses to create other sources of resilience. The entire sample had a shared background in the Islamic faith and none of the participants was agnostic or atheist. I found there was a consensus between interviewees that the Islamic religion played a crucial role in their resiliency and Sumud (steadfastness).

### **5.3.3 Theme 1 sub-theme 3: Love of nursing and nursing values**

The love of the nursing profession within the Sumud and Islamic cultures was a source which contributed to participants' resilience. The below fragment of his story describes

these meanings for one of the nurses. We were talking about things that helped him to remain in the nursing field in spite of the significant challenges he was facing.

*M: I love my profession although I knew nothing until I took my job and loved it. You feel that you are helping a person who needs this profession and needs you and your service. In this case, you feel happy. I call it happiness because it is really happiness when you feel that you have saved a person, in spite of the obstacles that face the nurse while carrying out their work with psychiatric patients.*

*[M.B. T. Interview, Government centre]*

As discussed above, there was consensus between the nurses that love of the nursing profession was a source of happiness and enjoyment. In the example below, one of the nurses described how her love for nursing helped her to cope with challenges.

*Mohammad: Yes. Could you mention other factors that helped you?*

*F: Plainly, before I decided to study mental health nursing, I didn't want to work in this field. However, when I worked and dealt with the mentally ill, I really liked this work from the depths of my heart since you feel that you are in another world. I mean that you should discover what is hidden in a patients' personality, and find what has disappeared, while the normal patient if he is wounded, you only dress his wound.*

*Mohammad: Yes.*

*F: I mean that you can deal with the mentally ill, for example --- and I liked this, but I need somebody to support me.*

*Mohammad: You want to say that you liked this?*

*F: Definitely yes.*

*Mohammad: Despite all these pressures, do you still want to deal with these kinds of patients?*

*F: Definitely, the mentally ill are simple; you can easily deal with them. They quickly understand and get used to you. Furthermore, whatever you do for them, they feel happy and satisfied. For your information, dealing with those people is easier than dealing with normal patients who don't have mental problems. And we should take into our consideration that the mentally ill are neglected by their society and their condition is very hard, therefore we have to provide assistance for them.*

*Mohammad: Do you think that faith affects your relation with patients--?*

*F: Yes, of course. Because I believe in Allah, I should deal with the patient as a human being who has emotions and dignity, I should be merciful and honest when treating him and prescribing medicine for him. I also shouldn't mock him; sometimes I deal with patients who don't know the meaning of cleanliness, but I never complain because I know this is out of their control. In brief, I should deal with the mentally ill without hurting his feelings, or making him feel that he is neglected or has no role in this life. We should bear in our mind that one day maybe, we may become like them and need someone to treat us mercifully.*

*[F.N. Interview, Governmental centre]*

Most of the interviewees remained positive about the profession in spite of its accompanying difficulties and challenges. For example, the nurses described how their role as nurses gave them increasing responsibilities toward their communities. Their love of the job helped them to cope with these additional responsibilities. Many nurses highlighted that the profession had called them and they saw it as a vocation. They felt if nobody worked in the nursing field then who would look after needy people. They described the clients as neglected and questioned if no one accepted to work with them who would do this job. The system of morals and values in their model of nursing care contributed to the CMHNS' resilience. One of the nurses described what helped him stay dedicated to working in the nursing field in spite of the challenges. This was his understanding of the philosophy of care, which is derived from his Islamic culture.

*Mohammad: Could you tell me what makes you dedicated in your job?*

*Ab: First as a person ---?*

*Mohammad: How can a person be dedicated?*

*Ab: Allah asks that when a person performs their job, they should do it properly. If you are pious in religion, you have consideration for others. You would not do them a disservice. Right.*

*Ab: This work is voluntary for the sake of Allah. A person comes to you so that you would give him an injection, even though they have nothing to give you in return?*

*Mohammad: Does this annoy or relieve you?*

*Ab: Why does it have to annoy me? It relieves me.*

*Mohammad: Why?*

*Ab: Because, it is a good thing when you help a person. You feel pleased, not annoyed.*

*Ab: When a person believes in Allah, he has to be tolerant. You will not suffer from anything unless Allah destines it. Of course, a person has to be patient. If he is patient, he receives his reward from Allah.*

*Ab: If a person has a strong faith in Allah. This is the most important thing. Faith in Allah is the most important thing because it relieves your pain.*

*[Ab. J. Interview, Government centre]*

As mentioned above, the moral system within the Islamic culture motivated interviewees to be tolerant and feel satisfied in nursing. They should receive salaries but when none were available, their consciences motivated them to keep going and to manage the challenges. They understood that the service users came to receive care and they might have no idea about the work pressures. The participants tried to treat the service users in a kind way as much as they possible. Their love of nursing, as a way of

offering care and generosity, increased their tolerance to work voluntarily. Therefore, the philosophy of nursing care that derived from their cultural historical and religious context was a source of their resilience. The model or philosophy of nursing care within the cultural context was discussed in the introductory chapter (see development of mental health care in the Arabic region).

From the above discussion, love of nursing helped the nurses to survive in the workplaces and cope within the overwhelming and challenging context. Philosophy of nursing care among Muslims was a source of resilience which was embedded in their religion and Sumud culture. For example, they talked about their support of the local community through nursing care. This was an example of cohesiveness and Sumud towards the local community in a collective way.

## **5.4 Summary**

The Sumud and Islamic cultures, derived from their religious, political, and historical context among nurses was a vital source of resilience. There were many Islamic instructions that motivated the nurses to be devoted to their profession and their homeland and to be productive. According to the Islamic faith, the human being consists of parts from psychology, (Nafs) heart, (Qalb) and soul (Rouh); all of these should work in harmony to fulfil needs and cope with hardships. This means many sources related to their way of thinking and belief systems enable the CMHNs to survive and cope with work and life challenges. For instance, the nurses gave meaning to their suffering and challenges. They used the positive mindful resources of their culture as a stock or shelter to help adapt to the challenges. Families and school taught the Islamic rituals, which contained many preparations to build up compassion and good morals on the personal and social level. Consequently, the Sumud and Islamic cultures influenced or shaped the other sources or themes of resilience which will be discussed in the following sections.

## 5.5 Theme 2: Supportive Relationships

The supportive relationship is one of the sources of resilience in work and life in general. This supportive relationship includes the community, family, colleagues and local managers. The following sections present an analysis of each sub theme in detail.

### 5.5.1 Theme 2 sub-theme 1: Community support

The local community support was a source which contributed to resilience among the participants especially during difficult times. This local community usually shared in each other's sorrows and offered support during dark times or times of adversity. For instance, one of the nurses spoke about his story when his father was in hospital and had open-heart surgery.

*Mohammad: Have you ever been exposed to a calamity in your life?*

*M: Sure, when my brother \*\*\*\* (name of his brother) married, my father suffered a stroke.*

*Mohammad: Is he ok now? When that happened, was he here or outside Palestine?*

*M: He was in \*\*\*\* (name of Gulf country), and he came here to undergo open-heart surgery.*

*Mohammad: Oh, go on*

*M: It was difficult times...*

*Mohammad: How did you manage this situation?*

*M: In regards to money, I got my salary with all my back pay all at once (around 8000 INS= about 1300 pounds). With my work, I fixed and modified the work shifts, and I did nights and afternoon shifts on the rota. I talked to the Nursing director that instead of working on two nights and afternoons, I wanted to spend more time with my dad since he was very sick; he had diarrhoea? ...*

*Mohammad: Are there other things that helped you other than salary and work coordination?*

*M: My cousins, relatives and friend, they were near my father whenever I visited him.*

*Mohammad: Did you conduct it in (the operation of his father, name of distant hospital) \*\*\*\*.*

*M: Yes, all of them were there.*

*Mohammad: What else?*

*M: My colleagues also helped me a lot; they took me to their accommodation to have some rest. These are the supports that made me feel the existence of people (neighbours, kinships, sisters) who are standing by us...*

*Mohammad: Do you mean that it played a role in overcoming the challenges that you faced, or not?*

*M: The small society or my family helped me...there needs to be a space here*

*Mohammad: Why don't you go abroad to study MSc?*

*M: Because I love my home; my nationalism is to Palestine. Though I lived a long period in \*\*\* (name of Gulf country) I feel the difference.*

*Mohammad: Why did you come back to Palestine?*

*M: Because all my relatives and friends are here. When I went anywhere I met them and talked. Even if I went to the café, I can greet and talk to a person I haven't met before; we can, for example, watch TV, drink coffee, and discuss matters without knowing each other's names. Whereas abroad you can't talk to a person you don't know. And your relationships would be superficial with others since you are thinking maybe different from that person so you should be careful in your discussions.*

*Mohammad: If you got an attractive offer abroad, would you leave Palestine?*

*M: I don't think so.*

*Mohammad: Why?*

*M: Because I belong to this country, I have the ability to introduce something to my people --- and they also will reward me in some way. I have never seen a person trying to limit the possibilities of another.*

*Mohammad: In general, do you think that the Palestinian society supported you throughout your life?*

*M: So far, yes.*

*Mohammad: Does this thing exist in other societies?*

*M: No*

*[M.A. Interview, NGO nurse]*

As we see above the nurse reported how his neighbours, friends and close relatives stood by him. They visited his father daily in the hospital, which was located in another city, in spite of transportation difficulties. Another example: many nurses talked about the intensive support they received when faced with the loss of one of their family members. As the following extract describes, one of the nurses mentioned family, friends, relatives, and local community as social support.

*H: Family and friends support you most.*

*...*

*H: Look, the community and the nature of relations in the community among relatives and non-relatives always stand with you in days of misfortunes. They would not leave you alone in your days of grieving.*

*[H.H. Interview, Governmental centre]*

The nurses explained that they had received intensive and remarkable support from close relatives and the local community. The participants highlighted that the people around them looked after their needs and offered care to them during their period of mourning. The social system within the community aided the participants to recover after a crisis and minimised the risk of their collapse. This included the support and consideration from their friends, relatives, neighbours, and the local society. One of the interviewees, in the following extract, mentioned that he felt a sense of responsibility toward the local people but also how carrying out these responsibilities helped relieve some psychological pressure.

*Ah: I personally believe that I have to help people. This gives me a kind of relief ...  
relieves me psychologically.*

*Mohammad: Why?*

*Ah: I feel that I have a responsibility towards the community where I live.*

*[Ah. J. Interview, Government centre]*

The society's supportive networks shown to the nursing profession enabled the participants to survive or cope with work and life challenges. The sense of cohesiveness within the community was considered a shielding source for the interviewees. As already discussed, the entire sample indicated that they worked voluntarily after their official duty hours. Their work, when off duty, was to gain rewards from Allah. This work was considered also a national responsibility within the culture of Sumud and collective community cohesiveness (see the Sumud and Islamic cultures). Therefore, the participants felt that their commitment to their health role and to their social responsibilities reflected the respect shown towards them by the local community. Some of the nurses reported that social pressure could play a motivating role. For example, a good reputation and appreciation, by word of mouth, within the society, regarding their performance, motivated them to keep going and treat service users

kindly. They feared being given a bad reputation by the local society, which would have affected their social status in a negative way within their local surroundings. Their care services, during the times of war especially, with injured people, increased the recognition of their roles in the local society. The encouragement of their local society was considered a social reward and motivator.

From the above discussion, the support and encouragement of the local society was considered a source of resilience. The nurses offer care to their local community and the local community supported them in facing challenges. It seems that there is a mutual or interdependent relationship and each side (nurses and community) offers support to one another. This was an example of cohesiveness and Sumud of the local community in a collective way. The sense of collective suffering increased the unity and emotional ties in the local community and motivated the people to support each other. As insider researcher, I think the Islamic culture also motivated the people to look after each other especially during hard times, such as bombardments by the Israelis. This contrast with those aspects of affiliations, nepotism, and stigma toward mental health nursing and mental illness inside their society were considered as challenges (see chapter four, societal challenges theme).

### **5.5.2 Theme 2 sub-theme 2: Family support**

All participants described how the family was like an “incubator” of resilience among the nurses. In the following extract, I asked one of the interviewees to mention things that helped him to overcome the challenges. He described the significance of family in helping him to conquer the life challenges successfully.

*Mohammad: You overcame successfully the challenges - worked, built a house and married --- what are the sources that helped you?*

*M: Primarily my mother, then my brother\*\*\*\* (name of his brother) and dad, those are the most important influences.*

*Mohammad: Who else*

*M: That is it.*

*Mohammad: Is there another thing in your life except your family?*

*M: No, just my family. In school and university, I was taking the lessons and leaving; there was no real influence of teachers on me. When I faced a problem, I immediately went to my mother and dad.*

*[M.A. Interview, NGO nurse]*

The data led me to understand that there are remarkable emotional ties, shared values and belief systems, which help to support the individuals within their families. One of the nurses reported that she received support and love from her family and her seven married brothers that lived next to her home. She stated that her loving, surrounding close relatives and family supported her when she needed guidance or emotional support. In the following quotation, I was talking with one of the interviewees about what helped him to face challenges. He described the significance of the social life of the family in helping to deal or cope with challenges or difficulties.

*M: This depends on the presence of a family. I live with a very large family. My family consists of my children, my brothers, their children, in addition to my sister's children and me. We are not a small family that lives in an apartment. You know, the interrelated social life of a family helps in dealing with the most difficult problems and circumstances.*

*[M.B. Interview, Governmental centre]*

Most of the participants were married and their partners and children supported them to remain strong when facing challenges, as in the following extract of one of the female nurses who talked about her children and husband. She was concerned how to look after her children and teach them good morals.

*F: In order to protect my children, I come to them unexpectedly while they are watching TV or sitting on the computer to make sure they do not watch*

*pornographic sites. In fact, I do this not because I don't trust my children, but because my experience in life has taught me that anything may happen...All praise is due to Allah; my children are smart and polite, I hope they grow up to complete their education, get certificates, and become effective people in society. I'm trying to help them avoid the problems that I once faced, and to help them in planning their future lives. I think that when my children complete their education, my responsibilities and obligations will be lessened; I mean that when\*\*\*\* (her son) graduates from the university, he will have his own job and salary, and our house will be ours...*

*Mohammad: In your opinion, what makes people keep hoping despite all the pressures they face?*

*F: For example, my husband\*\*\*\* (his name) has never refused any of my demands; such as participating in courses, studying, or doing anything else. When I was studying BA, I didn't take care of my house as should be; he was understanding, though he was blaming me from time to time.*

*Mohammad: Yes.*

*F: When I was studying, my husband asked the children to stay quiet in order to offer a quiet atmosphere for studying.*

*Mohammad: Do you think that the same resources (things/ persons) that supported you in the work do the same thing in the home or the vice versa?*

*F: Yes you find people who support you both in the work and in the house such as, my husband.*

*[F.N. Interview, Governmental centre]*

As mentioned in the above quotes, female nurses reported that marriage helped them to feel protected and more emotionally stable in the main. There were other meanings and cultural values to increase emotional cohesiveness inside families and local

communities. For example, religious beliefs might motivate parents that they may enter paradise on the Day of Judgment if they have done their best to look after and teach their children good morals. These examples encouraged the family to look after their members and shield them during times of hardship. However, the family support system is also embedded within the cultural context. My background as an insider researcher who grew up in this culture enabled me to give some explanations or interpretations for the above findings. I think parents also had some cultural motivators to teach their children how to survive and thrive. For example, good children would be a source of pride to their parents in the local community. There was very little provision of nursing homes and the children usually looked after their parents when they needed care in old age. This might motivate parents to do their best to teach their children good values and to form strong emotional ties.

From the above discussion, it is clear the family helped the participants to survive in the workplaces and cope within the overwhelming and challenging context. The interviewees' culture related to family relationships increased the emotional ties and cohesiveness. For example, they talked about their rewards from Allah if they foster their children in good ways and to become effective in society. The children also will be rewarded if they look after their parents and meet their needs and expectations as much as possible. They also used family support in order to remain steadfast on the land where there was little or no effective governmental support. It seems that they created strong family ties to compensate for the failure of government in meeting responsibilities.

### **5.5.3 Theme 2 sub-theme 3: Colleagues and local manager's support**

Most of the nurses talked about their colleagues and some of their managers as a source of resilience. Nurses had a sense of solidarity with each other in the face of shared challenges inside and outside the workplaces, as the following field note extract demonstrates.

*During my visit to one of the governmental centres to conduct an interview with the nurse, I observed one of the nurses laughing with her male colleagues most of the*

*time. They made jokes with the nurse, the work atmosphere seemed supportive, and the team close knit. I had a photograph taken with the team; the male team member stood close to the female nurse with a slight physical touch. This was uncommon in the surrounding culture but it showed that they had strong ties together and are supportive of one another. The team also described that they had worked together for many years and faced together hard times; they said "we are like a small family in the centre".*

*[Field notes, Governmental centre]*

As we see in the above extract, the mental health team described the team members as a family, which meant they supported each other like a family who faces collective suffering. This extract from the field notes illustrates the work environment and the good relationship between the (N.Q.) nurse and the mental health team. The same observed nurse (N.Q.) described during the interview that the mental health team and her colleagues helped her to deal with work pressure or problems.

*Mohammad: What helps you in adapting to stress, taking into account that you have been in your job for 38 years?*

*N: (Laughs)*

*Mohammad: (Laughs)*

*N: The staff team at the department.*

*Mohammad: Yes.*

*N: The members of the staff team are good and respectful. If any problem occurs, it is solved internally.*

*Mohammad: Yes.*

*N: That is to say that there is cooperation among the members of the staff team. We all help each other if there is work pressure. However, that is not the case with our supervisors.*

*[N.Q. Interview, Governmental centre]*

Nurses built an informal supportive network inside the workplaces to compensate for the gaps in formal staff coaching or mentorship. Some of the nurses used the collective term we [as nurses or team] which reflected the sense of solidarity with one another. Participants usually expressed their negative emotions to each other and exchanged their personal experiences due to the absence of formal and regular meetings or supervision. A few of the CMHNS mentioned that there were interpersonal tensions with other health teams due to competition for available resources or power and role conflicts sometimes. However, all of the nurses reported that they had at least one colleague (nurse or co-worker) who offered support and guidance.

As we see in the above extract, some of the managers were perceived as unsupportive or some of them caused challenges as was discussed in the previous chapter. However, some of the managers were supportive to the nurses. For example, some managers supported the nurse's opinions and tried to meet their needs as much as they could. Some managers also showed sympathy towards the nurses and helped them to gain their rights inside the organisation. Nursing managers sometimes were able to recognise the daily difficulties of nursing roles. One of the participants reported how the nursing supervisor helped him to amend the duty rota in order that he could look after his sick father (see the first extract in community support subtheme). Other participants indicated that the administrator tried to facilitate their mission, allow them flexibility to meet their daily tasks. In the following extract, (F.N.) described how the nursing director struggled or argued within the organisation for her to attend a training course. The nursing managers helped her to gain confidence, and supported her during difficult times. She also mentioned her colleagues who were supportive apart from the head of the department.

*F: And what really encouraged and gave me confidence is my director in the nursing department; she supported and helped me in my difficult times. For instance, if I wanted badly to register on a course and that did not happen, she did everything in order to help me obtain what I want because she believes that is my right. Therefore, you feel that there are people who are supporting you a little bit. Concerning my colleagues, they helped me a little, but there was some kind of flexibility, which helped me to adapt. In a few words, they all were supporters excluding the head of our department; she was choosy and unfathomable. When a problem happened between me and the head of the unit, I felt that the psychiatrist stood on my side. He defended me in front of the general director of the Mental Health in the Ministry of Health. He had said this was oppression and should not happen. He said that this nurse (me) was a hard worker and active. This, definitely, influenced me positively to adapt.*

*[F.N. Interview, Governmental centre]*

From the above discussion, workplace colleagues and some of the managers were sources of resilience and support, helping the participants to cope with the challenging context. The collective way of thinking related to relationships, increased the emotional ties and cohesiveness with colleagues and some of the managers.

## **5.6 Summary**

The collected data revealed that the networks of supportive relationships played a significant role in the nurses' resilience. They seek the support of relationships such as communities, families, colleagues and some managers. This social support system, which is consistent with a social ecological source approach to resilience, is embedded in their Sumud cultural context. For example, the participants reported that there was a lack of formal support or guidance from their employer and, hence, they created these informal supportive networks. The strong ties and cohesiveness were common in the society due to their sense of collective suffering. The collective suffering for Palestinians increased their sense of unity.

The Islamic culture also motivated the participants to increase the ties and cohesiveness in the community. For example, when nurses look after their family, friends, colleagues and society as a whole, they believe they will be rewarded in the afterlife. This encouraged the participants to create supportive networks inside and outside the work places. These networks were created through time and experience without effective support from government. The support from these relationship networks become a social responsibility or a traditional rule in the local culture.

## **5.7 Theme 3: Making use of available resources**

There was consensus between the participants that making use of the available resources were a source of resilience. There are several sub themes related to using the available resources such as education, rewards, and the available infrastructure or facilities. The nurses reported that they use these limited resources in order to cope with challenges. The following sections present an analysis of each sub theme in detail.

### **5.7.1 Theme 3 sub-theme 1: Education**

There was consensus between the participants that education and training was a source which contributed to resilience. Education and training helped them to cope with work and life challenges. In the following extract one of the interviewees explains that his willingness to learn has political dimensions. We were talking about education as a source of resilience and he found his motivation within the surrounding Sumud culture.

*H: It will be easier for the occupation to control illiterate people than educated people...*

*Mohammad: ...do you mean if you have a disaster, you expect that you can deal with the disaster better if you know how?*

*H: Of course, no doubt. This is why one has to develop himself academically and even culturally. Until now, I have to read a book every month either fiction or non-*

*fiction; even if I have not finished it, I have to change it and buy another book. I now read Freud.*

*[H.H. Interview, Governmental centre]*

There was a distinct lack of training due to national, political, and professional pressures (see chapter four, lack of funding subtheme – lack of resources challenge), thus it was unsurprising that nurses invested in any learning opportunity to try and gain knowledge. Even the very limited education and training they received in the mental health field helped them to be resilient. The following extract demonstrates a close link between national identity and education where one of the nurses mentions that he felt he had to prove himself and show his Palestinian identity when he was in schools in one of the Gulf countries.

*M: Yes, I was a foreigner, and stood out in my class, so I had to be always the first because I was a foreigner and had to prove myself.*

*Mohammad: Why?*

*M: To make people understand and realise that I am Palestinian and proud of it.*

*[M.A. Interview, NGO nurse]*

Most of the nurses believed in the importance of learning as a tool to overcome difficulties and survive in a highly stressful context of a conflict which threatened their existence, culture and national identity. The data led me to understand that participants used education as a defence against the occupation practices. The participants believed that the right to education had been targeted and become part of the conflict.

Restrictions on students in gaining access to education sectors created the opposite effect and strengthened the willingness to learn among Palestinian people. I think the strategy of the closing of roads to schools and universities had brought education into the conflict. This motivated the nurses to learn and struggle and to resist the oppression of their identities and their rights as human beings. Four of the participants expressed their desires to continue to a master degree in the mental health field but they were

unable to continue their education due to imposed movement restrictions on roads (see chapter four, lack of safety and freedom challenge), and also financial problems.

The nurses showed willingness to learn for professional reasons. The extract below described the conversation with one of the nurses about her Sumud in the workplaces. She mentioned that she feels she has to prove herself by learning new skills continuously.

*F: The same thing in regards to my work, I couldn't accept to be neglected, to be deprived of my rights, to have my role as a mental health nurse disrespected because I have an important role whether in the clinic or in the centre. I should, by all means, fight to prove my abilities and myself.*

*Mohammad: You have already mentioned that you should fight in order to prove yourself, as a mental health nurse how do you understand the idea of fighting? How will you fight?*

*F: I did not mean that I am going to carry a sword and go into the war.*

*Mohammad: (both were laughing) No I mean--*

*F: First of all, I always try to participate in any activity, any meeting or course. Furthermore, I try to see how the psychiatrist diagnoses mental illness, how he treats them, how he deals with them. I also sit with the social worker and the psychologist to discuss certain matters ----. Moreover, I endeavour to learn everything new which appears.*

*[F.N. Interview, Governmental centre]*

The nurses expressed the importance of proving their abilities within their culture which undervalued the nursing profession. They needed to feel educated to seek recognition and gain respect inside their workplaces and in the local community (see chapter four, professional status of nursing challenge). There were common misunderstandings of nurses' capabilities that motivated the nurses to learn new skills

and prove themselves especially in front of other, more dominating, health professionals. Many of the health professionals treated the nursing profession as an under skilled job consequently, the nurses tried to prove the opposite. They tried to increase their control and power by gaining as much knowledge as they could.

Some of interviewees also indicated that some training courses helped them to handle their children when faced with their problems. The following extract describes the conversation with this nurse who mentioned that her work in the mental health field helped her to cope with challenges inside and outside the workplaces.

*F: I think that taking courses with (NGO institution), and working in the mental health clinic has helped me; I applied what I studied to my work... I learnt how to be patient, how to understand and feel with people, especially the mentally ill...*

*F: ...So I told my young daughter if you do this-- I will punish you, sometimes I swear I will punish them and at the end I do nothing. As a result I decided to identify things that if they do, they will be punished (I learnt this from the course about treating--How to deal with children at home) for example, if they do-- They will be deprived of the computer or from visiting their grand-mother, and I behave strictly with them. At the end I felt that my children's behaviours changed.*

*[F.N. Interview, Governmental centre]*

Interviewees had received brief training and insufficient mental health modules during their undergraduate period or after their graduation. Nevertheless, this increased their capability to handle challenges. For example, many of the participants pointed out that their clinical training, during their undergraduate period, especially in the psychiatric hospital, was useful. It facilitated their mission later on to deal with psychiatric patients who displayed challenging symptoms. Their past training helped them to understand the illnesses and become more effective when dealing with service users. They also learned how to be good listeners and how to control their negative emotions inside and outside the workplaces.

From the above discussion it was obvious that education and learning is a crucial source of resilience for Palestinian nurses' within their cultural context. Education is used as a resource for empowerment both empowering the nation to resist the more powerful occupier and empowering nurses to resist being dominated by more powerful professions (where medicine is seen as superior). Participants used every opportunity available but these were limited due to national, political, and professional pressures. The Sumud culture motivated participants to learn and be educated to the best of their ability. The Islamic culture of the participants also contains instructions to motivate them to learn because they will be rewarded in the afterlife if they do so - a sub-theme that will be explored further in the next section.

### **5.7.2 Theme 3 sub-theme 2: Rewards**

The limited financial (wages) and non-financial rewards were a source of resilience among the participants. The non-financial rewards included feelings of productivity, warm gratitude from service users, and afterlife rewards. The following extract presents a conversation with one of the nurses who described her family demands. We were talking about the necessity of financial rewards to meet her dependants' needs. She described how her feelings of acceptance and the hope for a better future for her children helped her and her husband to tolerate the demands of life.

*F: My husband and I started from scratch; we spent our lives settling debts. We took loans...*

*F: ... You know how much the kids' needs are. They always try to imitate their peers; if someone buys a laptop or a computer, learns driving, or goes on a trip, they wanted to do the same. As a result, this caused pressures on us, and obliged us to deprive ourselves of certain things in order to meet their requirements. We want them to live as others, and to avoid for them the feeling of inferiority. This also has an effect on us.*

*[F.N. Interview, Governmental centre]*

There were little or no effective systems to protect people from poverty or hunger, which motivated the nurses to accept even lower wages. Their need to survive and exist motivated them to respond in a resilient way to cope with the occupational and life challenges. The interviewees might have limited choices but all of them had financial responsibilities or demands. There was a significant level of unemployment and people faced economic hardships inside the occupied territories. All the male participants worked in two jobs or more to meet the basic needs of their families. The entire sample had multiple financial responsibilities; for example, each participant had more than one dependant within their close families and all the male nurses were married. There were two single females but they also helped their families or relatives to survive. The employees tolerated the work pressures in order to be eligible for retirement and at least to have some source of income. They had limited choices but it was better than no income at all and then facing hunger or severe poverty. Therefore, within this challenging context, working as a community mental health nurse was considered a resource for survival, even when the financial rewards were minimal. (See the first quote earlier in community support subtheme when salary helped the nurse to overcome his father sickness).

The interviewees' feelings also of being productive were a reward and source of CMHNS' resilience. In the extended quotes, we were talking about why the nurse prefers to deal with additional challenges at work. She could stay at home rather than face significant challenges in her demanding job. She illustrates the positive feelings gained by working.

*Mohammad: What are the things that helped you to cope with all this?*

*F: When I see that we, and people in general, have the same problems, concerns, work pressures, and political divisions, and that I'm not the only one who is suffering; then I think I should live and adapt as people do. In other words, your problem becomes simple if compared with others' problems; as the proverb says "problem shared is a problem halved".*

*Mohammad: You mean that when one compares his condition with others; he feels--*

*F: Yes, he feels--for me keeping working with all its disadvantages and pressures, is better than staying in the house all the time. Since when you work, you feel that you still are an effective person, you can go, do whatever you want, and know what is going on in this world; you feel that you are in another world, you have identity and make a mark in it. I think that staying in the house without working will drive me crazy because I am young and could achieve more and more.*

*[F.N. Interview, Governmental centre]*

As discussed above, the female interviewee talked about work as a strategy of distraction which helped her to distance and distract herself from personal problems. The different activities inside the centre made the environment more interesting and broke the routine; it also encouraged her feelings of acceptance of the work and its challenges. The sense of feeling productive within their society motivated nurses to keep going. Most of the participants felt happy when they achieved something positive within a situation where there was a lack of hope and the environment was challenging. The high percentage of unemployment, within a situation of chronic conflict and lack of recreational activities, made nurses determined to make a positive difference. Their feeling of making a positive difference enabled them to face stressors and to maintain their sense of hope. Because of this most of the female nurses preferred to work instead of staying at home and looking after their children. The work was more interesting, felt more rewarding and offered better choices.

The female participants played an important role in protecting their families from severe poverty and hunger. Most of the unemployed people were men who faced more movement restrictions than women in the main. This context motivated female nurses to help their families avoid poverty or hunger and hold constructive roles by working in nursing. This created new roles within the home and swapped the stereotypical roles within the family. For example, one of the nurses spoke about her family's experience now that her husband was in prison due to his political activities. He had been dismissed from his government job due to his politics and for seeking the freedom to be active. He had stayed at home without working for many years, previously he had

worked for a bus company (see challenges chapter, first quote in lack of safety and freedom subtheme). They had swapped the traditional roles inside the house; he had undertaken the house duties and she worked in nursing to earn an income. I think this helped increase the status; enhance the self-esteem and position of women inside their homes and within the local community.

The non-financial rewards such as faith of the participants helped them to keep going and manage their daily challenges. The extract below with one of the participants illustrates the belief in rewards from nursing work in the afterlife. He also mentioned the ethical point of view which motivated him to help needy people.

*Mohammad: How from a religious perspective? What does religion have to do with your work?*

*S: The reward that we receive from a religious perspective is everything. As well as, from an ethical point of view...*

*Mohammad: How? What does a reward have to do with work?*

*S: You do something over and above your work. However, you help the patient more and you are rewarded.*

*Mohammad: How? How are you rewarded?*

*S: (Laughs) how can I tell you? Helping the others is required of you. From an ethical perspective, you help the others. From a religious perspective, you receive a reward. You give extra help other than your duty. Then you are rewarded. I don't mean financially, but rather morally.*

*[S.J. Interview, Government centre]*

The rewards from Allah and the ethical point of view motivated the nurses to face challenges (see earlier love of nursing and nursing values subtheme). Due to stigma, most of the mentally ill clients were not cared for within the community and people sometimes were afraid to talk to them. Their families, in the main, were unable to deal

properly with the psychiatric symptoms. The nurses believed that the service users were neglected and even the smallest interventions made a difference to their lives. The interviewees reported that the service users' thanks or supplications came from their heart and this motivated them to keep going in the face of pressures. For example, the nurses felt uplifted when the patients asked their Allah (God) to take care of them and reward them in the afterlife. Most of the nurses felt it significant when the service users missed them during their holidays from work. Nurses felt gratified and rewarded when the service users' smiled or when they made even little differences in their patients' lives. One of the nurses described that the good relationship with service users gave her a sense of satisfaction which helped motivate her. In the next extract, one of the nurses talked about his feeling of being productive and his feeling of satisfaction when he helped his patients.

*Mohammad: Why do you feel relieved if patients get better?*

*H: It is a personal internal feeling of relief when a patient gets better. I feel positively satisfied that my work is fruitful.*

*[H.H. Interview, Governmental centre]*

The above discussion illustrates that financial (limited wages) and non- financial rewards helped the nurses to survive and cope within an overwhelming and challenging context. Non-financial rewards were a crucial source of resilience within their Islamic and Sumud cultural context. For example, they talked about feeling productive and how service users' appreciation or supplications helped them to keep going. The participants questioned above mentioned rewards embedded in their Islamic and Sumud cultures. However, there was consensus between the participants that there was a lack of rewards and motivators as discussed in the previous chapter.

### **5.7.3 Theme 3 sub-theme 3: Available infrastructure and facilities**

The majority of the nurses felt that even though the resources were very limited (see chapter four, lack of resources theme) nevertheless, what was available in the

workplace enabled the participants to cope better with the challenges of work. For example, in the following extract, one of the nurses mentions that before the new centre was built, all the mental health team worked in one room only. Now she has her own office and she is able to offer nursing care better than before. She became more able to work effectively in the new buildings. The improved facilities helped her to cope better with the daily occupational problems and difficulties.

*F: Sure I did. There were two rooms downstairs; one for the social worker and the psychologist, and the other for the psychiatrist and the nurse.*

*Mohammad: Yes.*

*F: In the doctor's room there were students of privilege, the psychologist or the social worker, who came from Annajah University; they have to discuss the cases of the mentally ill, sometimes with patients present. When we were giving the mentally ill an injection, we opened the filing cabinet in order to use the door as a curtain to cover the patient...*

*Mohammad: Yes.*

*F: In the downstairs, there was no specific place for me; I had only a chair to sit on. However, when we moved here (new building), I got a room with a desk and cabinet. Consequently, I can now treat the patient in private. And the most important thing is that I can give the mentally ill the injection confidentially; the patient will have privacy ... And feel comfortable.*

*[F.N. Interview, Governmental centre]*

During the field note observation, it was seen that there were female volunteers in the centre who helped the team to cope with heavy workloads and staff shortages. The use of these human or practical resources helped the nurses to manage the workload challenges.

*There was a female volunteer in the activity room; she had been working with the clients for three years. She has a social support background; she had been unemployed since graduating from university, and she was looking for work experience to improve her CV. The volunteer served some refreshments to the clients...*

*[Field notes, NGO Centre]*

From the above discussion, using the available infrastructure and facilities was a source of resilience for the participants. For example, they talked about the importance of the new building in helping them to deal or cope with work challenges. Participants used the, very limited, available facilities in order to remain steadfast in the workplaces and to provide dignified care for the service users. There was consensus between the participants that there was a lack of resources, as discussed in the previous chapter. The data led me to understand that, when there are more supportive resources in work, this will enable nurses' to cope better with work challenges.

## **5.8 Summary**

The above discussion revealed how educational opportunities, although limited, rewards and improved facilities, were sources of resilience within a context which felt overwhelming at times. These sources need to be discussed within their Islamic cultural context and supportive relationships themes. For example, there was a significant lack of physical resources but the surrounding cultural context motivated the nurses to use these facilities in order to stay resilient. The data led me to conclude that the nurses try to use available tangible and intangible resources to find the strength to stay in their work and on their land and not be forced to leave. This was part of Sumud culture that was discussed in chapter two the literature review (see Sumud culture as a social ecological idea).

Nurses used available resources associated with other sources such as the surrounding social relationships. For example, most of the nurses described that gaining knowledge and training in the mental health field helped them to cope with work and life

challenges. Education also helped them to prove themselves in front of other dominant professionals (colleagues) and stand up for themselves in front of occupation authorities. Therefore, this source is associated with proving their identities to other dominant colleagues and when faced with occupying forces. The nurses also needed their managers' and partners' support in order to gain access or use these resources sometimes. As mentioned earlier, one of the nurses reported that her husband supported her to join training courses. The same nurse also needed her nursing managers' support to be allowed to join one of the training courses. Therefore, the available resources need to be considered within the surrounding culture and social relationships.

## **5.9 Theme 4: Personal capacity**

There was consensus between the participants that personal capacity was also a source of resilience. There are several sub themes related to using experience, individual characteristics, coping skills. The following sections present an analysis of this sub theme in detail.

### **5.9.1 Theme 4 sub-theme 1: Experience**

There was consensus between participants that gaining personal experience in work and life in general was a vital source of resilience. For instance, in the following extract, one of the nurses described how her professional experience as a nurse helped her to manage the challenges of childcare. She explained that she was irritable and shouted most of the time at her children. After she had training in the mental health field and worked in the centre, her behaviour and attitude changed. She had become more patient; her capacity to deal with problems at home improved.

*F: ...my experience in life taught me that anything might happen...*

*F: ... Hope to be a good example for my children helped me to keep on working despite the difficulties and the challenges.*

*Mohammad: Do you think that your working in the mental health unit reflects on your life in the house?*

*F: Surely, even with my children.*

*Mohammad: How?*

*F: I didn't listen to them, and I became angry and grouchy; if they told me something and I didn't like it, I asked them to change the subject. Now I'm trying to listen to them, to understand their perspectives because sometimes their points of view are more logical than mine. So I give them freedom to do what they want providing that they avoid doing wrong things; otherwise they will be punished...*

*Mohammad: You mean that working in the mental health clinic benefits you positively in the house.*

*F: Yes, especially with dealing with the children.*

*[F.N. Interview, Government centre]*

Several other nurses stated they became more able to deal with behavioural problems of their children after they worked in mental health settings. They also believed they became more knowledgeable about how to deal with their challenges at home. Most of them gained through work experience how to deal with the service users and became more skilful with time and practice. For example, most of them indicated that they were uncertain when they started to work with patients but after gaining experience, they felt more competent. In the extended quotes, we were talking about the challenge of stigma and how this interviewee coped with this problem through experience. Initially, he had been afraid to deal with service users but after many months of working with them, he became able to communicate easily. He used to feel shy in his work, but through the time and experience, he began to feel proud of his job.

*Ah: At the beginning, work at the psychiatric hospital was somehow difficult. The society asks - how can this person work with mental illness? However, I was able to*

*overcome that and convince people that it is normal to deal with mentally ill patients; it is not a problem. Then I would not feel awkward; in fact, I have become proud to work in this job and understand the psychiatric disease is as normal as any other disease.*

*Mohammad: Then, what helped you to overcome this problem?*

*Ah: I have become convinced, after gaining experience and working with psychiatric patients that the mental illness is as normal as any other disease...*

*Ah: After dealing with psychiatric patients, I have become convinced that the psychiatric disease is just a disease like other diseases. I deal with them and work with them without any fears. No fears.*

*[Ah. J. Interview, Government centre]*

As we see above, with time and practice, the nurses learned more about psychiatric diseases and patients' challenging symptoms. Most of the interviewees learned through practice how to handle aggressive patients; they used this experience in view of the lack of continuous educational opportunities. Some of the nurses also highlighted that their experience of being nurtured and their earlier childhood experiences enabled them to manage the occupational stress. For example, one of the male nurses spoke about his life when he was a child.

*Mohammad: What other things helped you to overcome problems?*

*H: My personal characteristics and the way I had been nurtured, did you understand what way of nurturing means? My father had a supermarket and he used to let me open and manage the supermarket alone. Although he knew in advance that he might lose out but he forced me to stay in the shop alone. We had a big supermarket 150-200 meters and I was responsible for the employees in the supermarket. I was 10-12 years old and the children of my age used to play in the street. I had to open and close the shop alone one day weekly. My father used to find mistakes due to my bad management and he used to correct all my mistakes, he used to teach me you did one,*

*two, three, four and five. I was sure that my father would become tired from correcting my mistakes but he had one day a week to have a rest. I used to find the workers were waiting for me in the early morning in order to open the supermarket. I used to manage on the cash machine little by little when I was 12, 13 years old. When I became 14, I started to order goods for the shop. My father helped me to become independent. When my father saw that I became competent and able to manage the shop alone and order goods and I loved the job; he stopped me from working in the store any more. He said to me that it was enough now, I was only allowed to enter the shop as a customer, told 'take what you need and go home'. He continued as a worker, and he refused to let me work anymore. I pleaded with him to let me work as any worker in the shop, he refused because he used to shout at workers sometimes but he cannot shout at his son and he didn't want anyone to annoy him. I asked my father "why did you teach me?" He replied "in order to become independent and one day will come and there will be no one around for you to depend on, what you will do? How will you manage?" And that is exactly what happened with me when I faced financial difficulties when I was here, away from my family. I depended on myself and this meant, I did not have to go back home, I did not go back home.*

*[H.H. Interview, Governmental centre]*

In the above example, the father let his son manage the work inside the family supermarket one day a week. The aim of his father was to increase the personal capabilities of his child. The nurse later described how his father became sick and the whole family was in financial crisis. Then, the nurse reported that, during his undergraduate study period, he worked in electronics repairing phones to help his family and to pay his university fees. The experiences made him 'stronger' and increased his personal abilities to cope with occupational stressors. The life experiences of the nurses also included what their families and parents had taught them.

Their experience was a transferable source of resilience meaning that their work experiences helped them to cope with life's broader challenges and vice versa. Some of them worked in more than one workplace; for example, their experience at the

community mental health centre helped them to face challenges in hospitals. They were confident to point out that their work in community mental health workplaces increased their personal capacity to deal with stressors in the other workplaces. As this interview extract illustrates, the NGO nurse worked in two workplaces to increase his income and gain experience. He believed that his work in the community mental health centre helped him in the second hospital job. He was nominated as the best nurse in the hospital after he worked in the mental health centre.

*Mohammad: Because you have two jobs, what are the challenges that you have faced in that respect?*

*M: Yes, I work both in the hospital and in the Centre. In addition, I am happy because working in the Centre has opened many doors for me in the hospital.*

*Mohammad: How?*

*M: I have enough expertise to deal with any Mental illness at the hospital and I dealt with many there. Once, for example, a patient----- who presented with mental symptoms and another had signs of hypertension and chest pain, I dealt with them when the doctor was in the ER.*

*Mohammad: In the ICU?*

*M: No, in the department of internal medicine...*

*Mohammad: That is right*

*M: Despite the exhaustion, I liked my job there.*

*Mohammad: Do you feel pressure by having two careers?*

*M: The physical fatigue but I got used to it. I am very comfortable....*

*M: I also got the highest evaluation (for his performance) among the nurses in the hospital.*

The above discussion highlighted how experience gained in work and life in general was a source of resilience for the participants. They talked about the importance of learning resilient strategies from their families and parents. It seems that resilience is built through learning from experiences in different circumstances and contexts which leads to resilience being itself transferable across different contexts. Again, the inter-relationship between Sumud and Islamic cultures and nurses' experiences inside and outside workplaces needs to be considered. For example, the parents usually taught their children how to survive or cope for religious and steadfastness reasons. The parents' believe they will be rewarded by Allah and their children will look after them when they reach old age. These strategies enhanced their nursing skills but also the experiences gained in the nursing workplace enhanced their domestic and personal lives.

#### **5.9.2 Theme 4 sub-theme 2: individual characteristics**

All of the nurses talked about specific characteristics in their personality which they considered as a source of their resilience. It was notable from the collected data that there were individual characteristics which enabled the participants to handle life and occupational challenges. During the interview with one of the nurses, we talked about sources which helped him to face the challenges of work. He mentioned how he loved helping the mentally ill patients who were excluded in the community. His reference to this being "my nature" (seen later in other data extracts too) also suggests that some of these personality characteristics are innate, in contrast to the last section where experiences were learnt and developed over time. This was his source of happiness and the humanity in nursing care gave him a sense of satisfaction. As this extract illustrates.

*Mohammad: Why do you like to help people?*

*M: This is my nature.*

*Mohammad: But why?*

*M: There is no why, this is my nature.*

*Mohammad: Ok, you lend a helping hand to someone--*

*M: I do; I humbly like people*

*Mohammad: Ok but why do you love people? You, for instance, saw a mentally ill person; you helped him and felt happy, what benefit did you get?*

*M: I got nothing, but I love my job in the Centre; and my job is to work with the patients, and I really like it.*

*Mohammad: One, for example, may feel happy if he won a million dollars, but you feel happy if you provide assistance for someone, what are the reasons behind that?*

*M: I do not know what I should say.*

*Mohammad: Sorry for pressing you, but I want to get as much information as I possibly can.*

*M: What I want to say is that when working with them, I feel that I am rewarded and satisfied.*

*Mohammad: But why do you like it?*

*M: Humanity is the core of nursing work. For me humanity - money and salary mean another thing...*

*[M.A. Interview, NGO nurse]*

In the extracts above, the nurse talked about his sense of humanity which was the main cause for choosing the nursing profession. A few of the participants felt their courage was the main source of overcoming hardships. During the interview with one of the nurses, she reported self-confidence and a strong will helped her to overcome challenges.

*Mohammad: What are the things that helped you to recover from the difficult things that happened to you?*

*L: I have tenacity*

*Mohammad: Tenacity?*

*L: I have a strong will. Even when I feel (Ah) (meaning ill), I work whether here or at home. I do not like anyone to say that I am weak in front of others at all.*

*Mohammad: What makes you have a "will"?*

*L: First, self-confidence. Second, the will of Allah. The first thing is the will of Allah before self-confidence. The will of Allah is above everything. I want to be powerful. I do not want anybody to say that I am weak. I do not want anybody to feel that I am weak. I do not want anybody to look at me with pity. I like to be powerful even when I am weak...*

*L: From the personal challenges perspective, I am suffering from diabetes and hypertension. Nevertheless, I tolerate my situation so that I can be stronger than my ailments because when a person is weak even the ordinary person, he will suffer from tension or depression. He keeps on thinking about life. Why am I like this? You have to be confident first in yourself before having confidence in your manager or other people...*

*[L.E.J. Interview, Government centre]*

As in the above extract, the participant indicated that her tenacity helped her manage the pressures caused by intense challenges. Some of them pointed out that their sense of enthusiasm (المثابرة) kept them from collapsing and helped them to keep struggling when faced with problems. Some of the nurses reported that their sense of generosity towards others was their source of happiness. Some of the nurses reported that their feelings of affection and kindness helped them to tolerate the patient's attitudes (see the quotes in love of nursing and nursing values subtheme earlier). In the next quotes with

one of the interviewees; she described how hope, flexibility and determination to achieve goals helped her to overcome work and life challenges.

*...there was some kind of flexibility, which helped me to adapt.*

*Mohammad: Ok; what has helped you to adapt and to keep on in life despite the challenges that you have faced in work and life as well?*

*F: First of all, my belief that everyone takes what Allah has destined for him. And one should keep on hoping and dreaming that things will be fine someday.*

*Mohammad: Do you think that the same resources (things/ persons) that supported you in the work do the same thing in the house or the vice versa?*

*F: Yes, you find people who support you both in the work and in the home such as, my husband. In addition, my determination and hope to be a good example for my children helped me to keep on working despite some of the difficulties and the challenges.*

*Mohammad: From where do you get determination to go on both at work and at home?*

*F: ---I do not know, maybe this is my nature. I was smart in the school--I could not accept to be side lined, or prevented from achieving things correctly, or to be inferior. I should perfect my work to please people... Therefore, this is my nature; I could not accept anything different, I should have determination.*

*[F.N. Interview, Government centre]*

The above nurse also felt that mental flexibility and hope helped her to manage challenges in the workplace. The extract below reveals that these individual characteristics were influenced by Sumud and Islamic cultures. The interviewee clarified that her religious beliefs motivate her to be tolerant, have endurance or patience and mercy (see also Islamic culture subtheme). She also narrated how she had

been dismissed from her job due to her husband's political interests and activities. Sumud culture and faith helped her to work hard, have enthusiasm and keep going.

*Mohammad: You already have mentioned that believing in Allah helped you, tell me how could faith help you in the work?*

*F: Definitely.*

*Mohammad: How?*

*F: First of all, if Allah destined for me to take a certificate or to work here or whatever, this will definitely happen. I should do my utmost then to place my trust in Allah, not waiting helpless for my fate, and Allah says, "Work hard and I will help you". When for example I was discharged from my job because of my husband's political activity, I returned because I worked hard to get back to my work and put my trust in Allah. In addition, at the end one should accept whatever Allah has destined for him...*

*Mohammad: Do you think that believing in fate affects your work?*

*F: It calms you.*

*Mohammad: Oh, calms you*

*F: Of course, you feel comfort, since you do what you should do, and the rest is decided by Allah. You will say to yourself" ok, this is my fate, and all praise is due to Allah" even if it was bad, we know that there is a wisdom behind it; things may appears as bad but there is good behind it...*

*Mohammad: Do you think that believing in Allah and in fate helped you to adapt to work pressures?*

*F: Sure, it is important to be patient. You know that they say that forbearance is one of the Muslims attributions. (It is nice to be tolerant) As we say, "After storm comes sunshine"; I mean that if one tolerates, Allah will reward him.*

[F.N. Interview, Government centre]

From the above section, the individual characteristics were found to be a source of resilience for the participants. Some talked about the importance of learning these individual traits from Sumud and Islamic cultures. Usually the Sumud culture and faith are something learned by the local community, families and schools. It seems that individual characteristics are built and operate in different circumstances and contexts. The data led me to realise that the personality characteristics were also important to consider within a social ecological context. The above-mentioned personality characteristics can only be understood and discussed within the surrounding religious and political cultural context. For example, Sumud as a social ecological idea helps to develop and strengthen the personality of the interviewees. The local community and families help to access the available teaching resources in order to build up these individual characteristics. Therefore, it is difficult to ignore the social ecological sources which might affect the personality traits.

### **5.9.3 Theme 4 sub-theme 3: Coping skills**

The participants used coping skills as a resilience source to deal with work and life challenges. They emphasised that they were working just to secure the basic needs for their families and there was little left for extras. In the following quote, one of the nurses reported that he dealt with economic hardship by encouraging his wife to work, buying the cheapest options and prioritising his family's needs.

*Ah: I got married to a working woman. We are living below average. You know, we have to build a house, save for the children. You see the sufferings of the Palestinian people. We need to sort things out. For example, if we go out, we have to eat free herbs such as lentil and thyme because they are economical foods, but prices of meat are high, so we only used to eat it once a week.*

[Ah. J. Interview, Government centre]

The nurses were mostly unable to take trips outside the country or outside their cities due to restrictions on movements as well as economic hardships. Therefore, they undertook recreational activities inside their homes or sometimes the surrounding area. As this extract with one of the nurses who described how she manages to go for picnics with her family shows -

*M: Yes. I like to go out on picnics but I do not like to leave the country.*

*Mohammad: Do you go picnicking?*

*M: Yes. I go picnicking with my husband and children.*

*Mohammad: Do you feel that this activity supports you?*

*M: Yes...*

*[M.E.J. Interview, Government centre]*

The participants reported that they used their problem solving techniques to manage problems. The below example describes how the nurse focused on the most urgent or basic tasks, and left the least important.

*I found from the collected documents that one of the nurses used prioritising strategies in her tasks. She did the most important tasks and she left the other tasks due to work over-load. She taught service users and she was unable to do other tasks such as home visits.*

*[Written work sheets, Governmental centre]*

Most of the nurses also described that they adopted strategies to create a balance between their work and their responsibilities towards their children. In the interview below, when we were discussing sources which helped her to adapt to work and life challenges, one of the interviewees reported that having a sense of fun helped.

*Mohammad: As a mental health nurse, are there common things between your work and your home that helped you both in working and in the house?*

*F: May be working pressures affect me in the house and vice versa.*

*Mohammad: How?*

*F: As you know, my work starts at 7.30 and ends at 3.00 o'clock, if for example, I am faced with a bad attitude during this time, I will return to the house with a very bad temperament, and won't bear any one to talk to me.*

*Mohammad: really?*

*F: I couldn't bear any one to talk to me if I was tired, irritable, had quarrelled with someone because I don't want them to ask me about the reason for my anger, instead of that I want to relax.. At the same time, if I felt comfortable at work; for example we carried out an activity and everything was fine, and I was happy, I will return to the house in a good mood...*

*Mohammad: So when you return tired, you prefer to take rest. Tell me how do you recharge your batteries?*

*F: I sit in my bedroom.*

*Mohammad: Do you close the door?*

*F: No, but I run the fan, stretch myself out, ask my children to stay calm in order to rest myself for a while, then I wake up.*

*Mohammad: Do you feel active after this hour?*

*F: Of course, I modify my mood then go to work in the house. Though I was physically tired but after this hour I become active. Sometimes I start cooking, cleaning... the moment I arrive home because I feel active. And this depends on my mood; if it was good, I start doing the house chores the moment I arrive. Whereas if my mood was bad, I have to take a rest then start working.*

*Mohammad: Yes.*

...

*Mohammad: Good. What are the other sources that helped you to adapt to-----?*

*F: Having a sense of humour and sense of fun.*

*[F.N. Interview, Government centre]*

The above nurse tried to separate between home and work when she returned home, to forget the stressors of work. She had a sense of fun and this enabled her to control negative emotions or mood changes which helped her to cope. In addition, during my observation, I noticed that one of the nurses (N.Q.) laughed with the team and exchanged jokes many times. She said if she did not laugh and take things easy she would have been unable to work for more than 38 years in the nursing field. There was a saying: 'if your problems increase smile about it' (see the field note quotes in colleague and local managers' support subthemes).

From the above discussion, these skills need to be considered within the Sumud and Islamic cultures. Nearly all Palestinians experienced challenges related to the context of political conflict. People face these common challenges in a collective way and they learn skills from each other. Usually their families and local community or neighbourhood taught them some of these skills. Some nurses used indifference as a strategy to negate the chronic difficulties and they chose not to spend energy on things out of their control. These coping skills were a source of resilience for the participants. They learned some of these strategies from their surrounding Sumud and Islamic cultures. For example, one of them used to priorities his needs and eats cheap food in to order to cope with the economic suffering of Palestinians. Another one reported having a sense of humour helped her to cope with work and life challenges. However, these skills need to be socially acceptable within the collective society.

## 5.10 Summary

There are several sub themes related to personal capacity such as experience, individual characteristics and coping skills. For example, the sample reported that experience played a crucial role in their resilience. They learned through time and experience how to overcome life and work challenges. There were many individual characteristics as sources of resilience. There was a wide range of individual characteristics which might differ from nurse to nurse and which supported their resilience. They used recreation as much as possible to overcome stress and also prioritised their needs. They tried to create a balance between life and work challenges and they tried to keep both separate. It was notable that the CMHNs used a wide range of coping strategies.

The above discussion illustrates that personal capacity needs to be discussed along with other sources. For example, most of the interviewees used coping or surviving strategies based on the Sumud culture. This meant none of the participants reported that they wished to leave this environment in spite of the pressures. Their families helped them to learn through time and experience how to build up these strategies depending on what was possible or available. These learning experiences need to be considered within what is available or acceptable within their collective social and cultural context. For instance, none of the participants mentioned drinking alcohol, or sexual experiences outside marriage as sources of resilience. Therefore, they learned strategies, mostly from their surroundings, which needed to be culturally and socially acceptable. Consequently, it is difficult to ignore the social ecological sources that might affect the personal capacity or the coping strategies.

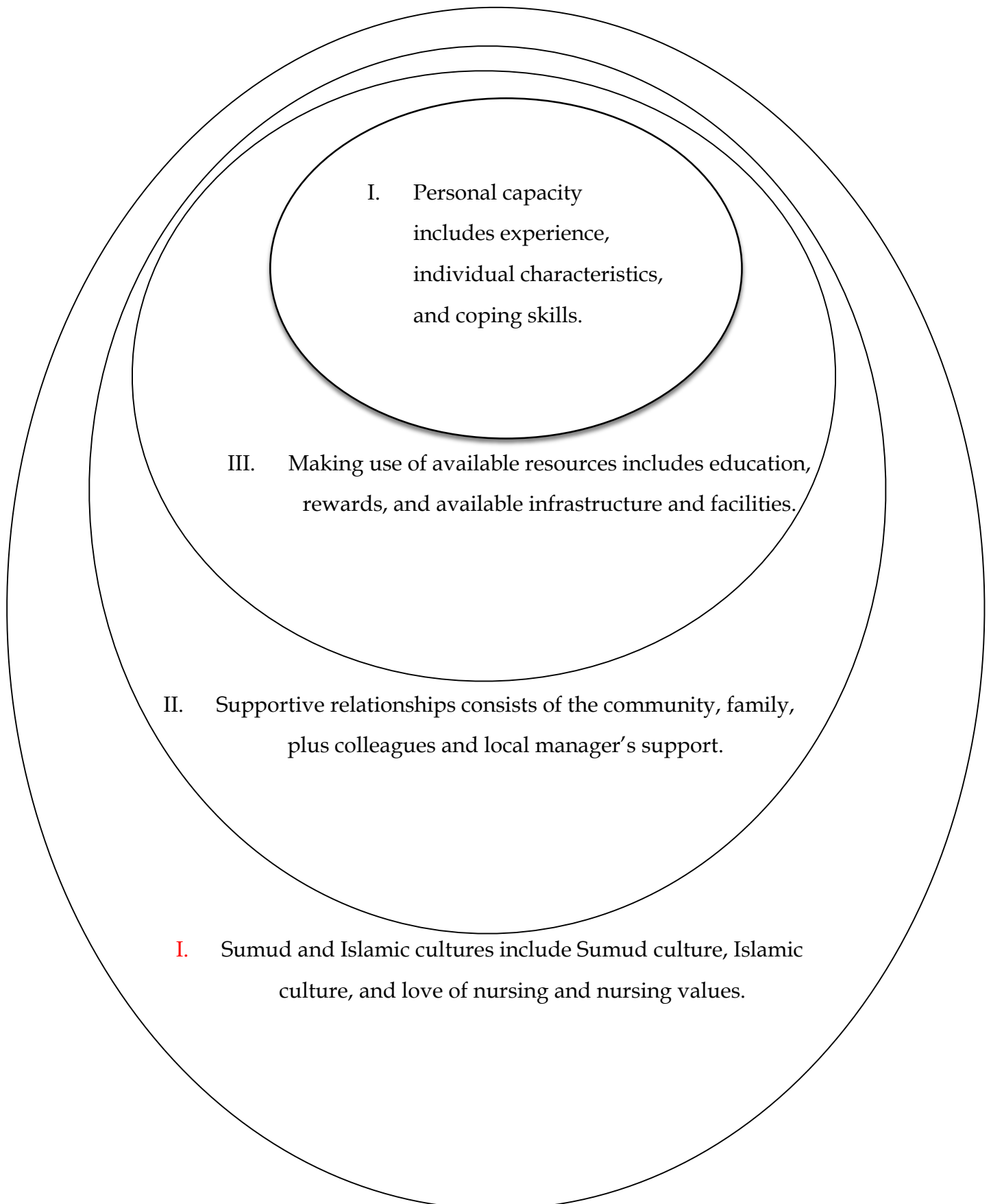
## 5.11 Conclusion

Sumud and Islamic cultures interwove or influenced other resilience sources. For example, some of the participants considered Islamic culture as their main source of resilience which motivated them to create other sources of resilience. They acknowledged that Islamic instructions encouraged them to create positive relationship with the surrounding people. The faith source also encouraged them to seek support

from their surrounding supportive networks based on the cultural traditions. For instance, three of the nurses had lost family members and their religion and social support were sources of their resilience. They usually learned the coping strategies from their role model, the prophet Mohammad (PBUH) who showed resilience when he lost some of his family members. Their personal experience in dealing with loss was associated with other sources such as supportive relationships and the surrounding culture. Therefore, it can be said, resilience sources were embedded in the Sumud and Islamic cultural context.

The figure below illustrates the inter-relationship between themes of the sources of resilience among CMHNs and the sub themes figure (5.1). Embedded means it is difficult to discuss one theme without mentioning with others.

Figure 5.1: Sources of resilience



The above figure (5.1) consisted of circles within the large circle of Sumud and Islamic cultures. This means other sources need to be discussed within the cultural context. Sources were embedded in Sumud and Islamic cultures and there are interwoven relationships with other sources. It is difficult to discuss one source without mentioning the other sources of resilience. For example, in order to understand the personal capacity we need to discuss this source within its relationships with other sources such as the available resources. The available resources need to be discussed within the supportive relationship sources. The relationship sources need to be discussed within the Sumud and Islamic cultures. This will offer better understanding of these resources within their cultural context. It is understood that nurses need to be resilient in order to be steadfast in centres and ensure nurses are retained in the field.

Nearly all of the mentioned resilience sources were shared or transferable sources used in health workplaces and life in general. Each one of interviewees inspired me by their stories of Sumud and resilience in work and life. The entire sample considered themselves as people who have Sumud and struggle to survive in their homeland. They remained steadfast in the workplaces in spite of challenges and they were resilient in the nursing field. I asked them, "do you consider yourself as someone able to cope and how would you score yourself"? All of them scored themselves highly or moderately and considered themselves mostly resilient and felt they applied Sumud in their life and job. Finally, the sources of resilience in this chapter are consistent with other studies worldwide. The following section links these findings with the existing literature.

## **5.12 Reading the above findings in light of the existing literature**

This section considers relevant findings from previous work outside Palestine with the findings in this chapter. The themes generated in this chapter will be discussed in relation to the existing literature.

### **5.12.1 Theme 1: Sumud and Islamic cultures**

Sumud and Islamic cultures are sources of resilience in work and in life in general amongst CMHNs. As presented earlier in this chapter, this theme consists of Sumud, Islamic culture, love of nursing and nursing values. This study produced findings which can be linked with the findings of previous work outside Palestine in this field. For example, in a study to explore resilience amongst immigrant Muslim women in the U.S.A., Abu zahra (2004) found that their faith within the Islamic culture played a role in their resilience. In another study to explore resilience among immigrant Arab American couples in the U.S.A., Beitin (2003) and Beitin and Allen (2005) found Islamic religion was associated with resilience. According to Milliano (2010) the Islamic faith played an important role in resilience among youths in Burkina Faso. Panter-Brick and Eggerman (2012) found that sources of resilience such as a sense of hope amongst people in Afghanistan were embedded within their Islamic cultural context. The reader is also referred back to the 'social ecology of resilience' section in the literature review chapter in this thesis.

These findings are also consistent with the studies found in Ungar's (2012) edited book, 'Social Ecology of Resilience'. There were scholars who discussed "culture" from a social ecological perspective. For example, Hopkins et al. (2012) investigated factors associated with resilient emotional and behavioural functioning of young people in the context of high family levels of risk. The study used data from a Western Australian Aboriginal Child Health Survey for a sample of aboriginal children ages from 10-17. The study found that the culture of aboriginal people and their heritage in Australia was a helping factors in adapting to challenges for the children. Knowledge about their local culture may be necessary for psychosocial adjustment. Kirmayer et al. (2012) also found that resilience amongst the aboriginal community in Canada was related to their connectedness to the land, cultural continuity and political activities.

Berliner et al. (2012) provides a case study of promoting community resilience in Greenland's Paamiut Asasara by using local values. The programme was a response to a history of a high rate of violence, child and drug abuse, neglect, and crimes in the

community. The aim of the programme was to enhance well-being and to strengthen community resilience by using local cultural values. Fifty nine interviews were conducted to identify the needs of the community. Interviews were also conducted with a random sample of local people and professionals to explore the values of the community. The intervention programme focused on the local culture, and on social and institutional aspects of the community. After two years, the collected data from the public resources showed decreases in rates of violence, abuse, neglect and crime. Developing the local cultural values in this study can be linked with the importance identified here to local culture for Palestinian CMHNS.

Other nurses have similar sources of resilience in health workplaces. For example, Birchenall (1997) undertook a study which focused on resilience of British nurses under German occupation in the Channel Islands between 1940-1945. The study found that the nurses and people who stayed on the Islands carried on their lives in spite of a war zone environment. The nurses tried to nurture themselves in spite of the difficulties, for example by playing tennis. They showed remarkable commitment towards their patients and their profession. The study found that the nurses were innovative and created new ways of coping. Finally, Koen et al. (2011c) conducted a study to explore resilience among hospital nurses in South Africa from their own point of view. The research consisted of two phases. The first phase was to measure the nurses' 'resiliency' and the second phase was to conduct focus groups with the nurses who have low and high resiliency in order to identify hindering and supportive factors. In the first phase, a resilience scale which had been used by the researchers in 2010 was used to validate the resilience among participants. The nurses who showed high resiliency numbered 133 and the number agreeing to take part in interviews was 35. The nurses who showed low resiliency numbered 14 and the number agreeing to share in the second phase was 10. The sample was from both genders and consisted of people from various cultural backgrounds. The nurses who agreed to share in the second phase were asked to write down their experiences. The resilient nurses were asked to write what helped them to be resilient and keep caring concern in the profession. The following themes and subthemes were revealed after the analysis of the supportive factors of resilient nurses:

strong belief and foundation, which included sub themes such as spiritual strength, and personal resources, sustained by values and professional assets. The other themes were supportive professional context, and being proud of the nursing profession as a secure base.

From the above studies, the culture contributes to resilience. These studies are consistent with the findings of this current research, where Sumud and Islamic culture are shown to play crucial roles in resilience among Palestinian CMHNs.

### **5.12.2 Theme 2: Supportive Relationships**

Supportive relationships are one of the sources of resilience in work and in life in general amongst CMHNs. As presented earlier in this chapter, these supportive relationships include the community, family, colleagues and some managers. This study produced findings linked with the findings of previous work conducted outside Palestine.

In a study to explore resilience among immigrant Muslim women in the U.S.A., Abuzahra (2004) found that their supportive relationships played crucial roles in their resilience. In another study to explore resilience among immigrant Arab American couples in the U.S.A., Beitin (2003) and Beitin and Allen (2005) found supportive relationships were associated with resilience. Panter-Brick and Eggerman (2012) found that family support within the Islamic cultural context was a source of resilience among people in Afghanistan. Kirmayer et al. (2012) found that resilience among the aboriginal community in Canada was related to community solidarity and collective identity. According to Milliano (2010) supportive relationships played important roles in resilience among youths in Burkina Faso. The reader is also referred back to the 'social ecology of resilience' section in the literature review chapter in this thesis.

Scholars have discussed supportive relationships from social ecological perspectives. For example, Weine et al. (2012) conducted a longitudinal ethnographic study to investigate the family resilience of 73 Liberian and Burundian refugees in the U.S.A. The study found that family and community support were main resources in order

to cope with multiple adversities such as settlement, displacement and exposure to war. Family resilience depended on secure and adequate living space, shared parenting responsibilities and finding or building churches. The study concluded that the social ecologies shape the family resilience of participants.

Murray and Zautra (2012) discussed resilience and concluded that individuals are resilient with or without the help of others within a larger social context. Community plays an important role in resilience in different cultures and contexts. For example, they argued that community collaboration, shared identity and empowerment increase bonding and bridging capital that promotes well-being among Sudanese refugees including those who experienced high levels of stress such as forced migration. Collective resilience can be crucial in non-Western cultures. Programmes and policies that support community and healing processes can be powerful and cost-effective in enhancing the well-being of people. In addition, Betancourt (2012) investigated resilience among war-affected youth in Sierra Leone. The findings from this mixed methods study were that family, community and culture are factors interacting with individual resources to maintain mental health and well-being. The surrounding social ecological environment is important in how children cope during and after exposure to violence. The psychosocial interventions and mental health care need to be appropriate to the cultural context. These findings can be linked to the finding relating to the importance of supportive relationships amongst Palestinian CMHNs.

Dolan (2012) explored the relationship between social support, resilience, and civic actions among youths in Ireland. He also discussed how each was affected by individuals, family, and wider ecological factors. The author concluded that reciprocal helping can assist in creating supportive relationships and to be or stay resilient. This conclusion needs to be discussed within the youth and community contexts. The concept of resilience was considered related to social support, ecologies, context and civic actions. Finally, Harvey (2012) discussed her own professional and personal experience as a queer therapist/supervisor. She provided case examples of youths who were marginalised by their community due to their sexual identities. The youths have multiple ways of coping in the community by using their families, schools, therapists,

and mentors as sources of their resilience. The author concluded that the creation of resilience is the creation of hope for these stigmatised youths. The creation of resilience is not only the responsibility of the youth or schools but is also a communal responsibility for all people in the community.

Scholars have discussed families contributing to resilience from a social ecological perspective. For example, Sanders et al. (2012) suggested that there is a need to understand resilience amongst young people in relation to their families and social support. There is a need to listen to youth experiences to determine which is the most helpful way to support them. This draws attention to the complexity of operationalising strategies to build resilience. Similarly, Windle and Bennett (2012) argued that there is a need to explore the context of caring relationships in families. Listening to informal caregiving experiences helps to determine what the main challenges are and what the sources of resilience are. This promises to promote or build resilience during challenging times. DuMont et al. (2012) focused on the importance of family involvement in understanding children's resilience. This helps to protect children from maltreatments and provide healthy nurturing experiences. This also might help the community and expand social resources to enhance resilience. Wekerle et al. (2012) argued that maltreatment inside the family interacts with individual resources. Therefore, there is a need to explore close and social relationships for a better understanding of persons' resilience. Finally, Walsh (2012) argued that facilitating family resilience might have a positive outcome for the healthier development of family members.

Other nurses have similar sources of resilience in health workplaces. For example, Zander et al. (2013) completed a study to explore resilience among five paediatric oncology nurses in a cancer unit in Australia. The participants' perceptions were explored toward their understanding of the concept of resilience. In addition, how they used coping mechanisms and their day-to-day work experiences were also explored. Interviews were conducted with the sample and thematic analysis. The study revealed that each nurse preferred to receive support from various resources such as colleagues, family and spouse. Hart et al. (2012) conducted a literature review to describe nursing

studies that have been done to enhance the understanding of the resilience phenomena in the nursing field. Databases were searched between 1990 and 2011 and keywords used were: nurse, resilience, resilient, resiliency. Seven studies were identified for inclusion. The researchers suggested strategies on the personal level and for health leaders to be aware of these for the recruitment and retention of nurses. They suggested strategies to build resilience among nurses within the personal, group and organisational levels. At the individual level, they suggested building supportive networks within nurses' surroundings. At the group level they suggested applying formal and informal debriefing, and establishing mentorship and residency programmes for the new nurses. At the organisational level they suggested establishing employee supportive and professional development programmes.

Finally, Koen et al. (2011b) found supportive relationships in the nursing field play a significant role in resilience among nurses in South Africa. Koen et al. (2011a) also suggested broad guidelines in order to enhance resilience and wellbeing among the nurses in South Africa. These guidelines were formulated after previous studies done to investigate resilience among the nurses in South Africa (Koen et al., 2011b, 2011c). The authors adopted a theoretical model to build up the resilience framework among the professional nurses. These strategies focused on the intra- and interpersonal levels, and aimed to increasing the sense of pride and integrity amongst the nurses (Koen et al., 2011a).

From the above studies, supportive relationships such as community, family, and colleagues or managers are shown to contribute to resilience. These studies are consistent with the findings of this current research, where supportive relationships play a role in resilience among Palestinian CMHNs.

### **5.12.3 Theme 3: Making use of available resources**

Making use of the available resources is one of the sources of resilience in work and in life in general amongst CMHNs. As presented earlier in this chapter, there are several sub-themes related to using available resources such as education, rewards, and the

available infrastructure or facilities. This study produced findings linked with the findings of previous work outside Palestine in this field. For example, in a study to explore resilience among immigrant Arab American couples in the U.S.A., Beitin (2003) and Beitin and Allen (2005) found available supportive resources from the government were associated with resilience.

Other nurses have similar sources of resilience in health workplaces. For example, to describe the experiences of 10 palliative care nurses in North West of England- UK; Ablett and Jones (2007) completed a qualitative study. The sample consisted of one male and nine female hospice nurses; interpretive phenomenological analysis was completed. Semi-structured interviews were conducted over about one hour each, where open-ended questions were used with a conversational style between the researcher and the nurse. During the interviews, the nurses asked about their general experiences then moved to explore the specific interpersonal factors as the interview progressed. Coding and analysis generated 10 themes related to hospice nurses' experiences of work in palliative care. Some of these themes are: an active choice to work in palliative care, and aspects of job satisfaction or reward. The findings suggested implications to promote resilience such as conduct training for the staff. This can be linked with the identification of education and reward as sources of resilience among Palestinian CMHNS.

Matos et al. (2010) studied the relationships between resilience and job satisfaction among 32 psychiatric nurses working in inpatient units in the U.S.A. This descriptive, quantitative, co-relational study was conducted in five closed psychiatric units. The participants were all staff nurses who were working full-time on the day of distributing the surveys and were of various ages and ethnicities. The researchers used two questionnaires: one measuring the level of resilience and the other to measure the level of job satisfaction. The reliability of the two scales was tested by using Cronbach's Alpha; it was 0.97 for the resilience scale and 0.92 for the job satisfaction scale. The resilience scale was used to measure the degree of individual resilience. The resilience scale consists of 25 items on a seven-point scale. The possible range of scores was 25 to 175 with higher scores meaning higher levels of resilience. The study showed that

nurses have high levels of resilience with high levels of job satisfaction. This means that the feeling of being satisfied or rewarded is associated with resilience. This finding can be linked with the feeling of being rewarded identified amongst the Palestinian CMHNs.

From the above studies, making use of the available resources such as education, rewards, and the available infrastructure or facilities contribute to resilience. These studies are consistent with the findings of this research, where making use of the available resources was associated with resilience among Palestinian CMHNs.

#### **5.12.4 Theme 4: Personal capacity**

Personal capacity is one of the sources of resilience in work and in life in general amongst CMHNs. As presented earlier in this chapter, there are several sub-themes related to using experience, individual characteristics and coping skills. This study produced findings linked with the findings of previous work outside Palestine in this field.

Scholars have discussed individual resilience in the context of a social ecological perspective. For example, Hine and Welford (2012) explored whether girls' violence is criminal behaviour or resilience in the UK. Usually the girls' violence is doubly condemned from society and is considered as an unsuitable expression of femininity. These girls were interviewed and their experiences were heard and explored. The study found that violence sometimes can be a rational response in order to cope with extreme adversity. Violent behaviour can be a resilient response in the face of the marginalisation of young women. Their violent behaviour sometimes needs to be discussed within the context of limited available choices. According to Kent (2012) the brain functions of the individual interact with social ecologies in its surrounding context to cope with distress or survive in extreme situations. The human being also needs to communicate socially for a purpose of fulfilling its needs such as to feel safe. Thus, not all adverse experiences can lead to trauma or extreme stress and the personal resilience can be a natural response to threats.

Similarly, Schoon (2012) suggested a contextual model of resilience which clarifies the interaction between the individual and the context ranging from micro to the macro level. Change for better or worse is a developmental process depending on the interaction between the individual and the changing socio-political context. The suggested model is an interdependent transaction between the environment and human being. Supkoff et al. (2012) support the claim that some children exposed to extreme situations become resilient due to contextual factors. In particular the social support and changes in life stress were considered as crucial factors that influence children's resilience. Therefore, individual resilience can be discussed as a process in context of developmental change.

Other nurses have similar sources of resilience in health workplaces. For example, to explore the nature of resilience among new baccalaureate prepared nurses in an acute care setting in the USA Hodges et al. (2008) completed a study to explore the strategies used to develop resilience and retain nurses in their work. A qualitative design was used and semi-structured interviews were conducted with 10 hospital nurses. The data were analysed thematically which revealed that resilience is a dynamic process of development and coping which consist of three stages. In the first stage, they learned the nursing skills and techniques that helped them to cope. The nurses learned from the surrounding culture and people by formal and informal ways by time or experience. The next stage was the nurses' struggle to fit their personal values with the professional job within the organisational culture. The final theme was moving through, with subthemes of turning points and being "street smart". This meant that nurses became self-sufficient and effective in their workplaces. They become more confident to find their way of surviving; they also created their protective mechanism within an adverse environment. One recommendation of the study was the nursing educator must focus on resilient behaviours and professional socialisation via a pedagogic process. This finding can be consistent with the findings from this study where resilience can be learned by time and experience.

Other nurses have similar sources of resilience in health workplaces. For example, Zander et al. (2013) argued that nurses believe that resilience can be developed by work

experience with some mentioning that resilience was part of their personality trait. The interviewees reported that each nurse preferred to use different strategies to deal with challenges in order to enhance his or her resilience. These strategies included looking after themselves, having luxury activities, engaging in emotional management, talking and problem solving. Koen et al. (2011b) found personal resources within religious and contextual resources in the nursing field play a significant role in resilience amongst nurses in South Africa. Finally, Hunter and Warren (2013) suggested in developing resiliency among midwives not to focus only on individual resources, but that the context and structure that contribute to work adversity need also to be considered.

From the above discussion, individual capacity which include experience, individual characteristics and coping skills all contribute to resilience. These studies are consistent with the findings of this current research, where individual capacity is associated with resilience among Palestinian CMHNs. However, individual resilience can be discussed within its social ecological context or cultural environment. The next chapter will also discuss these findings further with the existing literature in Palestine.

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## **Chapter Six:**

## **Discussion**

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# Chapter Six: Discussion

## **6.1 Introduction**

The aim of the thesis was to explore resiliency among Palestinian nurses who are working in the West Bank community mental health workplaces. In order to achieve the aims of this research, a qualitative design was chosen where multiple data collection methods (interviews, observation, and collecting documents) were used. In this discussion chapter the original contribution of this research is presented. In addition, the principal findings in the context of previous studies are discussed. The latter sections of the chapter include discussion of the implications of the findings for CMHNs' resilience. For example, implications for managers and policymakers, future research, and nursing education are discussed. Finally, the strengths and limitations of the study will be considered, and conclusions drawn.

## **6.2 Original contribution of the study**

The aim of the study is to explore resiliency among Palestinian nurses who are working in the West Bank community mental health workplaces. This study is the first study in the world which investigates the resilience of Palestinian community mental health nurses from a social ecological perspective. The contribution of this study is a new or better understanding of resilience in nursing which draws on wider cultural contexts and responses. The challenges faced by the Palestinian CMHNs in this study were embedded in the context of turmoil and unrest. It includes, the challenges associated with the context of turmoil, societal and organisational challenges and lack of resources. The context of the chronic political conflict motivated the nurses to create their own pathways of resilience within the collective surrounding culture. For instance, Sumud culture was created as a collective resilient response to the social suffering of the whole Palestinian people including participants in this study.

The resilience sources were deeply embedded in the collective Sumud and Islamic cultures. Sources include Sumud and Islamic cultures, supportive relationships, using

the available resources, and personal capacity. These resilient sources need to be discussed within the context of Sumud and Islamic cultures. This means that resilient personality traits are not only inherited and stable but also undergo a process of development within the broader cultural context of Palestine. For example, the social ecologies such as families, religious institutions, and local neighbourhoods helped the nurses to develop their individual resilient responses. Looking at resilience through a social ecological lens is also a unique contribution to nursing research. The findings of this thesis are consistent with the up to date thinking within the social ecological wave of resilience (see social ecology of resilience in literature review chapter).

## **6.3 Challenges faced by the community mental health nurses**

This section discusses the findings in chapter four, the challenges faced by Palestinian CMHNs. The findings of this chapter need to be discussed within the context of collective suffering of the whole Palestinian population and nurses in particular. The context of turmoil and unrest associated with other challenges such as societal challenges, lack of resources, and organisational challenges. Each theme is discussed or compared with the limited existing literature related to the findings.

### **6.3.1 The context of turmoil and unrest**

The findings illustrate that due to long term political unrest the participants faced contextual challenges such as a lack of safety and freedom. The findings also revealed that the CMHNs were facing a lack of support and consistency of care within their workplaces (see challenges of CMHNs chapter- first theme). This study produced findings which can be linked with the findings of previous work in this field. For example, these findings are in agreement with Manasra (1990) who declared that there was a near absence of support and an absence of community mental health centres providing care services in the community. In addition, McAuley et al. (2005) found that there was no evidence that the CMHNs receive clinical supervision or use reflective practices. They have to deal with excessive workloads and lack of medical supplies.

One possible explanation for the above challenges is that they are the result of political turmoil and unrest.

Some of the challenges faced by the CMHNS are transferable to other nurses or health workers in Palestine. These findings can be linked with the ideas of Vitullo et al. (2012) who found that health workers faced difficulties in accessing the health workplaces due to movement restrictions. Similarly, Gold (2009) described that the Palestinian nurses worked with a lack of safety and faced personal threats. These findings are consistent also with Castledine (2003) who reported that nurses need help and support in the workplaces. In addition, Hassan and Wick (2007) found that nurses also faced high levels of stress as a result of multifaceted occupation-related difficulties. For instance, they faced increasing home and family responsibilities. Midwives, as well as nurses, were facing similar challenges such as movement restrictions and other difficulties related to the context of occupation (Wick, 2008). From the above discussion it seems that the whole nursing workforce faces chronic challenges inside and outside their workplaces. These challenges need be discussed in the context of the collective suffering of the whole Palestinian population. .

### **6.3.2 Societal Challenges**

The findings reveal that CMHNS face challenges related to the local society or community. The participants in this study were facing challenges such as stigma toward mental illness and bias and discrimination against mental health nurses. This study produced findings which corroborate the findings of a great deal of the previous work in this field. For example, Manasra (1990) reported that mental health nursing was not a desired job due to the associated stigma. The local society created challenges for the nurses due to a lack of awareness and stigma toward mental illness (McAuley et al., 2005). According to Afana et al. (2004) mental ill-health is the least acknowledged, but constitutes one of the largest, of all health problems.

The bias and favouritism and discrimination inside and outside the workplaces created challenges for the participants in this research. This findings are consistent with AMAN (2013) which reported that favouritism (Wasta) is one of the major types of corruption

in Palestine. These challenges need to be discussed in the context of the social ecologies of the participants. There was an absence of effective legislation and transparency. The cohesiveness and strong ties within the local community could be misused at times. For example, the job and the available resources were distributed based on the political affiliation of the person or the influence of relatives rather than the suitability of the applicant.

### **6.3.3 Lack of resources**

CMHNs faced challenges related to the lack of resources, in addition to lack of rewards and motivating factors, as well as the challenge of managing psychiatric symptoms. The lack of resources needs to be addressed within the context of the collective suffering of Palestinians who have endured occupation for decades. This study produced findings which can be related to findings of previous work in this field. According to Giacaman et al. (2009), the health services managed by the Palestinian Authority have struggled with financial challenges since their creation in 1995. According to WHO and MOH (2006) the mental health services received only 2% of the whole budget of the Ministry of Health. Mental health services have been the most affected by the chronic lack of funding. As a result, McAuley et al. (2005) found that the level of available resources in Palestine is severely inadequate. For instance, they found the Hebron district, which has a population of some half a million, has only four mental health clinicians working in the community mental health centre with only one nurse. In addition, some of the community mental health centres have little or no telephone access. They also mentioned that sometimes out of date medications were used due to a lack of up to date supplies and this was due to the political situation. Even before the management by the Palestinian Authority for the health services in 1995, Manasra (1990) mentioned that nurses, who had worked in the mental health workplaces, experienced low wages, and severe staff shortages. Also, there were little or no opportunities to carry out home visits nor opportunities for continuing education or professional development.

According to Wick (2008) the lack of resources was a challenge experienced by other nurses in Palestine. For example, general nurses and midwives received inconsistent

salaries, worked long hours, suffered from severe staff shortages, and had excessive workloads. Hassan and Wick (2007) also found that the nurses and midwives worked in poor work environments and received little motivation. They were faced with a lack of medical supplies and equipment and also the absence of regular monthly financial payment. Therefore, the lack of resources can be related to the context of political restrictions before and after the management of the Palestinian Authority.

From the above discussion lack of motivation was considered as a part of the challenge of lack of resources. One possible explanation is the poor work environment included a lack of good management style. It seems that the nurses worked in an environment which lacked motivating factors such as being shown appreciation by management or offered up to date courses or bonuses. In addition, the chronic conflict within the country, plus the lack of hope and peace created feelings of frustration and a lack of motivation.

#### **6.3.4 Organisational**

The CMHNs were facing organisational challenges such as a gap between theory and practice, plus professional and inter-professional challenges. These challenges need to be discussed in relation to other challenges in the context of turmoil and unrest, societal, and lack of resources. This study produced findings which can be linked with the limited existing literature in the mental health nursing field. For example, McAuley et al. (2005) found that mental health nurses were unable to offer the level of care they wished due to the difference between what they learned and what they found in reality. In addition, some of them were keen to practise new strategies which they had learned but some of the mental health teams were resistant to change. For instance, physicians usually refused to involve nurses in assessment, evaluation and treatment plans effectively. Furthermore, they found that some of the psychiatrists described nurses' roles as receptionist or clerk; and the status of nurses was considerably lower than the status of physicians, psychologists and social workers. According to Manasra (1990) the nurses who worked in the mental health field experienced low status of their profession plus absence of clear job descriptions or identity. She also added that nurses were not

able to offer high quality of care and they received short training courses in the mental health field.

Some of the above mentioned challenges are transferable to other nurses in Palestine. According to Wick (2008) and Hassan and Wick (2007) Palestinian nurses and midwives have low status in comparison with physicians who control national health policies in the main. Nurses and midwives also have limited ability to gain their rights which is part of their collective suffering in Palestine. One possible explanation is that this is due to a lack of feeling of justice and autonomy inside and outside the workplaces. For example, the nurses lack national and professional identity. The CMHNs were also underprivileged within the workplaces due to stigma toward mental illness. There was a lack of awareness that the nurses could share effectively in treating mental illness. It is difficult to ignore the cultural context relevant to the CMHNs challenges inside and outside the workplaces.

## **6.4 Resilience sources among the community mental health nurses**

One of the objectives of this thesis was to explore the sources of resilience experienced in the CMHNs' general lives as well as in their workplaces. I am going to discuss the themes of sources of resilience within the Sumud and Islamic cultural context. The Sumud and Islamic cultures influence other sources such as supportive relationships, making use of the available resources, and personal capacity. Each theme will be discussed or compared with the very limited existing literature related to the findings.

### **6.4.1 Sumud and Islamic cultures**

Sumud and Islamic cultures are the main source of resilience among CMHNs in work and life in general. These sources inspired the participants to create other sources of resilience such as supportive relationship networks, the use of available resources, and personal capacity. These findings of this study are consistent with the findings of previous work in this field. For example, Teeffelen (2005) reported religion and faith are

an important source among Palestinians especially during times of adversity. He also mentioned that spirituality was associated with the Sumud culture of the individuals within the collective society. Ungar (2008) mentioned that the Islamic faith or spirituality is a more important factor among Palestinian youths than for young people in many other countries. According to Teeffelen (2009) Sumud is considered to be the soul of Palestinians. Schiocchet (2011) suggested that Sumud is derived from the Islamic culture and was even promoted by the (PLO) in the 1970s. Ungar (2007 p291) defined culture as *“culture is understood as the customs and traditions, languages and social interactions that provide identity conclusions for individuals and groups”*. Nguyen Gillham et al. (2008 p292) stated that *“the importance of positioning resilience within a context of ‘social suffering’. The Palestinian concept of Sumud - a determination to exist through being steadfast and rooted to the land – is at the heart of resilience”*.

One of the most important findings of the study is that the culture is considered a source of resilience among Palestinians including CMHNs (see sources of resilience chapter- first theme). Kårtveit (2010 p109) mentioned resilience within Sumud culture *“Within this concept of resilience, the struggle to maintain a sense of normalcy, to create small spaces of sanity through cultural, artistic and recreational activities, to experience moments of joy in the company of good friends under trying circumstances, is seen as a part of one’s everyday resistance”*. Barber (2013) also found that the local culture might play a crucial role in the resilience of Palestinian youths. Ungar (2008) argued that there are special considerations of a community’s cultural context in relation to resilience of Palestinian youths. Wick (2008 p345) found that the health professional in Palestine included nurses practising Sumud on a daily basis. She stated *“various categories of health professionals live their daily travails as Sumud...It has been seen, the term Sumud is rather adaptable, depending on the category of those within the national movement who apply it. Nonetheless, it fits into a system in which the various actors bore their hardships and carried out their responsibilities, not uncomplainingly, but without hesitation”*. From the above discussion, Palestinian CMHNs need to be resilient and use the sources of resiliency to be able to maintain their role in the workplaces in Palestine. The other sources of resilience were inspired by the local culture of the Palestinians in order to achieve the

collective and national goal of steadfastness (see relationship between, Sumud, resilience and nursing section in literature review chapter).

#### **6.4.2 Supportive Relationships**

Supportive relationships are one of the sources of resilience in work and in life in general. These supportive relationships include the community, family, colleagues and some managers. This study produced findings linked with the findings of previous work in this field. For example, Alhajar's (2013) findings showed that hospital nurses in Gaza used social support to cope with work stressors. In addition, Abushaikha and Saca-Hazboun (2009) suggested that having good relationship with peers and superiors supported the Palestinian nurses in their workplaces. AL Ajarma (2010) also found that family and community support are important sources of resilience among Palestinian adults. Similarly, Makkawi (2012) suggested that family and teachers were crucial sources of resilience among Palestinian female adults. In a study of Palestinian children, Punamäki et al. (2001) and (2011) found that family support and parental support contribute to children resilience.

The supportive relationship network needs to be explained within the local culture and traditions of the collective community in Palestine. According to Kårtveit (2010 p55) *“Traditionally, each family group had a family council, consisting of a group of men - often led by a Mukhtar – an appointed leader of the family, to which other members of the family would turn if they were in trouble, financial or otherwise, or if there were problems within the family”*. In other words, the Palestinian society consists of large families or tribes, called ‘Hamola’. These families usually offer support to individuals when they are in need, these folklore and cultural traditions become like a social rule. For instance, most of the large families owned a large hall called a ‘Diwan’ to conduct communal meetings or offer support to each other during times of hardship or times of crisis (Kårtveit, 2010). From the above discussion it is clear the supportive relationships are considered a source of resilience among Palestinians including CMHNs.

### **6.4.3 Making use of available resources**

Making use of available resources was a source associated with resilience in work and in life in general. Making use of the available resources included education, rewards, and the available infrastructure or facilities. The findings of the current study are consistent with those of Alhajjar (2013) who found that overtime work helped nurses to cope with financial difficulties and low and inconsistent salaries. Similarly, Hobfoll et al. (2011) argued that resources such as job availability and better access to transportation without the threat of obstruction or violence would promise to enhance Palestinian resilience. AL Ajarma (2010) and Makkawi (2012) also found that education is a source of resilience among Palestinians adults.

According to Wick (2008) making use of available resources can be discussed within the Sumud culture. For example, the story of the creation of Almakassed hospital in Jerusalem. The Israeli army were going to control the building and convert the hospital to a police station after the 1967 war. The nurses and doctors resisted, endured and worked hard with what was available until they saved the hospital and continue to this day to work there. Moreover, Hassan and Wick (2007) found that the ongoing availability of resources enabled the nurses and midwives to offer care in the work environment. The nurses and midwives have very limited choices to find better sources of income rather than nursing jobs. It seems that the collective culture of Sumud motivated the Palestinian and nurses to use the available resources to their utmost in order to achieve the collective goal of liberation and independence.

### **6.4.4 Personal capacity**

Individual capacity was a source associated with resilience. Individual capacity includes using personal experience, individual characteristics such as strength and endurance, and coping skills. These findings further support the idea of understanding individual characteristics among Palestinians within cultural contexts and social ecologies. For example, Gren (2009) suggested that the individual characteristics such as positive attitude are inspired from the surrounding Sumud culture. These findings

are in agreement with Nguyen- Gillham et al. (2008 p292) who stated *“Within a Palestinian context, suffering and endurance have to be interpreted at both an individual and collective level. The construct of resilience goes beyond an individualistic interpretation: resilience is (re)constituted as a wider collective and social representation of what it means to endure”*. This means that Palestinians have extra patience in comparison with other cultures or locations, have both individual strategies and resources for resilience as well as drawing from a collective level of resilience that exists at a community or national level. For instance, Kårtveit (2010 p118) mentioned *“Living under a constant state of emergency, the ability to endure long-term suspensions of normalcy became a test of one’s personal strength and national commitment. Under these circumstances, a notion of national solidarity and resilience equated with social piety and an ascetic denial of frivolity and joy gained strength among Palestinians”*. In a study of Palestinian children, Punamäki et al. (2001) found that creativity was an important individual characteristic as well as an active response to the political violence.

Ungar (2008) also suggested that personal traits of Palestinian youths such as resilient experiences need to be discussed within a cultural context. Ungar et al. stated (2007 p297) *“a Palestinian youth spoke of identity without any reference to the "I," and always in recognition of his role as a part of the collective political movement for a Palestinian state independent from Israel. Self-efficacy was measured in terms of his contribution toward that collective goal”*. The CMHNs in this research reported personal characteristics such as a sense of generosity, humour, strength, sense of hope and fun. According to Teeffelen (2009) Sumud culture can be educational and associated with keeping going, maintaining hope, having endurance and being caring and humane. *“Sumud is about keeping one’s humanity and soul, and it is therefore an eminently educational concept as well. It is about the core narrative and identity of the Palestinian people – the ability to challenge injustice and oppression, to fight for rights, but also to laugh, to see hope, and even to keep a belief in humanity that still prevails in Palestinian life, despite the impossible circumstances – where nothing less than the existence of a beautiful community is at stake... also a homely concept. What matters is not only continuing to protect the physical well-being of the family but equally the small, grounded things of daily life – the coffee, the welcoming, the mutual relations between neighbours, the caring for a mother-in-*

*law''*. This means we cannot ignore the cultural context when we discuss Palestinian characteristics such as endurance or self-efficacy.

## **6.5 Possible sources contributing to resilience unmentioned by the CMHNs**

From reviewing the findings in this study and the literature (see resiliency among Palestinian section in literature review chapter) it seems that some of the sources of resilience were not mentioned by participants such as sports and arts activities.

According to AL Ajarma (2010) arts activities such as folklore dancing, music, poetry, and painting contribute to resilience among Palestinian adults. For example, Palestinian adults used Dabka dancing which is derived from the heritage and culture and can be used as a source of expressive arts and enjoyment. In a study of Palestinian youths aged 15–18, Nguyen-Gillham et al. (2008) found that drawing and writing were sources of resilience for girls. However, it seems most of the above mentioned arts activities can be used to work towards the collective goal of freedom and independence within Sumud culture.

Another source not mentioned by the participants in this research is sports activities. According to Nguyen- Gillham et al. (2008) for Palestinian youths, sports activities contribute to resilience for boys. In a study of Palestinian children, Punamäki et al. (2011) having good school performance, and good physical and mental health were associated with resilient children. Punamäki et al. (2001) reported that active responses to the political violence contributed to children's resilience.

From the above information it seems there are individual differences associated with sources of resilience. Some sources were mentioned by children which differed from those of adults and vice versa. In addition, it seems not all resources mentioned by adults were true for all Palestinian adults. For example, CMHNs did not mention arts while other groups of adults reported the use of arts activities.

## **6.6 Implication of the study**

### **6.6.1 Implications for the CMHNs**

The findings of the study suggest the following recommendations for the CMHNs:

- 1) Nurses need to recognise the challenges inside and outside their workplaces. The details of these challenges may change from time to time or from one workplace to another. Therefore nurses need to have self-awareness in order to recognise these. Recognising these challenges may help nurses to develop strategies on how to deal with them and develop their resilient resources.
- 2) Nurses need also to focus on their current resilient resources or create new resources if possible. For example, they need to enhance their Islamic and Sumud culture resources. They also need to enhance their love of nursing and enrich the nursing values.
- 3) Nurses can enhance or develop their supportive relationships which include communities, families, colleagues and local managers. They need to retain or develop these supportive networks around them. For example the nurses can exchange their contact details in order to support each other.
- 4) Nurses need to develop or increase their use of available resilient resources such as reading books in order to learn and prove themselves. They need to use the available infrastructure or facilities as much as possible in order to reach their goals or mission. The nurses also need to keep positive and focus on rewards from their jobs.
- 5) Finally nurses need to develop their personal capacity which includes their learning experiences. This includes developing their individual characteristics and enhancing their coping strategies or skills. For example, nurses can engage themselves in activities inside and outside of their workplaces in order to gain more experiences in dealing with challenges or stressors.

### **6.6.2 Implications for health care managers and policy makers**

The findings of the study suggest the following recommendations for health care managers and policy makers:

- 1) A reasonable approach to decreasing the challenges of all Palestinians nurses as much as possible. There are a number of important changes which can be applied to support the nurses. For example, more arrangements should be made to enhance the feeling of safety and freedom among the participants inside and outside the workplaces. More actions and policies should be made available to support the nursing association, this would work towards enhancing their status.
- 2) The managers and policy makers need to evolve strategies to enhance transparency and prevent favouritism and nepotism in the workplaces. More action should be taken to distribute the available resources based on performance and achievement not based on political and social affiliation. There is a necessity also to enable nurses to be given their rights in an official way and improve the sense of justice inside the workplaces. These courses of action should decrease the stigma; and raise awareness, toward mental illness inside and outside the workplaces.
- 3) There is a requirement to increase availability of resources among nurses including CMHNs. There is a need to increase the efficacy of care services by increasing medical supplies and equipment. It is also essential to increase the budget of mental health services - so that they receive a realistic percentage of the Ministry of Health budget. The Ministry of Health and government must also increase the very small number of CMHNs, in order to enable them to apply nursing care effectively and in the manner they would wish. The CMHNs who have recently completed the master degree in mental health nursing should be offered employment immediately, so they can start working in the community mental health centres. Another vital implication is to increase the continuous and up to date educational opportunities for the current nurses. One strong

recommendation is for nurses to share learning and support each other through involvement in workshops, meetings, conferences, and the transformation process.

- 4) Another important practical implication is to decrease the suffering of the nurses by improving the status of nurses and increasing their feelings of self-respect, autonomy, and identity. The nurses need to be involved effectively in managing the available resources in order to enhance their feeling of competence. For example, more actions should be taken to involve nurses in designing and implementing the strategic plans of the health policies. The top leading positions inside the Ministry of Health need to include nurses; for example the Minister of Health or one of his assistants. There is a definite need to listen to their needs and suggestions carefully in order to solve problems associated with the nursing profession over the decades. Also, there is a need to produce clear job descriptions and decrease the excessive workloads and multiple responsibilities among nurses. It is essential to appreciate and value the performance of the nurses within the workplaces. Managers and policy makers need to enable the nurses to lead and offer them the opportunity to be innovative in applying the care plans. Taken together, these findings recommend the need to increase the control of the nurses in managing the available resources. This recognition would serve to increase motivation and a sense of reward among the CMHNs.
- 5) These findings suggest several courses of action to develop nurses' resilience which derive from Sumud and Islamic cultures. For example, there is a need to facilitate access to religious and national resources inside and outside the workplaces. This information can be used by managers to develop targeted interventions aimed at creating and developing formal and informal supportive networking within work and in the local community. There is a need to increase supportive social relationships inside and outside the work environment.

### **6.6.3 Implication for nursing education**

The findings of the study suggest the following recommendations for nursing education:

- 1) CMHNs face significant challenges inside and outside their workplaces. This means that it is worth developing resilience among the current nurses and the student nurses. These promises to improve health services, and also decrease the risks of nurses feeling overwhelmed within their workplaces (see justification of the study section in methodology chapter). My postdoctoral plan will focus on producing a module which focuses on resilience with current nurses, and post graduate mental health nurses at Annajah University. This will be consistent with the strategic plan of developing mental health services in Palestine.
- 2) The findings of this study can be used in building up a resilience module. This module could include suggestions to train nurses how to recognise the challenges in work and in life in general.
- 3) The module can be derived from Sumud and Islamic cultural resources. It also could include suggestions to create or enhance supportive relationships within their surroundings.
- 4) The findings of this research support the idea of developing the nurses learning experiences in work through reflection and supervision. Also to educate nurses how to enhance their coping skills and resilient personal characteristics such as endurance, self-confidence or efficacy. These strategies can be consistent with or inspired by their Sumud and Islamic cultures. For example, helping to find meaning for the CMHNs suffering as part of all Palestinian people.
- 5) Finally, love of the nursing profession helps buffer the challenges and helps participants to remain steadfast in spite of an overwhelming context. The new generation of student nurses at the universities need to have a real vocation for

nursing before committing to the profession. They also need to be prepared for the possible challenges of the profession in advance.

#### **6.6.4 Implication for future research**

The seventh objective of this thesis was to complete this project, return to Palestine and share in the process of mental health service and research development. The findings of the study suggest the following recommendations for future research:

- 1) After gaining my PhD, I aim to publish the thesis chapters in peer reviewed international journals to share the findings of this study with other researchers worldwide. This will further enhance understanding and enrich discussions related to resilience, particularly among CMHNs.
- 2) Further research needs to be carried out to investigate the nurses' resilience based on the up to date wave of research inside and outside Palestine. For example, there is a need for further resilience studies to include Palestinians who live in other areas such as Gaza, Jerusalem, and those refugees outside Palestine.
- 3) It would be useful to compare resilience among CMHNs with other health professionals such as nurses or midwives'. It would be interesting to compare experiences of individuals within the same group of nurses. For example, a study that includes nurses of other faiths such as Christians or those who have no faith at all. This will help us to determine the relationship between Sumud and other religions.
- 4) A longitudinal study also can be conducted to explore by what means resilience builds up over a period of time. These findings provide ideas for future research which would include developing resilience questionnaires suitable for the Palestinian cultural context. This resilience questionnaire can be used to measure the levels of resilience among CMHNs. For example, the resilience questionnaire can be used in experimental studies before and after teaching resilience modules.

## **6.7 Strength and limitation of the study**

### **6.7.1 Strengths**

- 1) The empirical findings from this study provide a new understanding of the resilience of Palestinian CMHNs from up to date waves of resilience based on the social ecology view.
- 2) The sample represented all CMHNs in the West Bank – Palestine. It also represented the Palestinian adults who applied resilience in life in general. The sample consisted of various age groups, genders and personal status (married, single, and divorced).
- 3) Multiple methods (interviews, observation and collecting documents) were utilised in generating the data for this qualitative research. It provided rich and meaningful information about resilience in, and challenges for, CMHNs. For example, using interviews as a method allowed me to hear the voice of the voiceless. It offered a detailed understanding of their point of view. It offered an opportunity - for me and for them - to explore how they participate in the challenges and resilience.
- 4) There was a high response rate from the participants; 15 nurses were interviewed from the total workforce of 17 nurses.

### **6.7.2 Limitations**

The search strategy of this research was limited to English and Arabic references. Other publications were not included due to language barriers. There was a lack of high quality available studies in general and there are very few studies in the mental health or nursing field in Palestine in particular.

- 1) The sample included Palestinians who lived in the West Bank only. The researcher was unable to access the nurses in Jerusalem due to political restrictions.

- 2) The project was limited by time and funds. The practical expenses for the project were very limited. Also, translation for all the data to English was impossible because of limitations on the study such as time restrictions and limited funding.

## **6.8 Conclusion**

This thesis explored resiliency among Palestinian nurses who are working in West Bank community mental health workplaces. This conclusion is consistent with the up to date fourth wave of resilience. The resilience of CMHNs and their challenges need to be discussed within the context of social ecologies (Ungar, 2012).

The primary objective of this thesis was to observe and describe the environment within community mental health workplaces. CMHNs have been shown to work in challenging environments within what is, at times, an overwhelming context.

The second objective of this thesis was to explore challenges facing CMHNs inside and outside of their workplaces. There is evidence that the CMHNs face multiple challenges. They faced challenges related to the context of unrest and turmoil, societal challenges and lack of resources in addition to organisational challenges.

The third and fourth objectives of this thesis were to explore sources of resiliency among Palestinian CMHNs in their practical work and in their lives in general. There is evidence that the Sumud and Islamic cultures are basic sources of resilience among the participants. These cultural sources inspired the CMHNs to create other resources such as supportive relationships, making use of available resources, and developing personal capacity.

The fifth objective of this thesis was to explore the sources of resiliency shared between CMHNs' lives in general and their workplaces. The findings suggested that the sources of resilience can be transferable from workplaces to general life and vice versa.

The final objective of this thesis was to complete this project, return to Palestine and share in the process of mental health service and research development. I have already signed a contract with my sponsor to return home and teach for at least 10 years at

Annajah University. This will offer me an opportunity to follow up the suggested implications for policy makers, education, and future research.

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## **Appendixes:**

### **Appendix 1:**

#### **Studies about the challenges facing nurses and midwives in Palestine:**

Source	(Abushaikha and Saca-Hazboun, 2009)
Aim	the level of job satisfaction and burnout
Method/instrument	demographic data; Minnesota satisfaction questionnaire (MSQ); Maslach Burnout Inventory (MBI)
Sample	152 Palestinian nurses
Main Findings	the sample have moderate levels of satisfaction and burnout

Source	(Abu Ajamieh et al., 1996)
Aim	job satisfaction correlates among nurses in the West Bank
Method/instrument	McCloskey/Mueller Satisfaction Scale (MMSS)
Sample	330 hospital nurses
Key Findings	almost 50% of the nurses were dissatisfied
Source	(Saadeh et al., 2003)
Aim	level of job stress among nurses in Nablus city
Method/instrument	self-developed questionnaire
Sample	144 hospital nurses
Key Findings	The level of stress of participants was considered high (75.6%)
Source	(Joudeh, 2003)

Aim	the degree of occupational stress
Method/instrument	four scales to measure the level of nurses' stress
Sample	276 hospital nurses
Main Findings	The level of job stress among participants was considered high (74%)
Source	(Ashour, 2003)
Aim	the effect of the conflict on Palestinian health workers
Method/instrument	self-developed questionnaire and open questions were used
Sample	500 health workers and 30% was nurses from the sample
Main Findings	The health services and workers affected negatively
Source	(Alhajjar, 2013)
Aim	the prevalence of occupational stress

Method/instrument	Psychological distress (GHQ-12), depression (SLC-D), sources of stress (NSS), trauma (IES-R) and demographic variables.
Sample	1133 hospital nurses in Gaza Strip
Key Findings	Prevalence of psychological distress (63%, GHQ-12), depression (59.7%, SCL-D) and trauma (69.4%, IES-R).
Source	(Umro, 2013)
Aim	Identify the possible causes and frequency of stress
Method/instrument	Nursing Stress Scale (NSS)
Sample	200 hospital nurses

Main Findings	<p>The most stressful items:</p> <p>Floating to other units that are short-staffed 82.5%</p> <p>Not enough staff to adequately cover unit 81%</p> <p>Too many non-nursing tasks required, such as clerical work 80.5%</p> <p>Watching a patient suffer 67.5%</p> <p>Not enough time to complete all nursing tasks 67.5%</p> <p>The death of a patient 63%</p> <p>Unpredictable staffing and scheduling 61%</p>
Source	(Elamassi, 2007)
Aim	Psychological factors associated with burnout
Method/instrument	Burnout inventory checklist, Work stress checklist, Social support checklist, Personal data sheet
Sample	122 hospital nurses

Key Findings	<p>The total score of burnout percentage was (50%)</p> <p>Work stress among participants was high (72%)</p> <p>The level of received social support was high (70%)</p>
Source	(Jaradat et al., 2012)
Aim	Assess the mental health status of nurses
Method/instrument	<p>The General Health Questionnaire 30-items (GHQ-30)</p> <p>Health Risk Behaviours scale and Generic Job Satisfaction scale</p>
Sample	261 nurses in Hebron district
Main Findings	<p>mental distress reactions in association with rotating shifts</p> <p>High job satisfaction moderated the mental distress</p>
Source	(Shawawra and Khleif, 2011)
Aim	Explore challenges and Obstacles Facing the Oncology Nurse

Method/instrument	Qualitative study and direct observations and interviews
Sample	The oncology nurses in the Palestinian territories
Main Findings	Lack of effective rules and regulations, challenges related to nursing practices e.g. workload, lack of up-to-date training and education, patients and their families misbelieves.
Source	(Hassan and Wick, 2007)
Aim	Assess the barriers to improve the quality of the maternity care
Method/instrument	Qualitative study; interviews, 120 hours of observation to the routine; written document were collected
Sample	include 14 interviews with nurses and midwives;
Main Findings	Work load, staff shortage; lack of training and supervision, lack of resources, equipment, supplies, and inconsistency of salaries. Ineffective management, lack of fund, low status of nurses, communication difficulties, overwork hours, demand on nurses. Finally, multifaceted conflict difficulties, low job satisfaction, high level of stress, lack of quality of care.
Source	(Wick, 2008)

Aim	explores the intersection between the professional politics of medicine and national politics during the second uprising
Method/instrument	qualitative (ethnography) study (observation of workplaces and interviews with nurses and other health professionals
Sample	23 nurse/ midwives and 'dayat' (traditional women who help women in delivery)
Main Findings	Movement restrictions, inconsistency of salaries; overwork hours. Staff shortage, workload, and underdeveloped quality of care. Low status of nurses, inter professional conflict and overlapping roles, lack of effective association and male domination. Home and family responsibilities and other context difficulties

## **Appendix 2:**

### **Databases and keywords:**

Search terms	CINAHL	Medline	PsycINFO	EMBASE	British Nursing Index	ASSIA
Resili* AND Arab*	0	9	8	2	0	8
Resili* AND Muslim*	0	1	5	12	0	6
Resili* AND Palestin*	6	3	11	6	0	12
Resili* AND Nurs*	27	46	34	94	23	11
Palestin* AND coping	1	4	17	4	0	31
Palestin* AND hardiness	0	1	0	0	0	0

Sumud	0	1	2	1	0	0
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### **Appendix 3:**

#### **My first letter in English to the gate stakeholders of the Palestinian Ministry of Health**

7th Floor, East Gate House -Room 702a

35-43 Newport Road

Cardiff CF24 0AB

10<sup>th</sup> June 2012

**Dear Dr. xxxxx – the general director of directorate of the primary health care**

I'm Mohammad Marie, Lecturer at Annajah National University and PhD student at Cardiff University -UK- School of Nursing and Midwifery Studies (SONMS). I write to get permission and approval to conduct PhD research at The Palestinian community mental health centres. The title of the research is [Resilience among Palestinian community mental health nurses in Palestine].

This study will explore the sources of resiliency among community mental health nurses in face of intense pressure in workplaces. The nurses in these centres will sign consent form which will explain their right to share voluntarily then face to face interview will be conducted with participants. In addition, I will observe the working environment of The Palestinian community mental health centres in West Bank.

The results will be used later on to focus on new nurses to be more able to cope with the stress and anxiety in workplaces. The unique experience of community mental health centres in the primary health care is important to develop the community mental health in occupied Palestine. Please in attachment more information about the study.

I would like to thank you very much for your approval and allow the precious work of the study in the governorate of Ramallah, but Later to the past official letter, please check out the previous written approval of the study was able to work in the rest of the provinces of West Bank cities. This must include all primary health care clinics (centres) that provide mental health services to citizens in all West Bank districts.

Please accept my highest consideration and appreciation.

Dr. xxx decision: was permitted and the approval to be Circulated to all Directorates of primary health in the West Bank.

Best regards

Mohammad Marie

مع المواقف  
لجميع الناس

بسم الله الرحمن الرحيم

2001/12/02

حضرة الدكتور اسعد رملوي مدير عام الادارة العامة للرعاية الاولى

تحية طيبة وبعد

الموضوع: عمل بحث علمي في هياكل ومراكز الصحة النفسية المجتمعية في جميع مدن الضفة الغربية  
اود ان اتقدم لكم بالشكر الجزيل على موافقتكم الكريمة والسماح بعمل الدراسة في محافظة رام الله ولكن

لاحقا للكتاب السابق الرجاء التكرم بالموافقة الخطية للتمكن من عمل الدراسة في باقي محافظات الضفة الغربية  
والتي تشمل كافة عيادات الرعاية الاولى التي تقدم خدمات الصحة النفسية للمواطنين

وتقبلوا فائق الاحترام والتقدير

Mohammad Marie  
PhD student at Cardiff University -School of Nursing and Midwifery Studies  
7th Floor, East Gate House -Room 702a  
35-43 Newport Road  
Cardiff CF24 0AB  
Mobile : (0044)7427660265  
Personal page : <http://staff.najah.edu/mmarie>  
[http://www.cardiff.ac.uk/sonms/contactsandpeople/postgraduatestudents/marie-mohammad-mr-overview\\_new.html](http://www.cardiff.ac.uk/sonms/contactsandpeople/postgraduatestudents/marie-mohammad-mr-overview_new.html)

2012/06/24

صاحب

د. نوري التميمي

م. بالبريد

26-6

The exchanged emails regarding the written permission from the general director and managers of NGO Centre

Good Morning,

Yes our nurse is willing to participate in your study

we will be waiting for your time schedule suggestions

Best

xxxxx (name of the coordinator)

2012/6/13 Mohammad Marie <MarieMM@cardiff.ac.uk>

Dear xxxx (name of the coordinator)

Thank you very much for your reply. Your cooperation highly appreciated. Later on I will contact you and do suitable appointment to visit the centre; I need to do interview with the nurse for 2-3 hours if he agree to participate voluntary in the study. I also need to do observation for the work environment inside the centre; how work in action inside the rehabilitation centre.

For more information please have look on the attached information sheet. Please if have any inquiry don't hesitate to contact me. Thank you again for warm welcome and effort....

All the best

Best regards

Mohammad Marie

-----xxxxxxxxx <@gmail.com> wrote: -----

To: MarieMM@cardiff.ac.uk  
From: xxxxxx@gmail.com>  
Date: 06/13/2012 01:57AM  
Cc: xxxxxx@gmail.com>, <xxxxx@hotmail.com>  
Subject: Your PhD research

Greetings

My name is xxxx I am a clinical psychologist working at the xxx centre. I've received your number from xxxxx the centre director.

I am the coordinator for a rehabilitation program for the chronically mentally ill patients at xxx district.

At our program, we have 4 employees, only one of them is a nurse.

We are willing of course to cooperate with you in your research, but please keep in mind the limited number of our staff. You are invited to be in direct touch with me for more information about our day care work for the patients

Good luck in your research

xxxxxx (name of the coordinator)

7th Floor, East Gate House -Room 702a  
35-43 Newport Road  
Cardiff CF24 0AB

06<sup>th</sup> June 2012

**Dear Dr. xxxxx the General Director of xxx Centre.**

I'm Mohammad Marie, Lecturer at Annajah National University and PhD student at Cardiff University -UK- School of Nursing and Midwifery Studies (SONMS). I write apply for approval to conduct PhD research at xxx centre xxx branch. The title of the research is [Resilience among Palestinian community mental health nurses in Palestine].

This study will explore the sources of resiliency among community mental health nurses in face of intense pressure in workplaces. The nurses in xxx centre will sign consent form which will explain their right to share voluntarily then face to face interview will be conducted with participants. In addition, I will observe the working environment of xxx Centre xxx branch.

The results will be used later on to focus on new nurses to be more able to cope with the stress and anxiety in workplaces. The unique experience of xxx centre is important to develop the community mental health in occupied Palestine. Please in attachment more information about the study.

I hope to get response as soon as possible to start collecting the data and please if you have any inquiry don't hesitate to contact me.

Your cooperation will be highly appreciated,

Yours faithfully,

Mohammad Marie

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[http://www.cardiff.ac.uk/sonms/contactsandpeople/postgraduatestudents/marie-mohammad-mr-overview\\_new.html](http://www.cardiff.ac.uk/sonms/contactsandpeople/postgraduatestudents/marie-mohammad-mr-overview_new.html)

## **Appendix 4:**



### **Participant Information Sheet for Community Mental Health Nurses**

➤ **Study Title:**

Resilience of community mental health nurses in Palestine.

#### **An invitation to participate in a research study**

I would like to introduce myself to you. My name is Mohammad Marie. I am currently a PhD student at Cardiff University in the UK. I would like to invite you to participate in this study. Before you decide whether to take part or not, please read carefully the following paragraphs which will provide you with sufficient information regarding the purpose of this study.

#### **What is the purpose of the study?**

This study will be the first in the world to examine the resilience of nurses within Arabic and Muslim culture, and the first to explore the resilience of Palestinian community mental health nurses (CMHNs).

The main aim of this study is to know the sources of resilience among Palestinian community mental health nurses who are working in Palestine within a Sumud cultural context.

The objectives of the study are:

To observe and describe the environment within community mental health centres.

To explore sources of resiliency among Palestinian CMHNs' lives in general.

To explore the sources of resiliency among Palestinian CMHNs' practical work.

To explore the sources of resiliency shared between CMHNs' general lives and their workplaces.

To complete my PhD, return to Palestine and share in the process of mental health service and research development.

### **Why have I been invited?**

You are invited to take part in this study because you are a community mental health nurse working in a community mental health workplaces in Palestine.

### **Do I have to take part?**

It is up to you to decide. This information sheet will provide you with information on the study. You can also ask me questions about the study. If you agree to take part I will ask you to sign a consent form to confirm you have voluntarily agreed to take part. You are also free to withdraw at any time, without giving a rationale.

### **What will happen to me if I take part?**

If you agree to take part I will interview you for a period ranging from 90 to 120 minutes. I will ask you to talk about your work and life challenges, and the things that support you to cope with these.

### **Will my taking part in this study be kept confidential?**

I will use a digital recorder to record my interviews. I will transcribe each interview myself in my private work place. This transcription will include all the information that is recorded excluding any data that helps to identify you. In this transcription I will replace all the real names referred to with pseudonyms. The transcribed data will be stored in my private, password-controlled, computer which is accessible only to me. A back up copy of these data will be saved in a locked drawer on a CD, and brought back

to Cardiff University. The paper copies of signed consent forms (with actual names on) will be stored in my locked office drawer until I bring them to Cardiff University. The procedures I will use to handle, process, and store and destroy all of the information I obtain about you will follow Cardiff University policies, and fulfil the requirements of the UK Data Protection Act 1998.

### **What will happen if I don't want to carry on with the study?**

If you withdraw from the study before I have published any results I will permanently destroy the information you have given me and not use any of this in my writing. If you withdraw after I have published any of my results (in either my PhD thesis or in journal articles) or have used the information you have given me in presentations then I will make sure that I do not use any information you have given me in further publications or presentations.

### **What are the possible benefits of taking part?**

There is no direct personal benefit to you from taking part in the study. However, the study may help stakeholders in the Palestinian Ministry of Health to focus on and develop resiliency among new nurses in the future and to develop interventions to support current nurses. It may help the Palestinian universities to focus on student nurses through teaching and training in a specific resiliency module in their curriculum. Publications from this study in scientific journals may help to develop resilience among nurses who face challenges in their workplaces throughout other parts of the world.

### **What are the possible disbenefits of taking part?**

If you become distressed during your participation we can stop the interview. I will use my background as a qualified mental health nurse to help me to know when to stop or suspend interviewing, and when and how to offer you support. If you wish for more support, I can refer you to a trained counsellor (who does not know you through your professional work) at a Palestinian Ministry of Health community mental health centre.

**What if there is a problem?**

This information sheet contains my contact details at the end. It will be my pleasure to answer any questions you may have about the study. You can also speak to me if you have any concerns about the way you have been dealt with, or if you feel you have been harmed in any way. If you are not satisfied with any of my answers you can also contact my supervisors at Cardiff University. Their contact details are at the end of this document.

**What will happen to the results of the research study?**

I will include the information you and other nurses voluntarily give me in my PhD thesis. You will receive feedback on my research results as a form of recognition and gratitude for your participation. I will send abstracts of my completed study to you, to the Palestinian Ministry of Health and to the Palestinian Counselling Centre. I will distribute the results of my study to all university libraries in Palestine so that they will be accessible to all interested people. I will publish my findings in scientific journals, present them at conferences and use them in teaching and curriculum development.

**Who is organizing and funding the research?**

This study is organized and funded by Annajah National University.

**Who has reviewed the study?**

This study has been reviewed and approved by the Research Ethics Committee and the Research Review and Ethics Screening Committee at Cardiff School of Nursing and Midwifery Studies, UK.

**Further information and contact details**

For further information on this study you are welcome to contact me using the following details:

Mohammad Marie

PhD student at Cardiff University -School of Nursing and Midwifery Studies

7th Floor, East Gate House -Room 702a

35-43 Newport Road

Cardiff CF24 0AB/UK

Mobile: (00972)568309667

Email: mariemm@cardiff.ac.uk

Personal page: <http://staff.najah.edu/mmariem>

[http://www.cardiff.ac.uk/sonms/contactsandpeople/postgraduatestudents/marie-mohammad-mr-overview\\_new.html](http://www.cardiff.ac.uk/sonms/contactsandpeople/postgraduatestudents/marie-mohammad-mr-overview_new.html)

My supervisors' contact details are:

Dr. Ben Hannigan, Reader, Cardiff School of Nursing and Midwifery Studies , Cardiff University, East Gate House, 35-43 Newport Road, Cardiff, CF24 0AB | UK, Telephone: +44(0)29 20917726 , Fax: +44(0)29 20917744, Email: [hanniganb@cardiff.ac.uk](mailto:hanniganb@cardiff.ac.uk)

Web:[http://www.cardiff.ac.uk/sonms/contactsandpeople/academicstaff/hannigan-ben-overview\\_new.html](http://www.cardiff.ac.uk/sonms/contactsandpeople/academicstaff/hannigan-ben-overview_new.html)

Dr. Aled Jones, Senior Lecturer , Cardiff School of Nursing and Midwifery Studies, Cardiff University, East Gate House, 35-43 Newport Road, Cardiff, CF24 0AB | UK, Telephone: +44(0)29 20917726, Fax: +44 (0)29 2091 7787, Email: [JonesA97@cf.ac.uk](mailto:JonesA97@cf.ac.uk), Web:[http://www.cardiff.ac.uk/sonms/contactsandpeople/academicstaff/jones-aled-dr-overview\\_new.html](http://www.cardiff.ac.uk/sonms/contactsandpeople/academicstaff/jones-aled-dr-overview_new.html)11/05/2015

## **Appendix 5:**

### **Sources of resilience for community mental health nurses in Palestine**

#### **Consent form for Palestinian community mental health nurses:**

Please read slowly and carefully each section below before you complete it. Tick in the spaces provided if you wish to participate in this study. Please feel free to ask questions about the study at any point before you sign.

Please read the sections below carefully before you tick the appropriate boxes	Tick
I confirm that I have read and understand the Participant Information Sheet for Community Mental Health Nurses, dated June 25 <sup>th</sup> 2012 (version 1), for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
I understand that my participation is completely voluntary and I am free to withdraw at any time without giving any reasons. I am aware that there will be no repercussions of any type if I decide to do so. I am also aware that a decision to withdraw will not affect my job status or legal rights.	<input type="checkbox"/>
I understand that data collected during the study may be looked at by my supervisors and by Research Governance staff working in Cardiff University. I give permission for these individuals to have access to my records.	<input type="checkbox"/>
I. I agree to the information I provide being used in a thesis, in publications, in conference presentations, in teaching and in curriculum development.	<input type="checkbox"/>
II. I agree to take part in the above study.	<input type="checkbox"/>

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

When completed, 1 for participant; 1 for researcher site file

### **Appendix 6:**

### **Ethical approval from Cardiff School of Nursing and Midwifery Studies**

Head of School and Dean Professor Sheila C Hunt

*Ysgol Astudiaethau Nyrsio a Bydwreigiaeth Caerdydd*

*Pennaeth yr Ysgol a Deon Yr Athrawes Sheila C Hunt*



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*Prifysgol Caerdydd*  
*Ysgol Astudiaethau Nyrsio a*  
*Bydwreigiaeth*

4<sup>th</sup> September 2012

Mohammad Marie

SONMS

East Gate House

35-43 Newport Road

Cardiff CF24 0AB

Dear Mohammad

**Application for School Research Ethics Committee approval**

**Reference: 2012/07/01**

Your project entitled “Sources of resilience among Community Mental Health Nurses in Occupied Palestine Territories” has been approved by the School of Nursing and Midwifery Studies Research Ethics Committee of Cardiff University and you can now commence the project. This approval is based on:

1. version 2 of the protocol (dated 28.08.12)
2. version 2 of the information sheet (dated 28.08.12)
3. version 2 of the consent form (dated 28.08.12)

Please note that since your project involves data collection abroad you may need approval from a competent body in the relevant jurisdiction.

If you make any substantial changes with ethical implications to the project as it progresses you need to inform the SREC about the nature of these changes. Such changes could be: 1) changes in the type of participants recruited (e.g. inclusion of a group potentially vulnerable participants), 2) changes to questionnaires, interview guides etc. (e.g. including new questions on sensitive issues), 3) changes to the way data are handled (e.g. sharing of non-anonymised data with other researchers).

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

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

A handwritten signature in dark ink, appearing to read 'Sally Anstey', is positioned to the left of a vertical line.

Dr Sally Anstey

**For the School of Nursing and Midwifery Studies Research Ethics Committee**