A phenomenological enquiry into the personal resilience of NHS executive leaders in England

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Abstract

Executive leaders within the National Health Service (NHS) operate within a highly pressurised, constantly changing, and performance focused environment. They are burdened with bureaucratic regulation, political and public scrutiny that emphasises their inadequacies over their successes (Janjua, 2014; Rose, 2015; Timmins, 2016). Personal resilience is needed to operate effectively as an executive leader within the NHS (Rose, 2015; Kelly et al., 2016) yet a review of the literature identifies that the personal resilience of NHS executive leaders is an understudied phenomenon. This study addresses this gap in knowledge.

Interpretive Phenomenological Analysis (IPA) was utilised to explore and interpret the lived experience of being personally resilient for nine NHS executive leaders in England during 2017 and 2018. Participants hold portfolios representative of the executive director of nursing, medicine, finance, human resources, operations, and the chief executive officer. Three superordinate themes are identified including: being exposed, developing personal resilience, and moving forward. These findings add new knowledge in relation to the stressors facing NHS executive leaders, how they experience personal resilience, and the distinguishing enablers of their personal resilience.

Stress from personal exposure, various forms of loss and moral issues are identified as distinctive stressors in relation to participants' executive leadership roles. The perceived intensity of this personal exposure, loss of humanity, and identity issues distinguish participants against the stressors documented within the existing body of leadership resilience literature.

Participants experience personal resilience as a continual process of seeking out and taking action against stressors. This challenges the well documented concept within resilience theory that defines personal resilience as a response. Metaphorically 'becoming stuck' uniquely describes being unable to be resilient for these leaders. An alternative perspective on the established 'fight, flight, freeze' stress response is offered in relation to these findings.

Personal resilience is enabled for these leaders by actively seeking out ways to develop their resilience, the transferable qualities surrounding their perceived personal energy and motivation, utilisation of positive framing, and a complexity of supportive relationships. The purposeful, complex, and interconnected nature of these supportive relationships adds a unique multi-directional perspective surrounding the utilisation of social support for this leadership community.

These findings also augment our understanding of the concepts of thriving, posttraumatic growth, psychological capital, and the broaden-and-build theory of positive emotion in relation to personal resilience of these leaders.

Findings in this study align to the perspective that personal resilience is a complex, dynamic, subjective, and contextual phenomenon. Future lines of enquiry are presented to further augment understanding of this phenomenon for both NHS executive leaders, and the leadership community more broadly.

Acknowledgements

I would like to begin by dedicating this study to the millions of healthcare professionals who graciously, compassionately, and humbly serve the public. At the time of publishing this study during the global pandemic, my healthcare colleagues have shown unprecedented personal resilience and commitment to the wellbeing of our global population. Thank you.

I would like to thank the NHS executive leaders who took part in this study. Your contribution and personal experiences have both enabled the development of my research, in addition to enabling me to grow my own leadership practice and personal resilience in a unique way.

I also wish to thank my supervisory team, Professor Lynn Nichol, Professor Eleanor Bradley, and Dr Scott Andrews. Your expert mentorship has helped me to craft and present a study that I am both proud of, and still enthusiastic about beyond the completion of this thesis.

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Chapter 1: Introduction

1.0 Introducing this thesis

> *"What is it like to be a chief executive in the NHS? Well, it goes from absolutely fantastic – the best job on the earth – to the depths: 'Oh my god, so what are we going to do about this?' It is that huge a spectrum … There were some dark points during that time without a shadow of a doubt … some really black points. I'm lucky because I managed to survive those [with] personal resilience, family and stuff like that – but I know some colleagues who've not done so well, and it's not been good for them" (A quote by an NHS Chief Executive from: Timmins, 2016 pp. 34)*

The need for the National Health Service (NHS) to develop and maintain the personal resilience of executive leaders is much debated in practice. Yet, there is no definition or empirical understanding for what personal resilience is for this group of leaders, how to develop it, or how to maintain it. Furthermore, there is a lack of understanding for what personal resilience is for the leadership community in general. This study addresses this gap in knowledge by illuminating what it means to be personally resilient as an NHS executive leader.

This chapter introduces the researcher and where their interest in the research topic originated. It then briefly introduces the context of this study, the importance of understanding the personal resilience of NHS executive leaders, and then the aim and questions for this study. Finally, it outlines how the remaining chapters contribute to the construction of this thesis.

1.1 Introducing the researcher

When starting this study into the personal resilience of NHS executive leaders, I worked within the field of leadership development within the English NHS. My job involved working at a regional and national level of the NHS to support a diversity of NHS leaders across a large variety of NHS organisations. As part of my portfolio, I led on the development of the NHS strategic approach to leadership talent management. Various government reports into the state of NHS leadership had called for more structured and supportive ways of developing senior and executive leadership talent. They stated that the stressful NHS environment made it very difficult for leaders to succeed

and that a 'blame culture' had deterred future talented NHS leaders from 'stepping up' and taking on more demanding senior and executive leadership roles (Rose, 2015; Smith, 2015).

My role working in NHS leadership development meant that I worked directly with this executive leadership community, giving me insider access to what is considered a hard-to-reach group of very senior individuals. Whilst working with the community, I became interested in their personal stories. They often discussed that despite the highly stressful NHS working environment, they were passionate about their executive leadership role, motivated by the potential to make a positive impact on society and could never think of doing anything else. I became curious as to how these arguably successful individuals as the most senior of NHS leaders, both flourished in their roles and remained personally resilient, whilst the stressful NHS environment worked against them. I also became fascinated by why more junior NHS leaders did not feel resilient enough take on these increasingly challenging roles. However, as a relatively mid-to-senior level leader in the NHS myself, I could also appreciate why. From my perception, I had seen first-hand the stressors that senior executive leaders had experienced and how the NHS bureaucratic and 'command and control' culture commonly cited by practitioners working in the NHS had negatively impacted them. I also perceived how it was often forgotten that NHS executive leaders can still experience stressors and adversity, just like everybody else does. It appeared that the NHS culture forced them to keep going and to keep leading, without compassion toward their personal circumstances, treating them as if they were not human beings. Forums that I worked within often discussed this, and they always came back to the same conclusion; these NHS leaders must 'be more resilient'. But what did this mean?

The following are extracts that illustrate a selection of participant experiences from my previously published study where I explored the impact of assessment centres as a way of selecting NHS leaders' readiness to advance their careers (Turner and Nichol, 2016).

> *"I'm quite an intrinsically motivated person. As soon as something knocks me off my kilter, I find it hard to get back ... [it] made me feel out of control ... I actually work in a very deprived area where trauma is part of peoples' everyday lives ... looking after families or mothers or whatever, who have had these traumatic experiences ... I don't know how to explain it really. I don't think they realised what [that stressful experience] means to you."*
>
> *"It took me a little part of the morning to actually twig, how to behave ... the first bit was actually trying to understand it."*

"I thought of it as a different side of me really ... I was enjoying a new confidence to speak out and direct things ... I think [the experience] brought me out of myself really."

"I've changed ... my manager has in fact noticed that [the experience] has improved me ... I can see myself I've changed." (Turner and Nichol, 2016)

It was during that research study that I became curious to better understand the personal resilience of NHS leaders from an empirical perspective. Whilst I identified various interesting discoveries, I was struck by my finding that the experience of such an assessment could not only be stressful, but also traumatising to some of these skilled and experienced NHS leaders. Equally, I was fascinated by the contrasting finding that some of these leaders had identified ways to adapt their behaviour and resiliently demonstrate their leadership qualities to gain a successful outcome. Furthermore, some participants described positive outcomes of the process and that their experience had enabled them to learn about themselves and grow as a leader. I now had questions. What made some of these NHS leaders personally resilient, yet others who had gone through 'exactly' the same scenario, stressed and traumatised?

I turned to the literature to explore this further. Surely there were answers to help me to understand and develop the personal resilience of these individuals. However, I quickly discovered it was not quite that simple. I learnt that there was no clear definition for what personal resilience is. Furthermore, there was a lack of empirical literature that engaged with the personal resilience of leaders in general, and very little literature that considered NHS leaders, which is something that I discuss in more detail within Chapter 2 of this thesis. I also noticed that the majority of the personal resilience literature had considered the phenomenon from a survival perspective, such as survivors of extreme trauma (Southwick and Charney, 2012). This led me to contemplating what could be learnt from exploring personal resilience from the opposite end of this spectrum, through the lens of highly successful resilient leaders. My curiosity about what made senior NHS leaders personally resilient, combined with the identified lack of literature in the area led me to developing the focus of this study, seeking to explore the personal resilience of NHS executive leaders.

Whilst the body of personal resilience related literature offered no consensus on what personal resilience is, scholars increasingly agreed that personal resilience is a complex, dynamic, contextual, and subjective phenomenon and should be studied as such (Ungar, 2003; Truffino, 2010; Forster and Duchek, 2017). To study the personal resilience of NHS executive leaders, I was in the position to become an 'insider researcher' (Costley et al., 2013) by leveraging my role in

NHS leadership development to access this executive leader community. By combining the advice within the literature to study personal resilience as a subjective and contextual phenomenon, with my position as an 'insider researcher', this led me to consider an interpretive phenomenological approach to this study and the application of Interpretive Phenomenological Analysis, which I discuss further in Chapter 3.

When introducing myself at the start of this thesis, I felt it important to write as 'me' to introduce the reader to my personal perspectives, which is an essential part of any interpretive phenomenological study (Smith et al., 2009). However, the remainder of this thesis is written in the third person, except for several bracketed (greyed out) reflexive contributions such as this one. I purposefully chose to write this thesis in the third person as it enhanced my ability to be interpretive as part of embracing an 'interpretive phenomenological attitude', which I speak of further in Chapter 3. This interpretive attitude is continued throughout this thesis, where in Chapter 4 I share both the participant voice and my own voice as the researcher when interpreting and presenting the experiences of my participants, and throughout Chapter 5 where I discuss my findings in relation to the existing body of knowledge.

This study offers an original contribution to knowledge that outlines what personal resilience is from the perspectives of a group of NHS executive leaders. My findings begin to close the identified gap within the knowledge, whilst also offering avenues for further enquiry to better understand the personal resilience of leaders more widely. Practically, this study also offers an empirically based perspective that can contribute to the development of more resilient NHS leaders, who in turn can better support the delivery of patient care.

1.2 Introducing this study and contribution to knowledge

It is established that the English NHS is a challenging environment to work in, where leaders experience a constant barrage of stressors that challenge their ability to be personally resilient and lead effectively (Rose, 2015). It is particularly challenging for board-level executive NHS leaders, as the most senior accountable leaders of their organisation who are managing complex services and portfolios that include human resources, medicine, nursing, finance, operations, and in the case of the chief executive being accountable for the running of the entire organisation. These senior NHS

leaders are operating within the highly pressurised, constantly changing, performance-focused NHS environment and are burdened with bureaucratic-regulation, political and public scrutiny that emphasises their inadequacies over their successes (Rose, 2015; Timmins, 2016). They are faced with chronic stressors that include high workload, corporate responsibility for care quality, reductions in staffing, tensions between financial solvency and the quality of care, and feelings of personal vulnerability arising from a constant fear of being dismissed due to being held accountable for the quality of patient care (Kelly et al., 2016). These NHS executive leaders continue to perform in their role of managing healthcare services, yet it is not understood how they continue to do so by remaining personally resilient within this stressful NHS environment.

Government reports (Rose, 2015; Smith, 2015) and literature (Janjua, 2014) exploring NHS leadership illuminate the need for the most senior leaders of the NHS to be more resilient, yet they do not describe what this resilience is or how these senior leaders can achieve it. There is an identified gap in the empirical body of knowledge surrounding what personal resilience is for NHS leaders (Hudgins, 2016). However, this may not be surprising in the context of NHS executive leaders, as these individuals could be considered an elite audience (Mikecz, 2012; Lancaster, 2017). This means that it is difficult to gain access to their personal accounts, as discussing personal resilience would require them to share their personal vulnerabilities within this highly regulated NHS environment.

Although the NHS is practically seeking for its NHS executive leaders to become more resilient (Hardacre and Keep, 2011; Rose, 2015; Smith, 2015; Mowbray, 2016) there are few empirical accounts that engage in describing what personal resilience is for these individuals and therefore how to develop it. It is also documented that the personal resilience of leaders is a contemporary area of study, with little empirical literature that has considered what personal resilience is for the leadership community more broadly (Forster and Duchek, 2017).

This study seeks to address this identified gap and contribute to the limited body of knowledge surrounding the personal resilience of NHS executive leaders. The overall aim of this study is to understand '**how do NHS executive leaders experience personal resilience**?'. It achieves this by addressing the following questions:

1. How do NHS executive leaders experience stressful healthcare working environments?

2. How do these NHS executive leaders experience and define personal resilience when responding to these stressful environments?

3. What is the difference between being resilient, and failing to be resilient for them?

4. How is personal resilience gained, developed, and retained for these individuals?

5. Have their perceptions toward personal resilience changed throughout the duration of their careers (i.e. is there a uniqueness relating to executive leader resilience?)

6. How do they perceive working in a care-based profession impacts their personal resilience as an NHS executive leader?

This study addresses this aim and questions by using Interpretive Phenomenological Analysis (Smith et al., 2009) to understanding the lived experiences of personal resilience from the perspectives of nine NHS executive leaders. In the context of this study, an NHS executive leader is defined as someone who sits on the NHS organisations board of executive directors, and has management responsibility and accountability for an established portfolio that is required to effectively run the NHS organisation (e.g. executive director of medicine, nursing, operations, human resources, finance, in addition to the chief executive having ultimate management responsibility across the entire organisation). This study considers why these individuals need to be personally resilient, how they experience resilience, how they develop it and maintain it, and the potentially unique aspects associated with their personal resilience in the context of their executive leadership roles within the NHS.

The findings and the impact of this study address the identified gap within the body of knowledge by articulating what personal resilience is for this sample group of senior NHS executive leaders. Avenues for future enquiry are identified, as well as practical considerations for how the NHS can address the 'call to action' within the NHS literature to better develop the personal resilience of its senior leaders (Hardacre and Keep, 2011; Janjua, 2014; Rose, 2015; Smith, 2015; Mowbray, 2016) and therefore enable these leaders to contribute to the effective and resilient running of NHS services, and delivery of high-quality patient care.

1.3 Navigating this thesis

The remainder of this thesis consists of the following chapters:

Chapter 2 - A thematic review of the literature and context for this study begins by illustrating the literature that attempts to define personal resilience as a phenomenon. It puts forward the argument from within this literature that personal resilience is a complex, contextual, subjective, and dynamic construct and needs to be studied as such. It then explores the literature in the context of this study by considering stressors and personal resilience from the perspectives of leaders, the healthcare workforce, the limited body of knowledge that has considered stress and resilience for healthcare leaders, and the gap within this body of knowledge.

Chapter 3 - Methodology begins by discussing the research aim and questions for this study, arising from the identified gap within the existing body of knowledge. Epistemological and ontological considerations are then presented in order to address the research questions and how they influence the methodological design for this study and choice of interpretive phenomenological analysis. The philosophical roots of phenomenology are presented and how these have been applied to this study. Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009) as the method and associated procedures for this study are then outlined, starting with how the researcher developed and maintained their 'interpretive phenomenological attitude' throughout the study, and the procedures for how IPA was applied during the study. It then discusses how the sample group of NHS executive leader participants were recruited, ethical considerations, and ends with how credibility and data quality are considered in relation to established principles for assessing qualitative research.

Chapter 4 - Findings presents the overarching thematic map (Figure 2) derived from the analysis of findings in relation to the research aim and questions and is split into two parts. Part 1 represents the participants' voice. It is designed to enable the reader of this study to connect with the lived experience of each participant and illustrate how these experiences have contributed to the development of the study's thematic map. Part 2 represents the researcher's voice. Following IPA conventions, it is designed to outline the researcher's interpretation, of participants' interpretation of personal resilience, in the context of them as NHS executive leaders and how the thematic map (Figure 2) was constructed.

Chapter 5 - Discussion addresses the research aim and questions by considering the analysis of findings and how they have contributed to the identified gap in knowledge within the existing body

of literature relating to personal resilience and as related to the study's thematic findings, following established IPA conventions (Smith et al., 2009). This chapter also identifies potential new avenues for future enquiry, which is seen as a good outcome of quality IPA research (Smith et al., 2009).

Chapter 6 - Contribution summarises how this study has addressed the research aim and questions, the overall contribution to knowledge, and the potential for impact. It achieves this by summarising the original contribution to knowledge and potential contribution to practice. It then examines the strengths and limitations of this study, and finally outlines potential avenues for future enquiry.

Chapter 2: A thematic review of the literature and context for this study

2.0 Introduction

This chapter outlines the context of this study by presenting a thematic review of the literature relevant to the personal resilience of NHS executive leaders. It starts by illustrating personal resilience as the overarching theme for this study, including interdisciplinary perspectives, how it has been defined in various ways including as a response, as factors, as qualities and traits, and as a process. The challenges associated with attempting to define personal resilience as a complex, multifaceted, subjective, and contextual phenomenon are also discussed.

The chapter then explores the themes of stressors and personal resilience in the context of NHS executive leaders. As there is a lack of literature in this area, views are considered from the broader interdisciplinary leadership related resilience literature, healthcare workforce related resilience literature, and the limited body of literature that has explored the personal resilience of healthcare leaders. The literature is predominantly taken from empirical and broader meta-analysis articles that relate to personal resilience as a phenomenon and more specifically to the personal resilience of NHS executive leaders.

2.1 Personal resilience as a phenomenon

Table 1 lists a variety of definitions for personal resilience over the past 20 years, grouped by various disciplinary perspectives. Personal resilience has received much attention in the health-related disciplines of psychology and nursing, and more recently in literature relating to business and people management.

Definitions in Table 1 demonstrate that whilst there is no clear consensus within and across these disciplinary perspectives, a commonly held view is that personal resilience involves an individual experiencing a form of stressor, adversity or trauma and then responding positively by either recovering, adapting and/or developing.

Table 1: Definitions for personal resilience across various disciplines over the past 20 years		
Definition	**Authors**	**Discipline**
"A dynamic process encompassing positive adaptation within the context of significant adversity"	Luthar et al., 2000 pp.543	Psychology
"The motivational force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony with a spiritual source of strength. This force is resilience, and it has a variety of names depending upon the discipline"	Richardson, 2002 pp.309	Psychology
"The ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning"	Bonanno, 2004 pp.20	Psychology
"Psychological resilience refers to effective coping and adaptation although faced with loss, hardship, or adversity"	Tugade and Fredrickson, 2004 pp.320	Psychology
"Resilience reflects a dynamic confluence of factors that promotes positive adaptation despite exposure to adverse life experiences"	Truffino, 2010 pp.145	Psychology
"Psychological resilience is the role of mental process and behaviour in promoting personal assets and protecting an individual from potential negative effects of stressors"	Fletcher and Sarkar, 2013 pp.16	Psychology
"The ability of an individual to recover from a traumatic event or to remain psychologically robust when faced with an adverse event"	deTerte et al., 2014 pp.416	Psychology
"Adult personal resilience is a multifaceted construct that includes a person's determination and ability to endure, adapt and recover from adversity"	Taormina, 2015 pp.36	Psychology
"A process to harness resources to sustain wellbeing"	Panter-Brick, 2013 pp.432	Anthropology
"The capacity to transcend adversity and transform it into the opportunity for growth"	Gillespie et al., 2007 pp.125	Nursing
"The ability of an individual to adjust to adversity and can be applied to building personal strengths in nurses"	Jackson et al., 2007 pp.1	Nursing
"The ability to bounce back or cope successfully despite adverse circumstances"	Hart et al., 2014 pp.720	Nursing
"Individualistic coping while encountering continual difficulties and challenges at work"	O'Dowd et al., 2018 pp.7	Medicine
"Best conceptualised in terms of process and outcome: the process of working through difficult challenges and the outcome of quicker recovery combined with an increased capacity to cope with pressure"	Flint-Taylor, Davda and Cooper, 2014 pp.1	Business Management
"A capacity that develops over time and incorporates interactions between the individual and the environment"	Forster and Duchek, 2017 pp.284	Human Resource Management

The literature also articulates that personal resilience is too complex to define within a short and concise definition, such as those within Table 1. Wider debate within the literature centres around personal resilience being the response of 'bouncing back' to one's original state, the impact of personal risk/protective factors, a mixture of personal traits, qualities and personality, a process of adaptation and learning, a subjective phenomenon that requires contextual definition, and potentially a multifaceted combination of all of these factors by considering personal resilience as a meta-theory.

2.1.1 'Bounce-back' response

The term resilience is historically derived from the Latin word '*resilire'* which means 'to leap back' (Gillespie et al., 2007; Fletcher and Sarker, 2013). Resilience as a concept has historical roots within the physical sciences, where materials and objects are termed resilient if they resume their original shape after being exposed to physical stressors (Southwick et al., 2012). For this reason, definitions of personal resilience often use the term 'bounce-back' from experiences of stress and adversity to an individual's original state to describe this responsive quality (Tugade and Fredrickson, 2004; Tomassini, 2015). Building on this responsive quality, many researchers conclude that personal resilience can be considered as a successful, effective, and rapid response that enables individuals to overcome personal adversity, challenging and stressful situations (McAllister and McKinnon, 2009; Fletcher and Sarkar, 2013; Southwick et al., 2014).

2.1.2 Risk and protective factors

The view that personal resilience is simply a 'bounce back' response lacks appreciation of the variety of potential factors that enable an individual to experience it as a response to stressors. A variety of established factors such as biological, environmental, sociocultural, and psychological have been cited for some time as impacting an individual's ability to be resilient (Egeland et al., 1993; Southwick et al., 2014).

It is cited that the origin of research into personal resilience has roots in child psychology, which originally explored 'risk factors' that could increase the likelihood of psychological issues in an individual, and later changed to focus on 'protective factors' following longitudinal research by Emmy Werner (Luthar et al., 2000; Richardson, 2002; Forster and Duchek, 2017). Werner (1989, 1997) studied children growing up in high-risk environments over a 40-year period and, contrary

to expectation, found that most of these children demonstrated positive development and grew up to be confident, accomplished, and caring adults. Werner identified that these children had specific 'protective factors' that mitigated them against the negative consequences of adversity, and therefore these factors contributed to them being personally resilient. These protective resilient factors were split into 'individual' factors, 'family' factors and 'community' factors, which have since been simplified into 'individual' and 'environmental' factors (Forster and Duchek, 2017).

More recently, Southwick et al. (2012) developed a ten-factor model as a result of a meta-analysis of themes across a variety of resilience studies relating to individuals/groups who had experienced extreme trauma, such as survivors of war. These factors include optimism, adaptation, morality, spirituality, social support, role models, physical fitness, mental fitness, emotional flexibility, meaning and purpose. However, whilst developed from a variety of studies into personal resilience, this ten-factor model is limited to the context of survivors of extreme trauma. A challenge when attempting to explain personal resilience in this way is that some of these factors may not be available to an individual due to the current context that they are in, for example social support may not be available at the particular time it is needed to support an individual's personal resilience. Furthermore, there are a variety of complex ways that these factors could interact and impact an individual's personal resilience. De Terte et al. (2009) attempt to address this in their five-factor model of personal resilience, which they later simplified to a three-factor model (De Terte et al., 2014). This model brings resilience factors together including cognitions, emotions and behaviours and attempts to explain how these factors interact in the context of the individual's environment and potential to access social support. However, similar to the ten-factor model by Southwick et al. (2012) their model is based on survivors of extreme trauma, meaning that it may not be applicable to wider populations.

Southwick et al. (2014 pp.2) went on to illustrate the limitations associated with considering personal resilience as a combination of factors, stating:

> *"Determinants of resilience include a host of biological, psychological, social and cultural factors that interact with one another to determine how one responds to stressful experiences … no single demographic, personality or biological factor has been shown to predict or enhance resilience by more than a small degree."*

This brings into question the relevance of taking a factor-based perspective when explaining personal resilience, as no particular factors have been found to have any significant impact on predicting an individual's ability to be personally resilient. This illustrates that despite study in the area, the phenomenon is complex, contextual, and difficult to predict.

2.1.3 Qualities and traits

Personal resilience has been considered as a mixture of innate personal attributes, traits, and qualities that individuals possess that enable them to adapt to stressful situations (Fletcher and Sarkar, 2013). Personality traits have been linked to an individual's ability to be resilient, including the 'Big 5 Personality Traits' (i.e. openness, conscientiousness, extraversion, agreeableness, and neuroticism). For example, in a review of the literature relating to coping and resilience by Carver and Smith (2010 pp. 679) it was found that:

> *"…optimism, extraversion, conscientiousness, and openness [leads] to more engagement coping; neuroticism [leads] to more disengagement coping; and optimism, conscientiousness, and agreeableness [leads] to less disengagement coping"*

Carver and Smith (2010) also found that increased neuroticism (i.e. experiencing negative emotion) has a negative impact on personal resilience, conscientiousness (i.e. being organised and dependable) predicts low stress exposure, and agreeableness (i.e. trusting, kind and helpful) leads to low social stressors. This demonstrates how a combination of these traits can combine and impact on an individual's ability to cope in different interrelated ways. However, personality alone cannot predict personal resilience. Flint-Taylor et al. (2014) concluded that whilst personality traits can interplay in how an individual experiences personal resilience, personality is complex and wider personal factors (e.g. intelligence) and contextual factors (e.g. environment) can impact on how personality is displayed, and therefore how resilience is exhibited.

A challenge with taking the view that personal resilience is a mixture of qualities, traits and characteristics is that there seems to be an inexhaustive list of them. Richardson and Waite (2002) highlight this by identifying variety of traits and personal characteristics documented within the literature that could constitute aspects of personal resilience, including; self-esteem, self-efficacy, social responsibility, adaptability, communication, achievement-focused, easy temperament, self-mastery, internal locus of control, humour, problem solving, critical thinking, achievement motivation, positive values, positive identity, sense of purpose, determination, intelligence, creativity, faith, gratitude, self-control, hope, optimism – to name but a few. This complex and exhaustive list of traits, personal attributes, and qualities demonstrates that there is no clear understanding of how these different elements impact personal resilience and supports the view that personal resilience is multifaceted and may be too complex to define in a trait-based way (Southwick et al., 2014; Aburn, 2015).

2.1.4 Process of adaptation and learning in response to stressors

A limitation with taking the view that personal resilience is a mixture of factors, personal qualities and traits is that it implies resilience is fixed. It does not account for the impact of varying environmental factors, how personal resilience can change over time, or that it can become different in different contexts for different people (Forster and Duchek, 2017). To account for this, personal resilience has also been considered as a dynamic contextual process of positive adaptation, adjustment and learning that an individual goes through in response to adversity, starting in childhood (Egeland et al., 1993) and continuing throughout adulthood (Luthar et al., 2000; Richardson, 2002; Aburn et al., 2015; Forster and Duchek, 2017).

Fletcher and Sarkar (2013) illustrate this by discussing personal resilience as a process that individuals go through in response to stressors, emphasising that the contextual nature of resilience means that the process may be different each time, even for the same individual repeatedly experiencing it. Richardson and Waite (2002 pp.65) endorse that personal resilience is a process and also illustrate the various contexts in which personal resilience can be experienced, stating:

> *"…the resiliency process is the experience of being disrupted by change, opportunities, adversity or challenges and, after some disorder, accessing personal gifts and strengths to grow stronger through the disruption."*

This builds on the literature that discusses personal resilience in the context of trauma and adversity (Southwick et al., 2012; De Terte et al., 2014) by illustrating that it can also be experienced in the context of change, and also as a positive experience such as embracing an opportunity. Forster and Duchek (2017 pp. 284) argue that taking a process view of resilience enables researchers to account for this contextual and dynamic nature of personal resilience, stating:

> *"The consideration of resilience as a process includes a more dynamic view in which it can vary contextually, situationally and temporally. It is acknowledged that global resilience does not exist and that there can be different resilience levels depending on the various spheres of life"*

This highlights the challenges associated with taking a process view of personal resilience, as it may never be possible to generalise or define the phenomenon without also articulating a rich understanding of the context in which personal resilience is presented.

2.1.5 Challenges and the need for contextual definitions

In a review into personal resilience literature, Fletcher and Sarkar (2013 pp.16) state:

> "*The key messages to emerge from the literature are that most definitions are based around the two core concepts of adversity and positive adaptation, resilience is required in response to different adversities ranging from ongoing daily hassles to major life events, and positive adaptation must be conceptually appropriate to the adversity examined in terms of the domain assessed and the stringency of criteria used. Notwithstanding these points, due to resilience being manifested across a variety of contexts, scholars need to be sensitive to the sociocultural factors that contextualize how it is defined by different populations."*

This supports the consensus within the various disciplinary definitions presented in Table 1**,** which predominantly share the view that personal resilience involves two core concepts of adversity and positive adaptation. It also illustrates the complexity of studying and attempting to define personal resilience as a phenomenon by outlining the multifaceted relationship between the varying contexts that an individual can experience personal resilience, and how this can also vary across different populations. Truffino (2010) illustrates this by highlighting the complexity of studying personal resilience as a concept, stating that the phenomenon is not defined by a single indicator and requires the consideration of different domains and ways it can be expressed. In an integrative review of empirical resilience literature, Aburn et al. (2015 pp.985) state:

> *"One could show great personal strength, courage and adaptability in one setting and area of life – for example, work – but may have tough hurdles to overcome in one's personal life."*

This demonstrates the challenge when attempting to generate a universal definition of personal resilience, as it is dependent upon the subjective context of the individual experiencing it, which is further complicated by individuals existing in various contexts throughout their lives in parallel, such as work life and personal life. Ungar (2003) makes the case that it is not possible to generalise personal resilience as a concept and argues for increased qualitative study to allow for the contextual nuances of the phenomenon to be considered through the unique voices of those experiencing it.

In a systematic review of resilience as a phenomenon from within the body of business management literature, Linnenluecke (2017 pp.4) state:

> *"…resilience has been conceptualised quite differently across studies, meaning that the different research streams have developed their own definitions, theorises and*

understandings of resilience … resilience research has been highly context-dependent … little is known about the transferability across different contexts …"

This establishes the view that personal resilience needs to be explored in multiple different contexts, and that further research is required to consider the conceptual and contextual similarities across these multiple studies and their contexts if resilience is to be better understood. Linnenluecke (2017) also highlights a further complexity in resilience research within the field of business management by considering the resilience of the 'organisation' as a collection of diverse employees, in relation to the 'personal resilience' of the individual employees within the organisation.

The view that personal resilience cannot be generalised and needs to be contextually explained is supported by many researchers into the phenomenon, often describing it as 'complex', 'multidimensional', 'dynamic', 'temporal', 'contextual' and 'subjective' and that it requires study in a variety of contexts with a variety of different populations in order to better define it as a phenomenon (Carver, 1998; Bonanno, 2004; McAllister and McKinnon, 2009; Fletcher and Sarkar, 2013; Flint-Taylor et al., 2014). It is also cited that personal resilience is idiographic in nature, meaning that it can only be defined by the individual experiencing it based upon their unique life-experiences and perspectives (Henning, 2011; Southwick et al., 2014). When considering all of the various multi-professional perspectives held on personal resilience, it is arguable that one single definition of personal resilience becomes somewhat meaningless, as definitions of personal resilience require specificity to the context and the stressors that a subjective population and/or specific individual are exposed to within that context.

2.1.6 Resilience as a metatheory

A challenge with the literature discussed above is that it describes personal resilience as multifaceted, subjective, contextual, and complex, yet is limited to pointing out this problem without attempting to offer an explanation or ways to address this. Richardson (2002) is the only identified work that attempts to address this, arguing that resilience is a metatheory that encompasses many theories as a way to rationalise this and proposes a 'metatheory of resilience' to attempt to embrace and explain this challenge (Richardson, 2002; Richardson and Waite, 2002). Understanding this theory offers a way to engage with the complexity of personal resilience by connecting resilient 'qualities' to the 'process' of being resilient through bringing together

interdisciplinary discussion (psychology, biology, medicine, physics, philosophy) and is described in 'three waves'.

Richardson (2002) describes 'wave 1' as defining resilient 'qualities', and states that the identification of resilient qualities has been enabled through a recent paradigm shift in resilience research, away from considering resilience as mitigating environmental problems and risk factors that lead to psychological difficulties, and toward the identification of strengths-based qualities and protective factors that enable an individual to cope. Richardson identifies many resilient qualities including happiness, wellbeing, optimism, faith, self-determination, wisdom, excellence, creativity, morals and self-control, gratitude, forgiveness, and humility (Richardson, 2002; Richardson and Waite, 2002).

Richardson defines 'wave 2' as the 'process' for how these resilient qualities are acquired and proposes a resiliency model. This model starts with an individual being disrupted from homeostasis, through 'life prompts' such as experiencing stress and adversity or engaging with opportunities, implying that personal resilience can be a response to both positive and negative stimuli. He states that individuals then experience disruption arising from these experiences and subsequently move on to process and respond to their experience and reintegrate in four ways. Firstly, they can recover with a level of dysfunction; secondly, they can recover with a loss of functioning; thirdly, they can reintegrate back to their original state of homeostasis; and fourthly, they can reintegrate resiliently, which he describes as growing from the experience and developing and/or enhancing their personal resilient qualities, as described in wave 1.

Richardson then goes on to describe 'wave 3', taking an interdisciplinary perspective of personal resilience to explain the driving force behind an individual's personal resilience. He states that individuals are driven by an innate energy to grow, reach self-actualisation, and by a sense of purpose, stating:

> *"A succinct statement of resilience theory is that there is a force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony with a spiritual source of strength. This force is resilience, and it has a variety of names depending upon the discipline." (Richardson, 2002 pp. 313)*

He uses various disciplines to explore this theory. For example, drawing on physics and its links between energy, matter and life, cell biology and how neuropeptides (relating to nerve activity) are formed through positive feelings, and psychoneuroimmunology in how the body's immune

system and mind are connected, citing links between people who are optimistic, energised, and hopeful to having better immune systems and therefore potentially more resilient.

This theory addresses the trait, qualities, and process debate within the literature by highlighting the connection between resilience as traits and qualities that can be developed, and the process of resilience that an individual goes through to be resilient and return to their original state or grow their resilient qualities when responding to stressors and opportunities. However, a problem with this theory is that it remains unproven, potentially due to the need for personal resilience to be viewed as an interdisciplinary phenomenon, which to date has not been embraced within the empirical literature. Wave 3 is also highly problematic, as whilst it positions personal resilience as something highly complex that needs consideration and connection between disciplinary perspectives, it only provides very limited examples to illustrate this point with no clear empirical evidence to justify this with any degree of certainty. Richardson (2002 p.313) acknowledges this, stating:

> "*It is with some hesitancy that a discussion of the third wave be presented here because it opens the doors to a vast diversity of opinion, scepticism, and perspective.*"

Whilst Richardson himself identifies that there are challenges and limitations with his metatheory of resilience, this remains one of the only theories that both engages with the contemporary notion that personal resilience is complex, contextual, subjective and dynamic phenomenon (Bonanno, 2004; McAllister and McKinnon, 2009; Henning, 2011; Fletcher and Sarkar, 2013; Flint-Taylor et al., 2014; Southwick et al., 2014; Aburn et al., 2015; Linnenluecke, 2017) and also attempts to explain why, by offering an interdisciplinary way for personal resilience to be better understood.

2.2 Stressors and personal resilience in the context of NHS executive leaders

As personal resilience is both contextual and subjective (Southwick et al., 2014; Aburn et al., 2015; Linnenluecke, 2017) it is important to consider the literature that is situated in both the context for this study (i.e. healthcare) and through the subjective lens of the participants (i.e. NHS executive leaders). Acknowledging that existing definitions share the view that personal resilience is a variety of facets that enable a positive response in the face of stressors (Fletcher and Sarkar, 2013; Flint-Taylor et al., 2014; Hart et al., 2014; Taormina, 2015; O'Dowd et al., 2018) this section firstly discusses the literature that considers stressors, and secondly the literature that considers how personal resilience is conceptualised in relation to these stressors. Perspectives are drawn from the body of leadership, healthcare workforce, and smaller body of healthcare leadership related personal resilience literature, and comparisons are discussed.

2.2.1 Stressors as antecedents to personal resilience

Fletcher and Sarkar (2013) state that resilience has two core contexts, adversity and positive adaptation, implying that personal resilience cannot exist without firstly experiencing stress, adversity or trauma. They also state that this experience of adversity can range from daily life hassles and minor stressors, through to traumatic major life events. Therefore, to understand personal resilience it is important to consider the concept of stress and potential stressors as antecedent to personal resilience.

The concept of stress is described as a non-specific response to the demands placed upon a person that exceeds their available personal resources to cope (Lambert et al., 2003; Goldstein and Kopin, 2007). Collins (2006) states that work-related stress is estimated to be the most common occupational health problem and that millions of working days are lost to work related stress annually in the UK. There are well researched links between stress from work intensity and resultant negative physical and mental health outcomes, in addition to wider negative personal wellbeing implications (Sutherland and Cooper, 1995; Collins, 2006; Franke, 2015).

2.2.2 Stressors facing leaders

Identifying the stressors facing leaders gained increased attention in the 1990s. However, there has been less engagement with stressors that affect senior executive leaders (Mannor et al., 2016). A review into leadership stress by Smith and Copper (1994) states that organisational culture, poor relationships, lack of work-life balance and role ambiguity affect the stress of leaders. Through a multi-sector review of leadership stress, Worrall and Cooper (1995) identified 89% of executive leaders as stressed and 33% experiencing a stress-related illness. Both Worrall and Cooper (1995) and Sutherland and Cooper (1995) found that competition, time pressures, volume of work and performance-targets were the main sources of executive leaders' stress, which ultimately negatively impacts upon their health. Whilst these studies are outdated, it appears that much of their findings are still valid. More recently, Sharma and Singh (2016) identified similar stressors facing executives, including lack of clarity and growth, work-life balance, workload, lack of autonomy, unachievable goals, poor communication, and poor interpersonal relationships. However, this study is focused on executives in the financial marketing sector and may not be transferable to wider contexts. Mannor et al. (2016) state that there has been little engagement with stressors that affect senior executive leaders and argue that this population may experience high levels of anxiety as a result of failing to meet overwhelming demands which could lead to the risk of dismissal.

Sonnenfeld and Ward (2008) considered how very senior and public-facing leaders such as politicians, business leaders and media stars rebound after severe stress from 'career disasters' such as being dismissed. Whilst not being empirically based, they do highlight the potential stressors and adversity that very senior and public-facing leaders experience. They state that a major source of stress is how any form of personal adversity is negatively compounded by being high-profile in the media and public eye. They highlight that because of this, loss of personal reputation is a major source of personal stress for these senior public-facing leaders, often compounded by their inability to tell their side of the story due to political, organisational, and personal factors. This can leave them unable to rebuild their reputation and therefore they never fully recover from severe personal adversity, such as being publicly dismissed from their job. They propose that because of their high-profile roles, another potential distinguishing factor is how any form of personal career or reputational adversity also impacts on the leader's friends and family, predominantly fuelled by public and media attention.

2.2.3 Stressors facing the healthcare workforce

The NHS national staff survey has documented a steady increase in all NHS staff reporting work related stress over the past several years. The proportion of NHS staff reporting '*feeling unwell as a result of work-related stress in the last 12 months'* has continually risen over the past several years, where 36.8% reported this in 2016, 40.3% in 2019, and 44% in 2020 (NHS Staff Survey, 2021).

A variety of stressors have been identified that affect the healthcare workforce. A literature review by Jackson et al. (2007) into workplace adversity in the nursing profession found that excessive workloads, lack of autonomy, bullying and violence from patients, and organisational issues such as restructuring were the main sources of stress. A similar study exploring the resilience of nurses by Hart et al. (2014) found that the main sources of stress included challenging workplaces, psychological emptiness, diminishing inner balance and a sense of dissonance. When studying stress, coping and resilience in doctors, O'Dowd et al. (2018) identified that workplace stressors included long shifts, lack of resources, competing demands, heavy workloads, dealing with complex and emotionally taxing nature of care delivery, lack of control, lack of work-life-balance, and negative cultures as perceived challenges to the medical profession.

A limitation facing the majority of the literature exploring stressors facing healthcare professionals in the workplace is that these studies mainly fall within one professional field, such as nursing or doctors, potentially limiting the context to that specific professional group. However, a review of stress in the healthcare workplace that considers clinical (i.e. nursing, doctors, allied health professionals) and non-clinical (i.e. administration, management) by Smollan (2015) identified similar stressors to Jackson et al. (2007) Hart et al. (2014) and O'Dowd et al. (2018) including high workload, limited resources, conflict, psychological and physiological demands, job-insecurity, limited social support. However, a differentiating factor is that Smollan also places emphasis on transition through change as the most stressful aspect of healthcare-work. Whilst Smollan's work is limited to a small sample group of healthcare workers from outside the UK, scholars such as Collins (2006) and reports into NHS leadership (Rose, 2015; Smith, 2015) endorse that the NHS has been in a state of continual change for some time, and state that this has caused significant stress and anxiety to the NHS workforce and NHS leaders. Collins (2006) argue that the cumulative effect of many smaller stressors leads to general 'wear and tear' that eventually manifests itself in physical illness for healthcare workers.

Healthcare specific and in-particular nursing related literature also considers an added emotional layer of stress specifically facing healthcare professionals. Jackson et al. (2007 pp.4) state:

> *"Nurses bear witness to tragedy, suffering and human distress as part of their daily working lives … although nurses spend a great deal of time and effort caring for others, they show little evidence of self-care"*

This suggests that emotional stressors arise from delivering healthcare and that this comes at self-sacrifice, potentially adding a further layer of stressors to the healthcare workforce. This is also illustrated in the study by Kornhaber et al. (2011) who identified that nurses that care for patients affected by extreme trauma and injury are themselves exposed to emotional exhaustion, distress, reduced self-esteem, and desensitisation to pain when delivering care to these patients. Healthcare professionals in certain settings such as mental health are also more routinely exposed to extreme personal trauma, such as experiencing violence from patients, adding continual physical and emotional stressors to their daily work-lives (Itzhaki et al., 2015). The concept of 'emotional labour' has recently been adopted in healthcare to describe this and how healthcare professionals can suppress their emotions or behave in a way that is not aligned to their actual feelings as a result of dealing with this additional emotional burden of caring (Delgado et al., 2017). Healthcare professionals also have to deal with stressors arising from the moral dilemmas that they face when delivering care services, particularly when their own personal morals are in conflict with an established organisational course of action (Dellve and Wikstrom, 2009; Wicks and Buck, 2013).

When considering the potential for extreme trauma exposure in the healthcare environment, Posttraumatic Stress Disorder (PTSD) has been identified within the healthcare workforce. PTSD is a mental disorder that can develop after exposure to extreme trauma, leading to complex psychological symptoms such as distress, avoidance and negatively altered mood (Bisson et al., 2015). Whilst PTSD is predominantly studied in populations exposed to extreme trauma such as survivors of war (Southwick and Charney, 2012) PTSD has also been identified as a risk factor associated with several healthcare professional roles such as paramedics (Streb et al., 2014) emergency department professionals (Laposa et al., 2003) and nurses (Czaja et al., 2012). Risk of exposure to PTSD is also significantly increased when responding to intensely traumatic situations in healthcare, such as dealing with a crisis situation (Carmassi et al., 2020).

2.2.4 Stressors facing healthcare leaders

Whilst stressors have been studied from the perspectives of various clinical healthcare professionals and the wider leadership community, there is little literature drawn from empirical

studies that explicitly examine the stressors facing leaders within healthcare. The small number of studies identified that do address this are either not empirically based, or are through a specific healthcare professional lens (i.e. nurses or doctors). For example, Jackson and Daly (2011) discuss adversity and the personal resilience of nurse leaders, arguing that they face stressors relating to increased personal accountability for the quality of care, imposed organisational change and restructuring, lack of resources, staff shortages, excessive workload, and lack of autonomy. However, this article is not empirically based. Dellve and Wilkstrom (2009) draw attention to the moral stressors faced by nurse and doctor leaders when making decisions a in their leadership roles that comply with organisational norms, yet conflict with their personal values. They also state that stressors arise from feeling isolated or excluded, due to the conflict between retaining their clinical-professional identity, and leadership-role identity, when having to make decisions in the interest of the corporate organisation that conflict with their own clinical-professional group views. However, whilst empirically based, this study is through the subjective lens of a small sample of nurses and doctors who also take on management and leadership responsibilities in addition to their clinical roles, meaning that it may not be transferable to wider populations of healthcare leaders.

There are only a small number of studies that consider the stressors facing senior NHS executive healthcare leaders, and much of this originates from studies where stressors are not the main focus of the research. Recent reviews into the state of NHS leadership (Rose, 2015) and how to develop future NHS leaders (Smith, 2015) describe the NHS as a stressful, highly pressurised, performance-focused environment, burdened with bureaucratic-regulation, political and public scrutiny.

> *"The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable". (Rose, 2015 pp.9)*

These reviews argue that this bureaucratic NHS environment creates stressors for NHS leaders when attempting to effectively manage their healthcare services. This concurs with studies by the Kings Fund into senior leadership vacancies in the NHS (Janjua, 2014) and the experiences of NHS chief executives (Timmins, 2016) which describe how NHS executive leaders are operating within an adverse, constantly changing, and pressurised environment that emphasises their inadequacies over their successes. Whilst executive roles are described as pivotal to running NHS services, they also state that due to the highly stressful nature of these jobs, fewer people are aspiring to become NHS executive leaders. This has resulted in the NHS operating with significant executive vacancies

and is adding further stressors to the existing executive leadership community who are trying to perform and compensate for a lack of peer leaders. Rose (2015 pp.24) states:

> *"The current level of support given to … senior individuals such as [lists of executive roles] … is woefully inadequate. There is no 'step up' for these individuals: either they have the necessary leadership skills, or they don't … NHS management careers depend too much on chance … There is limited investment in systematic leadership training for staff and as a consequence capability suffers which is ultimately poor for the patient".*

This identifies how the lack of support given to NHS executive leaders operating in this stressful environment and those aspiring to be in these positions, adds a further layer of stress by expecting these individuals to remain resilient, yet providing little support to enable them to do so.

Whilst Janjua (2014) Rose (2015) Smith (2015) and Timmins (2016) outline some of the stressors facing this community, this literature considers the state of NHS senior leadership in general and not through the specific lens of stress or resilience. The lack of empirical research specifically into the stressors facing executive healthcare leaders is perhaps not surprising, given the challenges associated with accessing what is considered an elite group (Mikecz, 2012; Lancaster, 2017). However, a very small number of studies have illuminated the stressors facing NHS executive leaders.

Kelly et al. (2016) is the only study identified that specifically considers the stressors of executive leaders. They identified both chronic (i.e. long term) and acute (i.e. short term) sources of stress faced by executive nurse directors. Chronic stressors included high workload, lack of corporate responsibility for care quality, reductions in staffing, tensions between financial solvency and the quality of care, and feeling personally vulnerable from a constant fear of being dismissed due to being held accountable for the quality of patient care. Acute stressors included dealing with complaints or responding to major incidents. Whilst Kelly et al.'s (2016) study showcases stressors that may face executive NHS leaders, it is only through the lens of nurse executives and therefore may not be transferable to the wider NHS executive leadership community such as finance, human resources, medical, operations and chief executive leader roles. Timmins (2016) research into generic experiences of NHS chief executive leaders argue the need for culture change to support NHS executive leaders with their demanding roles. Whilst their study is restricted to a small sample of chief executives and stress is not the main focus of the study, it does illuminate some of the stressors that this hard-to-reach audience face. These stressors include the burden of leading in a highly regulated environment, balancing ongoing financial pressures inversely against trying to improve the quality of services and patient care, an increasing lack of personal support to discharge

such demanding roles, how the perception of the executive role is negatively influenced by politics, and a feeling of loneliness from being the most accountable leaders and exposure to challenging behaviours from regulatory bodies and politicians, which some liken to bullying. *Timmins (2016 pp.21) states:*

> *"Several of the interviewees said that they knew of people who had suffered 'horrendous' experiences at the hands of regulators, or who had quit, or for whom the stress had led to early retirement. Two of those we approached to take part in this study declined because the experience of leaving when they didn't want to, or in effect of being sacked, was too raw".*

This illuminates the personally vulnerable nature of these roles, demonstrating the potential traumatic personal consequences for being the most senior and accountable leaders in a highly regulated environment. Timmins (2016) also found that this was especially true those from clinical professional backgrounds, as they risk losing both their professional registration as a clinician and their executive leader role if they are held accountable for organisational failings, which concurs with the findings by Kelly et al. (2016).

2.2.5 Comparison of the stress literature across the fields of leadership, healthcare workforce and healthcare leadership

Comparing the bodies of leadership, healthcare workforce, and healthcare leadership stress related literature, the common stressors across all of this literature includes work-life balance, lack of resource, workload, relationships and organisational culture. The body of leadership stress related literature appears to identify competition as a differentiating stressor to that of healthcare leaders, however this is not surprising as this literature is focused on leaders from the private sector, which is arguably focused on profit and less of a concern for healthcare sector leaders.

The body of healthcare workforce stress related literature places emphasis on ongoing change, emotional stressors, and moral stressors as potential differentiators to the body of leadership and healthcare leadership stress related literature. Furthermore, this literature suggests that healthcare professionals can be exposed to higher levels of trauma when delivering care, also linking PTSD to certain high-risk healthcare professional groups, which is not discussed in any of the leadership stress related literature. Whilst the small body of knowledge that considers healthcare leader stressors does suggest that these leaders face similar stressors including moral stressors and stress arising from ongoing change, it does not identify emotional stressors or

exposure to extreme trauma and PTSD for this group, potentially because healthcare leaders are removed from the frontline delivery of care services.

There is less literature that specifically considers the stressors facing very senior executive leaders, however the smally body of literature available suggests that fear of reputational damage due to being visible public figures could be a common stressor for this group. Whilst there is very little literature that considers the stressors facing NHS executive leaders, the most notable differentiator appears to be the lack of support to enable them to discharge their roles effectively, combined with a sense of vulnerability arising from the potential of being held personally accountable for organisational failures, as the most senior leaders in the highly regulated, political, and bureaucratic NHS environment.

2.2.6 Personal resilience of leaders

There is a lack of literature that considers the personal resilience of leaders, as this appears to be a new and understudied area with no established definition for this population. The literature relating to the personal resilience of leaders can be split into two areas, where the majority of the literature seeks to explore the leader's impact on other peoples' personal resilience (i.e. their peers, workforce, teams, employees and followers) and much less of the literature seeks to explore what personal resilience is for them as leaders, or what enables their personal resilience. This is supported by Forster and Duchek (2017) in one of the few studies identified that explores the personal resilience of leaders. They state that "*the resilience of leaders itself is still largely unexplored"* and argue that this lack of engagement in the literature means that there is no overall conceptualisation of resilience for leaders and that the small body of existing literature can only articulate a "*scattered collection of possible factors*" (Forster and Duchek, 2017 p.289).

When considering the leadership related personal resilience literature that considers the leader's impact on other peoples' personal resilience, it may be possible to infer factors from these studies that are important to a leader's own personal resilience. For example, Teo et al. (2017) studied how healthcare leaders respond to a crisis and found that these leaders utilise social relational networks and resources to help their workforce and their organisation respond effectively. They achieve this by promoting the creation of social networks to enable their workforce to collectively make sense of the situation and work together to manage it as they transition through the crisis. Whilst this concurs with the broader resilience literature (Southwick et al., 2012) and healthcare workforce resilience literature (Jackson et al., 2007) that identifies the importance of social support

in enabling personal resilience, it also suggests an added importance, connection, and complexity of this social support for senior leaders when orchestrating this social support for others. Carmeli et al. (2013) explored the relational connections between peers in senior management teams and their ability to make better decisions and foster personal resilience. They found that a senior management team who feel connected felt more psychological safe, more adaptable, and perceived that they could make better decisions. Whilst Teo et al. (2017) and Carmeli et al. (2013) identify the link between a leader's relationship with their peers and their workforce in enabling personal resilience, they do not consider in detail how this social support is enacted. However, several studies have identified the role that leaders have in enabling the personal resilience of others through the lens of personality, the use of personal leadership style, positive emotion, and enabling relationships.

Nguyen et al. (2016) explore how leaders' impact on employee personal resilience through the lens of leadership style and personality for a variety of white-collar workers across multiple industries. They found that a leadership style that empowers others, combined with proactive personality (i.e. predisposition to change-orientated behaviour and goal orientation) and the specific personality trait of optimism (i.e. tendency to expect positive outcomes) enabled the personal resilience of employees. Similarly, when exploring personal resilience in the context of the US military, Gaddy et al. (2017) found that 'authentic leadership style', defined as a pattern of behaviour that promotes positive psychological capacities and positive ethical climate, had a positive impact on employee resilience. Dordio-Dimas et al. (2018) found that leaders who demonstrated a 'transformational leadership' style (i.e. charismatic, visionary, empowering others, ideas focused and enabling change) enhanced the personal resilience of their teams through enabling better relationships and enhanced team viability. Similarly, when exploring leadership style on the resilience of teams during an organisational crisis in the context of healthcare, Sommer et al. (2016) found that transformational leadership behaviours increased followers' positive emotion and indirectly their ability to be resilient. In contrast they found that style of 'transactional leadership' behaviours (i.e. following established process, monitoring performance and correcting mistakes, focus on reward and punishment) has no impact, or a negative impact on the personal resilience of followers.

This body of literature focusing on the impact the leader has on other people's personal resilience suggests that positivity and optimism alongside an enabling leadership style could have an impact on a leader's own personal resilience, in addition to that of their followers. Furthermore, it suggests the importance and complexity of enabling social support to a leader's own personal resilience,

where Carmeli et al. (2013) and Teo et al. (2017) draw explicit attention to how a senior leader's personal resilience is interconnected with that of others.

Whilst the majority of the leadership resilience literature has explored the impact that the leader has on other people, there has been much less study into what personal resilience is to leaders themselves, which has been acknowledged as a gap within the current literature (Forster and Duchek, 2017). However, there has been some engagement in the literature that discusses personal resilience as a response to stress and identification of enabling qualities, traits, and factors that are associated with the personal resilience of leaders.

Ganster (2005) explored the link between the level of stress experienced by executive leaders and their ability to make decisions. Whilst much of the literature presents stress in a negative way, they found that stress can have a positive impact on a senior leader's performance and ability to make decisions, as it forces them to make rapid decisions by narrowing down their choices. This is similar to the 'fight or flight' response as commonly discussed within the stress and resilience related literature, where 'fight' is seen as tackling the problem and 'flight' is walking away from it (Semadeni et al., 2008; Webster et al., 2016). Fight or flight has been discussed as a response by employees when responding to a 'toxic leadership' environment (Webster et al., 2016) and as a response for how senior leaders themselves manage stress (Semadeni et al., 2008). It was found that executive leaders who opt for 'flight' suffer fewer labour market consequences when compared to those who choose to 'fight' and stay when an organisation is facing difficulty (Semadeni et al., 2008). However, these findings are within the context of banking executives and therefore potentially not transferable to other leadership contexts.

Ledesma (2014) considered how existing conceptual models of resilience within the literature relate to the personal resilience of leaders. They state that leaders who exhibit the qualities of positive self-esteem, hardiness, strong coping skills, self-efficacy, optimism, social resource, adaptability, determination, and tolerance of uncertainty enable them to be personally resilient when facing adverse situations. They also argue that leaders can develop their personal resilience, stating that leaders can engage with the concept of 'thriving', defined by them as the ability to develop beyond their original level of functioning despite exposure to stressful experiences. This concept remains unproven for leaders as Ledesma's discussion is restricted to conceptual engagement with the literature rather than being empirically based. However, the concept of thriving has received some discussion within the smally body of literature that links it to personal resilience more broadly and identifies how engaging in 'personal growth' and feeling of 'vitality'

can contribute toward experiencing personal resilience (Spreitzer et al., 2005; Carmeli and Spreitzer, 2009).

Lazaridou and Beka (2015) studied the personal resilience of Greek primary school principals and found that of the 'big five' personality traits, conscientiousness and extraversion were positively related to their personal resilience, whilst agreeableness was negatively related. However, as Lazaridou and Beka themselves state, this study is very specific in context and is unlikely to be generalisable.

Forster and Duchek (2017) were able to identify and categorise the enablers to leaders' personal resilience, including traits (being serene, rational, analytical, and optimistic) abilities (learning, relaxed, optimism, rational, analytical, and communicative) situational factors (social support and a positive work climate) and behavioural factors (reflexivity, analytical, structured, communicator, trustful, and sincere). Similar to Ledesma (2014) they suggest that leaders can develop their personal resilience, concluding that the majority of these identified factors can be influenced by the leader themselves. They also call for further studies to broaden the understanding of this phenomenon for leaders, acknowledging that there is a lack of research in this area and that their own research is limited to a small sample of leaders.

Whilst these studies begin to develop an understanding for what enables the personal resilience of leaders, there are very few studies that explicitly consider the personal resilience of very senior public-facing leaders, such as the NHS executive leaders as part of this study. Similar to the findings within the stress related literature discussed previously, this is potentially not surprising given the difficulty in engaging what can be considered an elite audience (Mikecz, 2012; Lancaster, 2017). However, a small number of studies have attempted to do this and identify the importance of positivity and optimism as enablers for this group of senior public-facing leaders.

Sonnenfeld and Ward (2008) are one of the few articles to highlight factors that may distinguish very senior public-facing leaders' personal resilience from other populations. They state that a leader's ability to resiliently rebound after career adversity is enabled in several ways. Firstly, they propose that a distinguishing factor for senior leaders is how they frame stressors, stating that the same situation can be viewed both positively and negatively, yet by looking at the stressor in a positive way, it makes the leader more likely to respond resiliently. They also state that successful leaders are able to keep sight of their personal 'heroic mission' and acute sense of purpose, and that despite setbacks and adversity, they are able to find ways to reconceptualise or reconnect to this sense of purpose to drive them to keep going. They also state that developing vast networks of social support can also enable senior leaders to recover quickly, as they can call on this support

when experiencing personal adversity and get multiple diverse perspectives, as well as direct support from these networks to respond more effectively. Whilst this is one of the few articles to consider the distinguishing factors for very senior leaders' personal resilience, it is not empirically based and is not possible to draw any conclusions of transferability. However, this is one of the few papers that has considered the resilience of very senior public-facing leadership figures in this way.

Sarkar and Fletcher (2014) studied the personal resilience of a small group of high achievers, such as public figures who have been recognised with awards. Similar to Sonnenfeld and Ward (2008) they found that optimism and positivity enabled the personal resilience of these individuals. They also found that the choice to work in a demanding environment and that taking personal responsibility to learn from engaging with the challenges faced within that environment, combined with being adaptable and seeking support from others enabled these individuals' personal resilience. They also acknowledge that personal resilience is multi-faceted in nature and that there need to be more studies that consider the phenomenon from the perspectives of successful individuals, rather than through the lens of people who survive adversity to better understand it. Whilst this study is focused on a small sample of high achievers rather than senior leaders directly, it is one of the few studies that offers understanding into how arguably successful and resilient leaders perceive personal resilience.

A commonality across Sonnenfeld and Ward (2008) Sarkar and Fletcher (2014) and Forster and Duchek (2017) is how these senior leaders draw on optimism to support their personal resilience. Peterson et al. (2008) is the only identified study that considers leaders who view stressors through an optimistic lens, and how this can impact their personal resilience. They propose that the concept of 'psychological capital', comprising of the combined qualities of optimism, hope, confidence to explain why some leaders are more resilient than others. Their preliminary work identified that leaders with higher psychological capital were more resilient, however concluded that further research is needed before any definitive conclusions can be made.

2.2.7 Personal resilience of the healthcare workforce

Personal resilience literature relating to the healthcare workforce generally agrees with the body of knowledge that defines personal resilience as a responsive process of adaptation and learning in the face of stressors (Gillespie et al., 2007; Jackson et al., 2007; Hart et al., 2014; O'Dowd et al., 2018). Personal resilience has received a broad level of discussion within the healthcare workforce

related literature and focuses on how healthcare professionals can enhance their personal resilience. However, a limitation with this body of literature is that it is predominantly based within the field of nursing, meaning that it may not be transferable to wider healthcare professional roles.

Jackson et al. (2007) conducted a review into the literature that considers workplace adversity and resiliency for nurses and argues that relationships and social support are the most significant enablers of personal resilience. They found that being reflexive and developing personal insight from experience enables nurses to better respond to stressors and that finding a sense of balance, connectedness, purpose, and spirituality in life are grounding for nurses and enable their personal resilience. They also state that personal resilience comes from maintaining a sense of optimism, finding positive meaning in the face of adversity and by focusing on positive emotion to regulate the impact of negative emotion during adverse situations. Hart et al. (2014) also conducted a review of the literature into what makes nurses resilient. Similar to Jackson et al. (2007) they identify that work-life balance and actively finding ways to focus on positivity in the face of adversity are enablers to nurses' personal resilience. In addition, they make the case that nurses are frequently exposed to emotional stressors when delivering care to others and need to develop not only a continual sense of positivity but also 'emotional toughness' which can include emotionally detaching from challenging situations in order to cope. Similarly, Kornhaber and Wilson (2011) and Delgado et al. (2017) argue that when delivering the burden of caring for others, nurses are exposed to highly distressing situations that require them to supress these emotions in order to cope and remain resilient.

McNeil et al. (2019) studied the personal resilience and wellbeing of care workers and how this impacted their perceptions of the quality of care delivered. They found that delivering high quality care to others had a positive impact on the personal resilience of care workers, summarising that 'doing good, leads to feeling good'. Other healthcare worker related personal resilience studies have identified similar findings. Ablett and Jones (2007) identified that whilst working in the emotive setting of end-of-life care, palliative care nurses' personal resilience was enabled by their conscious choice to work in that setting and their personal commitment to making a difference for their patients. Jackson et al. (2007) identified that a sense of connectedness and purpose to what nurses do enables their personal resilience through the positivity that this brings. O'Dowd et al. (2018) identified that a sense of job-related gratification was related to a sense of personal resilience in doctors. Both O'Dowd et al. (2018) in the context of doctors and Jackson et al. (2007) in the context of nurses also identified that reflexivity and being self-aware enables these healthcare workers to cope and be personally resilient when delivering care. The act of delivering

care being linked to enabling the personal resilience of healthcare workers by generating positive emotion (Ablett and Jones, 2007; O'Dowd et al., 2018; McNeil et al., 2019) is in contrast with how it has also been linked to experiencing negative emotions and reducing personal resilience (Delgado et al., 2017). This adds a further layer of complexity and unpredictability to how healthcare professionals may experience personal resilience in the context of delivering healthcare.

The healthcare workforce related resilience literature supports the view that personal resilience is something that can be learnt. For example, Itzhaki et al. (2015) argue that it is possible to learn from the most adverse of healthcare environments, such as working in mental health which is considered especially traumatic for healthcare workers due to the emotive nature of the mental health environment. They state that mental health workers are able to exhibit the concept of 'posttraumatic growth' in these contexts, defined as demonstrating positive psychological change from having learnt from adverse experiences. McAllister and McKinnon (2009) take the process view of personal resilience and make the argument that personal resilience can be learnt as part of an ongoing process of learning and should form part of training for all healthcare workers to enable them to cope. They also highlight that optimism is an important part of a healthcare professional's personal resilience and argue that it is possible to learn to be more optimistic.

2.2.8 Personal resilience of healthcare leaders

It has been noted that there is little empirical study into the personal resilience of healthcare leaders (Hudgins, 2016) which may not be surprising when considering that the personal resilience of leaders more broadly is thought of as being a contemporary area of research (Forster and Duchek, 2017). There has been some engagement in the literature that offers opinions on the personal resilience of healthcare leaders. For example, Hardacre and Keep (2011) argue that it is essential for healthcare leaders to have personal resilience, citing strategies to enhance personal resilience including focusing on options over solutions, being ok with not knowing the answer and embracing ambiguity, keeping connected to things they care about, avoid feeling overwhelmed, and making conscious and deliberate choices. However, these are opinions by Hardacre and Keep and lack the credibility of being empirically based. Very few empirical studies consider the personal resilience of healthcare leaders, and the small number that do predominantly focus upon the nursing profession rather than the breadth of healthcare leader professional roles.

Wei et al. (2018) considered the role that nurse leaders play in fostering the resilience of other nurses. They identified several strategies that nurse leaders use to achieve this, including facilitating social connections, promoting positivity, maximising nurses' strengths, nurturing personal growth, encouraging self-care, fostering mindfulness practice, and conveying altruistic personal qualities. Whilst it may be possible to infer how these strategies may impact upon the resilience of nurse leaders themselves, this study does not consider personal resilience of the nurse leader directly.

When considering what personal resilience is for healthcare leaders themselves, Jackson and Daly (2011) discuss the resilience of nurse leaders and define personal resilience as an ability to adjust to adversity with no loss of functioning. This suggests that nurse leaders are defined by their ability to continue to lead effectively when facing adversity, without impacting on their performance as leaders. They also suggest that emotional insight, life balance, spirituality, reflexivity, being optimistic, and being able to draw on social support from personal networks enhances personal resilience. However, their article is limited to discussion that considers a small body of leadership and resilience literature. Dellve and Wilkstrom (2009) studied a sample group of clinical leaders and found that their personal resilience was enabled by social support networks, access to support from organisational services such as Human Resources, and personal development in the form of courses, mentoring and learning on the job. However, this study is focused on junior management level clinical leaders and lacks detailed discussion on how personal resilience is viewed by this audience.

There is very little literature that considers the resilience of NHS executive leaders. A governmental report into the importance of building NHS executive leadership capacity and capability by Rose (2015 pp.27) states:

> *"The key leadership relationships within a Trust [NHS organisation] are between the Chief Executive, the Clinical Director and Chief Nurse, and between the Chief Executive and the Chair. A crucial relationship also exists between the Executive and the Non-Executive [Director] Team. There is a need for each group to … build their capability and resilience as well as their combined ability to lead".*

Whilst personal resilience was not the main focus of this report, it states the need to build the personal resilience of these NHS executive leaders. However, it fails to define what personal resilience is for this group or how to develop it, other than highlighting the importance of training and personal development for these executive leaders and how they must support each other.

There are only two identified studies that consider the personal resilience of NHS executive leaders. Timmins (2016 pp.72) study into the experiences of NHS chief executives highlights the importance of social support, stating:

> "*It is absolutely clear that having other [NHS] chief executives to talk to when under pressure really matters – whether that is through a formal, informal or build-it-yourself network*".

However, this study is limited to generic experiences of a small sample of NHS chief executives and did not set out to consider their experiences through the lens of stress or resilience. Kelly et al. (2016) is the only study that has specifically considered the personal resilience of NHS executive leaders. Similar to Timmins (2016) they identified that social support is the main enabler of their personal resilience, including support from fellow executives, peer nurse executives, family, personal mentors and coaches. However, their findings that relate to the enablers of personal resilience for this group received limited and anecdotal discussion within their article, with brief mention of management development courses, the need to take breaks to aid personal recovery, and a belief held by some nurse executives that personal resilience relates to innate personality traits. Whilst this is the only identified study that seeks to explicitly illuminate personal resilience for NHS executive leaders, it is also restricted in focus to the executive director of nursing role, meaning that findings cannot be considered in terms of wider NHS executive leader roles such as the medical, HR, finance, operations, or chief executive officer.

2.2.9 Comparison of the resilience literature across the fields of leadership, healthcare workforce and healthcare leadership

Comparing the bodies of leadership, healthcare workforce, and healthcare leadership related personal resilience literature, the commonalities across this body of literature is that they all liken it to the process view of resilience, stating that it is possible for an individual to develop personal resilience over time. Social support, a sense of purpose, positivity and optimism are common enablers across of these bodies of literature.

A distinguishing factor present in the healthcare workforce related personal resilience literature, yet not found in the leadership literature appears to be the need to emotionally detach. However, this could be explained by the emotive elements of delivering care for frontline healthcare workers, which is possibly not as relevant to individuals in detached leadership roles, or to leaders from other sectors where care is not the main focus of their business.

The body of leadership related personal resilience literature outlines various enablers that do not appear in the healthcare workforce literature, such as being adaptable and being able to deal with uncertainty. This may not be surprising, as a leader may be more likely to have to deal with ambiguity due to the complexity of their role. This body of literature also engages with personal resilience as a response to stress, likening it to 'fight or flight' and that stress can also be positive as it forces rapid decision making, which is not mentioned in the healthcare workforce literature. A further distinguishing factor in the body of leadership personal resilience literature is how it is split between the leader's impact on other peoples' personal resilience, and what resilience is to them personally. This potentially demonstrates a tension that leaders hold in both being personally resilient themselves, whilst also simultaneously having to enable the resilience of those around them, suggesting an additional layer to the importance of social support in a leader's personal resilience.

The small body of literature that considers the personal resilience of very senior leaders builds on the need for a sense of purpose to enable their personal resilience, suggesting their resilience is enabled through following their 'heroic mission'. It also adds a further layer to social support, suggesting that very senior leaders draw resilience from their peers and mentors. There is very little literature that considers the personal resilience of NHS executive leaders, meaning that it is not possible to draw any conclusions about how this population may differ from other healthcare workforce and other leadership roles.

2.3 Summary and implications for this study

This chapter has provided an overview into personal resilience as a phenomenon, drawing on interdisciplinary perspectives that present personal resilience as a response, risk and protective factors, traits, qualities, and a process of adaptation and learning. It has also outlined the lack of consensus in the literature for what personal resilience is, describing it as a dynamic, contextual, and subjective phenomenon that needs to be studied as such (Truffino, 2010; Forster and Duchek, 2017). This draws attention to how it may never be possible to develop one clear definition for what personal resilience is, as it could be unique to the individual experiencing it, in a specific context, and at a specific moment in time. The concept that personal resilience is a metatheory

has been discussed as a possible way of dealing with this tension of studying the phenomenon, enabling the comparison of personal resilience across different populations, and bringing in interdisciplinary perspectives. However, the literature has not yet embraced this perspective meaning that it is still a challenge for researchers to easily define and then compare how personal resilience is manifested. When engaging with the challenges of defining personal resilience, it has also been identified that researchers need to embrace qualitative research methodologies to capture the contextual nuances of personal resilience, and to be less driven by a need to create a generalisable definition through statistical study (Ungar, 2003). The implications of this for this study into the personal resilience of NHS executive leaders will therefore require a research methodology that is compatible with dealing with the contextual and subjective accounts from this population. This will enable the findings of this study to be better placed in relation to the body of personal resilience knowledge, and better enable engagement with its findings when considering personal resilience as a contextual and subjective phenomenon.

This chapter has also engaged with the leadership, healthcare workforce, and healthcare leadership related stress and personal resilience literature to consider the existing body of knowledge relating to context of this study (i.e. NHS healthcare) and its subjective audience (i.e. NHS executive leaders). Whilst government reports into NHS leadership call for NHS executive leaders to be more resilient (Rose, 2015; Smith, 2015) there is a lack of empirical study into the personal resilience of leaders (Forster and Duchek, 2017) and of healthcare leaders more specifically (Hudgins, 2016). Furthermore, there are no studies that have explicitly considered the personal resilience of all board level NHS executive leaders as a homogenous group (i.e. medical, nursing, human resources, operations, finance and chief executive). This gap in knowledge makes the aim of this study seeking to understand the personal resilience of NHS executive leaders a contemporary area, worthy of further study.

Whilst it may be unsurprising that there has been little study into the personal resilience of NHS executive leaders as they could be considered an elite audience (Mikecz, 2012; Lancaster, 2017) the literature also highlights the potentially vulnerable nature of being a very senior public-facing leader (Sonnenfeld and Ward, 2008; Janjua, 2014; Kelly et al., 2016; Timmins, 2016). Therefore, this study must account for these sensitivities as part of its methodological and participant wellbeing considerations if it is to be successful.

The following chapter considers the learning from within the existing body of knowledge discussed above and applies it to the methodological design of this study. It articulates the aim and questions of this study and how they are designed to address the identified gap in knowledge surrounding

the personal resilience of NHS executive leaders, including the need to define stressors as an antecedent to personal resilience and how personal resilience is experienced and defined for this population. It then outlines interpretive phenomenology as an appropriate methodology to study this contextual, dynamic, and subjective phenomenon with this NHS executive leader audience.

Chapter 3: Methodology

3.0 Introduction

This chapter introduces the research aim and questions for this study and then outlines the epistemological, theoretical, and methodological decisions as part of the research design to be able to address them. Phenomenology is introduced as the research philosophy appropriate for this study. Interpretive Phenomenology is presented as the methodological approach and the phenomenological attitude that the researcher adopted whilst undertaking the study is explained. Utilisation of Interpretive Phenomenological Analysis as method and procedures for this study are then detailed. Participant sampling, wellbeing, ethical considerations, and use of participant data are then discussed. The chapter concludes by discussing the credibility and quality of this study.

3.1 Research aim and questions

The previous chapter outlined a gap in the knowledge surrounding the personal resilience of NHS executive leaders. To address this identified gap within the knowledge, the aim developed for this study was to understand:

How do NHS executive leaders experience personal resilience?

The literature discussed in the previous chapter identifies that personal resilience needs to be understood and studied as a dynamic, contextual, and subjective phenomenon (Ungar, 2003; Truffino, 2010; Forster and Duchek, 2017). The term 'experience' was specifically chosen to reflect this and to enable the inductive investigation into the dynamic, contextual, and subjective aspects of the personal resilience of the NHS executive leader community. The literature outlines that to understand personal resilience, stressors as the antecedents to resilience must also be understood (Fletcher and Sarkar, 2013). The literature also identifies that personal resilience needs to be defined by the specific group or individual experiencing it, based upon their unique life-experiences and contextual perspectives (Henning, 2011; Southwick et al., 2014). The healthcare and leadership related personal resilience literature also highlights that there may be contextual differences in how healthcare workers and leaders experience personal resilience, and therefore this requires further consideration when exploring the personal resilience of NHS executive leaders as part of

this study. Applying this learning from the review of the literature toward addressing this study's research aim, the following questions were crafted:

1. How do NHS executive leaders experience stressful healthcare working environments?
2. How do these NHS executive leaders experience and define personal resilience when responding to these stressful environments?
3. What is the difference between being resilient, and failing to be resilient for them?
4. How is personal resilience gained, developed, and retained for these individuals?
5. Have their perceptions toward personal resilience changed throughout the duration of their careers (i.e. is there a uniqueness relating to executive leader resilience?)
6. How do they perceive working in a care-based profession impacts their personal resilience as an NHS executive leader?

These questions were developed in accordance with the Interpretive Phenomenological Analysis guidelines (Smith et al., 2009) that have been adopted for this study, which are discussed in detail during this chapter. Interpretive phenomenology was chosen as the methodological perspective to take forward this study, as it is well aligned to exploring the contextual and subjective nature of personal resilience as a phenomenon in an inductive way. It also aligns to the researcher being based within the research environment working in leadership development within the NHS, and the opportunities for creating knowledge that this aspect of the study brings. The remainder of this chapter will outline how the research study was designed and how Interpretive Phenomenological Analysis was used to address the research aim and questions in further detail.

3.2 Research design considerations

Crotty (1998) identifies four key elements to research design that a researcher must consider in relation to their study's aim and questions. Gray (2014) identifies that these four elements remain valid within social research due to their flexibility of approach and specific application to the social sciences, and are as follows:

1. What **epistemology** informs the study? i.e. the theory of knowledge embedded in the theoretical perspective and thereby in the methodology.
2. What is the **theoretical perspective**? i.e. the philosophical stance informing the methodology, providing context for the research process and grounding its logic and criteria.
3. What **methodology** governs the choice of methods? i.e. the strategy, plan of action, process or design underpinning the choice and use of particular methods.
4. What **methods** will the study use? i.e. the techniques and procedures used to gather and analyse data.

Utilising Crotty's (1998) elements of research design, Figure 1 illustrates how constructionism (as epistemological) interpretivism (as theoretical) and interpretive phenomenology (as methodological perspective) were aligned to this study. Figure 1 also visualises how phenomenology has the potential to span across a variety of theoretical perspectives of social research design including positivist, post-positivist, interpretivist, and constructionist philosophical paradigms (Crotty, 1998; Dowling, 2007). These elements will now be discussed in relation to the research design of this study.

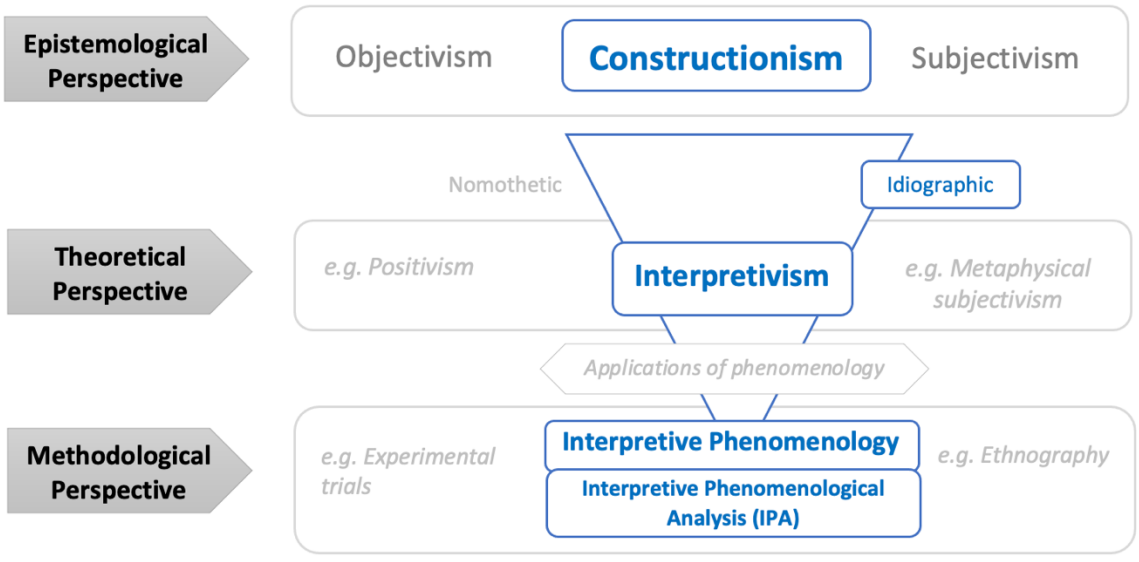

Figure 1: Epistemological, theoretical and methodological choices for this study (Developed from: Crotty, 1998; Dowling, 2007; Van Manen, 2014)

3.3 Epistemological perspective

In social science, which concerns itself with studying human beings, epistemological and ontological considerations must be considered (Crotty, 1998). Epistemology is the theory of how knowledge is created, and ontology is considered as the study of being and the nature of the reality under study, as derived from what human beings consider to be true and the meanings they give to this subjective truth within their perceived reality (Crotty, 1998; Gray, 2014).

When considering this in relation to this study into personal resilience, Henning (2011) and Southwick et al. (2014) refer to the idiographic nature of personal resilience as appealing to each individual's unique and contextual life experiences and the subjective meaning that they place on these experiences. They argue that personal resilience cannot be generalised and needs contextual and subjective explanation. Personal resilience is also described as something that people continually develop throughout their lives (Henning, 2011) and that this development is related to levels of social interaction (Southwick et al., 2014). McAllister and McKinnon (2009) emphasise that contextual social and cultural factors influence an individual's personal resilience. This potentially implies that personal resilience is something that is socially created, based upon the subjective meaning placed on personal resilience by individuals when creating their understanding of the phenomenon.

As this study seeks to embrace the subjective and contextual lived experience of personal resilience, these factors lend the study towards constructionism, which sees truth and meaning as constructed through the subject's interaction with their contextual world, rather than discovered through the general laws and detachment of objectivism, or seen as imposed on something by the individual through the lens of subjectivism (Crotty, 1998; Gray, 2014). Taking a constructionist perspective aligns to the aim of this study, seeking to add to the existing body of knowledge of personal resilience by gaining new insights about how NHS executive leaders experience and place meaning on their contextual and unique lived experience of it. Taking this perspective enables the participants within this study to construct their own unique meanings of personal resilience. This means that it is possible to see personal resilience as a phenomenon that has been constructed in different ways based upon each participant lived experience of it.

3.4 Theoretical perspectives

Human beings are unable to fully detach themselves from interpreting the world around them as they draw upon past experiences to enable them to make sense of any particular moment in time (Fleming et al., 2003; Van Manan, 2014). Combining this with personal resilience being considered as a subjective, contextual and dynamic phenomenon (Ungar, 2003; Truffino, 2010; Forster and Duchek, 2017) this perspective lends this study towards taking an interpretivist theoretical perspective. Interpretivist perspectives are closely aligned to constructionism and assert that whilst the natural sciences are nomothetic and seek to create generalisable laws through consistencies in data, the social sciences concern themselves with the ideographic, the contextual, the particular actions of individuals, and the unique meaning that they give to phenomena (Crotty, 1998; Gray, 2014).

When conducting research as a care worker in a care-based setting, Kahuna (2000) identifies both challenges and opportunities in the researcher's ability to create knowledge. For example, the challenge of making presumptions based upon the preconceptions from working within that environment, is balanced against the benefits to the research project such as an increased ability to empathise with participants and interpret data by being from the same environment. This is something that Costley et al. (2013) refer to as taking an 'insider researcher' perspective, where the researcher is situated within the research setting and has pre-existing relationships with the research environment, the participants, and preconceptions toward the research topic itself. Taking an interpretivist perspective acknowledges that the researcher can leverage the benefits of their insider researcher role by taking advantage of their pre-existing experience of the contextual research environment, their relationships with participants, and their preconceptions of the research topic (Kahuna, 2000; Costley et al., 2013).

Taking an interpretivist perspective as an insider researcher allows the researcher to construct knowledge in several ways:

- **Participant constructed**: The researcher interpreting the participants' description and interpretation of personal resilience as a phenomenon.
- **Constructed together**: Socially constructing an understanding of personal resilience through a shared dialogue.
- **Researcher constructed**: The researcher constructing their own understanding of personal resilience through continual observation and exploration of the phenomenon throughout the study.

3.5 Phenomenology

Ungar (2003) argues that qualitative research methodologies are best suited to exploring and understanding the contextual nature of personal resilience as a phenomenon. They argue that they enable discovery, study in context, are strengthened by description of that context, elicit minority voices to account for localised definitions, are tolerant to localised constructs by favouring transferability over generalisability, and are strengthened by the researcher having to account for their bias. Interpretive phenomenology was chosen as the qualitative methodological perspective for this study. It aligns to the epistemological possibilities and challenges for constructing knowledge within the context of this study, seeking to create contextual and subjective knowledge by leveraging the possibilities from the researcher being familiar and conversant with the research environment.

This section is designed to address Crotty's (1998) third (i.e. methodology) and fourth (i.e. method and procedures) points of research design in detail, by beginning with the overarching philosophical aspects of phenomenology and concluding with its practical application in relation to this study. The choice of interpretive phenomenology is outlined, how it can be applied to research when studying in the field of leadership, how the researcher in this study embraced an interpretive phenomenological attitude throughout the study, and finally details the procedures that were followed.

3.5.1 Introducing phenomenology

The term 'phenomenology' is used to describe both the philosophical movement initiated by the influential German philosophers Husserl and Heidegger, as well as a range of research methodology approaches. Underpinning both philosophical and methodological approaches to phenomenology is the quest to seek out new knowledge and understanding of phenomena, as experienced by human beings (Crotty, 1998; Van Manan, 2014; Vagle, 2014).

The word 'phenomenology' has origins in a Greek word meaning to 'bring something into the light', to 'show itself' or to 'appear' (Fleming et al., 2003; Dowling, 2007). The phenomenological movement arose from the need to 'go back to the things themselves', where these 'things' are the phenomena that present themselves to human beings prior to them becoming fully conscious of them (Crotty, 1998). Building upon this notion of bringing something forwards, Fleming et al.

(2003) describes phenomenology as looking past the obvious, and McNamara (2005) describes it as looking for the extraordinary in what could be considered ordinary. Conklin (2014) states how Husserl's 'transcendental' attitude, which involved putting aside the usual day-to-day things people believe to be true when they observe a phenomenon, allows the researcher to engage with the phenomenon afresh, to see new truth and discover new meaning.

Giorgi (2000) identifies the importance of differentiating between the 'philosophy' and the 'research methodology' of phenomenology. Giorgi states that a philosophical stance is more likened to 'reflecting on one's own experience', and a methodological stance is likened to 'investigating the experience of other people'.

Phenomenology as a research methodology refers to a suite of approaches that study how individuals make sense of their subjective world around them as it appears within their consciousness. This is achieved through the curious questioning relationship between the researcher and participant (Pringle et al., 2011; Van Manan, 2014). By being conscious of any preconceptions when engaging with these phenomena, this leads to a fresh, new, or enhanced understanding of the phenomenon under study (Crotty, 1998).

The flexibility of phenomenology allows for its application across a multitude of social research theoretical perspectives (Dowling, 2007). Whilst Husserl in his later work took phenomenology toward attempting to create a more objective perspective of a phenomenon (Dowling, 2007; Van Manan, 2014) phenomenology acknowledges that each human being will contextually see the world differently (Smith et al., 2009; Van Manan, 2014) and can easily align itself with a contextual view of the world. Phenomenologists refer to this using the term 'lived experience' to articulate how an individual's unique life experience causes them to perceive the world around them differently to one another and to place meaning on their experiences of that world in different ways. Crotty (1998) argues that whilst positivist research seeks to create a singular, objective and generalisable truth, phenomenology can readily align itself to the complete opposite. Scholars of phenomenology and particularly the interpretive branches are content in being unable to generalise from their research findings. They see the world of human beings as subjective and that it is impossible to generalise when each person has differing views of reality, developed from diverse and contextual life experience, culture and histories (Smith et al., 2009; Pringle et al., 2011; Smith and Osborn, 2015).

Gibson and Hanes (2003) pose that phenomenology is perfectly aligned to investigating the subjective nature of social science research. Practicing what has become referred to as a 'craft' (Smith et al., 2009; Vagle, 2014) enables scholars to embrace phenomenology's lack of

generalisability of findings, and instead seek to inductively answer research questions that allow for an immersive and meaningful exploration of a given phenomenon. For these reasons, phenomenological research is more likely to engage a small sample group of participants, who share similar experiences about the phenomenon in question (Smith et al., 2009; Smith and Osborn, 2015).

3.5.2 Applications of phenomenology in leadership research

The diverse application of phenomenology across the social sciences is growing, potentially due to how phenomenology can unearth new perspectives on the 'taken for granted' and how it readily aligns itself to exploring the lived experience of human beings. This is supported by scholars of phenomenology such as Smith et al. (2009) and Van Manen (2014) who readily call for phenomenology to branch out of its philosophical, healthcare and psychology origins and into wider social science fields.

The application of phenomenology within leadership studies and related social science fields such as human resource development, business management and organisational studies is also increasing. A search for phenomenological based leadership research as part of this study identified several recent applications of phenomenology within leadership studies. For example, taking a phenomenological perspective toward the lived experience of servant leadership (Savage-Austin and Guillaume, 2012) embracing a phenomenological attitude as linked to leadership development (Souba, 2014) in addition to utilising phenomenology in leadership related theses (Mays, 2008; McNeil, 2015).

Gibson and Hanes (2003) call for the Human Resource Development field to embrace phenomenology to capture the rich learning arising from exploring the complexity of subjective human experiences. They specifically draw attention to how the subjective, ontological, meaning-making focus of interpretive phenomenology resonates with Human Resource Development related fields. Gill (2014) supports this and describes a steady increase in organisational studies engagement with interpretive phenomenology.

Conklin (2014) endorses the application of phenomenology in organisational and management development fields, stating that phenomenology should be embraced to re-examine taken-for-granted preconceptions and generate new possibilities. Conklin provides a practical example in applying a phenomenological attitude towards the traditional deficit model of developing an employee's weakness, which gave rise to an alternative and liberating strengths-based approach

that focuses on 'good to great' and maximising their individual potential. Conklin also shares a practice-based example of applying the phenomenological attitude of curiosity, questioning and setting-aside preconceptions whilst dealing with a member of staff facing disciplinary action. This brought empathy and understanding towards a personally traumatic home-life situation that was causing their underperformance. Applying a generic, objective and taken-for-granted management policy would have missed their subjective personal context and left them disengaged, damaged, and their talent lost to the organisation.

A personal example is outlined within Turner and Nichol (2016) seeking to identify the participant voice when engaging in assessment centres to determine NHS leadership talent and potential. The study took a phenomenological, subjective, being-with attitude, removing prior assumptions about assessment centres, and focused on interpreting the participants' accounts of experience and meaning. This generated new insights that fundamentally challenged the traditional and ethical application of such people assessment and development activities.

3.5.3 Debate for applying phenomenology

Applying phenomenology to any research study does not come without its challenges. Sadala et al. (2002) and Pringle et al. (2011) in their review and critique of phenomenological approaches identify how scholars of phenomenology have been less clear in clarifying it as a research methodology. Van Manen (2014) outlines nearly forty philosophical branches of phenomenology, stating that it is easy to get lost in the vast array of phenomenological philosophy and miss its research application. Dowling (2007) identifies that this confusion between the philosophical and methodological approach has led to reducing the accessibility of phenomenology and therefore its benefits are going unrealised. Phenomenology as a research methodology has also been criticised by scholars such as Paley (1998) Sadala et al. (2002) and Pringle et al. (2011) for being inaccessible to the novice researcher, and confusing due to the lack of formal documented steps in applying the many forms of phenomenology.

In contrast to this critique, Conklin (2014) likens phenomenology to a suite of accessible and adaptable ideas for social science research. Dowling (2007) illustrates this by demonstrating the flexibility of phenomenology's application to a continuum of theoretical perspectives, including positivist (e.g. see the philosopher Husserl) post-positivist (e.g. see Merleau-Ponty) interpretivist (e.g. see Heidegger) and constructionist (e.g. see Gadamer) philosophical paradigms and related research methodologies. Vagle (2014) and Van Manen (2014) encourage the researcher to 'break

free' of the confines of traditional research methodological practice and take a 'leap of faith' in practicing phenomenology in a liberated way, trusting in one's own existing skill as a researcher and appealing to the creative aspects of phenomenological research. However, they also acknowledge that this is something only very experienced researchers are likely to aspire to do. To make phenomenology accessible, Smith et al. (2009, 2018) encourage the researcher to embrace the creativity and flexibility that taking a phenomenological approach can bring, in a way that is balanced against their own personal researcher experience.

3.5.4 Interpretive phenomenology philosophical roots

Husserl and Heidegger are German philosophers who are considered the founders of the two main branches of phenomenology. Husserl, as the originator of phenomenology, placed it within the epistemological (i.e. how knowledge is created) study of the human experience. Husserl grounds phenomenology within the descriptive sciences when applied to research and essentially seeks to describe experience as lived by humans (Crotty, 1998; Gill, 2014; Kaufer and Chemero, 2015).

Husserl employed the term 'reduction' to articulate a self-meditative process where the researcher puts aside the subjectivity and their preconceptions of the 'natural world' in order to see the phenomenon in its essence by 'bracketing out' (i.e. cognitively putting aside) their preunderstandings of the phenomenon. This begins to lend phenomenology towards a positivist theoretical perspective in being able to objectify the phenomenon in question (Dowling, 2007) and therefore away from the nature of this study which seeks to explore the contextual and subjective lived experience of participants.

Heidegger broke away from Husserl's descriptive and knowledge-seeking focus, stating that it discounts the interpretive potential of a research study, and instead took phenomenology towards the ontological (i.e. study of the nature of being and perceived realities) perspectives in exploring meaning, relationships and understanding of phenomena. Heidegger grounded phenomenology within the interpretive social sciences and moved towards explaining the world that is lived, rather than simply described or objectified (Gill, 2014; Kaufer and Chemero, 2015; Smith, 2019). Being at ease with the subjective, temporal, and contextual nature of what he described as 'the human experience', Heidegger also saw the researcher's interpretation as being a fundamental part of the research, seeing the interpretation as socially constructed between participant and researcher (Crotty, 1998; Smith, 2019). This is in contrast to Husserl's approach, endorsing that the researcher

should 'bracket out' their preconceptions in order to engage with, objectify and generalise the common essence of the phenomenon.

Philosophically it could be argued that scholars are never truly removed from their personal interpretation of research findings (Fleming et al., 2003). Even the purest of post-positivist researchers are required to personally interpret their findings from the statistical analysis of figures, drawing upon their own skills, knowledge, and experience of the research study. Paley (1998) argues that human beings are naturally self-interpreting and Van de Zalm and Bergum (2000) and Van Manan (2014) argue that phenomenology is therefore both descriptive and interpretive. Smith et al. (2009, 2015) see the practical benefit of initially describing the phenomenon, which then enables the researcher to engage with the text and interpret the meaning behind the transcript.

Considering the aim of this study to explore the lived experiences of NHS executive leaders' personal resilience, the Heideggerian approach to interpretive phenomenology is most aligned to this study. Interpretive phenomenology allows meaning to be generated from experience. It also takes into account the people-centric perspective required when conducting social science research where participants will be sharing personal accounts of their lived experience, which requires a degree of compassion from the researcher. It also appeals to the socially constructed nature of this study, as interpretive phenomenology acknowledges the benefit of the researcher being situated within the research environment and that the researcher's own unique interpretations and pre-conceptions of the phenomenon are a valid part of the subjective study of the participants' lived experiences (Smith et al., 2009; Smith, 2019).

3.5.5 Identifying Interpretive Phenomenological Analysis (IPA)

Table 2 illustrates Gill's (2014) comparison of established phenomenological research methods and procedures as relevant to organisational studies and related disciplines. It spans the dichotomy between taking a descriptive and objective phenomenological perspective (i.e. similar to Husserl) and interpretive and contextual perspective (i.e. similar to Heidegger). This is useful when appreciating the varying ways that phenomenological methods can be applied to different research questions and therefore assists the researcher in selecting the most appropriate phenomenological method and procedures for their study.

Being clear on the phenomenological method and procedures is important when considering how phenomenology can flexibly be applied across an array of methodological approaches (Dowling,

2007; Gill, 2104). This is also important in addressing the criticism within the literature, stating that published phenomenological research often lacks defined methods and procedures, meaning that it is not always clear how the researcher arrived at their conclusions, or how they applied phenomenology specifically (Paley, 1998; Sadala et al., 2002; Pringle et al., 2011).

	Phenomenology				
	Descriptive phenomenology (Husserlian)			**Interpretive phenomenology** (Heideggerian)	
	Sanders's phenomenology	**Giorgi's descriptive phenomenological method**	**van Manen's hermeneutic phenomenology**	**Benner's interpretive phenomenology**	**Smith's interpretative phenomenological analysis**
Disciplinary origin	Organization studies	Psychology	Pedagogy	Nursing	Psychology
Methodology as	Technique	Scientific method	Poetry	Practice	Craft
Aims	To make explicit the implicit structure (or essences) and meaning of human experiences	To establish the essence of a particular phenomenon	To transform lived experience into a textual expression of its essence	To articulate practical, everyday understandings and knowledge	To explore in detail how participants are making sense of their personal and social world
Participants (sampling)	3-6	At least 3	*Unspecified*	Until new informants reveal no new findings	1 or more
Key concepts	• Bracketing (*epoché*) • Eidetic reduction • Nomematic/noetic correlates	• Bracketing (*epoché*) • Eidetic reduction • Imaginative variation • Meaning units	• Depthful writing • Orientation • Thoughtfulness	• The background • Exemplars • Interpretive teams • Paradigm cases	• Double hermeneutic • Idiographic • Inductive
Applications in organization studies	Kram and Isabella (1985)	McClure and Brown (2008)	Gibson (2004)	Yakhlef and Essén (2012)	Murtagh, Lopes, and Lyons (2011)

Table 2: A typology of phenomenological methodologies (from Gill, 2014 p. 122)

In applying Gill's (2014) comparison to assist in narrowing down the most suitable phenomenological method for this study, Sanders and Giorgi's approach to phenomenology was incompatible as it is positioned within Husserl's phenomenology, which seeks to describe and objectify the phenomenon in question. Whilst Van Manen's phenomenology attempts to span both descriptive and interpretive stances, this was discounted due to lack of well-established, documented methods/procedures, and how it focuses on interpreting texts such as poetry, rather than people. Whilst Benner's interpretive approach is aligned with an interpretive stance, this too was discounted as it seeks to approach a broad sample group and reach saturation of interpretation. This would not be possible within the limited access issues likely encountered when engaging with NHS executive leaders as an elite audience (Mikecz, 2012; Lancaster, 2017) and would therefore be out-of-scope for the possibilities of this study.

Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009) was chosen for this study specifically because it lends itself to seeking rich, immersive, subjective accounts of individuals' experiences of a phenomenon from a smaller homogenous sample group. Smith et al. (2009) state that IPA allows experience to be expressed in its own terms, rather than against a predefined framework. Smith (2015, 2018) also argues that IPA is well suited to interpreting phenomena that

is complex, ambiguous, emotionally laden and psychologically related. This is compatible with the intention of this study and the identified research aim that seeks increased accounts of the subjective experiences of personal resilience to add to the knowledgebase of this contextual, subjective, and multifaceted phenomenon. When applied to the subjective and contextual nature of this study, whilst not generalisable, this allows for new and potentially undiscovered knowledge to be identified in relation to the subjective phenomena of personal resilience for executive leaders, within the context of the NHS where it is being explored.

Taking an IPA approach is also supportive to the insider researcher (Costley et al., 2013) aspect of the study, positioning the researcher being from within the NHS research environment as a benefit to the study (Kahuna, 2000). Utilising the concept of double hermeneutics described by Smith et al. (2009) the researcher in this study can utilise their own lived experience of the NHS, executive leaders, and personal resilience to enhance the interpretation of the participants' interpretation of the phenomenon to the study's advantage. This is opposed to 'bracketing out' their own preconceptions of the phenomenon to attempt to remain objective, which is aligned to Husserl's phenomenology. This aligns with the views documented by Wimpenny and Glass (2000), Fleming (2003) and Mauthner and Doucet (2003) who outline that it is impossible to truly bracket one's own preconceptions of a phenomena and instead these should be used to assist the interpretation of the phenomenon in question through continual reflexivity towards it.

3.6 Embracing an interpretive phenomenological attitude

Scholars such as Finlay (2008) Smith et al. (2009) Vagle (2014) and Van Manen (2014) outline the importance of embracing a 'phenomenological attitude' when conducting phenomenological research. A phenomenological attitude means to draw on the philosophical roots and ideas surrounding interpretive phenomenology, to enable the researcher to be able to apply them when conducting the research. This transforms phenomenological research from simply following an established method and procedures, to enabling it to 'become phenomenological', as aligned to Heidegger's philosophical underpinnings of interpretive phenomenology.

Appreciating that phenomenology is challenging to engage with for researchers who are new to it as both a philosophy and research methodology (Dowling, 2007; Pringle et al., 2011) the following section outlines several core philosophical principles crafted and followed by the researcher as

part of this study. They draw upon Heidegger's original philosophical teachings and are enhanced by the researcher's wider reading around phenomenology. The appreciation of how these principles were developed and applied during this study inform how the researcher was able to embrace an 'interpretive phenomenological attitude' when conducting this study and enabled to successfully apply Interpretive Phenomenological Analysis.

3.6.1 Double hermeneutics

Understanding 'hermeneutics' as theory of interpretation is a fundamental part of interpretive phenomenology. The word 'hermeneutics' was derived from the stories about the Greek God Hermes role in interpreting and communicating God's messages to humans and has since been historically grounded in reference to interpreting biblical and historic texts (Van Manen, 2014). Smith (2007) identifies how hermeneutics has since evolved into interpretation of history, law, arts and more recently the social sciences, as well as how the terms hermeneutics and interpretation are often interchanged.

Heidegger utilised the concept of hermeneutics as the basis to uncover the meaning of being in the world for human beings (Dowling, 2004; Braver, 2014). Heidegger saw that 'things' need to be 'coaxed out of hiding' to be seen and interpreted, and that engaging with what he called the 'hermeneutic spiral' was the means to uncover them and their meaning. This process started with appreciating one's own understanding of a phenomenon, then engaging with the participants understanding, and continually moving between these understandings as a means to uncover new insights and to interpret the phenomenon (Braver, 2014, Smith, 2019).

Applying hermeneutics to IPA, Smith (2007, 2019) points out that within social sciences the relationship and connection between the researcher (i.e. the interpreter) and the researched (i.e. the object of interpretation) enhances the interpretation by going beyond the text generated by the research encounter alone. For example, the transcript may read "I was ok", however the researcher may identify wider cues, such as the uncomfortable tone in the participant's voice and agitated body language, which allows for further questioning and a deeper interpretation and meaning of the participant's perception of the phenomenon under study. Smith articulates this as a 'double-hermeneutics', which refers to the researcher's interpretation of the participant's interpretation of the phenomenon being examined. Smith et al. (2009, 2015) see that interpretive phenomenology allows the researcher to 'discover' meaning in a phenomenon, and hermeneutics allows them to 'interpret' the meaning that is uncovered.

Crowther et al. (2016) argues that when considering hermeneutics, any interpretation within the social sciences is subjective, temporal, and open to multiple interpretations. It is therefore the researcher's role to openly embrace these tensions when transparently articulating the subjective meaning they have generated through their encounter with the participant.

3.6.2 Layers of lived experience

Capturing and analysing the 'lived experience' of day-to-day phenomenon is at the centre of interpretive phenomenology. Heidegger sought to capture experience of a phenomenon, rather that its description (Braver, 2014). For example, a book can be 'described' as pieces of paper bound together with text, however the 'experience' of the book could be an instrument to learn, a means of escapism, or something that brings back memories of childhood stories. A further example is how a restaurant is experienced as a place to eat, socialise and relax, rather than described as a series of tables, chairs and plates of food.

Smith et al. (2009) illustrates this by demonstrating that there are layers to lived experience. Smith sees that 'experience' is the smallest sub-unit of data in an interpretive phenomenological study (e.g. someone feeling the water on their toes on a beach). This then accumulates with other temporal sub-units of experience (e.g. someone feeling the sun on their back, noticing the pebbles when getting into the water, the emotional feelings occurring by being in this environment etc.) which then produces 'an experience' (e.g. swimming for the first time, whilst on holiday at the beach). Interpretive phenomenology concerns itself with capturing these major life experiences that are of significance to the individual.

3.6.3 'Being' in a world of 'beings'

Heidegger separates Being from beings. 'beings' (referred to with a lower case 'b') are simply the 'things' and 'people' around us, for example a cup, a book, a plate of food, the chef. Heidegger differentiates 'Being' (referred to with an upper case 'B') as the way these things are, their behaviours, and how people experience them (Braver, 2014). Heidegger uses the word 'Dasein' to ontologically refer to 'Being in the world'. He sees Being in a world as related to human-beings who are consciously aware and demonstrate this conscious awareness by caring about the worlds they are in. Heidegger also appreciates that each human-being's world will be subjective and different. Braver (2014) demonstrates the subjectivity in Being by articulating how a student may experience

a room differently to an electrician. A student may experience a classroom as a place to learn during their lived experience of being a student, whereas an electrician may experience it as a room that has electrical points within it.

Heidegger also sees that people are connected to other beings (people or objects) and that this connection helps people to make sense of their world they live in and care about. He sees that humans naturally seek connection, but also actively notice differences when 'Being with' others. 'Being with' and having empathy with others and objects within the world is something that is important when taking an interpretive stance and becomes essential when considering the potentially exposing nature of this study, which seeks to engage with participants unique and personal lived experience of personal resilience. Gibson and Hanes (2003) emphasise the importance of the researcher in building a trusting relationship that allows them to 'be with' participants as they are openly describing their views of their subjective world.

Dowling (2007) and Smith et al. (2009) point out that the notion of 'Being with' participants within an interpretive phenomenological stance is most appropriate for allowing the researcher to truly and empathically experience the phenomenon with the participant, and at the same time enhance their interpretation of the phenomenon. As a contextual consideration, 'Being with' and the empathic and caring nature of this aspect of interpretive phenomenology is also compatible with conducting research in the context of the health care environment, and the topic of personal resilience.

3.6.4 Temporality

Human beings have a subjective relationship with their world that is 'temporal' and Heidegger illustrates this by considering the past, present and future. He sees that people are 'already existing' and uses the term 'thrownness' to articulate how people have been 'thrown' into a world since birth that is full of a history that they cannot change, which therefore shapes their lived experiences of a phenomenon. He argues that as people live their lives, their choices and experiences will also continually change their perceptions of a phenomena. He also argues that people cognitively exist in the future, which is full of choices, and that they can cognitively project themselves into these choices (Braver, 2014).

Being temporal beings, this also means that for humans there is never one ultimate truth, as people can never know what will happen to them tomorrow. Their experiences of phenomena are always changing. However, Heidegger sees that the only truth is 'death', and that a series of 'endpoints'

punctuate throughout an individual's life leading up to this ultimate endpoint. When applied to interpreting phenomena, he argues that there will come an endpoint to each life experience. For example, someone stops Being a student when they graduate, as there are no more goals to achieve. Graduation is the endpoint to the experience of Being a student (Braver, 2014).

When engaging with participants within this study, it is important to remember that every encounter relates to a subjective period in time. The research encounter itself could alter the participants' perception surrounding the fluid phenomena in question (Van Manen, 2014) and the researcher has to factor this temporality into their analysis and interpretation.

3.6.5 Intentionality

To embrace a phenomenological attitude when studying a phenomenon, researchers need to be consciously curious about it. In phenomenology this is referred to as 'intentionality'. When experiencing phenomenon, Heidegger outlines a difference between 'readiness-to-hand' as something that is the focus of attention during the experience (e.g. eating the plate of food) and 'presence-at-hand' as the various other things that still exist in the world during the experience of eating the food, however are not the focus of attention (e.g. the table, chairs, people and atmosphere of the restaurant) and are still there, yet become distant when focusing on the experience at hand (Braver, 2014).

Gibson and Hanes (2003) describe intentionality as human consciousness as projected out into the world and towards objects of their attention. Crotty (1998) points out that consciousness is always conscious of something, and an object is always and object of someone's attention. In so, intentionality represents the relationship between human beings and their consciousness of Being in their world. In relation to this study, it can be thought of as both the researcher and participants being consciously curious about the phenomenon of personal resilience, in the context of being an executive leader in the NHS.

Heidegger also articulates that most of the time, human-beings are lost in their world that prevents them noticing things. He states that it is only when something does not work, people take notice of it. Likewise, he states that the mood of an individual will affect how they experience a phenomenon. He sees that the mood of anxiety has a particular phenomenological importance, as it actively 'illuminates the world around us' by forcing people to breakdown the meaning they give to objects of their experience by noticing the structures of their experience. For example, someone could become so anxious about something that they can no longer get lost in the experience of the

story in a book, and instead they begin to notice the book's structure simply as words on a page (Braver, 2014).

In relation to this study and when considered against layers to lived experience, anxiety has a close relationship with personal resilience. Therefore, the researcher must be consciously aware of the descriptions that participants give to personal accounts of being resilient during the interpretation. For example, are they anxiously focusing on the structures of the experience (e.g. I was in a room with windows, several people were there looking at me, I felt cold, I was on a chair etc.) or the overarching experience itself (I was afraid).

3.6.6 Inter-subjectivity and idiographic

The concept of 'inter-subjectivity' is a further part of an interpretive phenomenological attitude that reminds the researcher that peoples' worlds are already existing to them, subjectively-presupposed, and that their consciousness and understanding comes from their naturally evolving relationship with this subjective world. Drawing on Heidegger's notion of 'Dasein' (i.e. Being in the world) emphasises the importance of 'human being-ness' and that people have a subjective relationship being-in their subjective worlds. Building on the concept of Dasein, Smith et al. (2009) identify that interpretive phenomenology is idiographic in nature, meaning that it is concerned with 'the particular' in creating understanding from the subjective perspective of particular people, in particular circumstances.

This study is placed in the subjective, contextual, and particular. It acknowledges that scholars are seeking increased contextual and subjective accounts of personal resilience to augment knowledge and understanding of resilience as a multifaceted and contextual phenomenon.

3.6.7 Question and questioning

Understanding what constitutes the overarching phenomenological 'question' for the study is potentially one of the most important aspects of conducting phenomenological research. Van Manen (2014) outlines that a phenomenological question can arise from anything that gives reason to pause and reflect. He emphasises how people often live their day-to-day lives in a taken-for-granted way, never really reflecting on their experiences. However, the most interesting starting points for phenomenological lines of enquiry arise from exploring something that appears day-to-day ordinary, and upon reflection can bring a renewed sense of curiosity and wonder. To illustrate

this practically, consider the question 'describe salt, without using the term salty'. It is likely that this line of enquiry will provoke phenomenological engagement, and the reader is curiously left seeking renewed ways to describe their lived experience of something as day-to-day and ordinary as salt.

Phenomenological scholars practically state that 'questioning' is something of a methodological concern. For example, when describing how to undertake phenomenological research, Smith et al. (2009) Van Manan (2014) and Vagle (2014) outline that questioning naturally forms part of the interview process. Good questioning also actively demonstrates a 'Being with' attitude in Heideggerian phenomenological terms, enabling the development of good participant relationships, trust to share experience and therefore generate better research data. Smith et al. (2009) outline how successful interpretive phenomenological research is both questioning and empathic in generating understanding by attempting to see what it is like in 'somebody else's shoes'. Smith emphasises that successful phenomenological questioning is open and expansive and should build rapport with the participant to enable them to share their own personal account of the phenomenon under exploration.

Smith et al. (2009) and Vagle (2014) state that phenomenological interviewing should embrace semi-structured, or un-structured questioning. Vagle sees that the researcher must start with a clear sense of the phenomenon under investigation and emphasises that each interview is unique, and it is therefore not necessary to ask the same set of questions. Open, exploratory, and appreciative questioning enable the participant to elicit their unique subjective experience and uncover their meaning of the phenomenon. Van Manen (2014) shares this perspective and argues that phenomenological questioning is not about; generalising, creating theory, passing judgement, asking opinions and explanations, or anticipating the answers. He suggests that questioning should curiously elicit experience, for example; What was it like the first time, or last time? What happened before, during and after? What was the most memorable moment?

Gibson and Hanes (2003) outline how it should not be underestimated that the participant will likely gain a lot of personal development from sharing their accounts of the phenomenon through the researcher's naturally curious questioning. This should also be considered in relation to the temporal aspects of interpretive phenomenological research, as outlined above, in that the personal development aspect of the questions within the interview itself may shift the participants thinking around the phenomenon (Braver, 2014; Van Manen, 2014).

3.6.8 Reflexivity

Reflexivity enables phenomenological practitioners to embrace things afresh and to discover a new, different, or enhanced understanding of phenomena (Crotty, 1998). Depending upon the chosen phenomenological stance, the emphasis on reflexivity takes place before, or continuously throughout the study (Van Manan, 2014).

Considering reflexivity in relation to Husserl's originating view of descriptive phenomenology, the term 'bracketing' describes Husserl's notion of reflexively putting aside past knowledge, experience, and preconceptions at the beginning of any research to truly embrace the phenomenon. Fleming et al. (2003) emphasises that it is important for researchers to do this so that they do not distort the phenomenon in question. Bracketing preconceptions reflexively enhances the rigor and objectivity of the researched phenomenon by reducing the chance that the researcher attempts to fit their findings into their own preconceived notions (Dowling, 2004).

Aligning to Heidegger's perspectives that a researcher will have their own lived experience of a phenomenon and that this cannot be bracketed out of any study, this study embraces and leverages that the researcher is based within the NHS, working within leadership development, and comes with their own preconceptions of the phenomenon, the participants, the research environment. It is seen that that this aspect of the study will enhance the interpretation, analysis, and findings. When considering this, Paley (1998), Wimpenny and Gass (2000) and Fleming et al. (2003) question if it is truly possible to achieve Husserl's form of bracketing as the researcher is continuously involved with interpreting their research data. It is argued that people are always interpreting the world around them (Crotty, 1998) and that this supports the application of an interpretive phenomenological perspective in embracing the researcher's preconceptions as adding to the analysis and interpretation of findings. Whilst reflexivity is important to any form of social science research (Crotty, 1998) taking an interpretivist view will require the continual practice of reflexivity. Within interpretive phenomenology, Finlay (2008) and Smith et al. (2009) call for ongoing reflexivity and suggest that the objectivity in interpretive approaches is gained from the researcher's ability to be continually reflexive toward the study, before, during and after engagement with the phenomenon and analysis.

Mauthner and Doucet (2003) acknowledge that it is unlikely that the researcher will ever fully appreciate their preconceptions and bias toward a research topic and that reflexivity can only ever assist in the research process. Kahuna (2000) sees that any prior knowledge of a phenomenon is both an asset, and a challenge. Kahuna advises those undertaking phenomenological research to

critically analyse their prejudice around their research topic to ensure a layer of rigor and objectivity, as well as consciously appreciating how their preunderstandings can also enhance their subjective interpretation.

3.7 Applying Interpretive Phenomenological Analysis (IPA)

This study embraces scholars such as Smith at al. (2009) and Conklin's (2014) recommendations to apply IPAs steps imaginatively in line with the creative and liberating roots of interpretive phenomenology. The following procedures are presented for this study, based upon IPAs well documented (Smith et al., 2009) and well applied (Smith, 2011; Smith and Osborn, 2015) procedures. They are enhanced through the researcher's wider reading around interpretive phenomenology and applied utilising the 'phenomenological attitude' described above. They are outlined in detail, as quality phenomenological research should clearly outline the procedures followed so that others can understand how the data was gathered, analysed, and presented (Giorgi, 2010; Pringle et al., 2011).

3.7.1. Reflexivity towards the phenomena

Continual reflexivity is imperative to any interpretive phenomenological study as it allows the researcher to fully engage with the double hermeneutic cycle (Smith et al., 2009). It enables researchers' to be continually curious about their own preconceptions, the interpretation and meaning the participant presents, the joint interpretation, and any interpretation they generate themselves (Mauthner and Doucet, 2003; Finlay, 2008). Finley (2008) outlines the value of the researcher engaging in 'hermeneutic reflexivity' as an iterative, ongoing reflexive process in being self-critical to and becoming conscious of their own subjectivity, prejudice, and preconceptions, before, throughout and after the study.

To embrace this ongoing reflexivity, the researcher of this study reflexively considered questions such as: What is already known about the phenomena? What is the personal experience and beliefs about it? When is this true, untrue, or ambiguous? What bias and preconceptions are there? What will enable the researcher to remain open, curious and see it afresh?

To document and enhance this reflexivity, a reflective journal was kept throughout and periodically used to explore and document the researcher's engagement with the study, the phenomenon, the participants, and analysis. This was augmented by the reflexivity gained through regular contact with the research supervisory team, as well as seeking wider ways to reflexively explore personal resilience as a phenomenon, for example exploring the phenomenon with peers.

3.7.2. Engaging participants in phenomenological interviews

A phenomenological interview is specifically designed to elicit the participants' lived experience of the phenomena and allow the researcher to engage in the double hermeneutic cycle. Smith et al. (2009) see IPA as an ongoing cycle, as the researcher tries to make sense of the participants, trying to make sense of their world. Whilst it is acknowledged that the overarching phenomenological question for any study can arise from anything that gives reason to pause and reflect (Van Manen, 2014) the interviews themselves were designed to allow the participant to explore the phenomenon of personal resilience freely and openly. The interview is also the core aspect of demonstrating Heidegger's notion of 'Being with' the participant to gain their trust and elicit true accounts of their personal lived experience (Gibson and Hanes, 2003; Dowling, 2007).

Smith et al. (2009) and Vagle (2014) endorse the application of semi-structured or unstructured interviews to enable the participants to freely express their experience of the phenomenon. This approach yields a potential challenge that interviews may at times go off on tangents and may need refocusing (Vagle, 2014). Therefore, in accordance with how Smith et al. (2009) acknowledges the benefits of the researcher holding a framework of potential question areas in relation to the overarching phenomenological question and the research aim, a 'questioning place mat' was developed to assist with the interviews, aligned to the study's research aim and questions (Appendix 1).

Considering the need to quickly build trust and enable the participant to feel comfortable in sharing their accounts (Dowling, 2007) all interviews took place within a comfortable, mutually agreed, and undisturbed surrounding that was suitable for audio recording. This was important when considering the senior nature of NHS executives and how this study required them to express personal accounts, which is potentially something that they are less used to doing within their elite senior leader roles (Lancaster, 2017). The researcher eased each participant into the study by building rapport, ensuring that they were at ease with and fully agreed to participation in the study. Participants were then asked to provide an overview of their career history to assist the researcher

with understanding their background and add context when attempting to interpret their lived experience of the phenomenon. The overarching phenomenological question was then posed to the participant to begin the main investigation into their lived experiences of personal resilience:

> *What is your experience of personal resilience in the context of being an NHS executive leader?*

For participants who struggled with this broad initial question as a starting place for the interview, the researcher reframed this opening question to:

> *In the context of being an executive leader in the NHS, personal resilience to you is like… what?*

This reframe utilised 'clean language' questioning techniques, that have been documented to assist phenomenological (Owen, 1996) human resource and management research (Tosey, 2011; Tosey et al., 2014a, 2014b) by removing any bias from the question posed. This enabled the participant to connect to the question, respond in an un-bias way, and elicit metaphor in relation to the phenomenon under study.

As with Smith et al. (2009) accounts of phenomenological studies, the researcher then used open and exploratory questions to explore the participants' experience of the phenomenon. At times, the researcher summarised and reflected back what the participant had said to check for understanding. The researcher's 'in the moment' interpretations of aspects of the phenomenon were also shared with the participant as they conversed in their meaning-making together as part of the double hermeneutic process. At times, the researcher posed open questions, or where it was appropriate, further utilised clean language as an un-bias questioning technique to elicit deeper meaning of the accounts being expressed.

It was important for the researcher to remain in the phenomenological attitude described above at all times, empathically 'Being with' the participant, being open, reflexive, embracing intentionality and being curious about the phenomenon by utilising curious questioning to embrace the phenomenon as if it were fresh to both the researcher and the participant. Whilst the questioning 'place mat' (Appendix 1) acted as a mental reminder of the areas of interest in relation to the study, the participant led the interview. This inductive approach is aligned with IPAs exploratory and participant-led approach (Smith et al., 2009; Smith and Osborn, 2015) and is in accordance with personal resilience been identified as contextual and unique to each individual (Southwick et al., 2014). Therefore, it was not the researcher's role to question what the participant felt important in sharing in their personal accounts of this phenomenon.

Following Smith et al. (2009) guidelines, interviews lasted as long as it felt natural to explore the phenomenon and until both parties felt the need to disengage. Initially a 2-hour interview was planned and took place in 2017, and these interviews generally lasted between 1.5 to 2 hours (see Appendix 2). Following analysis from this initial interview phase, a further interview was planned and took place in 2018, approximately one year on from the first interview. This was designed to acknowledge the temporal aspects of interpretive phenomenology and how the initial interview itself can alter the participants' perceptions of the phenomenon (Smith et al., 2009; Braver, 2014; Van Manen, 2014). This was also to acknowledge the temporal and dynamic aspects associated with personal resilience as a phenomenon (Southwick et al., 2014). For some participants, this allowed the researcher to reflect back and further explore key interpretations occurring from the analysis of the initial interviews, and for others it allowed for the continuation of sharing wider thoughts and accounts of the lived experience of personal resilience that may have occurred following reflection upon their initial encounter.

3.7.3. Analysis and the hermeneutic cycle

Continuing with the double hermeneutic, Smith et al. (2009) suggest six stages of analysis to IPA research including:

1. Reading and re-reading
2. Initial noting
3. Developing emergent themes
4. Searching for connections in emerging themes
5. Moving to the next case, and
6. Looking for patterns across cases

Smith et al. (2009) also encourage that IPA lends itself to flexibility and creatively. Therefore, the following enhanced stages of analysis were designed specifically for this study. These are based learning gained from the researcher being immersed within, reflecting upon, and applying wider phenomenological methods and techniques, for example as outlined within Vagle (2014) and Van Manen (2014) and by embracing the phenomenological attitude crafted and described above.

> **Stage 1. Reflective journal**: Straight after the interviews, a reflective journal was written based upon what 'stuck out' about the interview and impacted the researcher from this shared experience. Initial interpretations and meanings derived from this were noted in brief to allow the researcher to document these initial impressions.

Stage 2. Connecting with the audio: The interview recording was then listened to, noting anything further that impacted the researcher about hearing the accounts of participants lived experience for a second time. This allowed the researcher to begin to immerse themselves further within the unique encounter with the participant.

Stage 3. Personal transcription: Each interview was personally transcribed by the researcher. This totalled 248,660 words across 27 hours and 28 minutes of interview audio (see Appendix 2). Personal transcription was important to the researcher, as the act of writing the transcript was a reflexive act within its own right. Simultaneously, the researcher was also able to note down anything else that impacted them from hearing the account for now, at least, the third time.

Stage 4. Generating themes from encounters: The researcher then re-engaged liberally with the transcript and recording, highlighting emerging insights, ideas and themes in the transcript and noting interpretation of these themes within the margins of the transcripts. Initially there were many overlapping and 'clumsy' themes, however all themes and insights were considered, no matter how insignificant they may have appeared. The researcher then summarised the emerging themes at the end of each transcript and began grouping them together into clusters of related themes. Appendix 2 illustrates small extracts examples of annotated interview transcripts to demonstrate how this was achieved. In accordance with the ethical considerations discussed later in this chapter and to protect the anonymity of participants, extracts are non-identifiable and presented for audit purposes only.

Stage 5. Consolidating themes: The researcher holistically re-engaged with the analysis and reflected upon all the identified themes and interpretations and how these relate. From this, overarching 'master' themes (i.e. superordinate) and related/supportive themes (i.e. subordinate) were identified for each transcript. As identified as enabling within IPA analysis by VanScoy and Evenstad (2015) a table outlining these relationships was constructed to begin to conceptualise this. Considering Finlay's (2008) perspectives on taking a phenomenological attitude to analysis, this took time and ongoing reflexivity and re-creation of the conceptual relationships between themes throughout the interpretation and meaning-making process, as the researcher re-connected to the findings within each unique transcript. The reflective journal was also utilised to assist in this process.

Stage 6. Supporting narratives: Key extracts from the interview transcript were identified that epitomise the interpreted themes and meanings arising. As Smith et al. (2009) outline,

this supports the justification of the themes and the overall analysis of the phenomena and provide validity toward findings.

> **Repeating stages 1 to 6 for follow-up interviews**: After the initial interviews and analysis up to analysis stage 6, a follow-up interview was undertaken. This allowed the researcher to reflect back identified themes from the first interview, to follow up on further lines of enquiry identified by the researcher arising from their analysis of the first interview, and for participants to continue sharing their lived experiences. This helped to test out interpretations and account for any temporal changes with how the participant perceived personal resilience since engaging in the initial interview. These subsequent transcripts were added to the end of the participants master transcript and analysis was repeated and augmented as per stage 1 onwards. Consideration toward any temporal changes to interpretation of the phenomenon were also considered.

Stage 7. Meta-analysis: After each transcript was analysed individually as outlined above, Smith et al. (2009) identify the potential of linking interview themes together between each participant case analysis into a meta-analysis of the study. Doing this identified both individual and shared themes or patterns across the sample group. Whilst interpretive phenomenology allows focus on individual cases and honours the individual's voice (Gill, 2014) and whilst IPAs focus is not generalisability, Smith et al. (2009) endorse that by taking this meta-perspective in comparing each individual case allows for comparison of experience of this phenomenon across the homogenous sample group. This enabled the generation of this study's overarching thematic map (Figure 2) which is discussed in detail within the following findings chapter.

Stage 8. Comparison of findings against knowledge within existing literature: Whilst there is a lack of specific guidance and potential flexibility in terms of how the IPA researcher engages with the existing literature in relation to the knowledge they have discovered, Smith et al. (2009) outline that there is scope to re-engage with literature in relation to what is known about the themes arising within the interpretations of participant experiences of the phenomena. Therefore, after themes had been identified, a further thematic literature review was undertaken in relation to the specific themes emerging from the data and existing links with the body of personal resilience literature. This allowed for the data analysis and interpretation to be compared to the existing body of knowledge to better locate the findings in relation to this unique study (see Chapter 5 – Discussion)

3.7.4. Documenting findings

The researcher continued to enact the phenomenological attitude described above throughout the entirety of this study. Smith et al. (2009) Van Manen (2014) and Vagle (2014) state that the craft of writing research findings is a phenomenological act within its own right, as the researcher must turn their interpretations and analysis into something that others can engage with and interpret for themselves. Smith et al. (2009) outline the twofold importance of IPA in: 1) giving the account of the data and communicating what has been found, and 2) offering the researcher's interpretation of the data and making a case for what it all means. Therefore, crafting the final analysis, discussion and articulating the contribution to the body of existing knowledge required the researcher to continue their reflexivity and practice of their interpretive phenomenological attitude throughout the entire development of this thesis, as the phenomenological act of writing the study in full continued to augment perspectives and interpretations in relation to the study's findings.

3.8 Sample group recruitment, ethics, and wellbeing

3.8.1 Inclusion criteria

Following IPAs purposive sampling guidelines by Smith et al. (2009) initially a sample group of between 6-10 participants were sought for interview, plus an additional participant for a pilot interview designed to test and refine the procedures. Purposive sampling means that the researcher intentionally engages a homogenous group of participants (i.e. they sit within the inclusion criteria) who can all provide a range of unique lived experiences of the given phenomena, relevant to the context of the study.

The **inclusion criteria** for participation in the study included individuals who:

- **Currently held an executive leader role within the NHS**: An executive in the context of this study is defined as an accountable member of an NHS organisation's executive leadership board with voting rights regarding decisions affecting how their organisation is managed.

- **Have experienced the role of an NHS executive cumulatively for at least 2 years**: This is based upon NHS literature discussed within Chapter 2 detailing that the average tenure of an NHS executive leader is just over 2 years (Janjua, 2014; Naylor et al, 2015; Timmins, 2016). Therefore, where participants have spent this length of time in post, it could be argued that the participant is successfully exhibiting resilient signs in relation to their role as an NHS executive leader.
- **Sampling from both a variety of urban and rural NHS services**: to ensure coverage of the breadth of healthcare services.
- **Establish an even mix of clinical (i.e. nursing, medical) and managerial professional backgrounds (e.g. chief executive, operational, human resources, financial)**: to ensure a variety of professional perspectives are considered.
- **Have English as their first / substantive language**: to acknowledge IPAs interpretative requirements.

Exclusion criteria included:

- **Close or compromising relationships to the researcher**: Whilst phenomenology values the relationship between the researcher and the participant (Gibson and Hanes, 2003; Gill, 2014) very close relationships such as work colleagues or those within the researcher's immediate organisation were excluded to avoid coercion.
- **Participants who express current and significant personal resilience challenges**: Whilst it was not expected that a senior leader sample group would find sharing their lived experience of personal resilience challenging, this criterion supported participant wellbeing.

3.8.2 Ethical considerations

This study successfully achieved ethical approval as part of the University of Worcester's ethical approval procedures during May 2017 (HASSREC Code: HCA16170025-R). Appendix 3 outlines the original ethical approval form and ethical considerations in detail. The following briefly summarises key points from the ethical approval process, with consideration toward working with NHS executive leaders as an elite audience (Lancaster, 2017) and the sensitivities required when studying the topic of personal resilience.

- **Confidentiality and data storage:** Being an elite audience (Lancaster, 2017) confidentiality was an important ethical aspect for the study to ensure participants felt able to engage

and that their personal reputation was not put at risk due to participation. The University of Worcester research data management and governance policy was followed at all times. Confidentiality was maintained throughout the study in several ways. Firstly, the researcher was the only person who knew the true identity of each participant. A pseudonym was used, known only to the researcher and participant. Participants were asked to choose their own pseudonym, or where they declined this the researcher chose one for them. Secondly, only the researcher had access to the original interview recordings. Thirdly, when writing up transcripts of these interviews, the researcher omitted or summarised in brackets any directly identifiable information, such as names of people, places, or events that could expose the participant. These original transcripts were only seen by the researcher and the three research supervisors for this study, and the supervisors only knew the participants by their pseudonym. Fourthly, when writing up this study, the researcher was careful to ensure that extracts used to support the analysis of findings did not have any contextual or identifiable information. To demonstrate an audit trail for this study, Appendix 2 outlines an example of participant transcripts and analysis. However, to maintain confidentiality, only short extracts were presented and the researcher was careful to ensure that no identifiable information could be gleaned.

- **Recruitment of participants and gaining consent:** As NHS executive leaders could be considered an elite group who are accustomed to formalities of engagement (Lancaster, 2017) participants matching the sample group criteria were formally invited via email to take part in the study. This approach leveraged the researcher's professional role working within the NHS to increase access (Costley et al., 2013). This invite also included the participant information sheet that was approved through the ethical review procedures. The researcher reviewed each expression of interest against the inclusion criteria and was open and transparent to any questions that the participants had before gaining consent. Participants were asked to formally read and sign the consent form before the interview, which was then countersigned at the start of the interview. Appendix 4 outlines the participant information sheet and consent form.
- **Participant wellbeing:** The ethical approval process deemed that this research posed no immediate threat or physical discomfort to the participants. This was in the context that these individuals had been chosen based on being well-developed, successful senior NHS leaders who were already exhibiting resilient qualities (i.e. sampling criteria of being at least 2 years in an executive leader post, indicating a level of resilience in role). It is

acknowledged that interviewing any elite audience can alter their 'normal' dynamics surrounding power, resulting in a level of personal exposure (Lancaster, 2017). An IPA study also actively encourages these individuals to embrace this openness to sharing their lived experience of being personally resilient (Smith et al., 2009). Therefore, the researcher embraced empathy, compassion, and ongoing consideration toward participant wellbeing throughout the study. This was in accordance with the Heideggerian notion of 'Being with' participants when taking the interpretive phenomenological attitude (Gibson and Hanes, 2003; Dowling, 2007) as described earlier. The researcher also had training and qualifications in coaching and counselling, which further supported this. Clear support and exit procedures were identified and documented in further detail within the ethical approval form (Appendix 3) and participant information sheet (Appendix 4).

- **Being an insider-researcher:** The researcher being from within the NHS and having a role in leadership development as an insider-researcher (Costley et al, 2013) is supportive to this study. It gave access to NHS executive leader participants, which could be seen as problematic for engaging with an elite audience (Lancaster, 2017) and also supported adding context to findings during interpretation and analysis (Smith et al., 2009). However, this also brought with it ethical considerations, such as coercion as part of IPAs purposive sampling approach. To avoid this, the researcher was open with participants at all times about their own personal interests in the subject and why they believed the study was important, as part of the participant information sheet (Appendix 4) and throughout all engagement with participants. The researcher also maintained reflexivity throughout, utilising a personal journal and having access to supervisory sessions to work through any other ethical issues, should they arise as part of being an insider-researcher.

3.9 Credibility and quality of data

Silverman (2016) states that the aim of social research is producing credible descriptions of the social world in some controllable way. To make phenomenological research credible, Smith et al. (2009) suggests that an IPA study should seek to demonstrate its quality and credibility against Yardley's (2000) principles for assessing qualitative research:

- Sensitivity to context,
- Commitment to rigor,
- Transparency and coherence, and
- Impact and importance.

The quality of this study is considered in comparison to these principles as follows.

3.9.1 Sensitivity to context

Yardley (2000) and Smith et al. (2009) describe sensitivity to context as paying attention to the existing literature, the sociocultural setting, sensitivity to the participants themselves, the possibilities for gathering data, and how these enhance the quality of the study. The context of this study sought to embrace the subjectivity and contextual nature of personal resilience as outlined within the existing literature (Henning, 2011; Southwick et al., 2014). Interpretive phenomenology was chosen as an appropriate methodological approach to generating such a contextual and subjective understanding of this phenomenon.

The study places the researcher within and conversant with the research environment. This enables the appreciation toward the social-cultural aspects of the study, the phenomenon in question and how participants experience this (Costley et al., 2013). This embraced the double-hermeneutic identified within IPA throughout the study, seeing the researcher's preconceptions as assisting rather than hindering the interpretation of the phenomenon in question (Smith et al., 2009).

Participant wellbeing was considered as a priority throughout this study, as documented within the methodology and ethical considerations above. The study considered the sensitivities in collecting personal accounts of an elite audience (Lancaster, 2017) and how the researcher encouraged participants to be open to sharing personal experiences of the phenomenon with sensitivity and respect (Smith et al., 2009).

Yardley (2000) outlines how phenomenological research specifically requires the demonstration of considerable understanding of phenomenology as a research methodology. Actively embracing the interpretive phenomenological attitude (e.g. being-with, reflexivity etc.) throughout this study was achieved by the researcher's immersive reading in phenomenology, an active commitment to practicing phenomenology, experience of conducting similar research studies in the past, as well as training in counselling and executive coaching skills. Explicitly outlining and embracing the

interpretive phenomenological attitude throughout the study ensured that the researcher paid ongoing attention to participant sensitivities and their wellbeing.

3.9.2 Commitment to rigor

Yardley (2000) and Smith et al. (2009) define rigor as the thoroughness of the data collection, analysis, reporting and a commitment to a prolonged exposure to the researched topic for both the researcher and the participants. To enhance data collection and analysis and building on Smith et al. (2009) guidance to test the approach to data collection, a pilot interview, transcription, and brief analysis was utilised to test and enhance the procedures.

When considering how to enhance quality of the interpretation for phenomenology specifically, Yardley (2000) emphasises how the role of the researcher in the analysis needs to be intuitive and imaginative using their own insights, rather than following a formalised analytic procedure. IPA emphasises how the researcher being situated within the research setting and embracing their preconceptions and preunderstandings of the phenomenon enhances their interpretations of the data (Smith et al., 2009). Taking this insider-researcher perspective (Costley et al., 2013) assisted with this and meant that the researcher had prolonged exposure to the research environment and an understanding of the participants which is supportive to their interpretation. The interviews being scheduled over several months also enabled both participants and the researcher to engage with a prolonged exposure to the research topic and consideration toward the temporal aspects of interpretive phenomenological research.

3.9.3 Transparency and coherence

Transparency refers to how well the researcher has documented their methodology and procedures (Yardley, 2000; Smith et al., 2009). Whilst it is argued that the philosophy and methodology of phenomenology is challenging to fully comprehend due to its sheer expansiveness (Dowling, 2007; Pringle et al., 2011) the researcher took significant time to familiarise themselves with phenomenology over several years of engagement with it, both theoretically and practically.

Phenomenological research has been criticised for failing to adequately document methodological approaches, which limits replicability, and therefore questions the reliability and quality of the findings (Paley, 1998; Sadala et al., 2002; Pringle et al., 2011). In response to this debate, Smith et al. (2009) suggest that any quality IPA study should present itself to be auditable by offering enough

detail to enable anyone to engage with precisely how the study was undertaken. To address this, the presentation and flow of this study is designed to enable the reader to follow the audit trail of how findings were developed, analysed, presented, and discussed. This study starts with articulating current understanding of personal resilience as a phenomenon and the gap within existing knowledge (Chapter 2 - Literature review). It then documents the methodological procedures taken in detail so that those wishing to engage with the findings can easily follow how the data, analysis and findings were derived (Chapter 3 - Methodology) including examples of participant transcripts and initial analysis (Appendix 2). Analysis of participant experiences (Chapter 4 - Findings) enables the reader to appreciate each unique individual participant, their voice, and how their personal lived experience informed the development of the overarching thematic map (Figure 2). The researcher's interpretation of each theme is then presented to demonstrate movement from participant voice to researcher voice. Findings are then discussed in relation to existing literature to identify the significance of this study and how it has successfully contributed to the existing body of personal resilience related knowledge (Chapters 5 – Discussion and 6 - Contribution).

Coherence refers to how the power and persuasiveness of the researcher's argumentation and the story presented from their findings (Yardley, 2000; Smith et al., 2009). This study sought to embrace the subjective and contextual nature of personal resilience and is sensitive to the researcher's interpretations being unique and non-generalisable throughout, as with any social sciences and phenomenological related research (Gray, 2014; Silverman, 2016). The outputs of IPA research are to enable the reader of the study to interpret and make sense of the researcher, trying to interpret and make sense of the participants experience of the phenomenon (Smith et al., 2009: Smith and Osborn, 2015). The procedures within this methodology chapter outline how great lengths were taken to immerse the researcher over a prolonged period of time in the participants lived experience of the subject. Through embracing the double hermeneutic, reflexivity, and prolonged engagement with the data generated, themes gradually emerged over a prolonged period of time through ongoing interpretation. Themes and sub-themes were then reinforced with verbatim extracts from participant transcripts. This allowed for the presentation of a transparent and coherent argument of findings. The overarching discussion continues the interpretation of findings. This brings together a synthesis of findings which provide an overarching account of the researcher's interpretation of the study findings in relation to the body of current knowledge, the contribution to knowledge and thought toward future avenues for enquiry.

3.9.4 Impact and Importance

Smith et al. (2009) and Yardley (2000) state that in the context of social sciences research, the credibility of a study is in whether it tells the reader something interesting, important, and useful that causes them to engage with the findings. This study addresses the identified gap within the body of personal resilience knowledge surrounding NHS executive leaders. It seeks subjective accounts of personal resilience to augment the contextual body of knowledge surrounding resilience as a multifaceted phenomenon to address this identified gap. NHS leadership related literature (see Rose, 2015; Hardacre and Keep, 2011; Smith, 2015; Mowbray, 2016) call for NHS senior executive leaders to be more resilient, however there is a lack of a knowledge to describe and interpret what resilience means to this group, within the NHS context. The original findings within this study presented in the following Chapter 4 and discussed in Chapter 5 address this identified gap in knowledge and articulate how findings endorse, augment, contrast and add unique insights into the personal resilience of NHS executive leaders as an understudied phenomenon. Original insights from this study also endorse ways for NHS practitioners to develop the current and future body of NHS executive leaders (Chapter 6).

3.10 Summary

This chapter has outlined the research aim and questions for this study and how interpretive phenomenology was identified as an appropriate methodology to address these. The phenomenological attitude crafted and applied throughout the study was also outlined in relation to how the study followed IPA procedures. This chapter also outlined how this study demonstrates a commitment to quality and credibility of findings. The following chapter will outline these findings in detail, with consideration toward the participants' voice and the researcher's voice.

3.10.1 - Reflective account: Conceptualising the phenomenological process in practice as an insider-researcher through continual reflexivity, interpretation and embracing it as a 'craft'

Becoming phenomenological as a researcher is more than following a process and procedures. When beginning this study, I was confident that an interpretive phenomenological approach would enable me to answer my research questions, as discussed in section 3.2 above. Yet, I also appreciated the argument that practicing phenomenology can be challenging for a novice researcher (Paley, 1998; Sadala et al., 2002; Pringle et al., 2011). I therefore went to great lengths to immerse myself in the phenomenological literature and utilised my learning from this to describe how I developed my 'phenomenological attitude', which I discuss in detail in section 3.6 above. This acted as my set of 'guiding principles' for how I personally applied my methodological procedures in a way that distinguished my research as interpretive phenomenology.

Yet, my journey to becoming phenomenological in my research practice went beyond this and I very much affiliated with the idea that phenomenology is likened to a 'craft' (Smith et al., 2009; Vagle, 2014). I conceptualised this metaphorically by likening my phenomenological research process to crafting a pot. Firstly, getting the lump of clay (i.e. the research questions) then gaining many ideas for what the pot could look like (i.e. by interpreting individual participant experiences) and moulding this into new forms as each idea was added. I achieved this through continual reflexivity when interpreting these ideas in relation to the clay and my own lived experience as the crafter and then refining the clay into something that represents the pot (i.e. my interpretation, of participants interpretation, of what the pot should look like) and finally, ongoing refinement and alignment of the pot in relation to other pots (i.e. orientation of my findings and interpretation with existing empirical knowledge).

In practice, this meant that I engaged in a process of being continually reflexive and interpretive (as described in sections 3.6 and 3.7 above) throughout the entirety of my study, which enabled me to manage the complexity of the many interrelated, overlapping, and complex ideas that emerged. This was enabled by being conscious of my own personal insight as an 'insider-researcher' (Costley et al., 2013) in being part of and conversant with the research environment, participants, and the topic of personal resilience. I was curious and reflective on what I knew about the phenomenon of personal resilience before I began my interviews. I journaled about what I saw in practice as an 'insider-researcher' and what I had learnt from the literature, which

assisted me with the design of the study. As participants offered new experiences during the interviews, my insider-researcher reflexivity helped me to orientate my interpretation and analysis in relation to what I knew through the double hermeneutic. Between and after the interviews, I was continually reflective about my interpretation of findings, exploring how emerging themes and ideas connected, overlapped, their relevance to my aim and research questions, relevance to what I knew about the subject area and the research environment, what was in and out of scope, and what was hiding that I needed to bring forward. This involved continually revisiting interview transcripts (audio and transcribed) and adding notes and ideas throughout each document, summarising my interpretations at the end of each transcript and revisiting these summaries each time I re-engaged with a transcript (see Appendix 2), the use of continual journaling to reflect on how and why my interpretations had evolved, visually exploring the overlapping themes and ideas across all participant transcripts by physically drawing and re-drawing many different versions of my thematic map as it was evolving in real-time whilst deconstructing and reconstructing my interpretations, documenting my interpretations and aligning supportive extracts from transcripts as I built the findings chapter, and continually reflecting on how my interpretation was evolving as a result of this cyclic interpretive process. This continued until I came to my final and refined interpretation of participant experiences of personal resilience as they presented themselves, which is illustrated in Figure 2 and discussed in Chapter 4 - Findings.

This reflexively and interpretive process continued when developing my discussion of findings in relation to the literature and when interpreting what my overall contribution to knowledge had been as part of constructing Chapters 5 - Discussion, and 6 - Contribution. I engaged in crafting a balance between three areas. Firstly, the reflective act of orientating my findings in relation to the existing body of literature enabled me to further enhance my interpretation. It gave me an evolved way to present and align my interpretation of themes in relation to existing knowledge, as a natural progression from how they had originally developed in Chapter 4 - Findings which represented participant experiences alone. Secondly, by constantly brining myself back to check that I was answering my research questions, this kept my discussion surrounding my continued interpretation of findings focused and within scope. Finally, I remained continually reflective toward ensuring that I could articulate how I was demonstrating the impact of my study and my contribution to knowledge, which is critical to a quality IPA study (Smith et al., 2009). This ongoing reflexivity and interpretation as part of developing the discussion section of my thesis further supported me in transforming the findings from within my original thematic map that

represented my interpretation of participant experiences (Figure 2 - Chapter 4 - Findings) into an evolved thematic map that interpreted my findings in relation to the existing body of knowledge (Figure 6 - Chapter 5 - Discussion).

Constructing this thesis in its entirety also assisted my phenomenological process of interpretation by continually considering how I could transparently articulate my research journey, how my interpretation has evolved through crafting each chapter, and how the reflective sections such as this one illustrate my own personal journey of 'becoming phenomenological' as a researcher.

Chapter 4: Findings

4.0 Introduction

This chapter illustrates the findings from the analysis of participant interview transcripts (see Appendix 2). Figure 2 illustrates the overarching thematic map with the superordinate and subordinate themes identified from analysis, including related reflective accounts, which are discussed throughout the remainder of this chapter. Themes are colour coded for ease of reference. Following IPA conventions (Smith et al., 2009) the analysis is split into two parts to separate the participant centred ideographic findings, and the overarching thematic findings within this study.

Part 1: Participant experiences of personal resilience - presents the idiographic lived experiences of personal resilience for all 9 participants as NHS executive leaders and is supported by participant extracts. Presenting findings in this way enables the reader to connect to each participant and gain a sense of their voice and insight into their lived experiences, as the researcher did when interviewing and analysing transcripts. This assists the reader to experience how different participant lived experiences of personal resilience relate to the various themes identified within the study and demonstrates an audit trail to illustrate how these experiences assisted the researcher with the development of the overarching thematic map.

Part 2: Presentation of themes - presents the three superordinate themes within the overarching thematic map, resulting from the analysis of participant transcripts and is supported by participant extracts. Reviewing the thematic map in this way will help the reader to engage with the overarching findings within this study and is designed to represent the researcher's voice within the analysis. Whilst there were many themes that presented themselves within the participant transcripts, these themes emerged from ongoing consideration toward the research aims and questions throughout the analysis and relate to all or most of the participant experiences of personal resilience as NHS executive leaders.

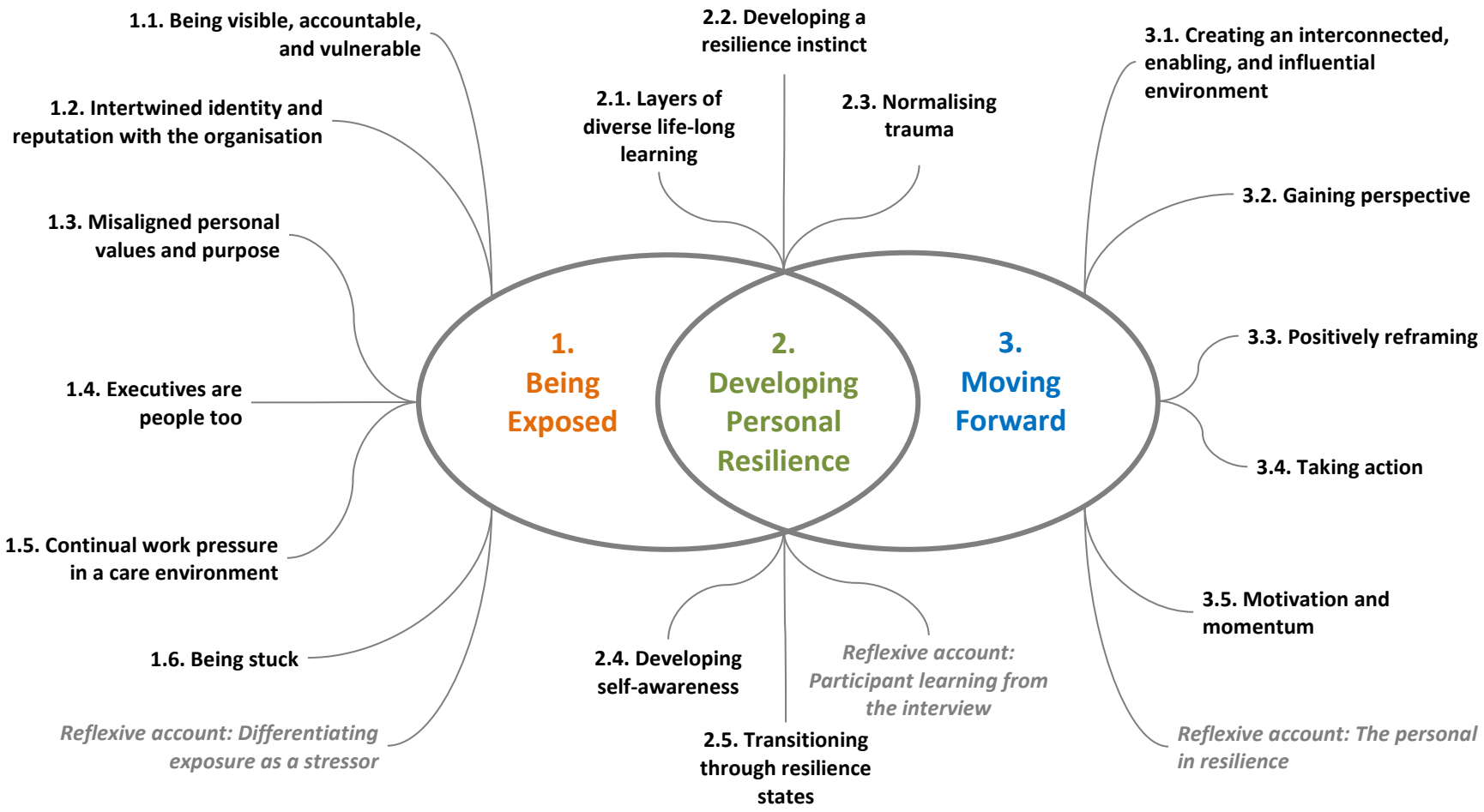

Figure 2: Overarching thematic map

4.1 Findings Part 1: Participant experiences of personal resilience

This section introduces the participants and their voice by providing insight into their lived experiences of personal resilience. It enables the reader to immerse themselves within the participant experiences of personal resilience, just as the researcher did when crafting the thematic map for this study. It also enables the reader to appreciate how each particular resilience related experience connects to multiple themes within this study's overarching thematic map, demonstrating the complexity of personal resilience for participants. This section also sets the scene for discussing each theme in detail within Part 2 of this chapter, which focuses on the researcher's voice and their interpretations of personal resilience in relation to the research aims and questions.

Experiences within this section were chosen by the researcher to represent different yet interrelated perspectives of participant perceptions of personal resilience. Each account begins with a brief introduction to the participant, kept to a minimum to ensure anonymity. It then outlines their experience and uses narrative extracts to support this. A concluding reflective account illustrates why the researcher felt it important to showcase this particular experience, how it helped to develop the conceptual understanding of the themes in relation to each other, and the overarching thematic map (Figure 2). Themes are colour coded for ease of reference throughout this chapter. Table 3 demonstrates how the participant experiences discussed in this section link to the themes within the overarching thematic map. Table 4 provides a high-level introduction to all participants within this study.

When reviewing this section, the following conventions are used to assist the reader in engaging with the participant extracts:

- *(word of phrase)* in round brackets indicates something unsaid out loud by the participant but was important to convey as part of the interpretation, such as a *(pause).*
- *[word or phrase]* in square brackets indicates summarised information, both contextual and/or omitted or summarised for confidentiality reasons that is relevant to interpreting the participant extract.
- *'word or phrase'* in inverted commas indicates an emphasis placed on that particular word.
- *'…'* indicates omitted text, to reduce word count and focus extracts on key findings.

Table 3: How participant experiences presented link to the overarching thematic map									
Superordinate and subordinate themes	**Andrew**	**Catherin**	**Diane**	**Elizabeth**	**Matthew**	**Sam**	**Stephen**	**Tim**	**Wendy**
Theme 1. Being exposed									
Theme 1.1. Being visible, accountable, and vulnerable	•	•	•	•	•	•	•		•
Theme 1.2. Intertwined identity and reputation with the organisation			•		•	•	•		
Theme 1.3. Misaligned personal values and purpose		•	•	•	•		•	•	
Theme 1.4. Executives are people too		•	•		•	•	•		•
Theme 1.5. Continual work pressure in a care environment	•	•		•	•		•		•
Theme 1.6. Being stuck	•		•	•		•	•		•
Theme 2. Developing personal resilience									
Theme 2.1. Layers of diverse life-long learning	•	•	•	•		•			
Theme 2.2. Developing a resilience instinct	•				•		•		
Theme 2.3. Normalising trauma			•	•			•		•
Theme 2.4. Developing self-awareness	•	•	•		•				
Theme 2.5. Transitioning through resilience states	•	•				•	•		
Theme 3. Moving forward									
Theme 3.1. Creating an interconnected, enabling, and influential environment	•	•	•			•		•	•
Theme 3.2. Gaining perspective	•		•			•			•
Theme 3.3. Positively reframing			•			•	•	•	
Theme 3.4. Taking action	•	•	•	•	•	•	•	•	•
Theme 3.5. Motivation and momentum	•	•	•	•	•	•	•	•	•

Table 4: Overview of participants			
Pseudonym	**Current role**	**Professional background**	**Current NHS organisation**
Pilot	*Chair of an Executive Board*	*CEO / Management*	*National NHS Body*
Andrew	Chief Executive Officer	Finance / Management	NHS Provider Trust
Catherine	Executive Director of HR	Human Resources	NHS Commissioning Trust
Diane	Chief Executive Officer	Nursing / Operations	NHS Provider Trust
Elizabeth	Director of Medicine	Medicine	NHS Provider Trust
Matthew	Chief Executive Officer	Management	NHS Commissioning Trust
Sam	Chief Executive Officer	Management	NHS Provider Trust
Stephen	Chief Executive Officer	Clinician	NHS Provider Trust
Tim	Executive Director of Finance	Finance	NHS Provider Trust
Wendy	Executive Director of Nursing	Nursing / Operations	NHS Provider Trust

4.1.1 Andrew: Learning to become a resilient CEO

Introducing Andrew: Andrew has worked in the NHS for many years, starting out in front-line finance administration, progressing into management, becoming an executive director of finance, and is currently several years into his first CEO position in an NHS provider trust.

Andrew believed that his childhood experiences instilled public sector values in him relating to helping people and 'doing the right thing'. He believed that the pleasure he got from living by these values enabled his sense of personal resilience throughout his career and motivated him to feel resilient enough to successfully transition into being a CEO.

> *I think it comes from my up-bringing … my mum and dad being public sector people … public sector values-base is inherent within me … I think the one thing that keeps my resilience is checking against my values … My personal values are absolutely 100% about people … am I doing the right thing, in the right way, for the right people … did [I] always want to be a CEO, well no. I've always got to a level and if I can make a contribution, I might try the next level … it's a pleasure, it's enjoyment, it's contribution … it's about making a difference, and that gives me a lot of pleasure. (Andrew, Interview 1)*

Andrew explored his perceptions of becoming increasingly resilience in his role of CEO by reflecting on his lived experience between interviews. During the first interview, Andrew explored his perceptions of the 'step change' between being resilient as an executive director and CEO. At the time, he seemed to be experiencing a transitional state between previously being a director of finance and feeling resilient as part of a supportive and connected executive team, to feeling distanced, disconnected, and vulnerable as a new CEO that had to manage an executive team that he previously felt part of.

> *As an exec director, part of your resilience is working with your executive team. Being able to share your challenges with your executive team, support colleagues to deliver their challenges is for me what maintains your resilience as an executive team ... I think when you step up to CEO level, all-of-a-sudden, you're managing the executive team. You have to find a different way to deal with that … as a CEO, you can't externalise as much. (Andrew, Interview 1)*

During his second interview, Andrew explored how he perceived his personal resilience had changed as CEO over the past ten months since his first interview. He shared a sense of 'stepping back' and 'gaining perspective', which he perceived had helped him to transition into feeling increasingly resilient as CEO. He believed that he had adapted himself and learned to 'let go' of his preferred way of operating as a 'firefighting' and detail orientated manager, into feeling confident to trust his wider executive team to run the organisation. He believed that this was only possible by personally developing his executive team to be more resilient, which he perceives made him more resilient by 'freeing him' to deal with more complex and strategic organisational stressors. He suggested a connectedness between his personal resilience as CEO, the resilience of his team, and the resilience of the organisation.

> *I think that was the big step change for me to say, I almost need to step back now and take the helicopter view … I worry less about not knowing the detail, I worry more on the wider organisation stuff … 12-18 months ago, I'd worry about the KPIs, send me a spreadsheet that shows me every Nth detail on it … over the last 12 month's I've moved from me being more, figure-heading some of this to going to the exec team and saying, there you go. It can't be me all the time … there's a lot of pressures on me and actually if we can develop the exec team to be part of that success of the organisation, then that's a shared responsibility and I can focus on more of the external stuff that can benefit the organisation. (Andrew, Interview 2)*

Andrew expressed that the transition and newfound confidence in becoming a resilient CEO was only possible through learning and adapting from his lived experience of being in the CEO role. He used several experiences to illustrate this developmental aspect of his personal resilience, included regulatory inspections, turning around organisational problems, and how he had managed a significantly challenging organisational issue that personally affected him and his sense of personal values. He used the metaphor of developing his resilience 'toolbox' to suggest that successfully adapting and learning from these experiences enabled him to feel more confident and self-aware to resiliently manage himself through similar stressful situations in the future.

> *I think the main thing has been more experience of more challenging things… [described challenging organisational issues] …the right thing to do, but challenging. A lot of focus on me. Probably what has changed for me is … adding experience and confidence to me … it's in my toolbox now. In terms of my resilience, I'd be more resilient if I had to deal with those situations again … It's experience. It has to be … because you've been through it, you can fear the consequence less … I'll learn from it, I'll reflect on it and what will I do differently next*

time … I think sometimes your lack of resilience can be around having a lack of experience … because I've got a whole breadth of experiences behind me now that I have been through and the outcomes have been ok, I feel more able to manage 'me'. (Andrew, Interview 2)

Andrew believed that to be resilient, he must always consider how he learns and adapts from stressful experiences. He suggested that repeating similar stressful situations without adapting his response would cause him to become 'stuck' and unable to move forward from the stressor.

Once you've done it you know … what you'd do differently next time and what you'd do the same … if I was sat there and doing the same stupid things over and over again, it just wouldn't happen. (Andrew, Interview 2)

Andrew used the metaphor of 'painting a picture' to represent how he believed that his life experiences had added 'layers' of knowledge and self-insight to his perceived personal resilience over time. Andrew's picture appeared to represent his metaphorical 'mental map' of reference points for how he had learnt and adapted from stressful experiences in the past, and how he felt increasingly confident to navigate future stressful situations. He suggested that his resilience is like a craft, and that over time the more he learns the less changes he needs to make to his picture, giving an evolving sense of 'mastery' toward his perceived personal resilience.

It's experience that helps with resilience … it's an evolving thing. It feels like painting a picture … different layers and different hues … my picture is built over the time I've done 25 years in the NHS, and my upbringing before that. That picture for me is there for the moment, but that will change in 10 years' time … I think as I get older, I will make less changes to it … and it's more about refining it now. (Andrew, Interview 1)

Contribution to themes:

Andrew's personal resilience seemed to have been guided and enabled by his personal values, combined with a learning focused mindset and ability to adapt himself. Cumulative learning from lived experience appeared to have developed an effective 'mental map' for Andrew that informed his understanding of his own personal resilience, how to effectively respond to future stressful situations, and enabled his self-confidence to transition into his demanding CEO role.

Andrew's experience contributed to the superordinate theme of developing personal resilience through his perception that learning and adapting from stressful life experiences increases his sense of personal resilience. His metaphor of painting a picture contributed to the sub-theme of creating layers of resilience learning. His experience also helped to centrally position the theme of

developing personal resilience, connecting the themes of being exposed to moving forward by visually suggesting that when participants experience stressors, they learn from these, to enable them to respond more effectively in the future.

4.1.2 Catherine: Balancing the burden of caring

Introducing Catherine: Catherine has been an executive director of Human Resources (HR) in an NHS commissioning trust for several years, in addition to managing complex system-wide programmes of work. She started her career in the NHS as a business trainee before moving into private sector consulting, and then back into commissioning of services, management, and HR.

Catherine believed that caring for people is at the heart of being part of the NHS as an organisation and that this is a heavy responsibility to carry as an executive leader responsible for many people. She feels that her position as executive director of HR obligates her to support other peoples' personal resilience and that this makes her more responsible for the organisation's people than any other executive.

> *It's absolutely because I am the people part of the organisation … people come to me for the people stuff … the people element always ends up at my door. That comes back to the job … As an executive leader you have a responsibility to all the organisation and the people that you employ. That' a big responsibility. (Catherine, Interview 1)*

Whilst Catherine seemed to experience being motivated by enabling and caring for other people, this also appeared to be one of her major personal stressors. She seemed to experience a sense of 'guilt' in letting people down, which demotivated her personal resilience by suggesting a sense personal failure.

> *When it comes to people issues, they can go wrong if they're not managed carefully and if we fail somebody within this organisation, that will challenge my personal resilience because then it comes back to, so where are our priorities really? … letting other people down, well that's a huge responsibility to carry. That will question your resilience, not just your own personal resilience or your personal expectations, but the expectations that others have got of you. (Catherine, Interview 1)*

Catherine seemed to experience a constant burden of supporting everyone else's personal resilience in her organisation in a '360 degree' way by supporting her team and her peer executives, giving the impression that the responsibilities of her executive HR director role made her feel caught in the middle of other peoples' stressors.

I do often ask myself about the rest of the team, because I have a sense of responsibility to them as well as myself ... I worry that people are going to reach burnout point or, that we're asking too much of them … because of my [HR] role, many of the other exec directors … look for support and a little bit of resilience building from me. (Catherine, Interview 1)

Catherine seemed to experience that there can be an emotional burden from supporting other peoples' resilience in this way, which can become a source of personal stress if not managed effectively. She seemed to have learned to cope with this by helping others to proactively take responsibility for their stressors, rather than taking the burden of them on herself.

They go away feeling better, but I'm left there thinking, bloody hell you know, you've just given me all of your problems as well. So, one of the things I've had to learn is not taking those problems from them, because it's easy to say well don't worry I can sort it out for you, so, helping people, but instead giving it back and saying that's what I think you should do. (Catherine, Interview 1)

Catherine also believed that by supporting the resilience of her team and other people in this altruistic way, these people will help her with her personal resilience in return. This seemed to create a sense of connectedness, reassurance, strength, and an enabling environment for her own personal resilience and that of other people in her organisation.

People around you will step in … and I know things will be ok … resilience is built and sustained by the team of people that you've got around you, they empower you, they give you strengths, they support you. I think as a leader if you lead your team in the right way, your team will be there to support you … that's for me, something else about the kind of leadership you show as an exec. (Catherine, Interview 2)

Catherine appeared to extend this 'connected resilience' by promoting work-life balance for everyone, believing that people have different needs and that by supporting them to be personally resilient, in turn enables the whole organisation to be resilient. This drive to support peoples' work-life balance appeared linked to how Catherine experienced her work-life and home-life as holistic, entwined and boundaryless, blurring the traditional work-life confines of a '9-5 job' that she metaphorically referred to as being 'confined to a box'. She appeared to embrace always being a mum and always being an executive leader, and by working flexibly she perceived that she was empowered and personally resilient in doing both.

Not everybody is the same, so you've got to adapt to your workforce … I find that if you give people back what they need for their life, and everybody is different, then they will give you

back so much more. I can use myself as an example of that … I will encourage flexible working here. I will have days where I go home early, so I can pick my son up from whatever he needs picking up from but then I give more at other times and that works for me … If I leave here, I can very often spend all of my time going home on the phone, I'll take [work] phone calls at home, but I'm 'at' home … If I was forced to fit into a box and stay here until that time and then you go, well that's not going to work for me. This organisation gets a lot more out of me because it offers the flexibility … I get a lot of energy from that balance. (Catherine, Interview 1)

Catherine experienced an immense sense of energy and pleasure from her home-life being a mum that seemed to motivate her personal resilience. However, she also seemed to experience an immense sense of guilt if she felt that she has let her children down, which had the opposite effect and drained her sense of personal resilience. She believed that her home-life was more important than her job, as family cannot be replaced in the same way.

You have to have points where you cut off and I turn into being a mum. That gives me a huge amount of energy as well. I think the worst weeks I have are where I feel like I'm failing at home, you know, you can be working really hard here but actually … home is more important … I can get a job elsewhere, you can't go and get another child, you have to put that into perspective. (Catherine, Interview 1)

Catherine focused more on being a parent in her second interview and explored what this meant to her personal resilience. She believed that her ability to keep being personally resilient was linked to her ability to keep learning and adapting to new life-situations. Believing that her personal resilience comes from embracing all aspects of her life equally, she perceived that being a good leader enables her to be a good parent, and vice-versa. Her sense of personal resilience seemed to be energised and motivated by her need to be a positive role-model for her children and that by doing this it would also pass on her ability to be resilient to them.

[Discusses being a mum] Do I think that I have to give up my career [because of being a mum] no I don't. What means is that I will just have to work in a slightly different way … as a parent, you can rely on people for a certain amount of help, but your responsibility is that little person … end of. Does it mean I'm going to be any less effective in my job, no … I'm a better parent because I work, it gives me something, I love being a mum, it's my priority, however I like to be 'me' as well, I like my career and I believe that sets good values to my child, and my next child. (Catherine, Interview 2)

Contribution to themes:

Catharine's people-focused values, being a mum, and embracing her executive HR leadership responsibilities appeared to give her 'heroine-like' qualities and a sense of work-life-balance that enabled her personal resilience. She seemed to gain energy and motivation from helping others, but also experienced guilt when she felt she could not achieve this, which seemed to de-energise her and challenged her sense of being personally resilient.

Catherine's experience contributed the superordinate theme of moving forward and the development of the sub-themes of creating an enabling environment, by suggesting that supporting other peoples' resilience, in turn helps her own personal resilience. Her experience of being a parent also contributed to the sub-themes of keeping learning and adapting when transitioning through new life-states, and also the sub-theme of motivation and momentum when considering the impact of work-life balance.

4.1.3 Diane: Learning from being vulnerable in the public eye

Introducing Diane: Diane is a nurse by background. She has been a CEO for several years within an NHS provider trust and has held executive director positions in nursing and operations for several years before that.

Diane's first experience involved being unexpectedly publicly criticised in front of hundreds of people in her first several weeks of being a CEO, for a past organisational decision that was not hers and outside of her control. Her emotive language suggested the extent of her trauma, eliciting a sense of being 'frozen' and 'numbness'. Diane used the experience to illustrate how rather than being overwhelmed by trauma, she had learnt from the experience and perceived that she became more personally resilient as a result.

> *I walked into three or four hundred people all wanting my, death really. That was the most traumatic thing I have ever experienced professionally, well, probably personally as well thinking about it. I wasn't prepared for that and whatever I said, they just started booing immediately. I'd never experienced anything like it. It hit my values, it hit my pride. I was 'very' traumatised … I can remember going home and walking back to my car feeling, absolutely numb, shocked, I was too shocked to cry … I got home and sat with a glass of wine. Couldn't touch it, didn't want it … I just sat at the kitchen table for about an hour … I've learnt from that, to be absolutely sure of what you're walking into, because you can say no to a public meeting, and you can walk away. (Diane, Interview 1)*

Diane shared a similar challenge to her personal resilience that she was living through at the time of her first interview. Diane believed that she lived by her personal value of equality and used her power and authority as CEO to publicly challenge the perceived discriminatory behaviours by others. This resulted in her feeling 'vilified' in a variety of national public, media, and political forums. Diane appeared to share 'raw' and 'in-the-moment' emotions in the interview, however she seemed clear of her sense of purpose and that she had 'done the right thing' by her personal values and by the people that she believed she had supported.

> *[I] have challenged that old guard and they are coming out fighting hard … I felt so exposed, just so, visible … On a human level I've been attacked I suppose (pause) but on a professional level I'm really clear I've done the right thing. I'm really clear about that. (Diane, Interview 1)*

Diane talked about how she feared for her personal safety, and the safety of others due to the traumatic situation she was experiencing during the first interview. She also seemed to link this experience to feeling a 'celebrity-like' status, illustrating the magnitude of her perceived exposure and feelings of vulnerability.

> *All the way through this I kept thinking about Ed Sheeran [a celebrity] in Game of Thrones [a TV show] … he got absolutely annihilated for it … It did cross my mind, will somebody come and try to hurt me? We had a senior leadership group planned for [location] but I made the decision not to go there … how could we make ourselves safe and how could I make myself safe, and I thought it's interesting that I'm thinking those things through. So, I have thought about personal safety because of the nature of some of these [threatening] emails. (Diane, Interview 1)*

Diane described applying the learning that she had gained from her first experience of being exposed as a CEO in a public forum to managing her similar current situation, referring to this as her 'survival strategy'. She gave a sense of developing 'buffers' between her and the negative criticism. She actively sought out people who would support her to deal with the situation in a positive way, but equally felt surprised and thankful for people supporting her in unexpected ways, both practically and emotionally. She also appeared to appreciate that the distraction found in continuing with her mundane daily activities as CEO seemed to help her to 'keep going' through the traumatic experience.

> *I think it's something about that survival strategy, I've got to have a clear head … The important thing is I now have different strategies. I don't read all the emails, I learnt that from last time. We had a comms manager, bless him, and I just sent them all to him and said you just screen them … the resilience bit isn't always people asking if you are alright, it's about somebody practically helping you, or practically distracting you by helping you with the normal business … I found some work colleagues, who have [said] … just don't worry, I'll just do it for you, then gone off and done it … all of my local colleagues have called me, supported me … now some of the big guns in [national healthcare body] have come out and supported me. (Diane, Interview 1)*

In her second interview several months later, Diane was able to reflect on the trauma and vulnerability that she had experienced in her fist interview. She suggested that at the time she had been experiencing the stress response of 'fight or flight'. She now perceived that she had both managed the traumatic situation effectively, and positively learnt from the experience. This positive framing appeared to enable Diane to feel that she had effectively moved forward with her

life. Learning implies growth, which implies a future, which implies a way forward. Retrospectively perceiving stressors and traumatic experiences as a learning opportunity seemed positive and energising for Diane, whereas perceiving them as an adversity that she had to overcome seemed negative and demotivating.

> *I think it's fair to say that I was in the grip at the time we met due to that particular challenge, and it was quite personal. What happened to me after that if I reflect back, I was in a crisis moment and I remember those feelings very well. Feeling overwhelmed, didn't know where I was going, feeling out of control, and quite vulnerable. I will never forget that. It's no different to if you're hurtling toward a road traffic accident. I was in fight or flight wasn't I. I was experiencing all those physical and mental feelings. What was most important was, although I was experiencing all of those, I also had to manage the situation. I couldn't go away and just process those feelings, I had to manage them. (Diane, Interview 2)*

Contribution to themes:

Diane shared two interrelated experiences of being traumatised, exposed and vulnerable as a CEO from being faced with public, media and political criticism that challenged her personal values. Learning from her first experience appeared to help Diane to be more resilient in her next more traumatic experience. She perceived that she was continuing to live by her personal values, knowing when to fight for what she believed in, and when to block negativity and walk away with dignity to enable herself to feel personally resilient.

The intensity and emotive way that Diane articulated her experiences of visibility, vulnerability and trauma as a CEO helped to distinguish exposure as the most notable form of stress that participants seemed to experience within their interviews and supported development of the superordinate theme of being exposed. Diane's perception that trauma and stressors can be framed as learning opportunities that make the experiences more manageable contributed to the superordinate theme of developing personal resilience, as well as the sub-theme of positively reframing stressors to make them more manageable. Diane seeking out people to support her whilst also being surprised by being supported by others in unexpected ways contributed to the sub-theme relating to creating an interconnected environment with others.

4.1.4 Elizabeth: Being free by admitting when you are wrong

Introducing Elizabeth: Elizabeth is a doctor by background. She has been the chief medical officer in an NHS provider trust for several years, having held deputy director of medicine positions for several years before that.

Elizabeth described an experience of feeling personally responsible for the death of a patient earlier in her career as the doctor in charge, even though she knew it was a known complication of the patient's condition and technically not her fault. She described experiencing personal trauma as a result of this and felt that she could have been unable to emotionally move on from that moment, had she had not lived by her personal value of honesty by telling the patient's family what had happened. She believed that this experience had reinforced her life-long learning that honesty empowered her sense of personal resilience and that this was a defining moment that supported her to be resilient later in her career as an executive leader. Her experience in having to deal with 'life and death' decisions that impact other people also outlines the emotional layer of stress that she faced by working in a healthcare environment.

> *I killed someone … [describes situation and how it was a known complication] … partly bad luck, partly my fault … The first thing I went to do was tell the family. I said, I've killed them and I'm sorry. I used those words, I'm sorry it's my fault I killed them ... Consultants were all trying to shut me up … I said, I've got to it's my fault. That's something that good clinicians, insightful clinicians, can do. They can admit they're human … I didn't think they would stop me practicing medicine because it's a known complication of what I was doing. It never happened in my hands before and has never happened since, but I knew that I had to be honest with them. It was absolutely crap, I felt awful for weeks, but then slowly got back to normal … Families appreciate that. Right up front, being honest. So, I suppose part of me is that's me and my values, but part of me is I've learned that. Time and time again I've watched and know how empowering the truth is. (Elizabeth, Interview 1)*

She used the condition of Posttraumatic-Stress-Disorder (PTSD) and the metaphor of 'poisoning themselves' to describe colleagues who she perceived were unable to be honest like she had been in similar tragic situations. She conveyed her belief that these colleagues had become metaphorically 'stuck' and unable to move forward with their lives as a result, which seemed to

reflect her view of not being personally resilient. Responsibly admitting "I killed someone" seemed to free her to move forwards and she believed that admitting this to the patient's family had a cascade-effect that enabled them to move forward with their lives and heal from the traumatic experience.

> *Having watched consultants or other clinicians who have not admitted they are wrong, or it was their fault, well, I didn't end up with PTSD, I just felt bad for 2-3 weeks … I'm sure, if the family had been angry with me, it may have been harder for me, but they weren't. I think they were grateful that I was completely candid at the beginning. It was pretty horrible at the time, but I got over it. (Elizabeth, Interview 1)*

> *I actually think that people who have messed up and then don't admit it, they poison themselves, they torture themselves. It's better to just say, I've messed up, help me here. I think that's an important part of resilience. (Elizabeth, Interview 2)*

Elizabeth believed that, had she put her self-preservation above being honest and had denied her sense of personal responsibility for the situation to preserve her professional career, she was still at risk of losing future personal resilience by being unable to mentally and emotionally move forward due to associated feelings of denial. She also appreciated that this appeared contradictory, as she understood that professionals could try to preserve their reputation, career, and personal resilience by denying what has happened. However, she believed that the feeling of denial resulting from this dishonesty overrides this and risks 'freezing' them in that moment by becoming unable to move forwards with their lives. Inversely, truth and honesty eliminated any feelings of denial and allowed her and others around her to move forward.

> *It's usually loss of face and fear of the consequences … when you judge self-preservation above the simple truth, when you put yourself first, and you're trying to save face (pause) I've watched other people dig themselves into a big hole by not being candid and not being completely honest. Complete honesty might hurt at the time, it might even feel cruel at the time, but actually nobody can come back to you and say you didn't tell me … in the long term it's less painful … they fear the pain at the time and they think that's the worst that can happened, but actually the worst that can happen is the truth can come out later, and the truth will come out later so you're better off being candid at the time. (Elizabeth, Interview 1)*

Whilst Elizabeth believes that honesty and learning from mistakes enables both her own and other peoples' personal resilience, she seemed to experience frustration and disappointment when she

had had to deal with people who did not share this belief. This appeared to de-energise and deplete her personal resilience, and she suggested that being around people who do not share her personal values could become a further stressor for her.

> *On one or two occasions, my consultants have not held their hands up and said this is my fault and I've known it's their fault, and I've had to walk them through why it's their fault. I find that challenges my motivation and challenges my values, because … I'm thinking, you will never learn unless you admit that you've screwed this up. (Elizabeth, Interview 1)*

Contribution to themes:

Elizabeth shared an experience of how her first patient death as a doctor had shaped her views on being resilience as an executive. Through being true to her personal value of honesty developed during her childhood upbringing, she perceived that this enabled a positive effect on her personal resilience, and also that of the patient's family. She believed that honesty enabled them all to feel resilient by being mentally and emotionally free to move forward with their lives. Her story also illustrated the added emotional stressors from working within a care-based environment.

Elizabeth's experience helped identify that enabling personal values such as honesty appear to enable the personal resilience of participants when moving forward in a resilient way, and how this has a relationship with enabling the resilience of other people. She also contributed to the sub-theme of being stuck to articulate what 'not being resilient' is for her and other participants and how denial of the situation appeared to contribute to this. Elizabeth's experience also illustrated how participants and in-particular those with clinical backgrounds appear to deal with the trauma of 'life and death' in their healthcare careers. This contributed to sub-theme articulating the emotional stressors of working in a care environment, and as something that potentially differentiates participants from executive leader roles in other sectors.

4.1.5 Matthew: The asymmetry of being a resilient NHS CEO

Introducing Matthew: Matthew's background is in management and commissioning of healthcare services. He is an established CEO of an NHS commissioning trust, having held several CEO and executive positions previously over many years.

Matthew perceived that as CEO, he was visibly accountable for every action within his organisation and that the 'buck stops with him'. He perceived that the NHS regulatory environment had made it a lonely place for him as CEO, believing that there were increasingly fewer personal support mechanisms available to him and that he now had to find his own ways of managing his personal resilience.

> *We've changed the dynamics in the NHS now, so the buck very much does stop with the CEO ... You are held to account … your relationship with the wider NHS is in the frame of a regulatory environment now. I don't think you can really reach upwards for resilience now … you have to have much more personal mechanisms for resilience than the system might be able to offer you … (Matthew, Interview 1)*

Matthew perceived that his reputation and personal identity as CEO were entwined with that of his organisation. He believed that if his organisation failed, he has failed and will be visibly held accountable for these failings by regulators, damaging his personal reputation, sense of personal identity, and personal resilience.

> *One of the things that I think is really important to understand is the impact that … the success or failure of the organisation can have on … your personal success and failure … you link the CEO to the organisation … your personal identity is very much connected more to the organisation when you are a CEO than in any other post … It becomes more interconnected I think the higher in the organisation you are … If your organisation is succeeding, that makes resilience easy. If your organisation is under pressure, or you're facing challenges in what you're doing, then your need for personal resilience is even greater. (Matthew, Interview 1)*

Matthew seemed to experience this entwined reputation and identity with his organisation as 'asymmetrical', believing that if things go wrong, he is the person who would be 'blamed', however the organisation will continue without him. He seemed to experience the organisation as a 'detached thing' that cannot experience emotion and therefore cannot experience stress like he

can. He is human and can experience stress by being personally 'vilified' if the organisation fails. Matthew felt that his resilience as CEO came from being aware of and managing this perceived asymmetrical relationship.

> *It's more an asymmetrical relationship … If things go wrong, who suffers more, the [CEO] does, because the organisation doesn't have feelings or emotions does it. But, the person can if things don't work out. As a leader, I've got more of an invested interest in the organisation than the organisation has in my success … Organisations will carry on regardless of individuals … the organisation just replaces you ... organisations don't really care about individuals … the organisation isn't emotionally connected to you … I'm talking about it as if the organisation is a 'thing', but it's not a thing with its own personal identity, it's not a person … [it] puts quite a lot of burden on the individual unless you are aware of that. (Matthew, Interview 1)*

Matthew appeared driven by his personal values to make things better for the greater good of the organisation. This appeared to balance the stressor of being visible and accountable as CEO and seemed to give him a 'hero-like' tenacity to keep going when facing stressors.

> *Part of it is personal motivation. My personal motivation to do my job has always been I want to make things better, I want to change things. (Matthew, Interview 1)*

Matthew considered how his personal resilience became affected by this motivational drive to keep going and likened it to 'Maslow's Hierarchy of Need' motivational model. He perceived that the bottom of the hierarchy was about survival and that he existed toward the top, being driven by his personal values to improve things. Matthew perceived that this required a more complex way of being personally resilient and seemed to experience an adapted form of the traditional stress response of 'fight', 'flight' and 'freeze' to achieve this. Matthew never appeared to experience 'freeze', to pause and not be able to move forward, as this seemed to be his definition of 'giving up' and not being resilient.

> *There's something about the ability for an individual to be personally resilient, partly depends on where they place themselves on Maslow's Hierarchy of Needs … I'm right at the top of the pyramid, so you've got to have a lot of personal strength, desire, and motivation to maintain yourself in that position when the context of the environment that you're operating in is going to eat away at that all the time … You probably need less personal motivation and confidence in a way if you're lower down on that hierarchy of needs structure, than if you're*

higher up … [I could] just to do what [the regulator] wants me to do … that would be my definition of giving up. (Matthew, Interview 1)

Likened to the 'fight' stress response, Matthew used the metaphor of a 'smashing' through stressors with a 'sledgehammer', evoking an aggressive mixture of passion and perseverance that motivated him to tackle any resilience challenge and achieve his values-based ambitions.

Resilience is perseverance. There are a number of examples in my role where I have to demonstrate perseverance, or stubbornness sometimes even … My response to that was to drive even harder to get through the barrier they were putting up ... When I hit a barrier, I get the sledgehammer out and smash through it (laughs) rather than allow it to stop me. So, my approach to loss is to not allow it to happen really. Now, it does happen, but as much as possible you try and fight to make sure that it doesn't. (Matthew, Interview 1)

He also appeared to experience an adapted 'flight' stress response, where he perceived himself as self-aware enough to know when to purposefully 'extract' himself from a stressful situation with consideration and dignity, rather than 'running away'. He had a belief that to be resilient he needed to find an environment that allowed him to 'flourish' to achieve, suggesting that his sense of 'self-worth' enabled his personal resilience.

Part of [personal resilience] is knowing when it's right to move on … I can remember one instance where my line manager had changed and I made the decision that, I can't work for that new person so … it was better for me personally to extract myself from the environment and go somewhere else, rather than sticking it out with someone who I didn't value … to be personally resilient and look after yourself, you have to remove yourself from the environment that's causing you the problem. (Matthew, Interview 1)

Matthew perceived that he could adapt to any stressor whilst keeping purposefully focused on his end goal, which enabled him to feel personally resilient. He believed that there was always a solution to a problem and that flexibility and innovative thinking helped him to overcome it.

You have to innovate and find an alternative way to get around the barrier … you just have to find alternate solutions all the time. Part of being resilient is being prepared to think outside the box, to innovate, be prepared not to change your direction, to change your way of thinking, and be prepared for doing things differently to overcome the issue you may face. I think you have to be flexible and also have to be purposeful. (Matthew, Interview 1)

Matthew's use of Maslow's Hierarchy of Need model to express his perceived difference between being resilient when 'surviving' at the bottom and being 'motivated to make things better' at the

top could perhaps explain how he experienced the established stress response of 'fight, flight and freeze' in what seemed like a positive and adaptable way. Surviving implied a more negative response to stress, whereas being motivated to improve things implied a more positive, motivated, and purposeful response. Matthew also described considering the future and attempting to foresee any potential stressors that he could encounter. He believed that this enabled him to proactively predict, mitigate and even avoid potential stressors altogether before they became stressful to him, or his organisation.

> *Quite a lot of what I have to do as a leader is try to predict and foresee problems. This is another example of resilience really, which is if you're good at foresight and predicting ahead, you can head-off problems that are going to affect you … either avoid the barrier or find a way around it. (Matthew, Interview 1)*

Contribution to themes:

Matthew felt accountable for the success and failure of his organisation and perceived that this entwines his reputation and identity with that of his organisation. He perceived an 'asymmetry' to this relationship, believing that the organisation cannot experience stress or accountability like he can as a human being. Matthew shared various ways that he perceived being resilient as a CEO, which evolved the traditional stress responses of 'fight', 'flight' and 'freeze'. He also appeared highly motivated by his personal values to improve things 'for the greater good' with a 'hero-like' tenacity, which he perceived had helped him to keep moving forward.

Matthew's perception that his identity was asymmetrically connected to his organisation contributed to the superordinate theme of being exposed and most of its sub-themes. His belief that his personal values motivated his ambition to improve things and feel able to keep going when encountering stressors contributed to the superordinate theme of moving forwards and the connection to personal values in this theme for all participants. Matthew also contributed to the sub-theme of taking action by demonstrating an evolution of thinking toward the established 'fight, flight and freeze' stress response, suggesting a more purposeful, adaptable and empowered sense in how these are expressed by him and fellow participants. His use of the 'Maslow's Hierarchy of Need' model and belief that being resilient can change depending on where he perceived himself on the motivational model supported the development of the sub-theme of motivation and momentum. This also supports thinking that personal resilience is a subjective, dynamic, and contextual phenomenon.

4.1.6 Sam: Re-framing the reality of failing a CEO assessment centre

Introducing Sam: Sam has held various CEO positions over many years, spanning various NHS settings that include provider and commissioning trusts. He has a background in general management and has been in his current CEO role for several years.

Sam perceived that his personal identity is closely linked to his CEO role and that personal resilience comes from his control over that identity.

> *My work identity is integral to my other identities. I don't have a separate identity ... my resilience … comes from having control over my personal identity. (Sam, Interview 2)*

Sam perceives that whilst he identified as being a successful NHS leader by having sustained several senior executive and CEO roles, he still experienced a seemingly unwarranted fear about being 'found out' as being an incompetent leader.

> *Another key area is the competence bit of it, that sense of 'they will find me out', actually I don't have what it takes to do this. (Sam, Interview 1)*

Combining his fear of being seen as incompetent and his sense of identity as a CEO, Sam's experience of failing a CEO assessment centre and losing his job during an NHS restructure seemed to have a severe impact on Sam's personal resilience at the time. It appeared to validate his fear of being 'found out' and challenged his personal identity, leaving him with a sense of shame at having to tell people the outcome.

> *There was a time when the NHS restructured … and I was a Primary Care Trust CEO and they did a two stage CEO assessment process … where they identified you as being fit for purpose for the CEO job … and, I failed (long pause) I didn't get through. I'd just been running a Primary Care Trust for [several] years, and the system processes said, we really don't think you've got what it takes to do this … I failed and that was a real challenge on a personal level, if you like for all of those things I just described about what's important to me and what 'is me'. That sense of (bangs table) you don't cut the mustard was huge. (Sam, Interview 1)*

Sam described going for a walk to avoid the situation, which elicited a sense of becoming 'stuck-in-the-moment' and unable to move forward. Throughout Sam's various experiences, his wife often featured in supporting his perceived resilience. In this experience, Sam's wife appeared to

give him a 'reality check', which enabled him to gain a sense of perspective and rapidly work through the traumatic experience and move forwards. Sam described a 'lump in his throat' when re-living the situation in the interview, demonstrating the long-lasting impact of this stressful experience. He also described how metaphorically taking 'breathing space' enabled him to 'step back' and gain 'perspective' on what to do next.

> *Instead of going home I went … for a walk … My wife rang me and said "where are you", and I told her the news and she said (bangs table and laughs) "stop being ridiculous, get your arse back in, get a grip, decide what you're going to do". It was really powerful. It just brought a lump to my throat did you just see that (points at throat) … I knew deep down that I was just ducking it for a bit, but I just needed that breathing space actually and I think … stepping back, just for a minute, I'm going to just go and absorb all of this. It was cut short and not unhelpfully by my wife … I wouldn't have gone and thrown myself under a bridge or anything just to be clear, but I was just coming to terms. (Sam, Interview 1)*

Sam perceived that taking action to move the situation forward enabled him to feel personally resilient and more in control. He gave the impression that doing nothing would have been detrimental to his personal resilience, and that it was gaining perspective, exploring options, and taking action that helped him to move forward.

> *Then it was so what are you going to do now … it is what it is (bangs table) you have a number of options … and that for me, was a really good example of where, the resilience bit was the responding to it, actually doing something about it, and that was you know, letting it lie and letting it simmer was just never going to be an answer, that would have pushed me in the wrong direction. (Sam, Interview 1)*

Sam's sense of personal resilience appeared to come from rapidly reframing the situation into something more positive, and how his positive reframe became the perceived reality that he would share with everyone else. This response appeared to mitigate the initial feeing of shame and failure and allowed Sam to feel more in control, more able to manage the situation, and move forward.

> *Quickly finding a different story to tell on a personal level is a really important part of that for me. Not to say a different story, but what is 'Sam's' story of how this presents, because I'm sitting there thinking I just failed, and everybody knows I've just failed and now I am in that category of failed. Actually, leaving that organisation was really embarrassing because I could have just slipped away … [instead] I chose to write to all of the staff very quickly and say, I want you to hear this from 'me', and worked hard on putting a very simple but very*

positive message … you have to tell the story in your terms … you can have a negative or a positive, and if you can find the positive and the way that you articulate that and say, OK this isn't great and it isn't what I wanted, but this is what I'm going to do about it. (Sam, Interview 1)

Sam also shared an anecdote for how he reframed his fear of the life-changing moment of becoming a dad from a traumatic into a positive perspective to illustrate the same resilient response as his CEO experience. Reframing the same reality from feeling overwhelmed into feeling positive appeared to give Sam an acceptance of the situation in a positive way that enabled him to enjoy the experience and move forward.

This is completely irrelevant and not part of the story, but my first daughter … there was a moment when I stopped saying "my wife's pregnant", and I started saying "I'm going to be a father". That strikes me as the same image when I wasn't wise or mature enough to grapple with that in the moment, but looking back at it I knew I stopped blaming somebody else for being pregnant, and started saying hey wow look at this I'm going to be a dad. It was in that same sentence, when these things happen, finding a way of changing that paragraph if you like. (Sam, Interview 1)

Sam also began to question the concept of truth and reality by considering if his interpretation was only positive by retrospectively reframing his experience as a resilience coping mechanism, or if it was actually more traumatic at the time than he remembered. He articulated that it was the same experience, but by keeping the positive framing helped him to perceive himself as resilient and able to cope when remembering past traumatic events.

I don't know how much of this is what I constructed after the event, and how much of this was real at the time. Was I just really running away from a difficult situation, or had I decided deep down I'd actually thought it was time for a change and to get a new job and this was the only way that I could manage that. (Sam, Interview 2)

Contribution to themes:

Sam's experience illustrated his journey of reframing stressors into an opportunity. He moved from being assessed as 'not being good enough' to continue to be a CEO during an NHS restructure which brought associated challenges to his personal identity, to turning this into a liberating and positive opportunity to move forward through positively reframing how he perceived the situation.

Sam's experience contributed to the superordinate theme of being exposed and the identity issues associated with this. His experience also seemed to demonstrate a journey that brought together most of the sub-themes within the superordinate theme of moving forwards, by being supported by his wife, gaining perspective, positively reframing of the situation, and then taking action to move forward. Whilst philosophically questioning reality is beyond the scope of this study, Sam's questioning of his perception of reality when positively reframing a stressful situation in retrospect supports the perspective that personal resilience is a complex, subjective, contextual, and temporal phenomenon.

4.1.7 Stephen: Transitioning with a resilience 'rucksack'

Introducing Stephen: Stephen is an established CEO of many years, having held several executive leadership positions in a variety of NHS settings throughout his career. He has a professional background as a clinician.

Stephen's metaphor of 'running with a rucksack' appeared to symbolise his personal resilience, where the act of running implied his ability to move forward and keep being resilient. He built on this metaphor by discussing 'stones' and 'boulders' being thrown into his rucksack to suggest the different perceived weights of stressors that he experienced as a CEO. He believed that a metaphorical 'boulder-sized' stressor could hit at any time, or that there could be many smaller stressful 'stones' hit at once that could equally weigh him down and slow his run to a walk. His overarching fear seemed to be becoming unable to keep running with his rucksack, causing him to 'fall backwards', 'become stuck', and therefore no longer be resilient.

> *As a CEO, I would describe the job like running with a rucksack on your back and you can't tell what people are putting in … you're building up fitness when you're running and … the rucksack is getting heavier … people just put things in, and occasionally people just put things in that are too big to cope with. You might spot them doing it, or you might not … it could be lots of little things all the same time … but at some point, you get older or poor health or whatever, and actually the rucksack just gets too much. I think ultimately the rucksack stops everybody, whether that's retirement or the rest of it. It's just too much, you can't cope with the burden of it … the little stones get bigger. It's that sort of, collection of stuff that happens … I think you get more of that, the more senior position you get. (Stephen, Interview 1)*

During the second interview, Stephen explored how his choice to recently retire had impacted his sense of personal resilience. He seemed to grapple with how his ability to continue to be physically and mentally resilient in the role of CEO was reducing due to naturally getting older. He wanted to exit his CEO role 'in his prime' and felt that he needed to transition to retirement to reduce the burden on his personal resilience and continue to stay personally healthy.

> *I like transition rather than end point … as a CEO you're running with a rucksack all the time. That analogy is great when you're fit and running, the rucksack doesn't feel like it's a weight. The minute you stop, it feels quite a [lot bigger] when you pick it up again … Then I think,*

what if I carried on and I wasn't able to quite perform at this level. What if I don't quite manage my resilience well … [I can] choose to go out on top … I feel like I can walk away with my head held high … I can feel it more now than I could a year ago. I haven't had the big rock thrown into it, I'm still quite fit. So, I'm going to hand it over in a position where I can say, OK, I can take that off. For me, that's a really nice feeling. (Stephen, Interview 2)

This perceived transition seemed to leave Stephen questioning his sense of self-identity. He seemed to be accepting the aspects of himself that he perceived he would lose, such as his influence as a healthcare leader. However, it also brought him a sense of gain by becoming liberated through 'letting go' of his resilience rucksack he held as CEO. He used the metaphor of 'baggage' to explain that through his life transitions, he had been unable to let go of certain stones that became stuck in his rucksack for a variety of reasons, both inside and outside of his personal control.

There is something of course where you carry baggage all the time, you go to a new job, you get a new lease of life for it, as well as the rucksack changes. It's like someone pulls a cord and you drop some of the rocks out. Occasionally though, you get some of the rocks still stuck in there … that baggage remains … it's this little stone here who didn't drop out the back. (Stephen, Interview 2)

Stephen illustrated this by sharing how he inherited a 'boulder-sized' traumatic stressor where the organisation's services had failed and led to someone's death before he took on the role of CEO. His personal values seemed to compel him to inherit the failure as his own, even though it had happened before he joined the organisation. Stephen gave the sense that he did not want to release this particular boulder, as whilst at great expense to himself, the pain and trauma seemed to act as a motivator to help him to make a positive difference. He seemed to have reframed the stressful 'boulder' into a positive opportunity to make the organisation better and prevent such an incident happening again, positively impacting the resilience of his organisation and patient care. However, Stephen also described this metaphorically as 'haunting' him throughout his time as CEO, giving the impression of being stuck in a sense of guilt and unable to move on from the patient's death because he could not gain a sense of closure by sharing how he had made a positive difference with the patient's family. Personifying this baggage and making it 'ghost-like' seemed to transform it from being a tangible and releasable boulder into something that became 'hauntingly attached' to him throughout his future life-transitions.

I'm emotional … I started to cry … this is someone who died before I came into the organisation, they were killed. They haunted my years in this post as CEO. Haunted not in a

negative way … they've impacted on my career here, because we failed them. The family have never wanted anything to do with me … That's a piece of baggage who sits with me. I do get very emotional about it … the individual errors that arose will not happen again in this organisation, so I should feel really proud of that, and it's a driving force, but actually there's a bit where I would love to sit down with the family and say, sit with them now and say, how are you (pause) and not try to justify myself but say, we really have learnt the lessons. I know you're unhappy, but how are you (pause) and I can't do that. That's (pause) hard. That is, I take that guilt on behalf of the whole organisation … it's important that we don't forget … you carry that baggage as a CEO, I think people would be surprised. This didn't even happen on my watch. (Stephen, Interview 2)

Stephen's anxiety whilst transitioning and letting go of the weights within his resilience rucksack seemed to arise from his personal values of being 'worthy to care' for others. Many of his experiences seemed to involve him using his positional leadership and personal resilience to positively impact the lives of others. This was demonstrated when talking about how James, a patient from his first clinical role still impacted his decisions today. Whilst being haunted by the death of one patient seemed to personify a need to do better as CEO in his current organisation, a photo he kept of James seemed to act as a visual reminder throughout his career to live by his personal values when faced with tough and stressful resilience challenges.

You can see the photograph of James who I looked after … (points to photo) he's sat above my office desk for my entire career and effectively he's looking down on me… I do look at the picture every day … and consciously think, what would James think about that. (Stephen, Interview 1)

James still featured in his thoughts when extensively debating what to mentally and emotionally keep or let go of into retirement and did not appear to simply be a photo. Like how Stephen kept hold of the patient's death to drive his resilience, James seemed to symbolise the part of Stephen's personal identity that acted as his conscience, anchoring his sense of self-worth to his personal resilience to maintain motivation through stressful times as an increasingly senior healthcare leader. To let go of James seemed to be to let go of his sense of purpose, his values, his motivation to keep running with his resilience rucksack as CEO, and to accept that his transition to retirement would fundamentally change him, and his personal resilience.

James is above my computer now. He's still incredibly powerful in my life and there's a bit of him … I need to hand-over, and there's a bit I need to hang onto … The bit I've got to hand-over is thinking directly the scale of healthcare services that I can have a direct impact on.

The bit I've got to hang onto is, well actually James is still someone who just grew older. He was an older man and I'm going to be an older man … my identity is going to become just someone who's growing older, now retired, and is now going to do different things. (Stephen, Interview 2)

Contribution to themes:

Stephen shared the metaphor of 'carrying a rucksack' and his constant struggle with it 'weighing him down' to illustrate his perception of personal resilience. Between interviews, Stephen chose to retire from his CEO position. This enabled an exploration of his transition between perceived resilience states from being 'high-profile CEO' Stephen to 'retired' Stephen. During this transition he appeared to struggle with what to keep, what to let go of, and what unconditionally remained stuck in his resilience rucksack. His experience also illustrated the added emotional stressors arising from working within a caring environment.

Stephen's resilience rucksack metaphor contributed toward the superordinate theme of being exposed and the sub-themes of becoming 'stuck' and unable to resiliently move forward and the emotional stressors arising from working in a caring environment. He also contributed to the superordinate theme of moving forward and sub-theme of positively reframing a situation with his experience of feeling stuck by inheriting and not letting go of the tragic death of a patient and turning this into a positive motivator for himself and others make things better on a bigger scale for the entire organisation. The ability to explore his perceptions of moving from CEO to becoming retired also contributed to the sub-theme of transitioning between resilience states.

4.1.8 Tim: Being the optimistic unsung hero

Introducing Tim: Tim is an established executive director of finance of many years, currently working within an NHS provider trust. He started out his professional career in the private sector and moved into the NHS many years ago.

Tim seemed driven by his personal values that relate to 'doing the right thing' for people with a sense of integrity. He stated that he moved from working in the private sector into the NHS early on in his career, as he wanted to make a positive difference to people. He believed that aligning everything he does to his personal values enabled his personal resilience. Believing that his actions are underpinned by good intentions seemed to create an energy, sense of purpose and self-belief that motivated him to keep going.

> *Values are, doing the right thing and integrity … if you believe something strongly, don't be afraid to say that … fundamentally, if you know what you're doing is right and you've got the right values, in the end you will get through this. It might be harrowing, it might be difficulty, but you'll get to the other side of this. (Tim, Interview 1)*

Being motivated by his personal values to help people seemed to give Tim an altruistic, 'hero-like' quality. He even referred to himself as the 'unsung hero', giving the impression that helping others in a way that aligned to his values gave him great personal satisfaction and motivation, regardless of being noticed for it.

> *By doing this, it actually builds and fosters that personal resilience stuff … If you come back to for the greater good for the organisation, that completely selfless type of approach, it builds that feeling good about myself … I pride myself on being almost the unsung hero … I really love making people feel better … and I've got the humble thing that I don't want to be recognised for it, as just doing it makes me feel better about myself. (Tim, Interview 1)*

Tim used the metaphor of a 'resilience bank' to articulate how he perceived that being altruistic created a positive personal reputation where others felt more likely to support him in the future. This created a complex and temporal connectedness to Tim's personal resilience that seemed to go beyond the established notion that social support networks enable personal resilience. 'Banking resilience' in this way appeared to enable him to feel supported through the followership of others,

rather than relying on his organisational authority as an executive leader to draw upon their support.

> *It does come to, this bit about the resilience bank, the investment, being values-based … If you do positive, it comes back. It's an investment in the future … being seen to do it, and people knowing that's what you do, you create that reputation … what goes around comes around … it makes it more likely you're going to get positive outcomes for yourself from doing that … you can rely on people you've worked with before if you've done right by them … when you haven't got organisational authority, you can still rely on that. (Tim, Interview 1)*

Tim believed that being authentic and honest as a leader enabled his personal resilience. Inversely, he perceived that dishonesty holds him back, as maintaining a 'facade of lies' would exhaust him and if discovered would damage his reputational 'resilience bank' and risk losing the support from others.

> *If you're making it up and it's not authentic, it is actually really difficult. Telling lies is much more difficult than being honest and open, because you've got to manage it through thinking about all the implications and that type of stuff and at the end of the day, that's really exhausting. If you get this right and work it though, it's far less tiring. (Tim, Interview 1)*

Tim appeared driven by being optimistic and action focused. He seemed to actively reject negativity and instead sought positive ways of reframing stressful situations, suggesting that finding the positive in everything is less draining to his personal resilience and is more likely to result in actions that achieve positive outcomes.

> *Wallowing in that stuff just creates an anxiety. So, it's just about energy, openness, positivity, constructive and trying to concentrate on what we 'can do' something about, as opposed to 'oh this is terrible' … How to do this differently and achieve that, gets you a more positive outcome and positive discussion and framing of the problem … what do we do to change the nature of that conversation … how you use it as a positive, so actually see this as a real wonderful opportunity to have the [regulatory body] come in and use them as a consultancy and show a mirror to you as an organisation … If there's enough positives, it outweighs the negatives. (Tim, Interview 1)*

Tim appeared to extend this optimism to those that he works with, giving a sense of passing on his personal resilience to others. By reframing a shared stressor in an optimistic and positive way, Tim perceived that the people he worked with were more likely to be motivated to tackle it positively and achieve a better result. This in turn seemed to enable Tim's personal resilience as their leader,

as being an executive leader, he believed that his personal resilience is dependent upon the success of the people that support him.

> *You've got to do enough that excites people in the organisation … demonstrates 'can do' stuff … You're trying to be a catalyst to, let's model behaviours, model making a difference … and taking out the barriers. Don't worry about the things you can do nothing about, spend time on the things you can do stuff about. (Tim, Interview 2)*

Contribution to themes:

Tim's 'hero-like' quality appeared to be at the heart of enabling his personal resilience. He seemed immensely driven by his personal values and a sense of optimism, which appeared to act as a motivator to keep him going through stressful situations. He appeared to have developed a way of optimistically reframing any stressor into a positive opportunity, which he perceived enabled him and others to cope. By altruistically supporting others, he believed that people are more likely to support him in return when his personal resilience feels compromised.

Tim's experience contributed to the superordinate theme of moving forward and the sub-theme of how positively reframing a stressor into an opportunity appears to enable participants' perceptions of feeling more resilient as a result. Tim's metaphor of the 'resilience bank' also evolved the traditional concept of social support being enabling to participants' personal resilience, into something that seems much more complex, interconnected and temporal. This supported the development of the sub-theme relating to creating an enabling resilient environment.

4.1.9 Wendy: Rebalancing personal energy with the support of others when facing personal tragedy

Introducing Wendy: Wendy is a nurse by background. She has been executive director for nursing for many years within an NHS provider trust, having held deputy director positions for many years before that.

Wendy shared that her personal values of care and compassion seemed to compel her to support the personal resilience of others. However, she also perceived these compassionate acts metaphorically 'bank' personal resilience with others, which enabled her to draw resilience support back from these people if she needed it in the future.

> *You craft an environment where other people support your resilience … It's almost like putting coins in the bank … The coins in the resilience bank are about your own personal resilience, but they're also about how you respond when somebody else is in a difficult place, so when it's not you that's actually under the greatest strain … what can you do to help … you're only as resilience as people are around you … I care about other people who might need some help. So, there's something about recognising that I'm in a difficult place here, or reaching out to others and say, I'm here if you need me. (Wendy, Interview 1)*

Wendy articulated herself as a values-driven, powerful, and ambitious individual who seemed extremely resilient in her first interview. However, in her second interview, Wendy shared how she was currently experiencing a stressful situation where a family member had been diagnosed with a terminal illness. This unexpected shock seemed to throw her off-balance, and she perceived her energy and personal resources that normally helped her to perform in her executive leadership role had to be diverted toward managing the traumatic personal home-life situation. Wendy likened this to a 'rollercoaster', giving the impression of something frightening that forces her to keep going with a sense of being out of control.

> *I've had a very personal thing that's really impacted me over the past 7-8 months or so. So, my [family member] … has got [terminal illness] … It's amazing how much something like that has a personal impact on you. It's a massive thing … It's almost like, another thing on top of everything else you're managing, so it has tested my resilience over the past several months … I suppose there was the initial shock bit, going back and telling my boss and …*

(pause) you're living through all this shock. You're in work, trying to do work, also support your family … those rollercoasters, they can happen at short notice, and it is amazing how much it impacts on you. (Wendy, Interview 2)

Wendy spoke often about 'balance and boundaries' during her interviews. These appeared to be metaphors for her response to realigning energy and personal resources across different aspects of her life when facing stressors, that helped her to perceive she was moving forward with her life. She applied this way of working to actively managing the situation by adapting and re-aligning her perceived boundaries to create a new balance that seemed to enable her to feel personally resilient at work and home. She also appreciated that she needed to draw on her 'banked resilience' with others, perceiving that the people she had supported in the past would be there for her during this difficult time.

It's another boundary if you like, what your capabilities are, how far you can be stretched. Still moving forward, but perhaps not as quickly as it otherwise would have happened … A key thing is around trying to get those balances … having an understanding boss … having people around you at work who support, will step in, you know they've got your back, you know, so my team said, whatever you need to do, you need to do, we will step up when we're needed. That has been really helpful. (Wendy, Interview 2)

In addition to re-prioritising and re-balancing where she was putting her personal energy and resources, Wendy also seemed to experience metaphorically 'freezing' some aspects of her life to be able to manage others. She paused her career ambitions to become a CEO and also experienced an inability to enjoy herself and take time for things like holidays. However, she did appreciate that self-care was important in enabling her personal resilience. Rebalancing her priorities seemed to enable her to keep going and deal with her personal tragedy and maintain her executive responsibilities.

That's part of being real and being resilient and not burning yourself totally out. What can you 'not' do, what can you gift yourself not to do, what can you just accept that it isn't going to happen this year. Otherwise, you're just on your way to becoming very un-resilient I suppose … I did have aspirations of potentially being a CEO myself … and that's almost got taken off the table, because how can you put yourself through [it] … I just want to put it on hold, as to just do a decent job and get through what we need to get through at work and personally get through things, is probably going to be a good goal right now … I have hardly taken any time off, I didn't feel able to … because we didn't know what was happening … there's an inability to enjoy yourself … what if I have some time off and all of a sudden, I need

some time off because something's happened, so… I've let that just carry on. On reflection I probably shouldn't have done that. (Wendy, Interview 2)

Contribution to themes:

Wendy's experience demonstrated how tragedy in her personal life could affect her sense of personal resilience in her work-life if not managed well. Whilst she was perceived as a powerful and resilient senior leader by others, she perceived herself as still human and vulnerable. By finding a new balance through realigning where she focused her personal energy and resources, choosing parts of her life to put on hold and pulling on the supportive connections that she has created throughout her life, Wendy was able to balance being personally resilient in all aspects of her life. This enabled her to keep going through unexpected personal adversity in her home-life.

Wendy's experience demonstrated that whilst participants perceived themselves as resilient executive leaders, they can still experience personal-life trauma, and this contributed to the sub-theme that executive leaders are still vulnerable people too. Both her and Tim's combined 'resilience bank' metaphor and notion of giving, growing, and receiving personal resilience evolved the traditional concept of social support and contributed to the sub-theme of interconnected resilience relationships. Wendy helped to develop the superordinate theme of moving forward, which was taken from a direct quote by her. Whilst most other participants perceive that their home-life gave them energy to keep their work-life going, Wendy demonstrated that this can also happen in reverse. This contributed to the sub-theme of motivation and momentum when moving forward.

4.1.10 Summary

Part 1 of this chapter has introduced each participant by presenting individual lived experiences of personal resilience as NHS executive leaders. It has illustrated how these different lived experiences of personal resilience have supported the generation of the various subthemes identified within the study and how they assisted with the development of the overarching thematic map (Figure 2). Part 2 of the chapter will present the thematic map and discuss each theme in further detail.

4.2 Findings Part 2: Presentation of themes

This section presents three superordinate themes that emerged from the analysis of participant transcripts. They are presented in a way to represent the researcher's voice within the analysis, building upon the participant voices within the previous section. Whilst many themes presented themselves during the analysis, these themes were identified through ongoing consideration of relevance toward the research aim and questions. Each superordinate theme is presented with a brief introduction followed by a discussion around the sub-themes, which is supported by participant transcript extracts. Each theme also contains a reflective account, to further establish the researcher's voice within this section.

In brief, Theme 1 illustrates how all participants appear to experience feelings of exposure, which seems to differentiate how they experience stress within their executive roles. Theme 2 illustrates how they appear to learn from the various stressors encountered throughout their lives, enabling them to perceive that they can be increasingly personally resilient toward similar future stressors. Theme 3 illustrates how they experience a sense of moving forward with their lives when responding to, and overcoming, the stressors they encounter.

These three themes appear to overlap, intertwine, and present themselves entirely or partially within the various experiences of personal resilience that participants shared. The holistic participant experiences presented earlier in Part 1 of this chapter demonstrates this further, in how some, but not all themes present themselves within each participant experience. The overarching thematic map (Figure 2) also demonstrates this visually in how the three superordinate themes overlap.

4.2.1 Theme 1: Being exposed

This superordinate theme illustrates how all participants experience 'being exposed' as NHS executive leaders and the subordinate themes showcase various contexts that this exposure appears to present itself. Participants express various ways of experiencing stress within their interviews, however feeling exposed appears to differentiate how participants perceive stress differently as the senior leaders of their organisations. This theme supports addressing the research questions of exploring participant experiences of stress and their perceived uniqueness of this in the context of being an executive leader in an NHS care-based environment.

Figure 3 - Theme 1 Map - Being exposed as an NHS executive leader visualises this theme and Table 5 demonstrates where sub-themes were identified within the different participant narratives in their entirety. The remainder of this section explains and discusses these findings in further detail and concludes with a reflective piece.

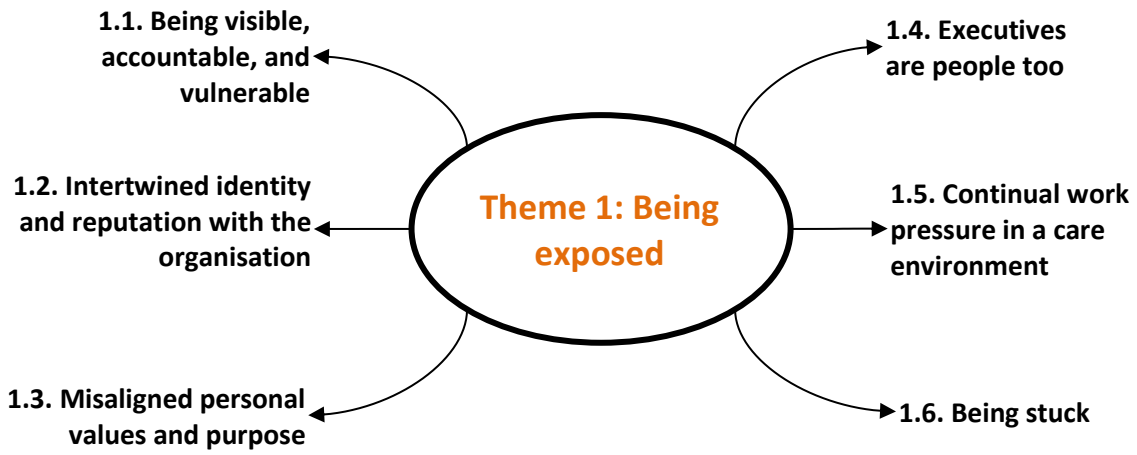

Figure 3: Theme 1 map - Being exposed

Table 5: Theme 1 - Being exposed									
Subordinate themes	**Andrew**	**Catherine**	**Diane**	**Elizabeth**	**Matthew**	**Sam**	**Stephen**	**Tim**	**Wendy**
Theme 1.1. Being visible, accountable, and vulnerable	●	●	●	●	●	●	●	●	●
Theme 1.2. Intertwined identity and reputation with the organisation	●	●	●	●	●	●	●	●	●
Theme 1.3. Misaligned personal values and purpose	●	●	●	●	●	●	●	●	●
Theme 1.4. Executives are people too	●	●	●	●	●	●	●	●	●
Theme 1.5. Continual work pressure in a care environment	●	●	●	●	●	●	●	●	●
Theme 1.6. Being stuck	●		●	●	●	●	●	●	●

4.2.1.1 - Theme 1.1: Being visible, accountable, and vulnerable

All participants express an awareness of being highly visible and accountable to their staff, healthcare regulators, to political and public scrutiny, and the media as the most senior leaders of their organisation. This visibility appears to lead to experiences of personal exposure and vulnerability. They perceive that the NHS regulatory culture is 'top down', performance driven and that of blame. This constant stressor seems taken-for-granted by all participants and appears to lead them to experiencing an ultimate accountability for their own actions, as well as the actions of their organisation and their staff. Several participants express this using the term 'the buck stops with you', eliciting feelings of blame, exposure, detachment, and a persistent sense of vulnerability, as participants are accountable for the actions of those working for them, yet can never feel fully in control. This appears especially relevant for CEOs, who express feeling ultimately accountable for their entire organisation's actions.

> *Once you get into these CEO roles, it does feel like that, like there's a public profile … it just goes with the territory to be honest … these are challenging jobs, they are high profile, public eye and people have high expectations of them, and when things aren't right, people look to see how you behave and react … There are things that are definitely more-scary than others about what we do as CEOs and the potential for them to go wrong … it's about patient care and the safety … there are things where I am absolutely the person where the buck stops, but so far removed on a day-to-day basis from that individual circumstance that, [I am]*

having that sense of confidence in and the reliance on the systems, processes, people and the support that they [bring]. (Sam, Interview 1)

Whilst this loss of control over the actions of their entire organisation and resultant imbalance of accountability could appear unfair, all participants seem to live with this constant and often forgotten background stressor in their day-to-day being, to the point that it becomes an 'accepted norm' within their role. Participants seem to justify and manage this constant background stressor by expressing a shared appreciation that if they find themselves in such a situation, it is likely the direct result of the NHS regulatory culture, rather than being ineffectual within their role.

I think you live with it and know it could be you. In your network of exec directors and CEOs, there is an acknowledgement that people who are moved on … most of the time it's not because they are incompetent, and they can't do the job. So, you accept it. You know and acknowledge that actually, it's highly likely that it's not about that person or not about that team, it's just something has to be seen to be done. (Wendy, Interview 1)

Whilst most participants share experiences of seeing colleagues being visibly held accountable through the perceived NHS 'blame culture', several participants share personal experiences of being on the receiving end of being visibly held accountable. Tim, in addition to sharing experiences of positively framing stressful situations (see Chapter 4 – Part 1) also shared contrasting experiences of immense trauma resulting from feeling blamed and then being dismissed from his executive role for organisational failings outside of his control, which demonstrates his level of exposure as an NHS executive. He describes it as falling "foul of the NHS rules of the game and bureaucracy", being "suddenly cast loose", receiving a tarnished reputation that had previously been exemplary, and experiencing a fear for the safety and security of his family. This illustrates the potential personal devastation, feelings of injustice, shame, confusion, and personal loss that participants could be exposed to, arising from their visible accountability as NHS executive leaders.

Whilst Tim's experience demonstrates a personal 'behind-the-scenes' sense of being held accountable and exposed, Diane story (see Chapter 4 – Part 1) of being publicly 'vilified' in front of hundreds of people on two occasions illustrates a more intense and visible sense of personal exposure and vulnerability. Both Tim and Diane share experiences of exposure, personal violation, and safety concerns, however Diane experiences this from an openly exposed public, political, and media-eye perspective likened to a 'celebrity-like' status and level of scrutiny. Diane's experience elicits feelings of physical and mental trauma, being stuck in the moment and fearing for her own personal safety and security, likened to how celebrities may feel exposed for their actions. Their accounts suggest that the visible accountability of participants' executive roles has the potential

for varying contextual levels of personal exposure, vulnerability, and loss of control, which whether encountered or not in role, lingers as potential stressors for all participants.

4.2.1.2 - Theme 1.2: Intertwined identity and reputation with the organisation

Entwined with visibility and potential 'celebrity-like' feelings of exposure, all participants appear to experience a connection between their personal reputation and that of their organisation. They describe being aware that their actions and behaviours as executive leaders shape how people experience both them as individuals, and their organisation. They express that this causes their reputation and personal identity to become increasingly entwined within a corporate sense of organisational identity, and this seems to add a further layer of exposure and background stress to their existence in role.

> *One of the things you need to understand when you [become an executive] is that it's not just about you as the individual … you also become part of the corporate executive and therefore you have part of a shared responsibility with the rest of the executive in terms of those corporate responsibilities. (Matthew, Interview 1)*

Whilst all participants experience a shared connection with their organisation's corporate reputation, this transpires through the combined actions of their executive team and seems to be experienced as a collective sense of exposure. However, as figureheads for their entire organisation, CEO participants suggest an explicit connection between their own personal reputation and identity, and that of their organisation. They seem to experience this as becoming the 'embodiment' of their organisation, as the lines between their personal identity and that of the organisation become increasingly blurred to the point that their personal identities become increasingly lost within this entanglement.

> *Your identity and the organisation, you become the organisation. If it's something on TV, it's you. If something goes wrong, it's you. If people refer to you, they say, oh you're the 'organisation name'. You are, whether you like it or not, the embodiment of the organisation. I find it an odd thing. I accept that actually, whether I'm at work or at home, I'm meant to be the organisation and display the organisations values. So, do I ever really let my hair down, no … I have an identity that is very much intertwined with the organisation. (Stephen, Interview 2)*

My work identity is integral to my other identities … I can't put a distance between that and the reflection on me. I'm very clear that it's me and my reputation just as much as the organisation's reputation. (Sam, Interview 2)

Several CEO participants appear to experience this relationship as 'asymmetrical'. This concept is articulated within Matthew's experience (see Chapter 4 - Part 1) perceiving that if the organisation is failing, he as the CEO suffers the most as he is ultimately accountable for his organisation's actions. However, Matthew and several other participants seem aware that the organisation is not a person, and its resilience cannot be damaged in the same way that theirs can. They perceive that the organisation will resiliently continue, despite continual changes to the executives who lead it throughout its existence.

4.2.1.3 - Theme 1.3: Misaligned personal values and purpose

All participants describe being driven by their personal values and a sense of purpose aligned to these values. Whilst participants' personal values appear subtly different to each other, these values seem to support them all to achieve an overarching shared purpose, which is often articulated as 'doing the right thing for people' in whatever context that it presents itself. Experiences that challenge these personal values and their ability to achieve this sense of purpose seem a common cause of stress for them. Being in a people-focused healthcare environment also seems to increase the potential of being exposed to such values-based challenges. It appears to frustrate and exhaust them if they perceive that the task at hand is not aligned to these personal values. Openly challenging this values misalignment in front of others can risk feelings of personal exposure if not aligned corporately, which has the potential to add a further layer of stress.

I think the one thing that keeps my resilience is checking against my values. Am I doing the right thing, in the right way. Am I doing it in a way that I think is appropriate. Because, quite often I find scenarios for me where my resilience is being tested, and it's being tested because I'm seeing things played out in front of me that aren't in line with what I would choose to do. I think my biggest test in terms of resilience is, making sure I handle those in an appropriate way that's true to me, true to our organisation's values, and not letting how others are choosing to handle this situation, transfer onto me. (Andrew, Interview 1)

Perceiving themselves as 'doing the right thing' with day-to-day tangible organisational business appears less stressful, as their executive role enables them to directly influence how the organisation functions. However, most participants express that they find it more stressful when

their personal values are not aligned with the people that they work with, as challenging other peoples' personal values and beliefs risks personal exposure and increased stress.

> *It does become 'actually', these people just don't have great values and it does give you personal problems when you have deep seated values, and you find someone who fundamentally has different values to you, it's really difficult to cope with. (Tim, Interview 1)*

As leaders of people, it is highly likely that participants will encounter others with different personal values to their own. This appears to leave them with the options of 'living with' this mismatch of personal values, 'visibly challenging' the values of other people, or 'moving on' to somewhere where their values are better aligned. All of these options impose different contextual levels of personal stress.

> *Alignment of values that you've got with your organisation and colleagues, if you're not aligned, one of you needs to budge. You either get the organisation to change, or you need to get out, because actually it builds up a conflict and you will struggle with that. I suppose the bit for me is, and I suppose the CEO role, I do probably spend even longer now thinking about those issues of values … when you're a CEO one of the challenges of being a CEO is that you're always working with people who just have different values. We've got 4,000 staff. Some of their values are completely different to mine. (Stephen, Interview 2)*

The context of the situation appears to present subtle nuances in how these unique personal values are expressed. Participants appear to interpret other peoples' values through their own lived experience of peoples' actions. They then consider this experience against their own personal values and assess its alignment. Non-alignment seems to cause stress by creating a sense of dissonance. If they perceive this as a personal challenge, this seems to increase their sense of stress further by eliciting feelings of personal anxiety and trauma.

> *[Describes personal values clashing with a peer] I took it really personally … it was having an impact on my professional identity and my professional role in this organisation. I took it really badly, it really upset me. It was around fairness, and it not being right and encroaching on [my] role … I can remember just sitting there and being on the verge of tears on how difficult it was … it impacted my values and where I was prepared to go, or not go. (Wendy, Interview 1)*

Whilst personal values seem linked to participants' personal resilience, the subjectivity and contextual nature of how these personal values are experienced suggests an unpredictability and complexity to participants experience of stressors within their roles and how they visibly express

the impact of this to others. For example, as well as eliciting feelings of anxiety, participants also express the potential of bringing out frustration and anger, which seem equally stressful to cope with.

> *[Describes clinicians who do not live by similar personal values and being honest] I get angry with them and that's not an emotion that I normally feel very often. Anger is not something that pops into my head very often, but I literally want to slap them around the head with a wet fish and say look, this is your fault … it's their own personal response, and I'm thinking you need to be better than this, and that annoys me, it makes me angry. That's not a helpful emotion for me. (Elizabeth, Interview 1)*

4.2.1.4 - Theme 1.4: Executives are people too

All participants express that personal-life stressors impact their ability to be resilient in their executive role in varying ways, depending upon the context of any wider work-life stressors affecting them at the time. Whilst they feel they are perceived as the resilient figureheads of the organisation, they also feel it gets forgotten that they are still fallible human beings too, leading to a sense of losing their humanity to their corporate leadership role.

> *People forget that execs are human beings as well … I mean, our Chief Finance Officer the other day, their dog was run over and killed by a car. Now, the emotional impact on them was exactly the same as it would have been as a band 3 [level of seniority] secretary or band 2 admin assistant. It doesn't matter what level of the organisation you are at, personal things will affect you. (Catherine, Interview 2)*

Most participants believe that their work-life balance is important in maintaining the boundaries of their personal resilience. Stress seems to arise when these boundaries become blurred, misaligned, or break down beyond their ability to manage them.

> *I often see people who struggle are those who don't have boundaries, who are boundary-less. They don't think about their health and wellbeing, thinking it's the right thing to give, give, give, but it's not the right thing, it doesn't pay off in the end. (Wendy, Interview 2)*

Participants' ability to be resilient in their executive role seems to be impeded if there is an imbalance across these work-life boundaries, such as a significantly stressful personal-life event happening in parallel.

My partner had a [describes long term health condition] … she was really in a bad way that got [close] to suicide, a number of remissions … I had a really trying time, that was really, really difficult … personally it was a real test, as bigger test as I've had in my life. (Tim, Interview 2)

Persevering without showing work-life vulnerability to others seems to enable participants to maintain their sense of status as resilient organisational figureheads. They perceive that maintaining this status forms part of their pastoral role, believing that other people draw personal resilience from their show of strength. However, most participants express an ongoing struggle with this, acknowledging a need to expose their vulnerability to others as part of being an authentic leader.

The most important thing is how you behave and how you manage yourself through this [stressor] because everybody's going to be looking at you. (Wendy, Interview 1)

[Describes personal-life tragedy] I can remember saying to the exec team and to my team, I don't know where this is going to go, I might be disappearing at short notice … [but] most of the time people wouldn't know that it was going on in my personal life. (Wendy, Interview 2)

Most participants express that their breadth of role makes it impossible to be the 'perfectly supportive' and 'infallible' organisational leader that the NHS regulatory culture requests of them, and that they do let people down at times including within their home-lives. To fail others who depend on them for their wellbeing seems to provoke feelings of anxiety, guilt, and inadequacy, which have the potential becoming additional stressors.

The biggest one for me on a personal level, when I think of who I am and the things that are important to me is, I don't like letting people down. I feel that when I'm getting things wrong, or I'm not grappling with this, I'm at least letting several thousand people in this organisation down. If not, a million patients, if not, four hundred partners and stakeholders. (Sam, Interview 1)

If we fail somebody within this organisation, that will challenge my personal resilience … I think the worst weeks I have are where I feel like I'm failing at home … home is more important as this is a job, and I can get a job elsewhere. You can't go and get another child. You have to put that into perspective. (Catherine, Interview 1)

4.2.1.5 - Theme 1.5: Continual work pressure in a caring environment

Participants describe experiencing a broad multitude of complex and demanding work pressures and perceive that this pressure is constantly increasing across all NHS services. They feel accountable for all the organisation's stressors as executive leaders. This contributes to feelings of exhaustion and potentially could differentiate the stressors that they experience from their wider workforce, who they perceive to have more focused responsibilities.

> *I think everybody would say that it's just relentless, whatever job you're in and I don't want to make light of anybody's job compared to what I do, particularly if you're in front line services … you get tested … I went through a period where … everything just seemed to be sliding the wrong way and I think that the personal resilience in a tough job is just ongoing when you're on top of it versus when things are starting to go, hang on a minute, that perfect storm expression you know, that's not working over there, this is going wrong over here, the money is a mess, you're in charge by the way (sigh). (Sam, Interview 2)*

This accountability appears compounded by an emotive layer of stress arising from the pressure of working within a care environment and having pastoral responsibility for the wellbeing of their staff, and patients accessing their services. One participant used the metaphor of 'juggling' an increasing number of balls to describe this, which could come 'crashing down' at any time, or reduce their ability to deliver a quality outcome.

> *I find myself in a unique position of having a huge workload in itself to manage, because as well as doing all of the national stuff and the development of the [new organisation] there's still all of this organisation to look after as well and the people in this organisation, that's still my responsibility … you're failing because you've taken on too much … when things go wrong that reminds you that you're juggling too many things and you're not giving each thing the time and attention that it needs. (Catherine, Interview 1)*

Several participants perceive a difference between the physical stressors from delivering their complex role, and the mental and emotional stressors caused by being unable to mentally detach from working within a caring environment.

> *There is a physical resilience in having to do a busy job, to work long hours, get up early, fly around hospitals, that kind of thing. There's a physical resilience as well as an emotional resilience. There's the emotional resilience of, how are you on the inside. (Elizabeth, Interview 2)*

Most participants seem to find it difficult to emotionally disconnect from their demanding roles and find that this more exhausting than managing their 'physical' workload. This is perceived by some participants as a distinguishing stressor when becoming a senior leader in healthcare compared to being in a front-line role, as participants predominantly experience working on cognitive tasks and feel continually emotionally accountable for others. They suggest that even when existing within their home-life, they are unable to 'switch off' and disassociate from being an NHS executive leader and feel continually exposed to their job-related responsibilities in all aspects of their life.

> *Obviously the higher up the chain you go … it's the level of responsibility I suppose. It is just different I suspect in that, resilience wise, I think the other thing is that [front line staff] go home at the end of the day and they are probably bothered and affected by what they've seen or what they've been through, but they can switch off. Resilience is also around the ability to switch off. I don't see that often amongst my exec colleagues, that ability to switch off. That's another element of resilience. I may go somewhere else, so I may go watch my little boy play football but at the same time I'm thinking about work challenges or what we're going to do about this service … it never really leaves you. (Catherine, Interview 1)*

Leaders in any context will likely have responsibilities for other people, however all participants directly experience responsibility for the wellbeing, life, and death of vulnerable patients as part of the services and staff they lead. This seems to add an additional emotional layer of stress for them, as to be involved in the death of other people is arguably an ultimate tragedy, leading to significant feelings of personal failure, grief, and exposure.

> *The life-death thinking puts stuff into perspective. My husband says a bad day at work, I lose a few million pounds. For me a bad day at work is somebody dies. The life-death thing does help you keep things in perspective. (Elizabeth, Interview 2)*

> *It could impact badly on people, tragically on people, and … feels more about a personal exposure to that went wrong and it was your fault that it went wrong. (Sam, Interview 1)*

> *Some of the things that we deal with are really stressful. There's that human endeavour to it, there's that fragility of humans in this, we have people who are committing suicide or are at end of life … there's something about just being a human and knowing what the health service has to deal with in terms of emotional labour. (Wendy, Interview 1)*

4.2.1.6 - Theme 1.6: Being stuck

The concept of 'being stuck' is a term developed in this study to expresses how participants perceive being unable to be resilient, having been taken from terms used by participants themselves (see Wendy's experience in Chapter 4 - Part 1). It is a definitive feeling of exposure, where they are seen by others as failing, frozen and unable to move forwards. All participants seem aware that this is an overhanging threat to their personal resilience. However, they do not seem to experience becoming completely stuck in their careers. Yet, they share experiences of becoming stuck in some parts of their lives, and share how they have seen other people become completely stuck and unable to find a way to move forward. Some participants referred to the similarities of becoming stuck with the psychological condition of Posttraumatic Stress Disorder (PTSD) which demonstrates the clinical and psychological links that they perceive with any extreme stressors they may experience.

> *You know when soldiers come out of the army and go civilian and they've seen a lot of action, they can't normalise can they, because what's normal. If they don't get passed the traumatised bit, well they get PTSD don't they because they haven't moved on from their trauma, so everything around them doesn't seem right. (Diane, Interview 1)*

A small number of participants articulate that 'denying' the reality of a situation leads to experiencing being stuck, as the stressor remains but the individual never truly moves forward until they face-up to it. They suggest that this could be a temporary response to stress whilst coming to terms with a situation, however if experienced longer-term it could completely impair the ability to cope in all aspects of an individual's life.

> *I actually had one consultant who ended up with PTSD, it happened when I was deputy Chief Medical Officer, and I handled the whole situation. He had PTSD for about 4-5 years and he's now half the man he used to be as a surgeon because he screwed up, and he could never admit, it was his fault. (Elizabeth, Interview 1)*

Some participants describe inheriting 'baggage' as a metaphor for experiencing an emotively burdensome stressor that is not theirs, but one that they feel compelled to visibly address within their leadership responsibilities. Whilst there seems an element of choice in taking this baggage on and becoming stuck with it, their personal values and perception of it being the 'right thing to do' seem to compel them to inherit it. Stephen's story (see Chapter 4 - Part 1) illustrates this by feeling compelled to positively improve on past organisational failings that caused someone's death. On a personal level he describes it as feeling 'haunted', which suggests the personal level of exposure

from being stuck with feelings of guilt arising from visibly taking on this devastating organisational life-death failing.

4.2.1.7 - Reflective account: Differentiating exposure as a stressor

It felt important to share how I finally became able to articulate participant experiences of being stressed in the context of being an NHS executive leader within this theme, as it demonstrates how my ongoing reflexivity as an insider-researcher enhanced my ability to interpret and present themes within my analysis in this chapter.

The research questions in my study aimed to identify what causes stress for NHS executive leaders and this was a natural line of enquiry throughout interviews. It was therefore unsurprising that 'stressors' began to lend itself to a theme throughout my analysis. However, when developing this theme, my main challenge was deciding how to best articulate my interpretation of stress for my participants and what was unique about it for them from their experiences in relation to their NHS executive leadership role.

Participants shared experiences of being stressed in many different ways. Some were similar to the research studies on stress and resilience that I had reviewed within the existing literature, whilst others seemed very personal and contextual, and overlapped between their role as NHS executive leaders and also their wider life stressors. This generated many intertwined ideas and sub-themes that constituted stressors for them, but it had no 'golden thread' to bring them together other than generically 'being stressed'. I began to challenge myself to articulate if this was a theme at all. I asked myself, if it was, how should I balance participants' accounts with my interpretation of what was presenting itself, what were the most important things to 'bring to life' for the reader of my study, and what was the new contribution to knowledge that sat outside of the existing literature that I was already conversant with?

Utilising my both my understanding of the existing literature and my position as an insider-researcher working in NHS leadership development supported my interpretation. I was conversant with the environment, leadership stressors for this audience and other leadership roles from my wider practice-based experience, which was augmented by what I had learnt about this from my previous review of the existing literature. Using journaling and crafting and re-crafting this theme and drawing upon my enhanced interpretation as an insider-researcher enabled me to address what I interpreted as different and most important about my participant experiences of stress in the context of being an executive NHS leader. My reflections toward the

uniqueness of the executive NHS leader role enabled me to identify what appeared as most unique to participants' stressors by enabling me to make sense of the 'noise' and phenomenologically 'bring to light' the most important ideas as part of my interpretation, and what connected these together.

My interpretation of stressors that linked participant experiences back to their leadership roles kept leading me back to the multiple and complex ways of 'being exposed' as NHS executive leaders. They could never hide away from their role as there was always someone watching them from multiple contextual perspectives, inside and outside of work. The term 'exposed' naturally emerged as a suitable word to articulate the main cause of participants' stressors in the context of their leadership roles. This superordinate theme of 'being exposed' then naturally aligned to showcasing the complexity of this exposure for participants as NHS executive leaders and became a way to differentiate the most important aspects to emphasise within and connect each sub-theme.

4.2.2. Theme 2: Developing personal resilience

This superordinate theme illustrates how all participants appear to experience 'developing personal resilience' by learning from their lifelong exposure to a variety of stressful experiences over time. The various ways participants appear to express this learning are illustrated within the subordinate themes. This theme addresses the research question seeking to explore how participants gain, develop, and retain their perceived personal resilience.

The theme is positioned to connect Theme 1 - Being exposed and Theme 3 - Moving forward in the overarching thematic map (Figure 2) to suggest the overlapping connection between how participants appear to perceive becoming increasingly personally resilient by learning from exposure to stressful situations throughout their lives as an ongoing enabler.

An overview of this theme is illustrated by Figure 4 - Theme 2 Map - Developing personal resilience, and Table 6 demonstrates where these themes were identified within different participant narratives in their entirety. The sub-themes in the remainder of this section discusses how participants experience developing their personal resilience in further detail.

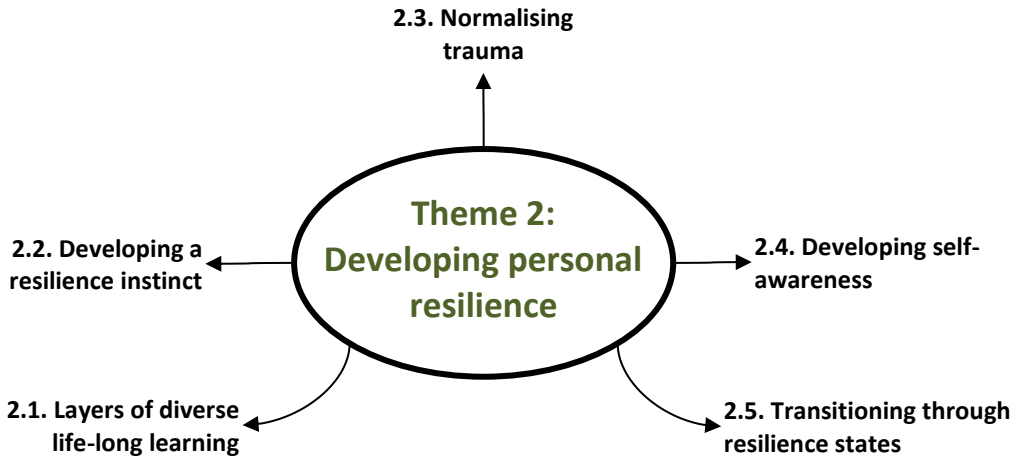

Figure 4: Theme 2 map - Developing personal resilience

Table 6: Theme 2 - Developing personal resilience									
Subordinate themes	**Andrew**	**Catherine**	**Diane**	**Elizabeth**	**Matthew**	**Sam**	**Stephen**	**Tim**	**Wendy**
Theme 2.1. Layers of diverse life-long learning	●	●	●	●	●	●	●	●	●
Theme 2.2. Developing a resilience instinct	●		●	●	●	●		●	●
Theme 2.3. Normalising trauma	●	●	●	●	●	●	●	●	●
Theme 2.4. Developing self-awareness	●	●	●	●	●	●	●	●	●
Theme 2.5. Transitioning through resilience states	●		●	●	●	●	●	●	●

4.2.2.1 - Theme 2.1: Layers of diverse life-long learning

Learning to be personally resilient from life experiences is a common theme for all participants. Exposure to different stressors appears to build metaphorical 'layers' of learning that enables them to feel increasingly confident to deal with resilience challenges in the future.

> *You don't just get resilience, it comes in layers through experience. You get through some tough or stressful thing, and you build your confidence that you can manage it. Then, that gives you more confidence for the next time. (Wendy, Interview 1)*

> *It's building experience through a number of different situations over a period of time … trying to understand what you're going through and see it as a learning experience after the event. (Tim, Interview 1)*

The more that participants experience exposure to a diversity of stressors throughout their lives, the more they appear to learn from these experiences, and the more they perceive they can effectively respond to similar stressful situations in the future. They perceive that developing from experience is a significant and ongoing enabler to their personal resilience. Some participants metaphorically liken developing resilience to a 'craft', suggesting that they continually build layers of learning as they would experience creating and refining a work of art over time (see Andrew's experience - Chapter 4 - Part 1).

All participants seem to store and recall learning from stressful experiences like they would store texts in a personal resilience 'reference library' that grows over time. The more they perceive a

learning experience as important to their personal development, and/or the more traumatic the memory may have been for them, the more they seem able to recall and articulate all aspects of that memory in vivid detail and explain its significance to developing their personal resilience.

> *It was one of those moments that just gave me another string to my bow. It was one of those things in your career that you know, it just pushed you forwards significantly in terms of your level of experience, level of understanding, and that was one of them, it was definitely one of them. It's a bit like, if I describe it from a clinical perspective, once you've had your first cardiac arrest, or somebody's dropped dead in front of you and there's nobody around, or there's your first outburst of somebody being quite aggressive toward you, once you've had your first one, you've then got a couple of strategies that you learn don't you. It felt like my first real exposure in that respect. The learning far outweighed any damage. (Diane, Interview 2)*

All participants seem to be targeted and proactive learners. Rather than waiting to experience challenging situations to learn from, they appear to proactively seek learning experiences to develop their personal resilience throughout their careers. They perceive that this proactively learning has enabled them to become resilient enough to take on the demanding aspects of their executive leader roles. Several participants use a metaphor of throwing themselves into the 'heat' and doing things that 'scare' them until they eventually feel confident to handle a stressor with ease to illustrate this. This rapid proactive learning approach to developing resilience could represent an aspect that differentiates participants as resilient executive leaders from wider populations. However, it could also be possible that their demanding careers have made it more likely to routinely experience these increasingly stressful learning situations.

> *I can remember that heat. As I've grown in my own knowledge and competence and confidence I guess, and in the nature of the job, I've felt that less and less. (Sam, Interview 1)*

> *…the heat for me is that learning curve and something that frightens me. You can't stay up there all the time, so I stick around long enough to (pause) the very best bit is when you've just tipped over, and you can feel it doesn't quite frighten me anymore, but it's still quite exciting, but I think I know how to do this now. That's the very best bit of a job, and you've got a handle on quite a few bits. So, it's still really motivating, but not blindingly frightening. Then it starts to dip doesn't it, and I get a bit bored. (Diane, Interview 1)*

4.2.2.2 - Theme 2.2: Developing a resilience instinct

Repeated exposure and learning from different stressful experiences seems to develop a 'resilience instinct' for most participants. They seem to experience this as a cumulative effect where they become mentally 'hardwired' to respond in an increasingly resilient way. For most participants, the more they perceive themselves as actively learning, improving, and refining this instinctive response toward stressors, the more they perceive themselves as resilient in wider aspects of their lives.

> *The brain works to patterns doesn't it, and when you've hardwired that pattern into the brain, it does it automatically. The best example of that is learning to drive. When you start, it's impossible, but once you've practiced the manoeuvre you don't have to think about it anymore because that's the way the brain works. The brain is designed to hardwire patterns to then make them straightforward. I think that's part of it, you develop skills over time that get hardwired into the brain, not necessarily you don't know about them, you just don't need to think about them because they've become innate in how you work, but they're learnt from experience and practice. (Matthew, Interview 2)*

Having a high degree of perceived instinctive resilience seems to enable participants to effortlessly and effectively be personally resilient in an increasing variety of situations, without consciously having to think about what they are doing. Several participants used the concept of creating resilience 'habits' to articulate this and how their instinctive resilience can make them feel proactive as well as reactive toward being resilient. They believe that these resilience habits enable them to focus their mental capacity on more demanding aspects of being resilient in their executive leader roles, therefore making them more personally resilient.

> *I've got to find a way that it becomes habit. Simple things like I have a habit when I come in, I always put my keys in the same place, so I never lose them … you've just got to find ways, so it just becomes routine habit, so you spend your conscious thinking time on the stuff that is important. (Tim, Interview 2)*

> *That makes me more efficient and allows me to concentrate. But I suspect that it's all habit. But, habits that I've reinforced to myself over the years. Habits do make you more efficient. If you change your routine in a morning, you're more likely to mess it up. Then you've got to spend 20 minutes going back to collect your lunch or something … There is something about optimising of your intellectual capacity to create extra space, extra capacity, so intellect,*

using your brain to make the fast decisions, so that you've got time to make the slow decisions. (Elizabeth, Interview 2)

In developing their resilience instinct, participants seem aware that they may naturally forget how or why they are personally resilient in certain situations. These resilience habits only seem to become noticeable when they are not working for them anymore and get actively brought into their consciousness as requiring further learning and adaptation. This seems likened seeing things 'afresh' by bringing the 'taken-for-granted' into focus, like a phenomenological enquiry, and suggests an ongoing cycle of learning from their experiences that enables them to adapt their perceived resilience instinct over time.

Is there stuff in there I've forgotten I know, absolutely … the longer you do this CEO job, the more that you get (pause) … in that hierarchy of things, a lot of things you either just take for granted as being, or maybe it isn't something that you need to worry about, you learn that actually you can cope with the ups and downs of that. (Sam, Interview 2)

I know the habits I've got are likely to be good for me. If I see that they're being bad, I've got to understand that I need to do something differently. (Tim, Interview 2)

4.2.2.3 - Theme 2.3: Normalising trauma

Where participants perceive that they have little control over certain stressors, or they become accepted aspects of their executive roles, they appear to learn to cope with these by labelling them as 'normal'. They seem to do this to the point of becoming 'numb' to these stressors to prevent them from impacting their day-to-day lives. Two participants with clinical backgrounds express this as 'normalising trauma' and liken it to how experiencing patients being ill or dying eventually becomes normal to them, however a wider population experiencing such a situation for the first time would likely find it traumatic.

You then go home and you're quite traumatised by it, you have to de-brief yourself and all of those kinds of things. Yeah, I think in my clinical role, that's where I probably did learn to do some of that sort of stuff, for sure. You do wonder if you're carrying little (pause) you learn strategies don't' you, but you do wonder if, if you've been traumatised by it, but you put that into your learning pot, that's probably alright isn't it really, it's helpful … I think it probably does come from some of those clinical experiences on how I manage (pause) you normalise it. You put yourself in situations that become normal. (Diane, Interview 2)

All participants seem to experience this normalising effect when operating as executive leaders within the stressful performance-driven NHS environment where they perceive 'the buck stops with them' as illustrated in Theme 1 - Being exposed. This 'normalising' effect gives a sense of detachment, taken-for-granted-ness, and/or denial that these aspects of their roles cause them stress, yet participants seem to accept and live with these ongoing background stressors throughout their career to the point that it does not seem to consciously affect them anymore.

4.2.2.4 - Theme 2.4: Developing self-awareness

Most participants seem to perceive themselves as unique individuals and that developing a self-awareness of what makes them who they are enables them to better appreciate how they are likely respond to certain stressors. They suggest that this self-awareness enables them to find personalised ways of regulating their response to stressors, which in-turn makes their response more personally effective. Some participants seem to experience self-awareness as understanding their relationship to their external world of stressors and how this may be similar or different to others when responding to them. Other participants experience their self-awareness as increasingly understanding and effectively utilising their perceived strengths to mitigate their limitations and respond more effectively.

> *An element of that is a self-awareness. It's understanding the external world, to your organisation. (Stephen, Interview 1)*

> *Everything you've got, there's a pro and con to it. For every strength, it's a potential risk and you have to get the right balance between those. (Tim, Interview 2)*

Developing this self-awareness appears to be a life-long and unique experience for participants as they seem to appreciate that there is always something new to learn about themselves and how they react to stress. Most participants articulate that they develop their self-awareness through connecting to and seeking feedback on other peoples' perceptions of them, and then integrating this back into their understanding of themselves.

> *I've always in every aspect tried to have a very fair perspective on my strengths and limitations. I think increasingly it's about having a degree of personal insight. The minute I think I've got all the insight I need, I think I'm into the hubris, but equally I do think I understand myself pretty well and how I come across because I've spent a lot of time in one way or another bouncing that feedback off people. That feels important and that's part of the being grounded. (Sam, Interview 1)*

Some participants suggest a connectedness between understanding themselves and understanding other people in supporting both their own and mutually shared resilience challenges. By learning to understand other peoples' perceived strengths and limitations, this seems to enable participants to regulate their response to a shared stressor with the people they work with and respond collectively in a more effective way, drawing upon each other's perceived strengths and mitigating limitations.

> *If you don't understand yourself, then how do you understand others. I think a good exec team has a good understanding about how each-other ticks and works with it, and then if somebody is having an off day or somebody responds in a certain way or gets themselves into a place, then there's some understanding and rallying around that. Equally, you know who to go to and who's strengths you need to place to and for what bits. Unless you've got great self-awareness, it does impact on your resilience but also the team that you're working with. (Wendy, Interview 1)*

4.2.2.5 - Theme 2.5: Transitioning through resilience states

Most participants appear to experience their personal resilience changing over time as they transition through different perceived states of being. For example, when their job-role changes as the NHS changes its services over time, personally changing jobs, during personal-life change such as family commitments, and at the end of career into retirement. Most participants appreciate that to be effective in their roles as NHS executive leaders, they must be comfortable with managing ongoing personal change and transitions, as the NHS is perceived as always changing.

> *The concept of [the NHS] is one of constant change. So, what does resilience mean in that context. In some respects, you have to be comfortable that roles are going to change, and organisations are going to change. (Matthew, Interview 1)*

When going through such a transition and linked to their self-awareness and sense of identity, participants appear to consider the aspects of their resilience that they need to actively hold on to, or develop further, and the aspects that they can let go of when entering this new phase of life. Many executives reference models including or similar-to the 'Kubler-Ross Change/Grief Curve' to explain how they experience these transitions, working through the change and identifying how to effectively learn to transition to a different resilience state.

Most participants transitional experiences seem to involve the perception that they need to become more resilient as they take on more demanding roles including becoming an executive leader. Some participants used the metaphor of adding to their resilience 'toolbox' to illustrate accumulating personal resilience to take into the next phases of their lives. However, two CEO participants articulated experiencing the opposite effect, being at the end of their careers and transitioning into retirement. They perceive that their resilience rapidly changes as they begin to let go of the demanding aspects of their roles as an executive, and transition into new personal resilience challenges, such as learning to manage their old age and declining health.

> *You only hang onto the stuff you need to … When I retire and stop being this person as CEO, I won't need the same resilience. There's a bit of me that thinks, that would be just gorgeous wouldn't it, but a bit of me worries that I would have lost something. (Sam, Interview 2)*

> *It's transition, it's about working through and sorting out your identity in the next phase of your life … you learn to take what you want to into the next phase ... In the same way we're talking about transition there, I think it can be applied in the same way to transition between jobs, and many different things. (Stephen, Interview 2)*

Actively considering transitions between life-states suggests that participants continue to develop their self-awareness and understanding of their personal resilience throughout their lives, considering what to keep and what to let go of in order to remain effectively resilient within whatever contextual and subjective part of their lives they are currently experiencing.

4.2.2.6 - Reflective account: Participant learning from the interviews

Being a coach, it is second nature to me to be consciously curious about how clients develop between coaching sessions. Although I was questioning participants as an interpretive phenomenological insider-researcher, I was also conscious that my coaching skills and insights were part of 'me' as a researcher and very much supported my phenomenological attitude (see Methodology Chapter 3 - Section 3.6). These skills were a strength in my study by naturally assisting with my reflexivity and were therefore part of what 'I' uniquely brought to 'my' interpretation. Drawing upon being an insider-researcher and being a qualified and practicing executive coach supported my interpretation of 'learning resilience' as a theme. I started to notice that exploring the developmental aspect of the interview itself was possible by being curious about participants' reflections and personal learning during and between interviews.

My reflections during and after Diane's interview had a significant impact on me and my interpretation of 'developing resilience' as an important overarching theme. Diane shared an experience of a current and highly emotive personal stressor during the time of interview 1, and then in interview 2 how this very 'raw' and traumatic experience had changed into reflections and personal learning (see Findings Chapter 4 - Part 1 - Diane's story). I was struck by how sharing her current and highly stressful experience with me was helping her to make sense of the stressors during her first interview in 'real time', and then during her second interview how she was able to articulate the process she had gone through to move herself forward beyond the stressors and how she had learnt and personally developed her resilience because of this. Furthermore, I was struck by how most participants were (in an unprovoked way) eager to share that the experience of the two interviews several months apart had enabled them to reflect on and develop their personal resilience further. Some even likened the interview to a reflective and developmental 'coaching' space.

> *I think it [the interview] was actually very useful to crystalise and verbalise things that are part of me. It was useful in the sense that, it was almost like, although it was a research interview, it was almost like coaching. It was quite like an affirmation in saying what I was saying. Having had our first session, sitting chatting and talking about resilience and my resilience and how I see it, you've almost muddied the waters, several months later, because what has that intervention done to me several months later. It will have had some effect, I have no doubt. (Elizabeth, Interview 2)*
>
> *It's only when we have this type of discussion [the interview] or a similar one, do you think about that (pause) when you articulate something to somebody else, it's far better than reflecting yourself because you don't get that different viewpoint. (Tim, Interview 2)*

Drawing on being a coach as part of being an insider-researcher, I also reflectively and critically considered how this 'real time' developmental aspect of the interviews could be due to participants being more accustomed to utilising coaching support as part of their executive roles. There were similarities between coaching and the open and exploratory questioning style of the phenomenological interview. However, all of these developmental aspects that I noticed participants sharing arising from the interviews themselves further emphasised to me the importance placed on developing personal resilience from experience. This reaffirmed the importance of continually developing personal resilience as a significant enabler for all participants, and the importance of this being a superordinate theme as part of my findings.

4.2.3 Theme 3: Moving forward

This superordinate theme illustrates how all participants appear to experience personal resilience as a sense of successfully 'moving forward' with their lives and addresses the research question seeking to explore how participants experience being personally resilient. Participant experiences of moving forward appear to suggest a flow that starts with preparing and ends with responding to stressors, which is illustrated by the flow of subthemes 3.1 to 3.5. This flow of moving forward appears to relate to effectively preparing to deal with stressors by creating supportive and influential connections with others, gaining a sense of perspective surrounding the stressors being experienced, and mentally reframing stressors into positive opportunities. Participants then seem to experience ways of taking action and keeping motivated when dealing with stressors to enable them to perceive that they are effectively moving forward with their lives.

Figure 5 - Theme 3 Map - Moving Forward visualises this theme, and Table 7 demonstrates how sub-themes were identified within the different participant narratives in their entirety. The remainder of this section explains and discusses these findings in further detail.

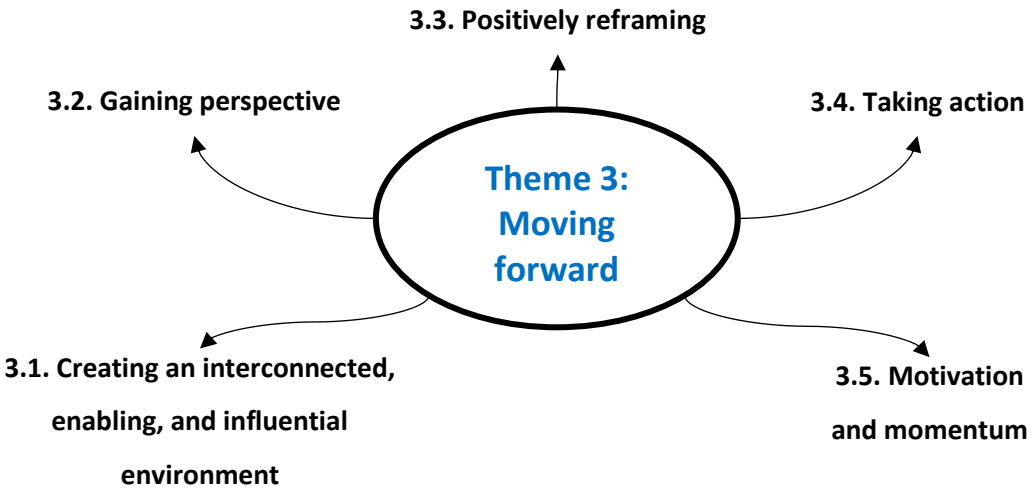

Figure 5: Theme 3 map - Moving forward

Table 7: Theme 3 - Moving forward									
Subordinate themes	**Andrew**	**Catherine**	**Diane**	**Elizabeth**	**Matthew**	**Sam**	**Stephen**	**Tim**	**Wendy**
Theme 3.1 Creating an interconnected, enabling, and influential environment	●	●	●	●	●	●	●	●	●
Theme 3.2 Gaining perspective	●	●	●	●	●	●	●	●	●
Theme 3.3 Positively reframing			●	●	●	●	●	●	●
Theme 3.4 Taking action	●	●	●	●	●	●	●	●	●
Theme 3.5 Motivation and momentum	●	●	●	●	●	●	●	●	●

4.2.3.1 - Theme 3.1: Creating an interconnected, enabling, and influential environment

All participants perceive that they are only as resilient as the people around them and appear to experience a shared and interconnected sense of personal resilience with the people within their organisation and across their personal networks. They believe that they use their senior positions to actively enable the personal resilience of others through offering direct support and by creating an enabling organisational resilience culture that is mutually beneficial.

> *You have to recognise that people have a life … I personally give so much more because I know that I've got that flexibility and if I have a problem, it's supported here. But, that's about the culture we've created isn't it … you've got to have a balance between adapting to what your workforce needs and adapting to what the business needs. (Catherine, Interview 1)*

Most participants perceive that their personal resilience relies on the strength of the relationships they have with the people they work closely with, such as their wider executive team and their direct reports. This appears to encourage them to support each other to move forward when faced with personal and mutual organisational stressors. They perceive that by enabling their team and wider organisational staff to feel resilient, their staff will more effectively support them in return, which in turn enables participants to take on more challenging work in their senior leadership roles. This seems to be driven by a sense of necessity as they believe that their jobs are too complex to deliver alone, and also through their altruistic personal values which they perceive compel them to support and empower others.

I empower them, so it frees me up to be empowered myself … a healthy team enables me to be healthy … strength of relationships and understanding are a key part to how you build resilience around yourself as well … I get strength from that situation in that I know my team here will do what I need them to and work well, but also because I know their weaknesses and strengths, I'm able to manage that … As a consequence of empowering them if you like, it's given them resilience and freed me up so that I can do the job more easily as I've got a team who are working well … It comes back to having an effective team … you can distribute the pressure at work. (Matthew, Interview 1)

Several participants describe the support that they give and receive from networks outside of their organisation, including colleagues in the wider healthcare system, and their personal friends and family. This support seems mutual, reciprocal, and interconnected, however is much less formal, suggesting that participants can freely express themselves in a trusting environment more akin to friendship than the formalities they receive within their roles as executive leaders.

I think one of the really supportive areas for me over the past few years has been the network of CEOs. Having them say hey, if you've got a problem, you can come and talk to me about it. (Andrew, Interview 1)

I spend quite a lot of time with a friend of mine who's … in a senior position in a private sector organisation. We spend a lot of time just bouncing things off each other because she has a totally different perspective ... You've always got to find somewhere where you can get resilience from, but for me it's not from within the organisation it's outside of the organisation. (Catherine, Interview 1)

All participants seem aware that through their interconnected and mutually supportive relationships, they can influence and leverage the support of others who they have previously helped in the past at any time when managing a stressor to enhance their own personal resilience in a reciprocal way. Both Wendy and Tim share the metaphor of 'banking resilience' (see Chapter 4 - Part 1) to illustrate their experience of interconnected and reciprocal personal resilience support, likening it to how they would bank savings to draw on at a later date. However, for most participants, their personal values appear to compel them to support those in need regardless of any potential support they may receive in return.

The coins in the resilience bank are about your own personal resilience, but they're also about how you respond when somebody else is in a difficult place … I do think you craft an environment where other people support your resilience … I also think that you're only as

resilience as people are around you. So, you can have your own personal resilience but if you're not supporting other people to be resilient, then it doesn't help you either, because one person doesn't fix the issue you're working on most of the time. If you're just focusing on your resilience, and the people around you haven't got a level of resilience, then that's not going to support your position. (Wendy, Interview 1)

Most participants believe that openly supporting others in this way throughout their careers creates an increasingly positive personal reputation, which they perceive influences others to feel compelled to support them in an altruistic rather than forced way.

By doing it, and being seen to do it, and people knowing that's what you do, you do create that reputation … it makes it more likely you're going to get positive outcomes for yourself from doing that. (Tim, Interview 1)

Some participants perceive that their positive personal reputation influences how regulatory bodies are more likely to trust them to manage stressful organisational situations. Rather than the regulatory body becoming an additional stressor by 'micromanaging' their response to these stressful regulatory challenges, they suggest that these bodies learn to trust them to move the situation forward based on their reputation of dealing with similar challenges in the past.

We've just had a regulator report and we've been downgraded one mark [describes detail]. Interestingly, our regulator, when they read the report did something interesting. They said … we know what you're going to sort out, why would we bother meeting you (long pause). Now, that was my regulator saying, we know you know this stuff. (Stephen, Interview 1)

Several participants with specific professional portfolios and in-particular clinical backgrounds perceive that they gain a sense of influence arising from the respect they are given arising from their 'professional status'. When faced with a stressor, they seem to leverage their professional status to influence the course of action that they believe is 'the right thing to do'.

How you see things clinically, that's respected, and it gives you an identity in the board, but it also reinforces the respect and the power and the say you've got. (Wendy, Interview 1)

I said no, these are professional views I am a registered nurse and I have a professional code of conduct, and as a public officer, how can I employ hundreds of nurses and rubberstamp an activity like that, I can't. Those are my responsibilities. So, that helped so much being clear about that. (Diane, Interview 1)

Regardless of the mutually connected and influential support that they perceive they have created for themselves throughout their careers, all participants seem to experience a sense of influence within their roles as executive leaders that arises from their formal hierarchical position within their organisation. They suggest that if the positive relationships they have built up do not lead to personal offers of support, they can still leverage this influential senior position to formally call on the support of wider organisational resources and staff to help them with stressful situations, which enables them to feel more personally resilient. This seems more evident in CEO participants, as they sit at the top of their organisational hierarchy and perceive that this level of influential support makes their stressful jobs more manageable.

> *I've got several thousand people, I can say actually, you do it for me … (laughs) I know it's not like that, but that is absolutely part of the sense of, this is what makes it doable. (Sam, Interview 1)*

4.2.3.2 - Theme 3.2: Gaining perspective

Most participants seem to experience an ability to 'mentally pause' the situation to fully explore their options when identifying current and potential future stressors. This appears to enable them to gain a sense of perspective by gathering information to inform how they might successfully respond. Several participants describe this as seeking out information, whilst others metaphorically describe it as taking 'breathing space'.

> *Not taking a knee jerk reaction, taking the time to reflect and make sure that I've got a clear narrative in my head as to the reasons why we were doing it … in this role, the CEO role you have to consider 'every' dimension … gathering evidence … I will step back and reflect how we've got to that situation … I probably won't reflect for long. (Andrew, Interview 1)*

> *I just needed that breathing space actually … let's just sleep on it, let's take stock of it… stepping back, just for a minute I'm going to just go and absorb all of this. (Sam, Interview 1)*

Pausing to gain an informed sense of perspective on stressors may provide a new perspective on 'freeze' in relation to the 'fight, flight, freeze' stress response. Rather than the stereotypical metaphor of freezing like a 'cornered mouse' hoping the stressor will go away, participants appear to experience a sense of stepping back to take a metaphorical 'deep breath' to pull themselves out of any stressful emotions being experienced and take time to assimilate wider information about the situation. This seems to create a calming effect on any anxiety being experienced to enables

them to perceive that they are making better informed decisions and increasing their chance of a successful outcome toward the stressor.

Some participants describe taking this sense of gaining perspective further by proactively considering the future to attempt to identify potential personal and organisational stressors before they happen. They suggest that this enables them to influence the situation by putting in place mitigating actions to either reduce the demand on their personal resilience, or even remove a potential stressor entirely before it becomes a problem.

> *The other thing is you learn that actually, if you spot something far enough away and you've got the time and you can make the effort to actually influence what's coming down the line sort of thing, then that can give you a greater sense of, I know this is coming, but if I invest my energy influencing how that might impact on me eventually, then that also helps. (Wendy, Interview 1)*

Several participants describe placing a considerable amount of their mental energy contemplating the future to achieve this, as they believe that it saves time and reduces the potential anxiety they would experience if the stressor did become a reality.

> *Quite a lot of what I have to do as a leader is try to predict and foresee problems. This is another example of resilience really, which is if you're good at foresight and predicting ahead, you can head off problems that are going to affect you. A big part of what I do is that I'm constantly looking down the line, constantly looking ahead. (Matthew, Interview 1)*

4.2.3.3 - Theme 3.3: Positively reframing

Most participants experience that focusing on negative aspects of any situation causes anxiety, which is unhelpful and potentially harmful to their sense of personal resilience, and likely leads to the sense of 'becoming stuck', as described earlier. Some participants describe ways of blocking out negative aspects of highly stressful situations to enable them to manage more effectively (see Diane's story - Chapter 4 - Part 1). Rather than becoming overwhelmed by negativity, most participants believe that identifying and accentuating positive aspects of stressful situations gives them personal resilience as they perceive that it makes them more likely to identify positive actions to move the situation forward successfully.

> *Don't look on the down, because you start to generate your own negatives … look at the good, concentrate on that, and how do you make sure you're more likely to get the good*

than the bad. Don't focus on managing the bad, just focus on accentuating the positive … at the top level you've just got to concentrate on enough positives … to offset the negative ones. (Tim, Interview 2)

All participants appear to experience stressful situations in a personal way and believe that the reality of these situations is a complex concept that is dependent upon the subjective interpretation of those experiencing it. These beliefs seem to afford participants flexibility in how they perceive the reality of stressful situations, and how they influence the reality of colleagues experiencing organisational stressors with them. Most participants describe 'reframing' their experience of stressors into something positive and optimistic for themselves and for those who are impacted in the organisation that they lead. Reframing the perceived reality of any stressor from a negative into a positive opportunity appears to enhance their perceived personal resilience to manage the situation. Furthermore, it increases the positive attitudes of the people in their organisation who are experiencing the stressor with them, and the perceived ability of everyone in the organisation involved to achieve a successful outcome.

If you talk negatively, or talk about negative things all of the time you just get ground down … It's got to be positive reinforcement going through. I'll sooner spend time around the positive. For instance, when we talk about sickness or turnover levels, they will say 12%, that's not good, it's high. That means on average someone's going to stay in an organisation 8 years, and I think that's pretty good. How do we make this into a positive … you change it and reframe it. (Tim, Interview 2)

Participants also apply positive reframing to their experiences of stressors that are affecting them personally. Believing that the reality of the situation is how they personally perceive it, positive reframing appears to remove negative personal feelings such as anxiety and increases their perceived positive sense of personal resilience.

Even when there are negatives in my career, I make them into positives. We talked about the example when my doctor said, pfffff, you're knackered mate and the prescription was change your job. You see, I've taken that looking back as a really positive thing … looking back I managed to turn those things into a positive way. (Stephen, Interview 2)

Several participants suggest that positive reframing provides them with a sense of 'taking control' of the stressful situation (see Sam's story - Chapter 4 - Part 1) by mitigating the fear of experiencing becoming stuck and unable to be resilient, as described in Theme 1 - Being exposed. One participant takes this positive reframing even further by believing that they never fail. They seem

to achieve this by adapting to the stressors they are facing, at the same time as reframing the stressors into positive learning opportunities. This reframing seems to enable them to remove any potential negativity and anxiety about the stressor and suggests replacing it with positive emotions such as a sense of self-worth and excitement toward learning from their experience.

> *I don't think I've ever failed in my job because I think when I've hit problems or we've made errors, you then correct them. You don't allow problems or failures to prevent you from fixing them and getting the right outcome in the end. How you frame it for yourself has a massive baring on your resilience really because you can beat yourself up over stuff, completely unnecessarily … There's a subtle difference in the way you perceive something, or the way you approach something, can have a massive impact on your sense of self-worth and your resilience as a result of that, or at least can dent it significantly, or can enable it significantly. (Matthew, Interview 2)*

Whilst this study does not seek to philosophically explore how participants experience reality, some participants acknowledge that this is a complex aspect of their personal resilience that requires further investigation. For example, there are temporal aspects of a perceived reality that seem to leave them questioning, were they actually resilient at the time, or did they work through a form of 'dissonance' and retrospective positive reframing that enabled them to cope later in their lives.

> *There is that sense of, having conversations like this helps you think about, are you just constructing something here that actually isn't real, but of course reality is that, perception is reality, if that's what works for me then, I'm going to keep doing that. (Sam, Interview 1)*

4.2.3.4 - Theme 3.4: Taking action

All participants seem to liken aspects of their personal resilience to taking positive actions that enable them to perceive that they are mentally moving forward in aspects of their lives and prevents them from becoming mentally 'stuck' as described in Theme 1 - Being exposed. In order to experience moving forward, they describe coming to decision points when dealing with stressful situations that require them to 'take action' or 'let go'. These decision points appear to place the stressor in the past and release them from feeling anxious about it, suggesting a sense of mental freedom to move forward.

> *If there's a dilemma, don't live with the dilemma, make a decision, because it's far better to make a decision. Even if it's wrong, you can go back and unpick it, rather than sit with no*

decision … Procrastination sucks energy. I know that there are difficult decisions that I'll procrastinate over, and it sucks more energy than just getting on and doing it. So, don't procrastinate. (Elizabeth, Interview 2)

Most participants believe that any form of action is better than no action at all, as they perceive that their decisions can be tweaked and adapted over time, and the momentum generated from taking action prevents them from becoming mentally stuck.

Once you're moving you can then nudge your movement, but if you haven't moved, you're not going to move, you're not going anywhere … if necessary, modify your path slightly. But you've got to create that sense of momentum. (Matthew, Interview 2)

When taking action, most participants experience being highly adaptive and flexible in how they rapidly respond to stressful situations. This is different to the personal lifelong learning expressed in Theme 2 - Developing resilience as it seems to relate to a rapid response to stressful situations that requires a level of 'in-the-moment' ingenuity, creativity, and problem solving. Potentially linked to being in the management profession, most participants express this using managerial language, as needing to 'change', 'adapt', 'innovate', 'think outside the box' to 'improve' and an ability to create 'solutions' to challenges they are facing to be able to move forward.

When you hit a barrier, what do you have to do. You have to innovate and find an alternative way to get around the barrier, but you're still on the course for the journey that you have to go on, you just have to find alternate solutions all the time. Part of being resilient is being prepared to think outside the box, to innovate, be prepared not to change your direction but to change your way of thinking and be prepared for doing things differently to overcome the issue you may face. I think you have to be flexible. (Matthew, Interview 1)

Some participants use metaphors that imply their personal resilience is 'malleable' to express how they experience the in-the-moment adaptability when taking action. One participant experiences the opposite to being malleable and adaptable is to remain 'rigid'. This could be likened to being mentally strong enough to fight against any stressor, however this perceived strength also suggests a risk of becoming brittle and breaking in the process if done in a maladaptive way, essentially damaging their personal resilience rather than enhancing it.

It's about being rubber as opposed to being steel or brittle. It's about being able to go with the flow, to adapt, to do stuff and soak it up, to move onto it as opposed to you've got one model and it's rigid and that can be broken. Being rubber it's less likely to be broken. It might not always be clear and sharp and all that type of stuff, but it means we can survive through

all this. So, other than the resilience investment bank, it's going from brittle, hard, rigid structures into resilient rubber, changeable, adaptable, flexible things. (Tim, Interview 1)

Demonstrating the strength of their personal resilience, most participants describe experiences of taking action that seem like the established stress response of 'fight'. However, rather than being physical, rapid, gut-reactions to stressors, they seem to experience fight as confronting stressors in a considered, flexible, optimistic, regulated, purposeful and persevering way.

When I hit a barrier, I get the sledgehammer out and smash through it (laughs) rather than allow it to stop me … my response to that was to drive even harder to get through the barrier … be even more determined … resilience is not accepting no … resilience is perseverance. There are a number of examples in my role where I have to demonstrate perseverance, or stubbornness sometimes even. (Matthew, Interview 1)

However, participants also seem to experience a more 'primal' sense of the 'fight' response when they believe that their personal values conflict with the stressful situation they are experiencing. Some participants use the metaphor of 'reaching their bottom line' to describe this sense of becoming compelled to confront the situation. To mitigate against a maladaptive primal 'gut reaction', they perceive that their personal values combined with life-long learning as described in Theme 2 - Developing resilience act as reference points for how to manage the stressful situation successfully. This seems to enable them to regulate any primal instinct when they believe they must 'fight for what they believe in' and move the situation forward with a sense of personal integrity, aligned to their personal values.

You have to accept that you might find yourself in a very difficult place and actually your resilience might be compromised even further if you don't stand up for your bottom line … I wasn't willing to accept it. I went through a position of being in conflict and sticking to me guns and causing quite a lot of disruption in that exec team at the time, because I wasn't going to move on it ... it impacted my values and where I was prepared to go, or not go. I have a strong core of determination like that. (Wendy, Interview 1)

Several participants experience instances of being highly conflicted with their personal values, having exhausted their ability to adapt and find a solution. In these situations, they seem to consider ways of moving on to maintain their sense of personal resilience in a way that is more likened to the traditional 'flight' response.

You fight what you can fight, and I do think that is true, there is no point in having battles that you just can't win, and that's got to be part of that personal resilience, being sensible about where you pick your fights isn't it. (Sam, Interview 1)

Participants do not generally perceive that the generic 'flight' stress response akin to taking action by walking away from a stressful situation is helpful to their personal resilience, as it seems to reinforce a sense of helplessness toward the situation that could lead to a sense of becoming stuck and unable to move forward described in Theme 1 - Being exposed.

If you just shut down and run away from it, you know, yes there is a line drawn under it, but actually what is then overhanging me would be well actually the next time I bump into this person in that particular case, or whatever it is, there's something residual if you don't deal with it in the moment. (Sam, Interview 1)

For most participants, 'flight' seems to be experienced as a last resort when their sense of personal integrity and self-worth drives them into this response. However, 'flight' in this context is not experienced as running away directionless. As with 'fight', their 'flight' response appears to be experienced as a positive action that enables them to take control of the stressful situation on their terms, in a purposeful, considered, values-driven way that gives them a sense of self-esteem.

There's got to be something about, a core where you're not willing to go beyond, and accepting that actually you might need to move on because you can't work in that environment. I know there are lots of colleagues who have said, it's not working for us, so I've got to go somewhere else. (Wendy, Interview 1)

Part of it is knowing when it's right to move on and do something else … to be personally resilient and look after yourself, you have … to say, I'm going to choose a different environment. (Matthew, Interview 2)

It's not running away from it so much that I can't see where I'm going. I mean, flight where you take off and don't know how you're going to land, oooh, that's scary. (Stephen, Interview 2)

Where there is no other action available to them, participants also seem to experience being able to mentally and emotionally 'let go' of situations to prevent feelings of becoming mentally stuck.

My view of resilience is actually, there's no point putting time and energy into things that you can do nothing about it. So, I can't change that. But, what can I do something about. (Tim, Interview 1)

Making the decision to mentally 'let go' and move on from something seems to be a form of taking action in its own right, as a decision has been made and there are no perceived blockers keeping the participant stuck in the anxiety of experiencing the stressor and unable to move forward. This seems to form a sense of mental 'release' that enables participants to keep mentally moving forward, as the act of letting go of the situation and/or current failing course of action opens new possibilities to explore and move forward. Letting go in this way could be the transition into normalising trauma as discussed in Theme 2 - Developing resilience.

4.2.3.5 - Theme 3.5: Motivation and momentum

Participants seem to perceive their ability to be personally resilient in a 'finite' way and liken it to having a form of 'motivational resilience energy'. Whilst participants seem to struggle to clearly articulate what this resilience energy is, their descriptions give the impression of a metaphorical form of 'currency', individually unique to them, that combines their perceived available personal resources and personal motivation to achieve a successful outcome. Some participants metaphorically articulate this as 'depleting' and 'topping-up' their resilience energy like a 'battery'.

> *For me the definition of resilience is to maintain your energy and your drive and enthusiasm, in the face of no matter what pressures come your way … Maintaining resilience is such a personal thing. Your personal circumstances will drive it, what you've got at home, what you like to do outside of work, everything will contribute to that for me. So, for me if we could describe the idea of a battery, everybody's would be wired up differently. I do genuinely believe that, because we all do lead different lifestyles. (Matthew, Interview 1)*

Participants seem to experience the need to prioritise where they focus their perceived resilience energies across the many stressors affecting them at any one time. This suggests that their resilience energy is dynamic, changes over time and requires constant reprioritisation when faced with changing stressful situations.

> *I'm not saying that it isn't worth it, but it's not worth all of your energy. There's almost an internal council with yourself to say, do I really need to be there … I might in context press the go button again, or, ramp it up again going a bit slower but ramp it up again. There is something about being purposeful, there is something about drive and energy and I don't know how much of that you can create, or it's something about somebody that means it's just them. (Wendy, Interview 2)*

All participants experience that their perceived resilience energy arises from their seemingly altruistic-focused personal values which compel them to keep going in the face of adversity to achieve personal and organisational goals that meet these values. Being driven by their personal values seems to portray 'heroic-like' motivational qualities to their personal resilience. Most participants experience a 'humbleness' to this aspect of their personal resilience, articulated by Tim's perception of himself as an 'unsung-hero' (see Chapter 4 - Part 1). These humble hero-like qualities seem to arise from their perception of altruistically achieving things for people, combined with a tenacity to deliver against their personal values in the face of multiple stressors.

All participants perceive that achieving against their sense of altruistic-focused personal values is personally rewarding and they appear to experience a sense of motivational pleasure and success from this that outweighs any anxiety from the stressors they are facing. This sense of values-based motivational achievement, big or small, appears to 'top-up' their perceived resilience energy and acts as a motivator to tenaciously manage any number of stressors being faced in the various aspects of their lives.

> *Knowing that you make that difference, you have that reference point all the time. I feel good about myself because of that, I know that I can make a difference to people. I really love making people feel better as a result of an interaction, and I've got the humble thing that I don't want to be recognised for it, as just doing it makes me feel better about myself. (Matthew, Interview 2)*

> *[You can] make a difference to people's working lives. Those moments give me real energy boosts … it's also a resilience boost to know that was a good thing. (Andrew, Interview 1)*

Experiencing these personal resilience 'top-ups' appears personal to each participant and suggests a relationship with their personal values. Several participants referred to motivational models such as 'Maslow's Hierarchy of Need' to describe how they gain a sense of 'self-actualisation' from living by their personal values and improving the lives of others, which gives them immense pleasure and 'tops-up' their perceived ability to be personally resilient.

> *My coach was saying, you operate in that at the top of the pyramid [describes Maslow Hierarchy of Needs model] an awful lot of the time, and I do ... I'm values-driven ... I must get enormous gratification out of it, because if I'm operating up there a lot of the time, that's probably why I enjoy going to work and why I can top my resilience up. I feel quite, what's the opposite of depleted, topped-up, resilience wise. You can top it up … I'm always looking*

out for the little guy, I'm always looking for my top-ups from those little things as well, I'm not looking for them in terms of popularity. (Diane, Interview 2)

One participant describes a sense of personal risk associated with investing their perceived resilience energy, which can increase or deplete it depending on the outcome of their actions. If successful, they will experience 'achievement' that 'tops-up' their perceived resilience energy. However, if unsuccessful they have still invested the same amount of perceived resilience energy, but will not experience a sense of 'top-up', leaving them depleted of perceived resilience energy and still facing a stressful situation that requires more personal energy to address. This gives an impression of 'gambling' their resilience energies, where a bigger investment could lead to bigger reward/top-up or risk a bigger loss and no personal reward.

The irony off when you work in this type of way is, what exhausts you also gives you energy at the same time. This week particularly has been a difficult week, but actually … it was such a successful outcome … Now, that could have had the opposite effect … I would have either have felt exhausted or exhilarated, and I felt exhilarated, yet it was still the same amount of time and same level of conversation and same drain on my energy levels … the outcome was what determined how I then felt, yesterday and then going into the rest of the week. (Catherine, Interview 2)

Some participants express a sense of being liberated by an 'honesty' and 'authenticity' associated with living by their personal values. They appear to experience that being truthful mentally frees both themselves and others to address any situation openly and move forwards in a positive and liberated way. This seems to act as a positive motivator for their personal resilience, as there are no perceived barriers to stop progress toward the situation and when mentally moving forward with their lives.

If you're making it up and it's not authentic, it is actually really difficult. Telling lies is much more difficult than being honest and open, because you've got to manage it through thinking about all the implications and that type of stuff and at the end of the day, that's really exhausting. If you get this right and work it though, it's far less tiring. You are in danger of wearing your heart on your sleeve and there could be damage off the back of that, but it's less emotionally draining than in taking a different approach. (Tim, Interview 1)

To emphasise this aspect of their personal resilience, some participants identify that when they experience people being dishonest with themselves and others about stressful situations, they

perceive that they get into a 'spiral of denial' and 'become stuck', unable to mentally move forward with their lives from the stressor (see Elizabeth's story - Chapter 4 - Part 1).

When prioritising how to distribute their perceived resilience energy, most participants appear to experience pockets of their lives in different ways and sometimes refer to this as having 'boundaries' or work-life 'balance'. Participants describe that these boundaries can act as 'protective spaces' to recharge their perceived resilience energy and enables them to keep motivated in managing different stressful aspects of their lives. Common examples of protective spaces include resting on holiday, the sense of pleasure they gain from family time, and finding time for personal hobbies and interests. Two participants describe planning their day to build in several small motivational activities to 'top-up' their perceived resilience energy in small amounts to keep them going.

> *When I'm on holiday, I'm on holiday … I feel it's my right to actually go away and be shut off for a whole week … the boundary of having a regular holiday, something to look forward to, something to give back to my family, to rest, is really important. (Wendy, Interview 1)*
>
> *I have two young children. In terms of resilience for me, there is no greater level than going home to them (happy laughter). I can be having the worse day possible in this role … but, when you walk in that door at home, you're not CEO … the kids will want you to draw with them or do something with them and, that can be a great thing for resilience, just to ground you again. (Andrew, Interview 1)*
>
> *The other thing that I think about balance is, I am pretty good at having loads of things in my life that I really love doing … the more challenging the stuff you have to do, the more that you need all those little highlights in there … I have lots of little markers so each day, I have 2-3 highlights, and each week needs to have a couple of key things. It's that sort of balance and that is important, that is one of my definitions of resilience about keeping that perspective. (Sam, Interview 1)*

Several participants seem to experience a 'transferable' quality of their perceived resilience energy between pockets of their lives. They describe that if one aspect of their boundaried life is going well, it can act as a motivator to make stressful aspects of their wider boundaried life more manageable. For example, some participants describe experiencing work as immensely stressful and demotivating at times, however because their home-life or interests outside of work are being experienced positively, they act as a motivator to enable them to cope better with their perceived work stressors, and vice-versa.

If I'm banging my head against a brick wall here at work, I know that something else in another part of my life is moving forward ... if you're having a difficult day here, you don't switch off, but you can go home and you know what, let's just put that to one side for a minute and do something that gives me that pleasure. That's the kind of stuff that gives me the warm feeling when I'm dealing with difficult stuff here [at work]. (Andrew, Interview 2)

You can have one that off-sets the other. I know that having a really stable situation at work and it being really positive, made me much more able to cope with the personal [describes home-life crisis] side. When it's going personally well, you're able to cope with the knocks. (Tim, Interview 2)

4.2.3.6 - Reflective account: Consciously becoming phenomenological in practice

I remember seeking out an expert in phenomenology as part of my development as a researcher and the advice that they offered me. They said that whilst they had practiced phenomenology for over 20 years, they were still learning about it and to remember that the more I practiced, the more I would notice myself 'becoming phenomenological'. This was reenforced by my learning from other phenomenological scholars whose work similarly implied that the researcher only 'becomes phenomenological' by actively doing the research. It was during the construction of this theme of 'moving forward' that I began to really appreciate this sentiment.

Throughout this study, I was conscious that my role as the phenomenological insider-researcher was to differentiate, interpret and present the most relevant of the many ideas and perspectives presenting themselves. However, whilst trying to make sense and interpret what personal resilience was for participants as NHS executive leaders, this initially became overwhelming. I was noticing that all participant ideas and themes around their personal resilience seemed to connect, overlap, and appeared inter-dependent upon one another. This was compounded by considering the subjective nature of personal resilience as documented in the literature, and how all themes presenting themselves could have relevance. I knew that I needed to distil this into a 'golden thread', representative of the research topic, the participants' voices, and my own voice as the researcher.

Initially, I grounded myself in my research aim and questions to distinguish the themes that seemed most important, however this felt quite mechanical. To further support me, I also revisited my methodology and phenomenological texts. I was reminded that as a

phenomenological insider-researcher, my interpretation was not about generalisability, but instead it was about my unique and personal interpretation. My insider-researcher status and being conversant with my research environment and topic in practice was a strength that enabled my unique interpretation, that no other researcher could replicate. I then experienced a moment where I felt that I truly began to embrace 'being' a phenomenological insider-researcher. I experienced 'letting go' of an innate feeling that my research needed to be perfect in the eyes of a 'generalisable' world. This restrictive and burdensome feeling then became replaced by a sense of personal 'ownership' for my research into personal resilience as something unique to me and my participants. My interpretation, of participants interpretation of resilience as phenomenon was distinct and non-generalisable, and that was ok. This renewed sense of perspective enabled me to consider the themes presenting themselves more critically and distinguish between what appeared most relevant to 'my' unique research and the story that 'I' personally interpreted as most significant, drawing upon my personal reflexivity as the phenomenological insider-researcher.

I was then able move away from feeling overwhelmed, by embracing what increasingly felt like 'becoming phenomenological'; embracing the double-hermeneutic, distilling the phenomenon into its constituent sub-theme parts and reassembling them into the essence of what was presenting itself, deconstructing and reconstructing ideas and themes until I found what I perceived to be the 'golden thread'. I was finally able to identify that continually and actively 'moving forward' with their lives distinguished participants experiences of personal resilience in their leadership roles. Furthermore, this sense of personally 'breaking free' and 'becoming phenomenological' enabled me to revisit all previous themes that were presenting themselves throughout my entire analysis and further enhanced my interpretations to what became a higher quality of interpretation and analysis.

4.2.4 Summary

Good quality IPA research should present itself as auditable to the reader by detailing how themes and interpretations were generated (Smith et al., 2009) and this chapter has demonstrated how this study has achieved this.

Part 1 of this chapter outlined researcher's interpretations of each unique participant voice by articulating various experiences of personal resilience in the context of their NHS executive leader roles. Whilst it was not possible to present all interpretations gleaned from each participant due to word count limitations, Part 1 demonstrated an audit trail to illustrate how the experiences documented in participant interview transcripts (see Appendix 2) were interpreted and contributed toward the development of the study's overarching thematic map (Figure 2).

Part 2 of this chapter built upon these individual participant interpretations and presented the study's overarching thematic map (Figure 2) as a meta-layer of interpretation across all participant accounts. It outlined the researcher's voice by discussing their interpretation of the overarching themes that were identified from within and across participant experiences.

The next chapter will further build on the researcher's voice and their interpretation by presenting a discussion of findings in relation to the aims and questions of this study, and how they are positioned within the current body of knowledge.

Chapter 5: Discussion

5.0 Introduction

The aim of this study was to explore the lived experience of personal resilience for NHS executive leaders by addressing the following research questions using Interpretive Phenomenological Analysis (IPA):

> ***Question 1:*** *How do NHS executive leaders experience stressful healthcare working environments?*
>
> ***Question 2:*** *How do these NHS executive leaders experience and define personal resilience when responding to these stressful environments?*
>
> ***Question 3:*** *What is the difference between being resilient, and failing to be resilient to them?*
>
> ***Question 4:*** *How is personal resilience gained, developed, and retained for these individuals?*
>
> ***Question 5:*** *Have their perceptions toward personal resilience changed throughout the duration of their careers (i.e. is there a uniqueness relating to executive leader resilience?)*
>
> ***Question 6:*** *How do they perceive working in a care-based profession impacts their personal resilience as an NHS executive leader?*

Smith et al. (2009) state that the nature of any IPA study may take the research into unanticipated territory with many potential avenues of discussion in relation to the findings, and this study is no exception. Smith et al. (2009) Van Manen (2014) and Vagle (2014) also state that the 'craft' of writing research findings is a phenomenological act within its own right. They argue that the process of interpreting findings further evolves when establishing, making sense, and discussing where these findings are placed in relation to the existing body of knowledge and when ensuring that the research questions have been answered. This chapter addresses this by presenting a discussion that further evolves the interpretation of findings from those presented in Chapter 4 that relate to participant experiences alone. It achieves this by both answering the research questions, whilst also examining how these findings are situated within and interpreted against existing knowledge within the literature. Discussion is presented in relation the following three evolved thematic sections:

1. ***Stress from personal exposure and loss in the caring environment***
2. ***Experiencing being resilient as moving forward***
3. ***Enabling personal resilience through connection, positive framing and thriving***

Reflective accounts are presented within each of these thematic discussion sections to enable transparency and explain how the interpretation of findings has further evolved in this chapter. At the end of this chapter, Figure 6 visualises this and Table 8 summarises how this discussion both answers the research questions and evolves and maps to the interpretation of participant experiences that are documented within Chapter 4.

In addition to considering the literature as part of a thematic literature review (see Chapter 2) Smith et al. (2009) outline that following analysis of findings, there is scope to re-engage with the literature in relation to what is known about the themes arising from the interpretations of participant experiences of the phenomena. Therefore, after themes were identified, a further thematic literature review was undertaken, focusing on the specific themes emerging from the data that demonstrated links with the body of personal resilience and related literature. Smith et al. (2009) view that a good outcome of any quality IPA research is to identify fresh avenues for enquiry that lend themselves to future research. By focusing on the findings in relation to the research questions and the gaps within the related literature, this chapter also highlights potential avenues of enquiry for future research studies to consider.

5.1 Stress from personal exposure and loss in the caring environment

This section addresses the first research question of this study, seeking to understand how NHS executive leaders experience stressful healthcare working environments. It also addresses research questions 5 and 6 which seek to understand any perceived uniqueness of executive leader personal resilience in the context of the NHS healthcare environment.

5.1.1 Stress from being exposed

This study has identified that personal exposure is a distinctive stressor that all participants experience in the context of their NHS executive leader roles. This level of exposure distinguishes them from other healthcare leadership roles, arising from their unique visibility and accountability in a highly scrutinised healthcare environment, described as ‘the buck stops with you’. For some

participants, this exposure is likened to that of being a 'celebrity', and for others it is similar to being seen as a 'hero' due to the strong associations of their leadership role with their personal values of 'doing the right thing for people'. Stress arises from a conflict between these 'heroic' personal leadership qualities against the vulnerability associated with this high level of exposure, visibility, celebrity-like and highly accountable status within a heavily regulated NHS environment that is perceived as a 'blame culture', where participants are expected to have all the solutions to challenges facing their organisation.

Schweiger et al. (2020) highlight that the notion of the 'heroic leader' is the predominant discourse within the body of leadership literature that articulates the leader being the single individual who has all the answers to the challenges being faced by them and their followers. They argue that this is a 'romanticised' and harmful view, as it discounts the complexities of the social reality, may force leaders into arrogant views of their leadership role, and limits solutions to the leader as a 'hero saving the day' by discounting the potential support from their followers. Schweiger et al. (2020) put forward the concept of 'processual leadership' as a way of moving away from this discourse, toward one that leverages 'connection' and 'emergence'. However, this view of leadership conflicts with participant experiences of ultimate accountability and the documented NHS 'blame culture' (Rose, 2015; Smith, 2015) experienced as part of their NHS executive leader roles. This NHS culture arguably forces them to remain in this heroic leadership discourse with celebrity-like levels of scrutiny, and therefore continually experience stress in relation to personal exposure, where they can be publicly 'blamed' if things go wrong.

This is the first study to identify 'exposure' arising from the conflict between being 'heroic leaders' and the NHS blame culture, which leads to personal vulnerability as a significant and potentially unique source of stress for NHS executive leaders. NHS reports that explore the state of senior NHS leadership (Janjua, 2014; Rose, 2015; Timmins, 2016) acknowledge the impact of the NHS regulatory and accountability culture on executive healthcare leaders. However, this is only discussed in terms of process and generic experiences of the healthcare environment, rather than through the direct lens of stress and personal resilience. Empirical studies that explore healthcare workforce related stressors identify a broad range of stressors, such as lack of autonomy, challenges to professional status and dealing with constant change (Jackson et al., 2007) exposure to violence in the workplace (Itzhaki et al., 2015) and lack of resources and heavy workloads (O'Dowd et al., 2018). Whilst these findings could potentially be perceived as having an indirect link to being exposed, they are limited to the generic body of healthcare professionals and do not

consider the levels of accountability that participants experience in their executive leader roles, having to lead organisation-wide healthcare services.

Kelly et al. (2016) found that NHS nurse directors feel stress and vulnerability from the fear of being 'sacked' due to the failings of their organisation, as a result of the NHS regulatory environment. This is the only empirical research identified that considers NHS executive leader resilience. However, it is limited to the perspectives of senior NHS nurses, focuses on more generic corporate stressors such as quality of care, financial management and workforce capacity, and lacks consideration toward the wider exposing nature of NHS executive leadership roles that the participants in this study have described.

By having a small sample group that is representative of all board level executive roles, this study has been able to contrast participants perspectives of stressors relevant to their role and identify exposure as a common and significant stressor experienced by all participants as NHS executive leaders. Stress arising from personal exposure is worthy of further study beyond this small sample group, into broader leadership positions, in addition to the association between leader, celebrity and how the NHS culture forces executive leaders to remain within a heroic leadership discourse.

5.1.2 Stress from loss

This study has identified that the distinctive level of personal exposure that participants experience from being the most senior organisational leaders results in them experiencing varying forms of personal loss.

Stressors described by participants relating to loss of 'control' and detachment from day-to-day running of their organisation (see De Rijk et al., 1998; Lambert et al., 2003) and loss of 'reputation' when things go wrong (see Sonnenfeld and Ward, 2008; Kelly et al., 2016) appear to be the more apparent forms of loss experienced by participants. However, this study has also been able to identify two further and more nuanced forms of loss that cause participants' stress, which add to their feelings of personal exposure. These forms of loss relate to their perceived 'humanity' and their 'personal identity' and have not been documented in this way before.

In their NHS executive leader roles, participants experience a sense of loss by no longer being perceived as 'human beings', who are equally able to experience vulnerability arising from stressors as everyone else within their organisation. This stressor is further compounded by how they perceive that the NHS culture actively discourages them from showing any vulnerability associated with this level of exposure in their executive leadership role. Jackson et al. (2007) argue

that vulnerability is the opposite to being personally resilient for healthcare leaders, yet this study has identified that participants experience personal vulnerability every day from their 'exposing' NHS executive leader roles. This creates two incompatible personal identities that participants simultaneously experience, by being both a 'resilient leader' and also being a 'normal vulnerable human being'. Continually managing these two incompatible identities generates ongoing background levels of anxiety for them. Corlett et al. (2019) discuss identity, vulnerability, and loss for middle managers in relation to a well-established 'masculine' management rhetoric that associates vulnerability with a display of weakness. They found that vulnerability can become a strength if these middle managers reconceptualise vulnerability by being at ease with sharing that they do not have all the answers, and the opportunities that this brings. However, in contrast to Corlett's findings, participants in this study experience being 'forced' to engage with this traditional masculine rhetoric due to the NHS culture that they experience and lead within. Their followers, the media, the public, and the regulatory bodies all turn to them to demand solutions due to their accountable leadership roles. They perceive that they have lost their ability to identify as being vulnerable human beings like those around them and are required to hide their vulnerability and weakness due to being forced to remain within a discourse of 'heroic leadership' (Schweiger et al., 2020). Therefore, displaying vulnerability and openness to not having the solutions is not an option for them, regardless of the cost to them personally. This contrast between vulnerability as a strength (Corlett et al., 2019) and participants inability to display vulnerability in their leadership role due to the current NHS culture is worthy of further study in relation to personal resilience.

A further complex stressor relating to loss of identity is how participants perceive that their personal identity becomes increasingly entwined with that of their organisation's corporate identity, arising from being the most senior leaders in their organisation. They describe that when the organisation experiences stress, this results in them experiencing personal stress. This is perceived as almost inseparable for participants who are chief executives, as they are the most senior accountable leader and figurehead for their organisation. Participants describe living with the knowledge that their ultimate leadership accountability could lead them to losing their 'heroic' and 'celebrity-like' status at any point if their organisation fails, leaving them to deal with the very human, personal trauma and sense of personal loss as a result. This potentially relates to heroic leadership (Schweiger et al., 2020) being a dominant discourse experienced by participants in the context of their NHS leadership roles, and when things go wrong they are blamed and lose their heroic status. Furthermore, this results in an 'asymmetrical relationship', as whilst participants experience adversity arising from organisational stressors, they perceive that the organisation is

not a living being and cannot experience the same in return. Yet the inverse could also be argued, as if participants are unable to function well in their executive leader roles, this is likely to have an impact on how their organisation functions.

This distinguishing stressor of losing control over personal identity facing participants as NHS executive leaders has not been documented in the literature in this way before. Sonnenfeld and Ward (2008) discuss that a leader's identity is intertwined with that of their organisation through their positional power and status and when this is taken away from them, they also risk the loss of their personal identity. However, their discussion on this topic is not empirically based. The detailed discussion of studies into leadership and identity by Hogg et al. (2012) found that the existing literature mainly considers how a leader's personal identity is socially constructed, however none of these studies considers the interrelation between the leader and their organisation's identity. Schweiger et al. (2000) argue that leaders can be both powerful and powerless in the context of the heroic leadership discourse arguably experienced by participants. Whilst their work is not specifically related to leader identity, it does offer an additional way to interpret participants identity challenges as 'heroic' NHS executive leaders. Participants are perceived by others as powerful leaders who are expected to hold all the answers, yet they themselves still perceive themselves as less powerful and vulnerable when held accountable within the perceived NHS blame culture. If vulnerability is considered to be the opposite to being resilient for healthcare leaders (Jackson et al., 2007) then participants managing the ongoing stressors from being exposed, vulnerable and powerless in a way that challenges their personal identity and humanity, whilst attempting to remain heroically resilient as leaders in the eyes of others demonstrates the unique depth and complexity of the ongoing stressors experienced by participants in their NHS executive leader roles. Having identified stressors arising from the personal identity challenges facing NHS executive leaders, this study addresses this gap in knowledge and offers a new avenue of enquiry worthy of further study.

5.1.3 Moral stressors from a caring environment

Participants experience moral stressors arising from leading in a healthcare environment. They describe their personal and moral accountability for the lives of others, including their employees their patients, the wellbeing of the wider population, and how this is linked to their personal values surrounding 'doing the right thing for people'. This adds a further layer of complexity to the stressors experienced by participants, such as personal exposure when they are forced to publicly

display these personal moral values if the organisation's course of action is in conflict with their own, or from the personal moral and emotional impact of when things go wrong whilst being accountable for the lives of other people. Whilst this study does not seek to enter the moral vs. ethical debate, it should be noted that these terms are often used interchangeably in the literature, where morals lend themselves to the personal, and ethics toward more societal rule-based norms (Grannan, 2021). This could explain the stressors that participants perceive when their personal (i.e. moral) course of action is in conflict with the wider NHS organisational regulatory (i.e. ethical) course of action to which they are held accountable to.

The moral stressors facing NHS executive leaders are not currently documented, however this topic does receive some debate within the wider healthcare leadership literature that is similar to participant experiences. Dellve and Wilkstrom (2009) identify moral dilemmas that junior healthcare clinical leaders experience from the ethical stressors faced when they perceive an organisational course of action conflicts with their professional personal values and ethics. They illustrate this by using the anecdote of how a values-driven leader compares the situation of 'doing the right thing' as directed by their own moral personal values, to 'doing things right' as dictated by an organisational norm and established managerial procedures. However, their research is limited to junior and first-time healthcare clinical leaders that do not hold the breadth of accountability or level of leadership experience that the executive leader participants in this study do. Nyberg and Sveningsson (2014) similarly found that leaders can struggle from being true to their personal values when conflicted with social and organisational expectations and that being unable to lead as their authentic self can result in feelings of guilt and stress. The concept of 'emotional labour' has also been linked to stressors facing a range of healthcare professionals, predominantly in the field of nursing (McAllister and McKinnon, 2009; Delgado et al., 2017). Emotional labour refers to healthcare professionals suppressing their emotions, and 'faking' outward displays of emotion by behaving in a way that is expected of them in enacting caring roles, even if this behaviour is not aligned to their actual feelings (Delgado et al., 2017). This is similar to how participants describe being faced with a choice of feeling exposed and vulnerable by opposing an organisational course of action if it does not align to what they believe is the right thing to do, or 'faking' their alignment to the organisational course of action and resultantly feeling stress, inner turmoil and guilt arising from suppressing their true feelings. Both options potentially add to their perceived sense of loss of personal identity.

Whilst moral stressors associated with healthcare professionals working in a care-based environment is not new, this is the first study to have documented how these moral stressors can

also impact NHS executive leaders, and furthermore how they could experience this in a compounded way due to their senior accountable roles. It also opens a new avenue for enquiry, to further understand how moral issues impact the stressors faced by the broader leadership population.

5.1.4 Summary

In summary, in the context of their NHS executive leader roles, participants experience stress from being 'exposed' in a variety of ways. This exposure leads to a sense of 'loss', including loss of 'control' from being detached from service delivery, 'reputation' when things go wrong, their sense of 'humanity' in the eyes of others, and their sense of 'personal identity' from becoming entwined with the corporate identity of their organisation. Additionally, their people-focused personal values add a further layer of complexity to how stress is morally experienced whilst leading in a care-based environment. These distinguishing stressors that participants experience have not been documented in literature in this way before.

There are few studies identified that have explored how generic populations of executive leaders' experience stress, and very few studies that have considered how NHS executive leaders experience this phenomenon. This study has contributed to this limited body of knowledge by distilling the unique stressors experienced by the participant group, who together represent the spectrum of NHS board level executive roles (i.e. the sample group represented chief, nursing, medical, finance, operations and human resource executives).

5.1.5 Reflective account: Continuing the interpretation of findings

Re-engaging with the literature relating to my theme of 'being exposed' (Chapter 4 - Theme 1) whilst developing this chapter, this reaffirmed to me that this theme should remain as an important and prominent part of my interpretation of findings. I noticed that whilst much of the literature articulated the pressures that senior NHS leaders faced, none of this body of literature articulated the heroic and celebrity-like levels of this exposure and vulnerability that participants expressed in the context of their NHS executive leader roles. Whilst it was suggested that leaders can embrace vulnerability as a strength rather than weakness (Corlett et al., 2019) and should move away from a heroic leadership discourse and toward one of shared leadership (Schweiger et al., 2000) it struck me how this was not possible for participants in their NHS executive leader

roles due to the perceived NHS culture that emphasises participants accountability and exposes any vulnerabilities. The debate that leaders are both powerful and powerless (Schweiger et al., 2000) also emphasised this level of exposure as an important finding in relation to the identity challenges participants experience (see Chapter 4 - Theme 1.2). Participants' experience being caught between being perceived as powerful heroes with all the answers, yet powerless to do anything about the 'blame culture' that they perceive is enforced upon them by the NHS culture, including its regulators, the media, and in expectations of the public.

Whilst reflecting on participant experiences of exposure and the literature concerning thematic findings relating to the perceived NHS 'blame culture' and reputational damage (Chapter 4 - Theme 1.1) the identity challenges participants face as corporate leaders (Chapter 4 - Theme 1.2) not being perceived as values driven (Chapter 4 - Themes 1.3) and normal human beings (Chapter 4 - Theme 1.4) I noticed how personal 'loss' was discussed in literature relating to leadership stressors and identity challenges (Sonnenfeld and Ward, 2008; Timmins, 2016; Corlett et al., 2019). This enabled me to identify the concept of 'loss' to conceptually connect these themes together with the literature, and further evolved my interpretation of findings in relation to my original thematic map (Chapter 4 - Figure 2).

When relating the theme surrounding the pressures experienced from working in a caring environment (Chapter 4 - Theme 1.5) to the literature, I noticed that whilst the healthcare workforce resilience literature discussed the 'moral issues' and the 'emotional labour' of working in a caring environment, this had not been discussed in relation to healthcare leaders. Yet, participant experiences aligned to these concepts. Discussing my interpretation of findings in relation to the concepts of moral stressors and emotional labour enhanced my interpretation of findings by connecting them with this body of literature. It also augmented existing knowledge by demonstrating that participants equally experience these concepts in a similar way to the wider healthcare workforce, yet at a more complex, interconnected, and larger scale as they are responsible for their employees, all the care provided by their organisation, and health of their local population.

5.2 Experiencing being personally resilient as continually moving forward

This section addresses research questions 2 and 3 by contrasting participants perceptions of being, and not being resilient in the context of their NHS executive leader roles. It also addresses research questions 5 and 6 which seek to understand any perceived uniqueness of executive leader personal resilience in the context of the NHS environment.

5.2.1 Becoming metaphorically 'stuck'

This study has developed the metaphor of 'becoming stuck' to express how participants perceive being unable to move forward with their lives after experiencing traumatic events. This offers a unique insight into the perceptions of 'not being resilient' for these arguably successful and resilient NHS executive leaders, which has not been articulated in the literature in this way before. Becoming stuck is the opposite to being resilient for them. Perceiving themselves, or to be seen by others as unable to move forward with their lives and remaining in a stressed state is perceived as an ultimate form of personal exposure by participants.

Participants linked experiencing becoming stuck to being in 'denial'. They perceive that denying a stressful experience can mentally and emotionally keep them in that situation, and unable to move forward with their lives. This is the first study to have identified this link between denial and ongoing trauma for NHS executive leaders. In their concept analysis of denial as related to healthcare practice, Wheeler and Lord (1999) state that there is no clear definition for denial, however it is generally seen as a defence mechanism in response to stressors that can have adaptive and maladaptive consequences. They state that adaptive consequences can result in individuals coping better by controlling overwhelming thoughts, whilst maladaptive consequences such as complete avoidance of the stressor can result in longer-term ill-health. This is supported by Ortega and Alegria (2005) who identified that individuals who acknowledge the situation rather than denying it are more likely to seek help and resultantly obtain better mental health outcomes. This is similar to how participants experience personal resilience in relation to denial. Whilst these studies link denial to the concept of 'becoming stuck', there is less literature surrounding how denial links to the concepts of stress and resilience more broadly, or to the contexts of leadership

and healthcare professionals. Canyon (2014) identified that denial of the need to change and adapt is a barrier for the healthcare workforce when responding effectively in a crisis. They suggest that a leader's role is to help their followers to embrace change and work through this denial, which will better enable the healthcare organisation to respond resiliently in a crisis. However, Canyon does not discuss denial in relation to the leader themselves, or their personal resilience. More recently, Hendy and Tucker (2021) similarly considered how collective denial of the situation, including by leaders and clinicians, leads to systemic failures in healthcare services. They argue that the NHS bureaucratic and regulatory culture forces leaders to collectively engage in a state of denial of the challenging situations they face, which in turn leads to poor patient care and organisational failure. Whilst Hendy and Tucker's work does not explicitly relate to the personal resilience of healthcare leaders, this does support participants view of the NHS regulatory culture and how denial can lead to a state of becoming stuck and unable to resiliently move forward. However, participants in this study also experience the opposite to findings by Hendy and Tucker (2021) when actively trying to embrace the stressful situation to move it forward, in addition to the values-based frustration they describe when seeing others around them that engage in this maladaptive practice of denial. The link identified within this study between perceiving being stuck within an experience of trauma resulting from being in denial of the situation offers a new perspective on what may prevent senior leaders from being resilient and recovering from traumatic situations and offers a potentially new avenue for future enquiry.

Participants with clinical experience discussed 'becoming stuck' and denial in relation to Posttraumatic Stress Disorder (PTSD) potentially due to their clinical training. They stated that whilst they had not experienced PTSD themselves, they had identified it in other more junior colleagues. PTSD is a mental disorder that can develop after exposure to extreme trauma, leading to complex psychological symptoms such as distress, avoidance and negatively altered mood (Bisson et al., 2015). There is a lack of literature that explores PTSD in relation to healthcare leadership roles. However, experiencing PTSD has been linked to healthcare professionals working in stressful environments, including paramedics (Streb et al., 2014) emergency department professionals (Laposa et al., 2003) and nurses (Czaja et al., 2012). The risk of experiencing PTSD is also significantly higher for healthcare professionals when responding to intensely traumatic situations such as dealing with a crisis situation (Carmassi et al., 2020). However, having personal resilience is recognised as a mediating factor to reduce the likelihood of PTSD for those who work in healthcare (Mealer et al., 2017).

Much of this existing body of knowledge surrounding personal resilience and PTSD takes a 'deficit approach', having explored accounts of being resilient after major trauma, adversity and recovering from PTSD, such as survivors of war (Southwick and Charney, 2012). In contrast, this study offers an original lens to the main body of personal resilience knowledge, by exploring the perceptions of PTSD in relation to personal resilience through the eyes of participants as very senior healthcare leaders who are arguably successful and resilient individuals, as opposed to survivors of trauma. There also appear to be no empirical accounts of PTSD in relation to NHS executive leaders, or PTSD in relation to executive leaders more broadly. Whilst this may indicate that this area remains understudied, it may also indicate that the context of senior leadership roles makes it less likely to expose leaders to extreme trauma, or that there are qualities associated with individuals who successfully enter leadership roles that mediate their potential to experience PTSD. Participants arguably describe intensely traumatic personal experiences within their executive roles, and their perceived absence of PTSD symptoms and accounts of continuing to be successfully resilient therefore suggest that the qualities associated with their personal resilience may act to mitigate more severe forms of trauma. However, the wider findings discussed within this study offer original insight into how arguably successful senior leaders mitigate the risk of experiencing PTSD. Whilst the metaphor of 'becoming stuck' illustrates how participants perceive not being resilient, this study did not seek to explore the personal resilience of executive leaders through the psychological lens of extreme trauma and PTSD. However, this study has highlighted the lack of knowledge surrounding how senior leaders experience PTSD and the related experience of metaphorically 'becoming stuck' and unable to move forward with their lives, which is worthy of further study.

An insight that is not discussed within the literature is how participants perceive experiencing one part of their life as becoming stuck, whilst other parts of their life are simultaneously experienced as moving forward. Being and not-being personally resilient simultaneously in different aspects of their lives illustrates the contextual complexity of participants perceptions of being resilient as executive leaders. This novel finding may also explain why they perceive themselves as remaining successfully resilient in their executive roles. As long as one part of their life is perceived to be moving forward, they can draw on this movement to keep experiencing themselves as personally resilient. This finding may offer new avenues for enquiry to explore how wider populations experience being and not-being personally resilient simultaneously, and the relationship between these experiences.

5.2.2 Actively moving forward

Participants describe experiencing being resilient as a sense of continually and actively 'moving forward' with their lives. This is in contrast to 'becoming stuck', as to do nothing is to passively become stuck and risk experiencing vulnerability and exposure in their NHS executive leader roles. This metaphor to describe personal resilience has had little engagement in the literature, with the exception of Southwick et al. (2014 pp.3) who state, "*for a person, perhaps it is better to conceptualise resilience as a process of moving forward and not returning back*". However, this definition was offered as opinion in the context of an expert panel discussion on resilience, rather than being empirically based. Yet, findings in this study support this definition as a way for people to easily engage with a potentially more accessible explanation of personal resilience.

An original finding in this study is how participants achieve this sense of moving forward through various forms of 'taking action' that both seek out and mitigate the risk of stressors in addition to responding to them. Taking action enables them to perceive that they are continually moving forward with their lives, enabling their organisation to move forward, and therefore perceiving themselves as being personally resilient in their executive roles. The importance placed upon taking action being at the centre of a leader's personal resilience has not been documented in the literature in this way before and contributes an original view on what resilience is for participants as NHS executive leaders. Furthermore, participants perceive themselves in a state of 'continually' taking action to move forward in their executive leader roles by actively seeking out and engaging with stressors before they occur in order to mitigate them. This is a significant finding, as it directly contrasts with existing resilience theory and the body of personal resilience literature that predominantly discusses resilience as a 'response' that follows encountering a stressor in relation to general populations (Jackson et al., 2007; Southwick et al., 2014; Aburn et al., 2015) and for leaders (Forster and Duchek, 2017). This continually active nature of participants personal resilience, rather than experiencing it only as a response to stressors, offers a fresh perspective for how personal resilience could be understood. This continual experience of identification and mitigation against stressors before they happen enables participants to maintain their sense of being personally resilient, as well as maintaining the resilience of the organisation that they lead and their employees within it.

In their review of resilience within business management literature, Linnenluecke (2017) discuss the contemporary concept of 'resilience activation' to describe how organisations need to proactively detect potential threats and mitigate them to remain resilient. This is similar to how participants describe their experiences of continually taking action, yet Linnenluecke discusses this

in terms of 'the organisation' as a detached entity. However, this study has established how participants uniquely perceive that their personal identity and resilience as executive leaders is entwined with that of their organisation as part of their corporate leadership roles. This unique interconnectedness between themselves and their organisation as an entity could account for why participants experience a similar sense of 'resilience activation'. This study builds on the contemporary concept of resilience activation discussed by Linnenluecke and identifies a new avenue for enquiry to consider the role that these executive leaders play in this phenomenon.

A further aspect surrounding continually taking action is how participants perceive that the complexity of their executive leadership roles means that there is often no obvious solution to the complex stressors they face. They describe that complex problems will require a series of iterative actions to move them forward, which affords them the ability to shape their personal response and their organisations response gradually. Doci and Hofmans (2015) found that when leaders encounter tasks that are overwhelmingly complex, they act in less transformational ways because they momentarily lack the psychological resources to do so. However, participants in this study experience the opposite of this, by 'standing back to gain perspective' and utilisation of positive framing to transform the stressor into a positive opportunity. This offers a novel insight into the complex and active nature of participants personal resilience and is this worthy of further study.

Whist continually taking action is a core component of participants sense of personal resilience when experiencing personal resilience as moving forward, stress and resilience related literature do not appear to discuss the importance of taking action in depth and mainly consider the enablers to being resilient. However, much of the literature does discuss personal resilience as a contextual 'process' in response to stress (Richardson, 2002; Jackson et al., 2007; Southwick et al., 2014; Aburn et al., 2015) which implies a sense of moving forward through processual stages. The 'stress response' process includes options for 'fight', 'flight', and 'freeze' as choices available for individuals to take resilient action when facing stressors (Semadeni et al., 2008; Webster et al., 2016; Seng, 2019) and was referenced by participants in the context of how they remain resilient. However, rather than the generic way that the fight, flight, or freeze responses are represented within the literature, an original finding within this study is that participant experiences of taking action appear to be more developed, regulated, purposeful, intentional, continual, and driven by their personal values and learning from their previous lived experience of similar stressors.

A further novel finding in this study is how participants appear to experience this response in a different order to that which is normally referenced in the literature. Rather than 'fight' first, they start by 'freezing' the situation and 'standing back' to gain perspective of the stressor, and arguably

do this on a continual basis as they are 'scanning the horizon' for future potential stressors. Participants arguably perceive the traditional 'physically freezing' stress response as something maladaptive, passive, responsive, and helpless that risks them becoming stuck and unable to move forward when facing a stressor. Instead, participants describe 'mentally freezing' the situation to gain perspective. This enables them to consider broader options, previous experience, social support, and more uniquely, how the situation could be reframed into something more positive or as an opportunity in the context of leading their organisation, as well as identifying and mitigating wider future potential stressors before they happen. The approach to look for positive framing enables them to make the best choice they can to take positive action toward the stressor. This makes their perception of the stressor easier to cope with for both themselves and when framing it for the people they are leading. Bracha et al. (2004) argues that the traditional order of how the stress response is portrayed within the literature needs to be updated, agreeing with how participants perceive freezing the situation to gain perspective comes first. However, Bracha liken freeze to focusing on the negative aspects of the situation and becoming 'hyper vigilant', focused and alert in a reactive way. This is supported by Webster et al. (2016) who discuss the use on negative emotion in relation to fight, flight and freeze in the context of toxic leadership environments. Yet, findings in this study indicate that participants experience the opposite to this and use positive emotions to expand their cognitive possibilities to gain perspective and consider broader options. This initial action to 'mentally freeze' the situation to gain a broader and positive perspective offers an original perspective on the traditional stress response for participants as senior leaders, which has not been documented within the literature before.

Having gained a positively framed perspective and chosen an appropriate response, participants then describe taking further action, which in stress response terms could be likened to the two action orientated responses of 'fight' or 'flight' (Semadeni et al., 2008; Webster et al., 2016; Seng, 2019). However, rather than a primal sense of 'fight' as described within the existing literature, this study has established that participants experience this response as persevering with something that is driven by their personal values and personal motivations. This is equally extended toward an alternate action for 'flight'. Rather than 'running away directionless' to escape a stressor as metaphorically described in the existing literature, participants liken flight to taking themselves out of the stressful situation in a considered, purposeful, and decisive way. They move themselves toward their new chosen scenario through considered alignment to their personal values where they perceive that they can be more motivated and therefore more effective. Semandeni et al. (2008) found that private sector executive leaders who leave their organisation

before the company fails (i.e. similar to 'flight') compared to those who stay until the end (i.e. similar to 'fight') suffer less labour market consequences when progressing their careers, suggesting that 'flight' could be a self-protective characteristic for them. Yet, there are no empirical studies that explicitly link fight or flight to the personal resilience of senior leaders, or the use of their personal values and motivations to drive their sense of action. The original perspective identified within this study in how participants experience resilience as ongoing, and an evolved form of the stress 'response' in light of this, offers new insights and potential further avenues for future enquiry.

5.2.3 Summary

In summary, two interlinked metaphors were developed in this study to articulate how participants experience personal resilience. 'Becoming stuck' illustrates participants perceptions of being unable to be resilient, where participants perceive denial of the situation as a major contributory factor to entering this state. In contrast, 'moving forward' illustrates participants perceptions of being resilient when facing stress and adversity, where continually taking action to move the stressful situation forward forms the core of their resilient response. This is the first study that has been able to examine and interpret personal resilience as a phenomenon for NHS executive leaders in this way. This study has also been able to offer an original perspective on the traditional stress response, by considering participants experiences of continually seeking out and taking action against stressors through the lens of being an arguably successful and personally resilient NHS executive leader. Findings relating to participants experiencing personal resilience as a constant and 'continual active process' challenges well-established personal resilience theory that places resilience as a 'response' to stressors.

5.2.4 Reflective account: Continuing the interpretation of findings

When considering how to further my interpretation of findings in relation to the existing body of knowledge and to answer my research questions relating to being and not being resilient, I realised that I needed to evolve how my original thematic map of participant experiences (Chapter 4 - Figure 2) was presented. I reflected on how I needed to better align the themes of 'becoming stuck' (Chapter 4 - Theme 1.6) and 'moving forward' (Chapter 4 - Theme 3) as they

are interrelated. As part of this discussion chapter, I was able to achieve this and present these themes together to demonstrate my continued and enhanced interpretation of findings.

By considering the literature that defines personal resilience in relation to my interpretation of participant experiences, I became excited when I realised that my findings did not align to existing personal resilience theory and definitions, as the general body of literature defined it as 'a response'. Even literature that discussed resilience as a 'process', implying enhancement and development, discussed it as a process that starts when an individual encounters and responds to a stressor. Yet my interpretation of participant experiences identified that personal resilience was not a response. Instead, it was constantly there, it was continual, and participants were always actively being resilient in their roles as NHS executive leaders to enable themselves, and their organisation, to keep moving forward beyond the stressors being experienced. As existing literature implied individuals passively wait to encounter stressors before needing personal resilience, I also realised that my interpretation needed to emphasise the 'active' nature of this for participants, which is why I draw particular attention to this within the discussion above.

I reflected on how participants described this actively moving forward as the 'fight flight freeze' stress/resilience response. As an insider-researcher, I knew what this stress/resilience response was often discussed as part of leadership development interventions, which is potentially why participants were conversant with this particular stress/resilience theory, and therefore I felt I had to factor this into my interpretation. I had to consider, what was different about how participants experienced this to how it was articulated within the literature. I realised that when participants described experiences of taking action in this way, they were doing it differently to how it was described in the literature, as their chosen course of action was driven by their personal values and drive to make a positive difference. Their continual approach to horizon scanning to mitigate stressors also challenged the concept of freeze as participants experienced it as something active, rather than how it is passively described in the literature. These reflections on the differences in how participants experienced this concept to how it was described in the literature enabled me to further enhance my interpretation of findings in relation to this well documented stress/resilience response, as part of this discussion chapter.

5.3 Enabling personal resilience through connection, positive framing and thriving

This section addresses research question 4 seeking to understand how personal resilience is gained, developed, and retained for participants. It also addresses research questions 5 and 6 which seek to understand any perceived uniqueness of executive leader personal resilience in the context of the NHS environment.

5.3.1 Intentionally developing interconnected and supportive resilience relationships

Participants experience an interconnectedness to their personal resilience with others, both inside work (e.g. with direct reports, peer leaders, executive colleagues, staff, formal coaching and mentoring relationships, regulatory body representatives) and within their personal lives (e.g. with friends, family and wider personal networks). Supportive social connections and relationships are a well-established enabler of personal resilience (Southwick and Charney, 2012; Southwick et al., 2014) and are also acknowledged as a generic enabler for the personal resilience of leaders (Carmeli et al., 2013; Forster and Duchek, 2017). Whilst limited in focus to executive nurse directors, Kelly et al. (2016) found that peer executive leaders and wider support networks are associated with enabling factors in reducing stress and enhancing the personal resilience of healthcare executive nurse directors when dealing with the highly exposing demands of leading within the NHS regulatory environment. Although social support is seen as an established and generic enabler of personal resilience, an original finding in this study establishes a more intentionally developed quality associated with the interconnectedness of participants' personal resilience to others as part of their NHS executive leader role, which is not described in the current body of resilience or stress related literature.

Firstly, participants describe actively and intentionally creating mutually supportive relationships that enable both their own and the other individuals' personal resilience in return. This is in contrast to the main body of knowledge that documents this support in a one-directional way. For example, when considering leadership qualities and resilience, Gaddy et al. (2017) identifies that 'authentic leadership' behaviours (such as being enabling, developmental, relationship focused, self-aware, and developing a positive environment from being moral and ethical) have a positive impact upon their followers' personal resilience. Sommer et al. (2015) and Dordio-Dimas et al.

(2018) identify a connection between the similar concept of 'transformational leadership' behaviours (such as supporting others to achieve, being innovative, visionary, and charismatic) to enabling the resilience of others. Yet, these studies only focus on the single direction in how the leader supports the resilience of other people. They neglect the complex and interconnected resilience relationship identified in this study in how participants perceive that supporting other peoples' resilience, enables these people to support the resilience of participants in their executive leader role in return.

Secondly, this study has identified how participants actively invest in developing other peoples' personal resilience throughout their careers in a way that is not discussed in the literature. Likening this to a metaphorical 'resilience bank', participants describe how the support that they 'invest' in developing the personal resilience of others can 'mature' over time, to be drawn on when participants need it in the future. This interconnectedness is perceived as vital to being personally resilient by participants in their NHS executive leadership positions, as they experience their roles as highly complex and dependent upon the resilience of those around them to perform in role. Teo et al. (2017) identify that successful leaders are able to swiftly develop social networks and trusting relationships to help their organisation to successfully respond during a crisis. This aligns to participant experiences of developing other peoples' resilience to in return enable their own resilience as leaders, yet Tao et al.'s findings lack consideration toward the importance of the intentional and active development of such supportive relationships before the crisis began. Carmeli et al. (2013) identify that a strongly connected and mutually supportive senior management team enhances the team's resilience, yet they do not consider the complexities of developing wider enabling and interconnected relationships beyond the senior management team. This study has identified the importance that participants place on developing enabling relationships across a diversity of different people, throughout their careers, and before needing to call on them for support in their executive leadership roles.

Whilst supporting other peoples' personal resilience in this way could arguably be a self-protective behaviour, a further distinguishing factor that is not discussed in the literature is how participants express being motivated to support others by their people-focused personal values and sense of purpose, regardless of any personal gain. They express a sense of altruism and perceive that enabling others is part of their personal duty as a leader operating within a caring environment.

Whilst social support is not a new concept to personal resilience, this study has identified subtly nuanced, complex, and intentional ways in which participants as NHS executive leaders experience their personal resilience as mutually interconnected with a diversity of people, related to their

personal values, and is developed over time. These identified complexities surrounding the interconnectedness of participants' personal resilience with others in the context of being a senior healthcare leader offers a worthy avenue of future enquiry.

5.3.2 Enabling personal resilience through positive framing

Participants describe both positive and negative aspects of their stressful experiences. However, they identify that a core enabler to their perceived ability to cope and move forward is how they place greater importance on actively framing their stressful experiences through a positive and optimistic lens. Existing literature engages with how a leader can generate a positive impact on follower performance as a result of their positive and optimistic framing of a situation (Baker, 2019) yet, there is a lack of literature that considers how positive framing impacts the leader personally. However, looking for positive aspects within adverse situations has received some discussion in the literature for wider populations, identifying that experiencing positive emotion and positive framing are seen to increase levels of personal resilience (Fredrickson, 2001; Fredrickson et al., 2003; Luthans et al., 2006) and team performance (Penalver et al., 2019). This may not be surprising, as these insights fall mainly within the field of positive psychology which places importance on taking a 'strengths-based' view by positively focusing what is right with an individual, rather than negatively focusing on what is wrong or dysfunctional about them (Luthans et al., 2006).

Fredrickson et al. (2003) state that resilient individuals appear to accept there are both positive and negative emotions associated with adverse situations, however rather than denying the existence of negative emotions they instead accentuate feelings of positive emotions. They state that this appears to mediate the impact of negative emotion and buffers against longer term mental illness such as depression. This type of protective factor could account for why participants perceive PTSD symptoms in others who deny or avoid coping with traumatic situations that they experience, yet do not experience this themselves, as they differentiate themselves by focusing on creating positively and optimistically framed ways to move the situation forward. Fredrickson et al.'s work is limited in focus to positive 'emotion' as an enabler. This study augments this, as participants describe the importance of positively framing their 'entire experience' of the stressor, beyond positive emotion alone. Additionally, participants also reframe the situation by considering the positive 'opportunities' that arise as a result of the stressor, moving focus away from the stressor they are currently experiencing toward a positively framed future. This enables them to

take positive actions to get there and enables them to perceive that they are responding in a personally resilient way.

An original finding in this study is that participants positive and optimistic reframing of the situation is not limited to enabling their own personal resilience, but also extends to that of other people. This augments the small body of literature that identifies leaders positive framing impacts employee performance (Baker, 2019) by extending this to employee resilience. This offers a new avenue for future enquiry to further explore how positive framing impacts the leader's personal resilience, their followers' resilience, and how this impacts their collective experiences of social support as a well-documented enabler of personal resilience for general populations (Southwick et al., 2014) and for leaders (Kelly et al., 2016; Forster and Duchek, 2017).

Whilst positive framing has had limited engagement in the literature, there are a lack of empirical studies that link personal resilience and positive framing to the fields of leadership and the healthcare environment. Webster et al. (2016) found that reframing is a possible response for individuals when experiencing stressors from a toxic leadership environment. However, their work is limited to followers rather than the leaders themselves and considers only a small cross-sector sample group. Whilst there is a lack of empirical literature in this area, there are a small number of discussion papers that conceptually explore this for the contexts of leadership and the healthcare environment. For example, Peterson et al. (2008) link being resilient as a leader to positive thinking through the concept of 'psychological capital', and Jackson et al. (2007) link the 'broaden and build theory' of resilience and positive emotions to the resilience of nurses when facing workplace adversity within a care-based environment. This study has been able to address this gap in empirical knowledge with consideration toward concept of psychological capital and the broaden and build theory within these discussion papers as applied to the context of leadership in the healthcare environment.

Luthans et al. (2006) state that it is possible to positively reframe stressors through the lens of psychological capital characteristics to enable an individual to be more resilient. This study has identified that participants exhibit similar qualities to the four key characteristics of psychological capital in their executive NHS leadership roles, which could account for their disposition to positively framing stressful situations. These characteristics include 'self-efficacy' as confidence in oneself to achieve, 'optimism' as an individual's belief that they will succeed in the future, 'hope' as the belief that persevering toward a goal enables achievement, and 'resiliency' defined in the context of psychological capital as sustaining, bouncing back or beyond when facing adversity (Luthans et al., 2006; Peterson et al., 2008). Peterson et al. (2008) identify that leaders who exhibit

psychological capital can positively impact the personal resilience of their employees, which in turn increases the resilience of their organisation. They also state that psychological capital could explain why some leaders are more resilient than others. Having psychological capital has also been linked to good management practice and enabling the personal resilience of employees (Bardoel, 2014; Linnenluecke, 2017). Whilst psychological capital has been identified as an enabling quality in the personal resilience of leaders more broadly, this is the first study to consider the link between psychological capital and being successfully resilient in the context of participants demanding senior healthcare leadership roles. This offers a future avenue for enquiry and consideration toward practical ways of building psychological capital in NHS senior leaders, to enable them to actively develop their personal resilience and therefore better cope with the stressors that they will likely face.

Luthans et al. (2006) linked the concept of psychological capital to the 'broaden and build theory' to explain the impact of experiencing positive emotion upon personal resilience. The 'broaden and build' theory was posed by Fredrickson (2001) and subsequently further developed for general populations (Fredrickson et al., 2003; Tugade and Fredrickson, 2004; Cohn and Fredrickson et al., 2009) and more recently relating to positive and improved team performance (Meneghel et al., 2016; Penalver et al., 2019) to explain how positive emotions enable individuals to be more personally resilient. Fredrickson's model states that negative emotions such as fear instinctively brings a mental focus to individuals, which enables them to narrow down their options and make fast decisions to survive. However, in contrast, positive emotions such as joy, happiness and curiosity enable individuals to gain perspective by broadening their ability to see opportunity and creatively solve problems when faced with stressful situations. This is similar to how participants experience taking action as a core part of being resilient and the novel way they perceive the 'freeze' stress response, as discussed earlier in this chapter. Rather than freezing with fear from negative emotions, they take perspective and consider positive opportunities before making their choice of action, which in turn leads to better options and more successful decisions.

Fredrickson and their colleagues empirical work appear limited in focus to proving the broaden and build theory in a general way for a small audience (Fredrickson et al., 2003; Tugade and Fredrickson, 2004; Cohn and Fredrickson et al., 2009). Jackson et al. (2007) considers the broaden and build theory as a potential way to explain the personal resilience of nurses, however this is limited to discussion rather than empirical evidence. More recently, Meneghel et al. (2016) and Penalver et al. (2019) linked the broaden and build theory of positive emotion to improved team resilience and performance. Yet, both studies are limited to a focus on team members,

performance rather than their resilience, and do not consider the mediating factor of the leader's role in those teams, or the impact of positive emotion on the leader themselves. This study has augmented this body of knowledge surrounding the broaden and build theory and is the first empirical study to have identified application of this theory in a diversity of senior healthcare professionals, and for those in senior leadership roles more generically. This study identifies how participants in their executive leadership roles enact the theory for themselves, yet also actively use positive framing to enable their teams and wider interconnected networks of people they lead. This makes it more likely that their teams and network of followers will positively engage with stressors and find creative solutions themselves. Furthermore, by combining positive framing with participants focus on continually taking action as discussed previously, this moves the emphasis away from just experiencing positive emotion alone. It moves focus towards how they as leaders place emphasis on the action-orientated aspect of creating positive opportunities out of stressors, giving both themselves and their teams a tangible way to move the stressor forward.

Whilst the presence of psychological capital (Luthans et al., 2006) and ability to enact the broaden and build theory of positive emotion (Fredrickson, 2001) could account for how participants are able to frame stressors in a positive way and increase their personal resilience, this does not explain what enabled them to engage in positive framing as a way to enhance their personal resilience in the first place. A distinguishing factor identified within this study that could explain this is how participants describe experiencing 'reality' as a complex and subjective construct, perceiving that the same reality can be experienced either positively or negatively. This perception affords them flexibility to experience the reality of stressful situations more positively, as well as how they positively influence the reality of others who are experiencing the same stressors with them as part of their organisational leadership roles. Their influential executive leadership positions also enable them to influence and shape the reality of others in a positive way, by presenting the situation in a more positive and resilient frame. This positive reframing of their perceived reality also appears to give them an increased sense of control, which is something that is seen as important in enabling a sense of being resilient (Jackson et al., 2007). Fredrickson (2001) describes the purpose of negative emotion in narrowing down choices and therefore gaining a sense of control. Yet, this study offers a novel and contrasting perspective. Rather than a sense of control arising from quickly reacting to new and complex stressors in a focused way and moving on, participants appear to gain their sense of control from their positive framing of the stressor and perceiving that they have multiple options to explore and address it. This enables them to feel that they can keep moving forward through new and complex stressful situations. Gaining a sense of

control from the positive framing and actively seeking a variety of options to address stressors in this way offers a potentially novel avenue for enquiry in how senior leaders experience personal resilience, in addition to augmenting knowledge surrounding the broaden and build theory.

Whilst the use of positive framing has had limited engagement in the literature to explain why some people are more resilient than others, through consideration toward the application of the broaden and build theory of positive emotion and the presence of psychological capital, this study has uniquely considered this in relation to executive leaders in an NHS healthcare environment and augments the current body of knowledge bringing these areas together. Furthermore, current discussion within the literature surrounding positive framing places emphasis on experiencing positive emotion, yet participants in this study perceive the importance of looking for positive opportunities and taking action, whilst also extending and influencing this positive framing and action toward the people they lead. This new perspective on positive framing and seeking out opportunities from stressors, combined with a general lack of identified empirical studies into this as an enabler to personal resilience of leaders makes this an important aspect for further study.

5.3.3 Enabling personal resilience by 'thriving' from experience

The belief that personal resilience is something that can be developed throughout an individual's lifetime is not new and is often contrasted against resilience being innate 'traits', or malleable personal 'qualities' that can be developed over time, or a mixture of both (Egeland et al., 1993; Jackson et al., 2007; Buckle-Henning, 2011; Fletcher and Sarkar, 2013; Brooks et al., 2018). It is acknowledged that much of the existing literature has explored developing personal resilience from the perspectives of individuals who have experienced extreme trauma and adversity, arguably taking a 'deficit' approach to understanding this phenomenon (Richardson, 2002; Bonanno, 2004; Sarkar and Fletcher, 2014). Taking this deficit lens to interpreting participant experiences of personal resilience could infer that they have become skilled at learning to survive within the well document adverse NHS working environments (see Rose, 2015; Smith, 2015; Timmins, 2016). Yet, this study has found that whilst all participants articulate experiences of personal adversity, they do not perceive themselves as 'survivors' of that adversity. Whilst they express that their lived experience of adversity seemed stressful at the time, a distinguishing quality of all participants is their ability to motivate themselves to push through the adversity and find ways to frame the experience into an opportunity for personal growth, both during and after the event. These qualities align to the concept of 'thriving', which was originally posed by Carver

(1998) and has subsequently been adopted and further developed (Spreitzer et al., 2005; Carmeli and Spreitzer, 2009; Klein et al., 2019).

Carver (1998) originally proposed the concept of thriving as a resilience response, stating that after an adverse event, individuals can respond in four ways. Firstly, they can 'succumb' and fail to recover. Secondly, they can 'survive' with some impairment, meaning that they will never reach full functioning again. Both of these outcomes fit into the metaphor of 'becoming stuck' as discussed earlier, where participants perceive as being unable to move forward beyond a particular adverse experience and in more severe cases potentially leading to PTSD. Thirdly, individuals can 'recover' to their original level of functioning, which Carver views as personal resilience. However, recovery does not fit with how participants in this study experience personal resilience as a state of continually moving forward. Finally, Carver suggests that people who are highly motivated to move forward with their lives can experience 'thriving' which he defines as growing from adversity, which is better aligned with how participants in this study experience personal resilience. More broadly, the concept of thriving is seen to have two subconstructs that further relate to participant experiences of personal resilience, including 'vitality' described as being energised, and 'development' described as learning and adapting from experience (Spreitzer et al., 2005; Carmeli and Spreitzer, 2009; Klein et al., 2019). Whilst the concept of thriving has been proven to positively impact employee performance and health (Klein et al., 2019) it has only been conceptually linked to leadership development theory (Ledesma, 2014) and remains unstudied for the leadership community. However, this study has addressed this gap in empirical knowledge and identified that participants experience thriving by associating 'vitality' and 'development' as core enablers to their personal resilience in their NHS executive leader roles.

'Vitality' (i.e. energy) is the first subconstruct of the concept of thriving. This study has demonstrated that participants experience vitality as a core part of enabling their personal resilience, having developed the metaphor of 'resilience energy' to describe how they are aware of their perceived personal energy available to them to keep mentally and physically moving forward through stressful situations, including what increases and depletes this personal resilience energy. Whilst there are few articles that explain vitality as a core aspect of thriving (Spreitzer et al., 2005; Carmeli and Spreitzer, 2009; Klein et al., 2019) there are a lack of empirical studies that consider the factors that lead to this sense of vitality and being energised to being personally resilient. This study has been able to contribute to this gap in knowledge by identifying the way that personal 'motivational' factors enable participants to develop their perceived sense of resilience energy. When participants perceive that they are being motivated by a task, this rewards

them with a sense of metaphorical 'resilience energy' (i.e. 'vitality') when considered in the context of thriving. In the context of their NHS executive leader roles, participants describe two similar ways of feeling motivated and energised in relation to their personal resilience.

Firstly, participants describe being motivated and energised by 'altruistic acts', expressed as 'doing the right thing for people' and aligned to their people-focused personal values. Several healthcare-based studies link the act of 'caring' to being motivated and more resilient. Ablett and Jones (2007) identified that the personal resilience of palliative care staff is linked to being motivated by making a positive difference, and more recently McNeil et al. (2019) found that the concept of 'doing good leads to feeling good' and that this influences the personal resilience of those in the nursing profession. Whilst being motivated and energised by altruistic people-focused activities may not be surprising when considering participants as healthcare professionals, this is the first study to identify similar altruistic motivational factors to be associated with NHS executive leaders. When considering leadership motivators in the context of Self Determination Theory and burnout/stress, Roche and Haar (2013) found that leaders who are motivated by 'extrinsic' factors (i.e. satisfying material or social reward, such as wealth, fame and image) were more likely to burnout during stressful situations. They also found that those motivated by 'intrinsic' factors (i.e. satisfying basic psychological needs such as personal growth, health, relationships and community) who were more likely to maintain their sense of personal wellbeing. Participants' personal drive to 'do the right thing for people' aligns them to these 'intrinsic' motivators and suggests that this enables their personal resilience, supporting findings by Roche and Haar (2013). However, this study has also identified conflicting factors to Roach and Harr's work, as participants experience 'celebrity' and 'heroic' like aspects associated with their exposing NHS executive leadership roles, which forces them to deal with extrinsic motivational factors and therefore increases their likelihood of experiencing stress and burnout. This study augments Roche and Haar's (2013) findings by demonstrating the complexity of being motivated by intrinsic factors, yet also having to deal with extrinsic factors in the context of being resilient in their NHS executive leader roles.

Secondly, participants describe being motivated by 'achievement' in their role as NHS executive leaders. Several participants referenced motivational theories such as the well-established Maslow's Hierarchy of Needs (Maslow, 1943) to explain this and how they perceive that their personal resilience differs within the different contextual levels of the Hierarchy model and their associated stressful experiences. Whilst acknowledging that they still engage with the lower levels of the hierarchy such as relationships, safety and security, participants experience that within their NHS executive leader roles, they experience being more motivated and energised by engaging with

contextual scenarios toward the top of the hierarchy. Participants describe how experiences relating to Maslow's Hierarchy levels of 'esteem' (i.e. achievement, being unique, confident, respected) and 'self-actualisation' (i.e. achieving a sense of purpose and reaching one's full potential) enable them to feel like they are achieving and making a positive difference, which leads them to feeling motivated and energised, and therefore more resilient. The use of Maslow's model in this way by participants is potentially due to it being seen as a well-established motivational model by them in their managerial roles. Whilst this theory could be considered outdated, it is still commonly used within healthcare professional development (Hale et al., 2019). However, it could be equally argued that they are describing intrinsic motivational factors such as those referenced in Roche and Haar (2013) in their work linking personal motivational factors and burnout.

Being energised and motivated is an important enabler to participants' personal resilience, yet there is limited discussion in the literature that relates motivation to personal resilience or thriving. The concept of resilience energy has some similarities to Richardson's (2002) metatheory of resilience, stating that individuals require energy to be personally resilient. Richardson describes this resilience energy as an innate force that drives people toward self-actualisation, altruism, and harmony, which is similar to participants in this study. However, he draws attention to being unable to define the source of this energy, suggesting that it is something innate or spiritual. Also, his work is not empirically proven and suggests that resilience as a phenomenon needs to be better understood in an interdisciplinary way to achieve this (i.e. from philosophy, spirituality, biology, physics, psychology, medicine). Brown et al.'s (2017) concept review of thriving briefly discuss motivation in relation to human beings inherent drive for self-improvement and growth, yet this is not discussed in detail and lacks the link to personal resilience. Hale et al. (2019) discuss motivation in relation to trainee doctors' personal resilience using Maslow's Hierarchy model, however their article is not empirically based. This study addresses this gap in how personal motivation acts as an antecedent to thriving, vitality and energising (or draining) participants' personal resilience in the context of their NHS executive leadership roles. The perception that different motivational contexts can bring with them different experiences of stressors and varying ability to be personally resilient in relation to executive leadership roles has not been discussed within the literature in this way before and is worthy of further study.

This study has also been able to augment the body of knowledge surrounding how vitality as a subconstruct of thriving is experienced by participants in their executive leader roles. Firstly, participants describe that their perceived resilience energy can be 'topped up' and 'depleted' like a metaphorical 'battery' through engaging with personally motivating activities (e.g. connecting

with their staff, receiving/giving out positive feedback, engaging in charity work, as well as undertaking physically energising activities such as doing exercise) and demotivating activities (e.g. work stressors or things that do not align to their personal values). Secondly, participants describe a 'transferable' quality to their perceived resilience energy. When one contextual stressor is draining their perceived resilience energy, they experience that this resilience energy can be 'topped up' in other aspects of their lives through engaging with personally motivational activities, which can then be diverted toward the stressful situation. These 'topping up', 'depleting' and 'transferable' elements to their perceived resilience energy have not been discussed in the literature relating to personal resilience, thriving and vitality in this way before and offer a novel avenue for future enquiry.

These findings also contribute to the lack of identified research into the connection between personal resilience, thriving, and the vitality of successful senior leaders. Sarkar and Fletcher (2014) is the only work identified that has considered thriving and vitality of high achievers. However, whilst high achievers could be considered as a loosely similar group to participants in their role as successful NHS executive leaders, Sarkar and Fletcher do not explicitly consider this through a leadership lens. Furthermore, they clearly state that their findings do not identify vitality as a characteristic of their small sample group of high achievers. In contrast, this study has identified that participants, as arguably high achievers in the most senior leadership roles in the NHS, place great emphasis on managing their personal vitality, in how their 'resilience energy' is a core enabler to being successfully resilient in role. These findings offer a novel perspective on enabling personal resilience of senior leaders in relation to thriving and vitality, which has not been articulated in the literature in this way before, offering further avenues for future enquiry.

Findings in this study also support the body of knowledge that positions personal resilience as something that can be developed (Buckle-Henning, 2011; Fletcher and Sarkar, 2013; Southwick et al., 2014; Brooks et al., 2018). 'Development' is the second subconstruct of the concept of thriving (Spreitzer et al., 2005; Carmeli and Spreitzer, 2009; Klein et al., 2019). Development coupled with experiences of 'resilience energy' establishes that participants experience 'thriving' in relation to being personally resilient in the context of their executive leader roles.

Participants describe development as a central enabler to resiliently leading in the challenging healthcare environment. They describe experiencing this developmental quality of their personal resilience as 'layers' of diverse learning that continually build throughout their life. This enables them to grow their self-awareness, continually enhance their ability to cope and more instinctively respond to similar stressful situations in the future. However, a novel and distinguishing finding in

this study is how participants do not simply develop as a result of encountering stressors, and instead they 'actively seek out' stressors to challenge themselves and develop their personal resilience throughout their career. This quality of actively seeking out ways to develop personal resilience is not discussed in the main body of resilience literature. However, participants experiencing the concept of thriving may partially explain this aspect and why they actively develop their personal resilience in this way, as thriving requires individuals to actively develop themselves (Carmeli and Spreitzer, 2009; Klein et al., 2019).

Carver (1998) originally referred to development being part of the thriving model, and frames this as personal 'growth' arising from encountering adversity, and/or an innate need for personal mastery. Since then, it has been clarified that whilst experiencing personal resilience relies firstly on experiencing stressors or adversity, thriving does not. Thriving can be experienced as a result of adversity, or seeking out opportunity to develop (Spreitzer et al., 2005; Brown et al., 2017; Klein et al., 2019). This aligns to participant experiences of enabling their personal resilience by learning from stressful experiences, and actively seeking them out. Actively seeking out ways to develop personal resilience in this way has limited discussion in the literature. Sarkar and Fletcher's (2014) research into resilience and thriving in high achievers is the only work found to have identified similar findings to this study, however their work is limited to the perspectives of a small number of high achievers. This study has been able to link these active developmental qualities associated with thriving to enabling the personal resilience of arguably successful NHS executive leaders, augmenting the limited body of knowledge in this area as related to the fields of healthcare and leadership.

A further original finding in this study is how participants describe actively embracing ways of developing their resilience in a controlled, purposeful, and balanced way. This enables them to enter a stressful situation perceiving it as a 'challenge' to overcome and develop from, rather than as an experience to 'cope' with and get through. In their study into lifetime adversity and being resilient, Seery et al. (2010) created a model that suggests continual and moderate exposure to lifetime adversity enables individuals to develop and become more resilient throughout their lives, as opposed to experiencing too much and becoming overwhelmed, or not enough and losing the opportunity to develop their personal resilience. Findings in this this study suggest that participants are able to balance how they develop their personal resilience throughout their careers in this way. Whilst the model by Seery et al. (2010) could help to explain this, it does not discuss the active 'choice' identified by participants in this study, who seek out stressful situations as a way to develop and enable their personal resilience. There are few studies that explore why some

individuals may 'choose' to actively engage in stressful experiences to learn from them to enhance their personal resilience in this way. Ablett and Jones (2007) found that a distinguishing factor to explain why palliative care nurses appear to be more resilient than other professional group is being at ease with the choice to work in an extremely adverse environment, coupled with their passion to make a difference in caring for patients at the end of their lives. However, they do not elaborate on how or why this choice enables their sense of personal resilience. Sarkar and Fletcher (2014) found that high achievers were able to keep a sense of personal control in the knowledge that it was their personal choice to engage with the challenges they are facing, safe in the knowledge that they could equally choose to disengage at any time. Yet simply 'choosing' to enter and learn from a stressful with the knowledge you are safe to disengage from the situation at any time does not account for why participants in this study are able to learn from these experiences, rather than becoming overwhelmed by them. However, the previously discussed enabler of positive framing could also account for this. Weinstein and Ryan (2011) articulate the importance of personal perception when considering stress in relation to Self Determination Theory as the inherent and positive human tendency to move towards personal growth. They state that perceiving something as 'challenging' implies that the individual believes they have the personal resources to cope and develop from the experience, whilst perceiving it as 'stressful' does not. Brown et al. (2017) briefly discusses taking a positive perspective in relation to enabling thriving, but do not elaborate on this in relation to personal resilience. Furthermore, Weinstein and Ryan (2011) and Brown et al.'s (2017) work are limited to being discussion papers and are not empirically based. However, the original findings in this study support their assertions that entering a stressful situation framed as a developmental opportunity maintains participants motivation, enabling them to feel more energised, that the situation is more manageable, and they are therefore more able to develop their personal resilience as a result.

There is very limited research that considers thriving, resilience and actively engaging in stressful situation to learn from them in this way. Sarkar and Fletcher (2014) are an exception to this and call for further research that extends the body of knowledge into how high achievers experience thriving to actively develop their resilience. Considering the personal resilience of arguably successful NHS executive leaders, this study has augmented this limited body of knowledge and supports Sakar and Fletcher's call for further research into thriving qualities of high achievers. It also widens this discussion to the fields of leadership and healthcare by adding valuable insight into findings that support NHS executive leaders experiencing thriving qualities to actively develop

their personal resilience throughout their careers to enable them to successfully cope with the demands of leading in the highly pressurised healthcare environment.

Whilst the concept of 'thriving' frames developing the personal resilience of participants in a positive and active way, it cannot be discounted that they have all experienced unexpected and significantly adverse and traumatic events that they did not intentionally seek out. Yet, when reflecting on these unexpectedly adverse life experiences, whilst traumatic at the time, they all express these experiences as something that they have learnt from, which enabled them to feel more resilient as a result. This study presented a unique opportunity that demonstrated this whilst exploring one participant's traumatic lived experience between interviews (see Diane's experience, Chapter 4 - Part 1). Initially expressing a very current and personal trauma that the participant was facing in her NHS executive role during her first interview, she was later able to reflect on this traumatic experience as something that she had learnt from in her subsequent interview. This finding afforded a unique opportunity that demonstrates how participants as NHS executive leaders can deal with what was perceived as extreme trauma related to their NHS executive leader role, and how they can then reflexively reframe this into a learning opportunity at a later time.

When considering participants ability to develop following these severely adverse, traumatic, and unexpected life events, Richardson's (2002) resiliency model could be applied. The model suggests that following encountering a stressor and period of disruption, individuals can respond by partially recovering with loss or dysfunction, return to their original state, or reintegrate resiliently by growing their resilient qualities. He suggests that resilient individuals will actively choose to grow from exposure to stressors, adversity, or exposure to challenging new opportunities. Whilst he does not elaborate on how this choice to grow from the experience is enabled and his work is not empirically based, findings in this study supports his assertion and offers empirical examples of how participants engage in this active choice to develop their personal resilience.

Similar to Richardson's model, the concept of 'posttraumatic growth' has been linked to individuals who exhibit resilient qualities when faced with extremely traumatic events, including working in adverse environments such as healthcare and other public services (Brooks et al., 2018). Posttraumatic growth is described as similar to personal resilience in terms of recovering from trauma, however, is distinguished by focusing on the positive and developmental aspects that may occur for individuals as a result, such as the sense of accomplishment, increased confidence, developing new competencies and renewed sense of purpose (Ramos and Leal, 2013; Brooks et al., 2018). Posttraumatic growth is seen as related to, but distinct from the concept of thriving, as

posttraumatic growth follows an adverse event, yet thriving does not depend on the occurrence of a stressful or negative encounter (Brown et al., 2017). Whilst posttraumatic growth as a concept can explain how participants develop from unexpected trauma, it does not explain what enables them to turn this trauma into a learning experience. The findings in this study that demonstrate how participants are able to positively frame stressful situations could provide insight into how they are able to achieve this and could also account for their ability to retrospectively learn from extremely traumatic experiences.

This study has been able to link and augment the concepts of thriving and posttraumatic growth and position these as enabling concepts for participants in managing their personal resilience as NHS executive leaders, for both experiences of actively seeking out and unexpectedly stressful situations. Sarkar and Fletcher (2014) state that the majority of personal resilience literature has sampled individuals who have survived traumatic events outside of their control, rather than exploring the personal resilience of high achievers, such as the participants in this study. This study has addressed this identified lack of literature in this area by considering the personal resilience and thriving qualities of arguably successful individuals, whilst also offering a fresh perspective on how these enablers apply to NHS executive leaders. It has also opened future avenues of enquiry to further investigate how thriving and concepts of development, resilience energy, motivation, and positive framing discussed above enable the personal resilience of leaders, healthcare professionals, and other understudied populations more widely.

5.3.4 Summary

In summary, this section discusses the enablers of participants' personal resilience that support them in being resilient when faced with stressful situations in their NHS executive leader roles. These enablers include intentionally developing interconnected and supportive resilience relationships, actively framing their experience through a positive lens, and developing their personal resilience throughout their career by thriving from experience, where thriving conceptually relates to a combination of being energised from their personal motivators and enabled through ongoing personal development.

Whilst social support is not a new phenomenon in relation to personal resilience, this study offers a novel layer to how this social support is intentionally developed and experienced by participants as a multi-directional and interconnected way. It also augments the limited body of knowledge surrounding the impact and application of positive framing upon not only participants' personal

resilience in their leadership roles, but also in enabling the resilience of the people they lead. It also uniquely establishes that participants experience the concept of thriving as a core enabler to their personal resilience, augmenting the limited body of knowledge that connects thriving to leadership, resilience and healthcare and offering new avenues for future enquiry.

5.3.5 Reflective account: Continuing the interpretation of findings

When orientating my findings in relation to existing personal resilience literature, I noticed how the body of literature relating to the healthcare workforce and lesser body relating to leaders was conversant with 'enablers' of personal resilience as a practical way to support others to enhance their personal resilience. As an insider-researcher and practitioner in NHS leadership development, and conscious that quality IPA research needs to demonstrate impact and importance (Yardley, 2000; Smith et al., 2009) I considered how aligning my findings in a similar way would increase the impact of my work and further support my enhanced interpretation toward my findings in relation to the existing body of knowledge. When re-engaging with the literature, I identified that my thematic findings relating to developing resilience (Chapter 4 - Theme 2) and moving forwards (Chapter 4 - Theme 3) were connected through this concept of 'enabling personal resilience' within the literature. This also aligned with my practical need to address research question 4 (developing and maintaining resilience) and led me to realigning my findings toward the evolved theme of 'enabling personal resilience' within this chapter.

My themes of interconnected relationships (Chapter 4 - Theme 3.1) and positive framing (Chapter 4 - Theme 3.3) received some level of engagement within the existing literature as enables for personal resilience, and therefore it made sense to keep these as sub-themes that related to this new emerging theme of enabling personal resilience. However, whilst reviewing the literature relating to my theme of developing personal resilience (Chapter 4 - Theme 2) and how much of this literature was in relation to survivors of trauma, I was struck by how participants did not perceive themselves as 'survivors' of trauma and that their experiences could not be interpreted as such. By re-visiting and reflecting on the literature that was not aligned to this 'survivor lens', this led me toward the limited body of literature that linked the concept of 'thriving' in relation to personal resilience (Carver, 1998; Carmeli and Spreitzer, 2009; Klein et al., 2019). I realised that 'development' and 'vitality' (i.e. energy) as subconstructs of thriving were in alignment with

how my participants experienced personal resilience, and therefore that they experience thriving as a core enabler to their personal resilience in their NHS executive leader roles. This enabled me to re-work and amalgamate my original themes of developing personal resilience (Chapter 4 - Theme 2) and motivation and momentum (Chapter 4 - Theme 3.5) together under the concept of 'thriving' as part of my continued and enhanced interpretation of findings in relation to the existing literature within this discussion chapter.

5.4 Summary

This chapter has presented and discussed three evolved themes and subthemes that bring together the learning from within this study to explore the personal resilience of NHS executive leaders, which is summarised in Figure 6 as an evolved thematic map. It has discussed and demonstrated how findings from participant-focused interpretations within Chapter 4 have evolved by being further interpreted in relation to existing knowledge within the literature and by answering the research questions to address the overall aim of this study, which is summarised in Table 8. This demonstrates how the interpretive phenomenological analysis process naturally continues whilst orientating findings in relation to existing knowledge and when reflexively answering the original research questions (Smith et al., 2009; Van Manen, 2014; Vagle, 2014).

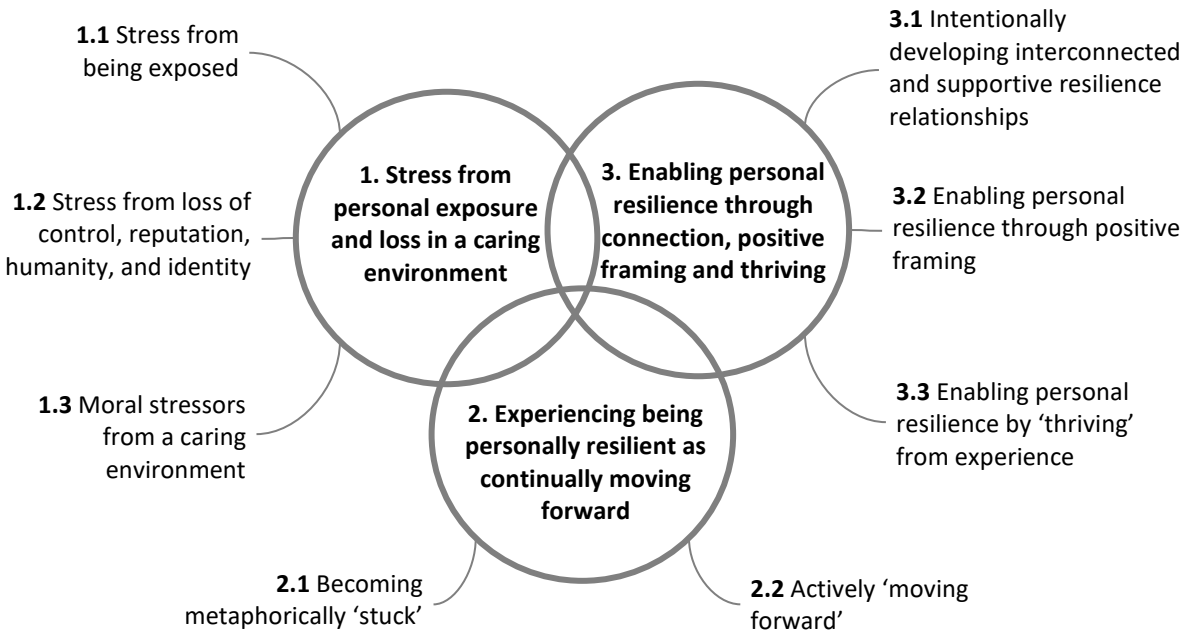

Figure 6: Evolved thematic map in relation to the existing body of knowledge

The following chapter will build on this by considering this study's overall contribution to knowledge and summarise this with regard to application in practice, elaborate on potential avenues for further enquiry, and comment on the overall strengths and limitations of the study.

Table 8: Summary of how themes in Chapter 5 - Discussion relate to answering the research questions and map to the initial interpretation of findings from Chapter 4									
	Mapping to research questions						Mapping to thematic findings from Chapter 4		
Evolved thematic areas within this discussion chapter	**Question 1** (Experiencing stress)	**Question 2** (Defining resilience)	**Question 3** (Being vs. not being resilient)	**Question 4** (Develop and maintain	**Question 5** (Unique to executive leader role)	**Question 6** (Impact of care-based profession)	**Original Theme 1:** Being Exposed	**Original Theme 2:** Developing resilience	**Original theme 3:** Moving forward
5.1. Stress from personal exposure and loss in a caring environment									
5.1.1. Stress from being exposed	●				●	●	(1.1) (1.5)		
5.1.2 Stress from loss	●				●	●	(1.2) (1.3) (1.4)		
5.1.3 Moral stressors from a caring environment	●				●	●	(1.3) (1.4)		
5.2. Experiencing being resilient as continually moving forward									
5.2.1 Becoming metaphorically stuck		●	●		●	●	(1.6)		
5.2.2 Actively moving forward		●	●		●	●			(3.2) (3.4)
5.3. Enabling personal resilience through connection, positive framing and thriving									
5.3.1 Intentionally developing interconnected and supportive resilience relationships				●	●	●			(3.1)
5.3.2 Enabling personal resilience through positive framing				●	●	●			(3.3)
5.3.3 Enabling personal resilience by 'thriving' from experience				●	●	●		(2.1) (2.2) (2.3) (2.4) (2.5)	(3.5)

Chapter 6: Contribution

6.0 Introduction

This chapter considers the overall contribution and potential impact of this study by:

- Summarising the original contribution to knowledge
- Considering contribution to practice
- Examining the strengths and limitations, and
- Identifying future avenues for enquiry

6.1 Contribution to knowledge

This study has applied Interpretive Phenomenological Analysis (IPA) to address the identified gap in empirical knowledge surrounding the personal resilience of NHS executive leaders. It has achieved this by interpreting and documenting how a sample of the NHS executive leader population experience stressors in the context of their leadership roles, experience personal resilience in response, and how they enable their personal resilience to remain successful in their demanding healthcare leadership positions.

The original contribution to knowledge derived from this study is presented in the form of the original thematic map that interprets what personal resilience is to the participant group of NHS executive leaders, supported by rich and textured participant experiences and interpretive analysis (see Chapter 4 - Findings - Figure 2) in addition to a final and evolved thematic map following continued interpretation whilst orientating these findings in relation to the existing body of knowledge (Figure 6). This is the first study to have explored the shared lived experience of personal resilience in relation to all NHS board level executive leadership positions (i.e. NHS executive directors of nursing, medicine, human resources, finance and operations and the chief executive). Furthermore, this study has contributed toward the lack of empirical knowledge that considers personal resilience from the perspectives of a hard to access elite group (Lancaster, 2017) of arguably successfully resilient individuals, rather than from a deficit perspective which has been cited as the focus of the majority of resilience related literature (Bonanno, 2004; Sarkar and Fletcher, 2014).

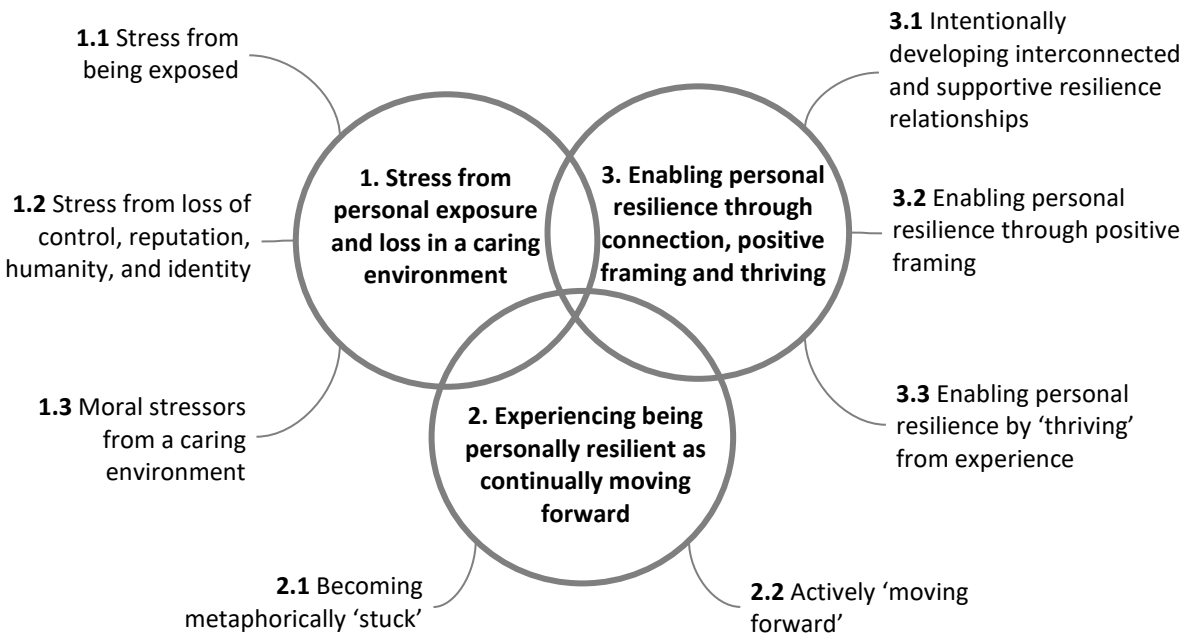

Figure 6: Evolved thematic map in relation to the existing body of knowledge and research questions

Whilst some of the findings from this study align to and augment the body of existing knowledge relating to personal resilience and stress for these leaders, it has also been possible to identify a more nuanced and original contribution to knowledge. These key findings are summarised as follows:

- **Continually and actively moving forward**: Participants experience personal resilience as something active, continual, and always there in the context of their NHS executive leader roles. This challenges the existing body of resilience theory that has positioned personal resilience as a response to stressors (Gillespie et al., 2007; Fletcher and Sarkar, 2013; Southwick et al., 2014). Findings have also redefined how the well-established resilience/stress response of 'fight, flight, freeze' (Webster et al., 2016; Seng, 2019) is experienced by participants in a continual and active way. Participants continually 'freeze' to gain perspective and 'horizon scan' for potential future stressors, taking a broader and active perspective to mitigate these stressors before they happen, for themselves and their organisation. When encountering unexpected stressors, participants also utilise 'freeze' as a way to rapidly gain perspective and generate ideas for how best to respond, to increase their likelihood of moving forward in a resilient way. They also enact 'fight' or 'flight' in a

purposeful and adaptive way, driven by their personal values, rather than a primitive survival reaction. This study has also challenged the traditional order of 'fight, flight or freeze', suggesting rearrangement to 'freeze, fight, flight' to account for the active quality of continually gaining perspective and taking action to keep moving forward. These findings that orientate personal resilience as active and continual offer original insight into experiences of personal resilience for this leadership community that augments, yet also diverges from established theory and definitions.

- **Becoming stuck**: This study offers an original insight into how failing to be personally resilient is experienced from the perspective of senior leaders as an understudied group (Bonanno, 2004; Sarkar and Fletcher, 2014; Forster and Duchek, 2017) and hard-to-access audience (Lancaster, 2017). The metaphor of 'becoming stuck' was developed in this study to explain how participants perceive being unable to be personally resilient when facing traumatic events. Denial of the stressful situation has also been uniquely linked to participants perceptions of the main contributor to becoming stuck in their executive roles, which has not been discussed in the literature in this way before. It has also been possible to explore perceptions toward Posttraumatic Stress Disorder (PTSD) from the perspectives of these successfully resilient NHS leaders, some of which also hold clinical perspectives, and how they have perceived PTSD in others, but not experienced it personally.

- **Stress from exposure**: This study has identified that personal 'exposure' is a unique stressor that participants experience in their roles as NHS executive leaders. This level of exposure differentiates participants from other healthcare leadership roles due to their status and accountability as the most senior organisational leaders. It brings 'celebrity' like qualities arising from their high level of visibility in the public, media and regulatory-body eyes, and 'heroic' like qualities associated with their strong people-focused personal values and accountable leadership role in looking after their employees and patients. Exposure has not been documented as a stressor facing NHS executive leaders in this way before and offers new understanding toward stress for this senior leader community.

- **Stress from loss**: Various forms of personal loss relating to their roles as NHS executive leaders result in unique stressors for participants. Loss has not been discussed in the literature in this way before and offers a unique perspective of the complex interrelated stressors facing participants in their executive leader roles. Loss of 'control' arises from being detached from the day to day running of their organisation. Loss of 'reputation' may arise if something goes wrong, for which they are personally held accountable for as the

most senior leaders in a highly regulated NHS environment. Whilst findings relating to loss of control and reputation augments the limited engagement that this has received within the literature relating to NHS executive leader resilience (Kelly et al., 2016) this study has identified more complex and nuanced forms of loss. Loss of 'humanity' arises from the complex balance between being perceived as the resilient corporate figureheads of their organisation, conflicted against being equally if not more vulnerable as the most senior organisational leaders. Loss of 'identity' arises from how their personal identity becomes entwined with that of the corporate identity of their organisation in their NHS executive leader roles. This adds a unique and complex layer of stress for participants in their executive leader roles, as if the organisation is facing stressors, these stressors also impact them personally. This has not been documented within the literature before and offers a new understanding for how NHS executive leaders experience stress.

- **Moral stressors**: Participants experience stressors arising from balancing what they morally believe is the right thing to do for people, compared to an established course of organisational action in an NHS corporate and bureaucratic environment. This is the first study to have considered how moral stressors impact NHS executive leadership roles. Participants experience their roles as highly morals driven in delivering patient care, which is compounded by having to deal with the moral choices and actions of their entire organisational workforce, which as the most senior organisational leaders they can only influence and not control. This is further compounded by being driven by their own caring and people-focused personal values, which they perceive is forgotten about as their identity and humanity becomes entwined with that of their corporate organisation's identity.

- **CEO stressors**: This study has identified that the Chief Executive Officer, as those holding ultimate accountability for their organisation, are uniquely impacted by these various forms of loss including control, perceived humanity, potentially reputation and identity. The complex combination of these stressors combined with having the most exposing role as figurehead for their organisation form a perceived asymmetrical relationship between CEOs personal resilience and the resilience of their organisation. This has not been documented in the literature before and offers new insight into the complex stressors facing NHS CEOs and how they are potentially more adversely impacted.

- **Enabling interconnected relationships**: Whilst social support is seen as an established enabler to personal resilience (Southwick and Charney, 2012) and leaders' personal

resilience (Carmeli et al., 2013) this study has identified the more complex, values-driven and interconnected relationships that participants intentionally develop to enable them in their executive leader roles. Furthermore, whilst the literature documents the single direction of these relationships in enabling resilience including leader to follower (Gaddy et al., 2017) or follower to leader (Teo et al., 2017) this is the first study to identify the complex multi-directional nature of these relationships in enabling the personal resilience of participants in their NHS executive leader roles.

- **Positive framing**: This study extends the limited body of knowledge that has considered positive framing as an enabler to leaders' personal resilience. It considers how participants demonstrate psychological capital (Luthans et al., 2006) and enact the broaden and build theory of positive emotion (Fredrickson et al., 2003; Cohn and Fredrickson et al., 2009) through the perspective of their leadership roles, which has not been discussed in the literature in this way before. Furthermore, this study offers a new perspective into how participants use positive framing in their executive leader roles to enable their own personal resilience, yet also pass this framing onto their followers to enable their personal resilience in return, which has not been documented before.
- **Thriving, motivational resilience energy, and development**: This study has identified that participants' personal resilience is enabled from being energised by personal motivators and positively framing stressors as a development opportunity. This uniquely identifies how participants experience the concept of thriving (Carver, 1998; Carmeli and Spreitzer, 2009) as an enabler to their personal resilience as NHS executive leaders. This study has augmented knowledge surrounding the concept of vitality as a subconstruct of thriving, by linking participants' personal motivators aligned to their personal values as an antecedent to developing a perceived 'resilience energy' (i.e. vitality) in their NHS executive leader roles. Furthermore, the study has demonstrated a transferable quality to this resilience energy which has not been discussed in resilience and thriving literature in this way before, where motivational activities in one aspect of participants' lives can be transferred toward stressful situations in another. Findings in this study also support the body of knowledge that positions personal resilience as something that can be developed (Fletcher and Sarkar, 2013; Brooks et al., 2018). It has identified that where participants encounter unexpected stressors, they demonstrate posttraumatic growth (Ramos and Leal, 2013; Brooks et al., 2018) to positively develop from traumatic experiences, which has not been identified in the context of senior leaders before. This study has also linked the use of positive framing

of stressful situations as an enabler to these thriving and posttraumatic growth qualities. Furthermore, an original finding in this study is that participants not only develop their personal resilience in response to stress, they also actively seek out challenging and stressful situations in a regulated way throughout their careers, in order to develop their personal resilience. This active developmental quality has afforded them the perceived personal resilience to be successful in their demanding NHS executive leader roles. This offers new insight into how these successful senior leaders experience resilience as something that is actively and continually developed throughout their careers, affording them the resilient qualities to successfully lead in demanding NHS executive leader roles.

6.2 Contribution to practice

This study has been able to augment the limited body of knowledge that describes the generic lived experiences of NHS executive leaders (Janjua, 2014; Rose, 2015; Timmins, 2016) and address the gap in knowledge surrounding how they experience personal resilience in their practice as leaders. In addressing this identified gap in knowledge and by the researcher taking an 'insider-researcher' perspective (Costley et al., 2013) this study has been able to consider ways in which leaders of national strategic NHS bodies like the NHS England and Improvement and the NHS Leadership Academy can better understand and better enable the personal resilience of its executive leader community. It has also identified ways in which NHS leadership and talent development professionals, such as human resources and people development professionals, can better develop the personal resilience of senior NHS leaders. The richly textured accounts and unique insight into what personal resilience is for participants can also support the development of future executive leader talent pipelines, seen as critical to developing future NHS leaders (Smith, 2015; Rose, 2015; NHS Improvement, 2016; NHS England and Improvement, 2020). This study also offers those aspiring to these senior executive leadership positions a perspective on the challenges and potential development areas required in order to be successful in the role of an NHS executive leader. Finally, findings from this study also identify the potential for researchers and practitioners in leadership development to craft and test a new conceptual model for how NHS executive leaders experience personal resilience in practice.

- **National strategic NHS body leaders and policy makers:** This study has identified that being exposed and various forms of loss form unique stressors to these most senior NHS executive leaders. With this knowledge, it is possible to consider strategic ways to better support this senior leadership community. For example, the unique level of personal exposure likened to that of 'celebrity' illustrates the immense level of personal vulnerability that these NHS executive leaders may have to manage as part of their demanding roles. Policy makers within national strategic NHS regulatory bodies such as NHS England and Improvement can use this insight to consider ways to mitigate this level of exposure and better support this community to manage their healthcare organisations. The various aspects of loss identified as stressors for participants also offer ways to better understand and support the NHS executive leader community. Whilst loss of control is a more established stressor associated with being an executive healthcare leader (Kelly et al., 2016) loss of reputation, sense of humanity and personal identity, compounded by the moral stressors identified from leading within a care environment are complex psychological stressors that have not been associated with the NHS executive leaders' roles in this way before. By understanding these stressors, better support can be established by leaders of national bodies such as NHS England and Improvement and the NHS Leadership Academy for existing executive healthcare leaders, and better ways to prepare those who are aspiring into these roles can be developed. For example, by nationally offering therapeutic support such as counselling to deal with these psychological stressors, to complement the more established support mechanisms of coaching and mentoring as described by participants and identified in the literature (Kelly et al., 2016). To encourage access to this support, sensitive consideration may be required to break down the identified perceptions that NHS executive leaders are 'detached from humanity', seen as 'celebrity' and 'invulnerable heroes', for example with an accompanying message that 'leaders need support too'.

  Recent national NHS strategy identifies the need to develop compassionate leadership qualities across all levels of NHS leadership and sets out ambitions of utilising global best practice in leadership development to achieve this (NHS England and Improvement, 2020). Whilst this strategy focuses on ensuring senior leaders present compassionate behaviours to their workforce, this study also illustrates that it is important for national NHS strategic body policy makers to remember that its most senior NHS executive leaders are still vulnerable human beings and require compassion too. Participants in this study

demonstrated strong, people-focused, altruistic, and compassionate characteristics and articulated how these are important in enabling their own personal resilience, and how this supports them in enabling the resilience of others. These experiences may help build ways of passing on resilience qualities on to future NHS leaders and advance how NHS strategists, policy makers and leadership development practitioners view enabling compassionate leadership through the lens of executive leaders.

- **NHS leadership and talent development practitioners:** This study supports the view that personal resilience can be developed (Gillespie et al., 2007; Grafton et al., 2010) both in response to adverse experiences and in a controlled way throughout a leader's career. This finding encourages NHS people development and human resources practitioners to find ways of developing the resilience of the executive and aspiring executive leadership community. This study also endorses the view that personal resilience is considered to be subjective, contextual and dynamic phenomenon (McAllister and McKinnon, 2009; Fletcher and Sarkar, 2013; Southwick et al., 2014) and therefore the personal resilience challenges that NHS executive leaders experience need to be contextually and personally understood if they are to be effectively supported in practice. Combining this with participants preference for developing their personal resilience by pursuing practical, vocational, and on-the-job stressful experiences, may mean that traditional talent and personal development courses may not be the most appropriate option for developing the personal resilience of these very senior leaders. Instead, a combination of personal and peer development interventions that these individuals can selectively engage with, may be more suitable. For example; coaching offers the possibility for these leaders to work through and learn from on-the-job contextual work-stressors; therapeutic interventions such as counselling or psychotherapy enables these leaders to work through the subjective elements of how they contextually respond to complex stressors, learn from these and enhance their self-understanding and sense of personal resilience; mentoring offers the opportunity for these leaders to learn from more experienced individuals who have faced similar contextual stressors; group development workshops offers ways for these leaders to learn from the diversity of each other's contextual and subjective experiences; and combining the above with stretch assignments will offer 'on-the-job' learning in a safer and development-focused environment.

  NHS strategy states a lack of adequate supply of future NHS executive leaders and the challenges in developing these executive leader talent pipelines (NHS Improvement, 2016).

The original finding in this study where participants actively engage with stressful situations to learn from these throughout their careers and to prepare them for the challenges of senior leadership roles identifies the need for the NHS to find active ways of developing all parts of its leadership talent pipelines if it wishes to ensure adequate supply of future executive leaders. Whilst there is an existing NHS graduate manager trainee scheme for entry points into leadership talent pipelines (Rose, 2015; Smith, 2015; NHS Improvement, 2016) there are currently no well-established practical vocational development programmes offered within the NHS to develop future very senior and executive leaders. To address this gap in executive leader talent, the findings from this study suggest the need to consider a similar approach to vocational leadership development at all levels of NHS leadership talent pipelines. The original findings in this study identifying thriving qualities (Carver, 1998; Carmeli and Spreitzer, 2009) as active ways to develop resilience, and posttraumatic growth (Ramos and Leal, 2013; Brooks et al., 2018) when recovering from adversity for participants as executive leaders also offers potential models that can be applied to NHS leadership development practice to support this.

- **Enabling NHS senior and aspiring executive leaders:** Sharing findings from this study surrounding the importance of continually taking action as a core aspect of personal resilience and developing knowledge of and personal application in thriving (Carver, 1998; Carmeli and Spreitzer, 2009) could bring learning opportunities for NHS senior leaders to compare and contrast personal experiences. Enabling these individuals to become explicitly aware of their personal motivators as linked to their personal values and how this links to generating a sense of 'resilience energy' described in this study may also be of benefit in the development of these leaders to actively sustain their resilience when facing adverse situations. Furthermore, exploring ways to consider positive framing as identified as an enabler of personal resilience for participants, and encouraging the incorporation of a positive psychological and 'strengths based' approach (Luthans et al., 2006; Cohn, Fredrickson et al., 2009) as associated with these enablers, may further aid these developmental interventions. The original finding in this study in how participants personal resilience is enabled through a complexity of interconnected resilience relationships also suggests that these senior leaders may benefit from both a mix of peer support, ways to increase the diversity of their support networks, and also opportunities to learn from a diversity of perspectives as part of developing their personal resilience.

The finding in this study that defines personal resilience for participants as continually taking action and avoiding metaphorically 'becoming stuck' (i.e. inaction) and how the stress response is experienced in a different way to how it is described in the literature and is more connected to their personal values and motivators also adds practical insight in how other senior leaders may successfully consider approaching stressful situations. Furthermore, there is potential learning for aspiring senior and executive leader talent from the finding in this study that places personal resilience as something continually active to keep them moving forward, rather than waiting to respond to a stressor. Aspiring executive leaders may therefore benefit from developing their ability to consider their personal resilience as something constantly there, by actively seeking out and mitigating potential future stressors, as opposed to dealing with and learning from stressful situations in a reactive way.

- **Developing conceptual models for how NHS leaders experience personal resilience in practice:** Whilst this study does not seek to develop a universal model for NHS executive leader personal resilience, there is potential for researchers and practitioners in personal resilience and leadership development to use the findings in this study to inform future research and application in practice. Findings discussed above may lend themselves toward the development of an initial conceptual model that documents personal resilience for NHS senior leaders, which could be tested. For example, an interlinked model of 'assess, act, sustain and develop' could be formed by considering the process and order for how participants experience resilience within findings from this study, where:
    - '**Assess**' brings together the active elements as identified in this study, such as seeking out and mitigating stressors, gaining perspective, and framing the stressor in a positive and opportunistic way when encountering it for the first time.
    - '**Act**' articulates the action-orientated aspect within findings, relating to choosing the most appropriate response based on past learning, bringing in wider social support and adapting oneself to the situation.
    - '**Sustain**' describes the identified concept of transferable 'resilience energy' and personal motivational factors to enable individuals to perceive that they are continually moving the stressful situation forward.

- '**Develop**' articulates the findings relating to how these executive leaders actively develop their personal resilience throughout their careers by seeking out and learning from stressful experiences through a positive frame.

6.3 Strengths and limitations

Interpretive Phenomenological Analysis (IPA) was chosen as a suitable methodology for this study due to the lack of existing knowledge surrounding NHS executive leader personal resilience, the need to inductively and intuitively explore this phenomenon, and also the need for a methodology that enabled sensitivity when exploring personal resilience with participants in the context of their leadership positions. Whilst this study achieved its aim of exploring personal resilience with the sample group of NHS executive leaders and identified potential future avenues for enquiry, there are limitations associated with this study arising from this choice of methodology, participant sample group, the nature of the research topic, and being an 'insider-researcher' (Costley et al., 2013).

A strength of this study is its ability to consider and contrast perspectives from a homogenous sample group representing all NHS executive leader roles (i.e. CEO, nurse, medical, human resources, finance and operational NHS executive directors). However, this also posed several limitations. The limited sample size meant that it was not possible to easily differentiate how the experiences of different professional backgrounds have influenced participants' personal resilience. Furthermore, having the CEO as the most senior accountable leader and manager for the other executive leader positions in the study brings with it two hierarchical levels of perspectives. This was accounted for by seeking to understand the shared lived experiences of participants and by considering any differences between roles. However, future studies could consider separating these two hierarchical levels of executive leader perceptions, and/or differences between professional background.

A strength of this study is how it outlines methods for recruitment and presents these in full, to aid transparency. However, taking the approach where participants self-select to take part has potential limitations. For example, this poses questions surrounding the perspectives of those who did not engage and if their apprehension to engage gives them a naturally different perspective on personal resilience in their NHS executive leader roles. Whilst this approach to recruitment is unavoidable in the context of this study, the predisposition to participate in the research study

could also bring with it a shared bias. For example, being more interested in the subject, having a personal motivation to share particular perspectives, or being naturally interested in developing others and how the impact of this study will support other people. This must be considered when interpreting findings. For example, this may explain the emphasis that participants placed on developing themselves and others as identified within the findings of this study.

Access to participants is a further limitation of this study. Participants in their senior and highly pressurised NHS executive leader roles are considered an elite group (Lancaster, 2017) meaning that adequate time for interviews was a challenge. However, it was possible to engage with two interviews with each participant, which enabled consideration toward temporal aspects of the phenomenon and to augment the researcher's interpretations. Whilst the majority of interviews were between one and a half to two hours long, two interviews were slightly rushed and lasted less than this due to the demanding nature of participant's role, which unavoidably meant that certain lines of enquiry could not be explored in as much detail.

Taking an 'insider-researcher' perspective (Costley et al., 2013) where the researcher is also an NHS practitioner gave this study strength by enabling easier access to the participant sample group and assisted the researcher in their contextual interpretation of findings. However, this also brought potential challenges. For example, being perceived as less impartial and/or a threat by participants could have impacted participants willingness to share their experiences. Exploring the sensitive topic of personal resilience with participants, who are considered an elite audience (Lancaster, 2017) also meant that they were required to share stressful past experiences. Whilst the methodology, ethical considerations, and researcher's sensitivity to the topic accounted for this, these factors may have impacted participants ability to share their lived experience by holding back or avoiding certain lines of enquiry. Findings arguably demonstrate that participants were able to share very sensitive personal accounts, however it is unknown the extent of how these personal accounts truly represent the entirety of participants perceptions toward the phenomenon. Furthermore, IPA as the method and procedures for this study acknowledges the influence of the researcher's professional and personal lived experience throughout the research process (Smith et al., 2009). It is therefore important to acknowledge that a different researcher will likely have interpreted different aspects of the phenomenon and developed a different analysis.

6.4 Future lines of enquiry

Generating future avenues for enquiry is seen as a good outcome of quality IPA research (Smith et al., 2009). Whilst it is recommended that all themes within this study offer potential avenues for further enquiry, through consideration of findings in relation to the existing body of personal resilience related knowledge and with thought toward the limitations of this study, the following lines of future enquiry are proposed.

Firstly, the following lines of enquiry are proposed in relation to the sample group:

- **Widening the sample group**: There is potential for gathering and interpreting data from a wider audience of NHS executive leaders with a view to developing more generalisable findings. This study also focused on NHS executive leaders and therefore did not seek the views of all NHS board-level leadership roles such as Non-Executive Directors and Chairs. Replicating the study for this related population of senior NHS leaders will enable comparison of experiences of personal resilience across all board level senior NHS leadership roles.
- **Broader experiences of personal resilience from the perspectives of other successful leaders and similar individuals**: Whilst this study has helped to address a lack of knowledge surrounding personal resilience from the perspectives of arguably successful individuals (Bonanno, 2004; Sarkar and Fletcher, 2014) there is still a gap in knowledge surrounding personal resilience from a strengths-based perspective of subjectively successful individuals. Future studies could replicate the arguably successful methodology outlined within this study to explore personal resilience for non-NHS executive leaders or other equivalent leadership roles in different contexts. This will enable comparison of personal resilience from arguably successful leaders through meta-analysis, which may establish a definition of personal resilience from the perspective of subjectively successful leaders/individuals. This may also enable future comparisons of resilience between deficit (i.e. from the perspective of adversity or survivors of trauma) and strengths-based (i.e. demonstrated continued successful resilience) perspectives, as an identified gap in the current knowledge.

Secondly, the following lines of enquiry are proposed when considering the original findings in this study and related gaps in knowledge that were identified when comparing these to the existing literature:

- **Celebrity-like exposure, loss of identity, and perceived humanity of senior leaders**: The finding that 'exposure' is the most significant stressor for participants in relation to their executive role, coupled with perceptions that this is likened to that of 'celebrity' or 'heroes' has not been documented in the personal resilience literature in this way before. The related finding that this level of exposure impacts participants perception of not being seen as a 'human being' and how their identity as executive leaders it is entwined with the resilience of their organisation have also not been considered in the literature relating to the resilience of executive leaders. These offer new lines of enquiry that could be explored with a broader senior and executive leader audience in different contexts such as other public sector, and private sector organisations. Whilst it was also out of scope to consider literature that examines 'celebrity', a further line of enquiry could be to compare the similarities and differences between the personal resilience of celebrities and that of senior leaders more broadly.
- **Being 'stuck', denial, trauma and resilience**: This study identified participants perceived link between denial, trauma and Posttraumatic Stress Disorder (PTSD). Denial has not been identified in the literature as a contributing factor that leads to senior leaders failing to be resilient and offers a future avenue for enquiry in wider leadership populations. The lack of literature that relates PTSD to arguably successful leaders may also be worthy of further study to understand if PTSD is experienced by leaders and/or if the qualities of the wider senior executive leader population act as factors to mitigate experiencing PTSD. The metaphor of 'becoming stuck' that was uniquely developed in this study to articulate participant perceptions of failing to be resilient could also be used as a future avenue for enquiry, for example in exploring wider populations experiences of metaphorically 'becoming stuck', the causes of this, and the enablers to become 'unstuck'.
- **Active resilience**: In contrast to the majority of literature placing personal resilience as a response, this study identified that resilience is something that is constant and always there, and that taking action is a continually active part of participants personal resilience as NHS executive leaders. This identified active quality of their personal resilience, as opposed to it being reactive, is worthy of further study. It may be possible to consider if this active resilient quality is associated with wider leadership populations, and if this could be a unique and differentiating quality that enables the personal resilience of successful leaders more broadly.

- **Re-evaluating fight, flight, and freeze for leaders**: This study has challenged the traditional perspective of the 'fight, flight, freeze' response to stressors (Webster et al., 2016; Seng, 2019) by taking a 'strengths-based' perspective on the resilience response from arguably successful leaders, as opposed to the majority of literature considering stress and resilience from a deficit perspective (Bonanno, 2004; Sarkar and Fletcher, 2014). This identifies a gap in knowledge and avenue for future enquiry that re-considers the established stress response in the context of arguably successfully resilient leaders.
- **Perspective, positive framing, and control**: This study identified that participants gain a sense of control of stressful situations from being able to gain perspective, seek opportunity from stressors and frame the stressful situation in a positive way. There is a gap in literature that considers these combined enablers for leaders and is worthy of further investigation in wider populations.
- **Complexities of multi-directional social support**: This study identified a gap in knowledge relating to how social support is discussed as a one-directional way in relation to the resilience of leaders in the literature (i.e. leader to follower / follower to leader). Findings in this study augment the documented view of social support in personal resilience by highlighting complex multi-directional enabling aspects for participants as leaders, including the concept of 'banking resilience', which is worthy of further study in wider leadership populations.
- **Thriving in relation to development and resilience**: Whilst this study identified that posttraumatic growth may account for developing resilience as a reaction to experiences of unexpected trauma and adversity (Brooks et al., 2018) this study also identified that participants actively and purposefully seek out stressful situations throughout their careers with the intention of developing from them as an enabler to being successfully resilient in their executive leader roles. Actively seeking out stressful situations has not been discussed as an enabler of leaders' personal resilience in this way before and is worthy of further study in relation to it being a distinct enabling factor for this community in relation to wider populations. This study was able to link the concept of thriving (Carver, 1998; Carmeli and Spreitzer, 2009) and its subconstruct of development to potentially account for this. However, there is a lack of literature that considers thriving in relation to leadership and personal resilience more broadly, which is also worthy of further study.
- **Thriving in relation to vitality ('resilience energy') motivation and personal values**: The metaphor of 'resilience energy', as related to the subconstruct of 'vitality' in the concept

of thriving, was developed in this study to describe how participants experience personal resilience as moving forward and that this perceived 'resilience energy' enables them to achieve this. This has not been discussed in the literature in this way before. This opens new lines of enquiry to consider findings relating this perceived 'resilience energy' including the identified links to personal motivational factors/models, how this energy can be 'topped up' or 'depleted', and the transferable qualities of this energy between life scenarios and stressors. This study has also identified a gap in the knowledge surrounding the findings of how personal values and motivational factors more broadly link to enabling the personal resilience of participants in their NHS executive leader roles, which is worthy of further exploration both for NHS leaders and the wider leadership community.

- **Impact of the pandemic:** At the time of publishing this study, the COVID-19 global pandemic arose. This placed great strain on the personal resilience of the NHS workforce and NHS executive leaders to manage resultant ongoing adversity, on a scale that has never been experienced before (McLellan, 2021). Whilst the COVID-19 pandemic is outside of the scope and findings in this study, it is recommended that a future line of enquiry should be to re-run this study, with a view to exploring how the perceptions of personal resilience have changed for NHS executive leaders as a result of leading throughout this global pandemic.

6.5 Summary

This study aimed to explore the personal resilience of NHS executive leaders, having identified the need for these very senior leaders to be personally resilient in practice, yet having also identified a gap within the empirical body of knowledge that could define what this personal resilience is, or how to develop it for this community. Applying Interpretive Phenomenological Analysis, this study has provided a detailed picture into how a small group of NHS executive leaders experience personal resilience. It has addressed the identified gap within the body of knowledge, whilst also offering insights that may offer ways of developing the personal resilience of these NHS leaders in practice.

The study found that personal exposure, forms of loss and moral issues form the basis of stressors for this community, that they experience personal resilience as a sense of 'moving forward', and that they develop and enhance their personal resilience through complex and supportive multi-directional relationships, the use of positive framing, and enacting the concept of thriving to maintain personal motivation whilst continually developing their ability to be resilient. This study has also identified avenues for future enquiry which may lead to a better understanding the personal resilience of the leadership community more widely, and of personal resilience as a complex, dynamic, contextual, and subjective phenomenon.

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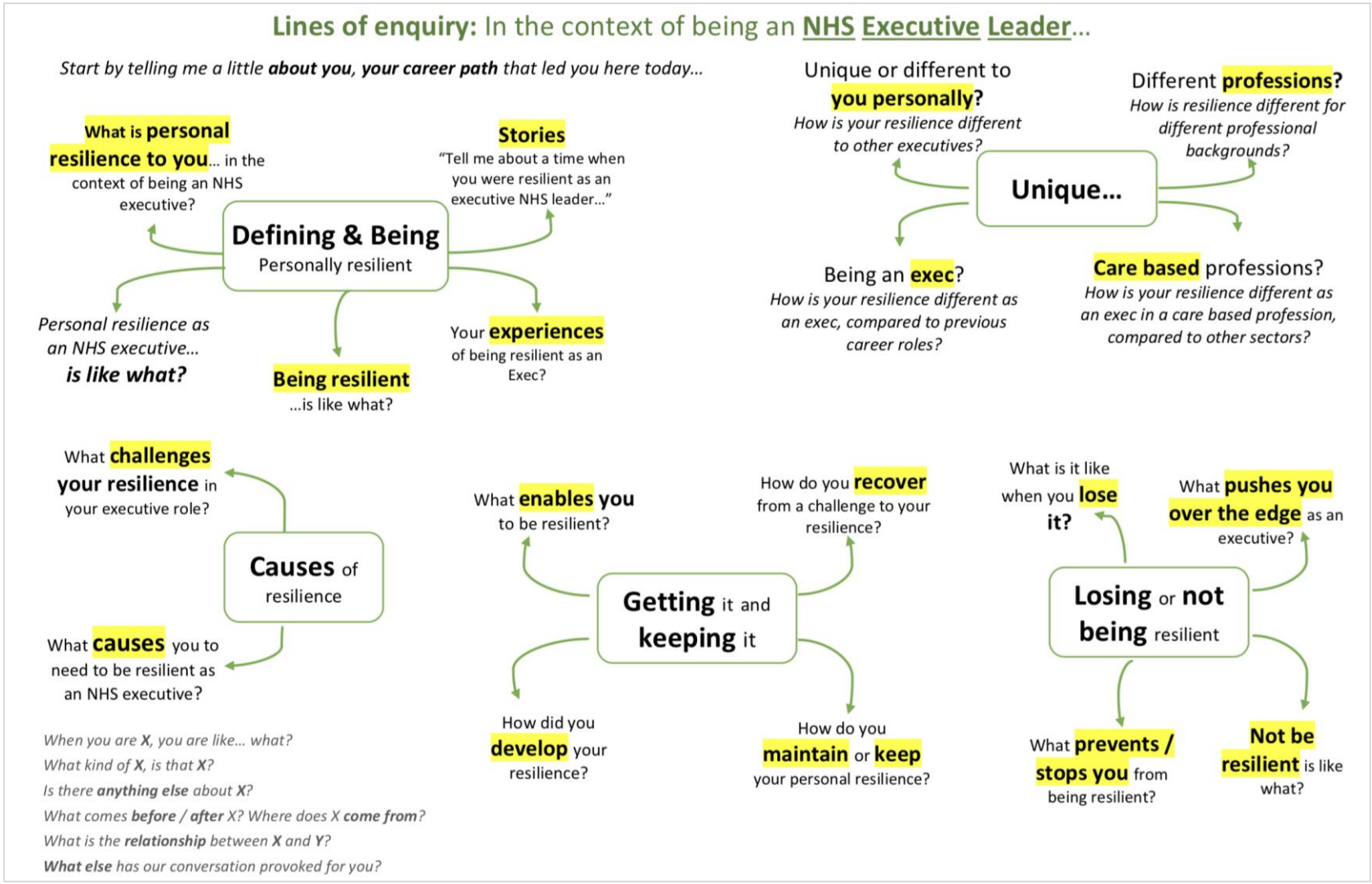
Appendices

Appendix 1: Interview lines of enquiry - visual prompt sheet



Appendix 2: Participant interviews - overview and an example of transcripts

The following table summarises the duration (hours/minutes) and word count for all participant interviews and transcripts as part of this study during 2017-2018. The pilot interview was used to test the methodology only and was not included within any analysis as part of this study.

Participant name	Interview 1 - in 2017		Interview 2 - in 2018	
	Duration	Words	Duration	Words
Pilot *	*1 hour 4 mins*	*11,070*	*N/A*	*N/A*
Andrew	1 hour 28 mins	13,700	1 hour	9,870
Catherine	1 hour	10,170	36 mins	4,030
Diane	2 hours 5 mins	20,140	1 hour 2 mins	9,380
Elizabeth	1 hour 59 mins	18,710	1 hour 57 mins	15,160
Matthew	1 hour 47 mins	14,970	1 hour 52 mins	15,700
Sam	1 hour 52 mins	16,730	1 hour 30 mins	13,030
Stephen	1 hour 18 mins	13,620	1 hour 20 mins	13,160
Tim	1 hour 46 mins	19,560	1 hour 19 mins	14,000
Wendy	1 hour 35 mins	14,300	1 hour 22 mins	12,430
All interviews total duration		**27 hours 28 mins** **(28 hours 32 mins including pilot*		
All interviews total words		**248,660 words** **(259,730 including pilot)*		

The following presents an example of an interview transcript extract and analysis. The extract is presented as an example only, for data analysis audit purposes. It is presented in accordance with ethical procedures and does not contain any identifiable information to protect the anonymity of the participants. The methodology chapter in this thesis outlines how data was analysed in accordance with IPA guidelines (Smith et al., 2009). This extract demonstrates how the researcher analysed and interpreted the interview transcripts by:

- **Documenting each interview** verbatim, using the following conventions:
  - *A time stamp used throughout (hours.minutes.seconds)*
  - *Interviewer in bold font type, and participant is in normal font type.*
  - *[ ] to summarise information that may be identifiable.*
  - *( ) for contextual/unspoken information, such as (laughs).*
- **Beginning the analysis** by highlighting initial areas of interest (in yellow) then emerging ideas (underlined) and finally emerging themes (in blue).
- **Advancing the analysis** by annotating the emerging ideas, interpretations, and themes in the right-hand column.
- **Summarising the emerging themes** from each interview at the end of the transcript. Additionally, in interview 1, identifying specific questions to follow up for clarification or further exploration in interview 2. The summary presented represent the full analysis from the entire interview, and not only the small transcript extract.

Example: Extract from Dianne's transcript and analysis

Extract from Diane interview 1

(Removed for this publication to protect anonymity)

Summary of themes, ideas, interpretations and further lines of enquiry from Diane interview 1

Learning mindset 'be frightened' pattern for continual personal growth and self-improvement
Overcoming fear/in the heat - throwing self into new frightening experiences, to learn and master them
Cyclic - frightened, in the heat, learn, become bored, changed (with time out to recuperate)
Reward - for mastering the job
Experience - enables you to do the job - A&E helped (resilience, team support) through to experience of different exec role
Self-improvement - learnt about self, and improved
Learning from role models/others - how other CEO did it, doing it differently to them, seeing others burn out/destroyed/traumatised - learnt from seeing them deal with it
Celebrity/unlikely role model learning – 'Ed Sheehan' came of social media, through similar incident to them
Curiosity - in how people, things work and improving everything (and self)
Learn from failure - handled situation of merging wards and public backlash badly but learnt from it
Future line of enquiry *– What enables you to learn / move on / better self from trauma/failure - rather than be destroyed by it?*

Action helps resilience through challenges
Doing things, taking-action – helps you to be resilient
Falling off horse - when traumatic experience, went straight back to work to face the fear
Distraction - doing other things helps you
Future line of enquiry *– Facing fear, link to putting self in frightening roles to learn?*

Balance/recuperate/recharge
Take a breath / time to think/ perspective - Time off between roles, travel - doing something for you - time for you, between jobs (travel) in the resilience trauma challenge (being at home away from work)

Driven, current and innovative
Wanted a career - go against norm at time
Reinvention - changed self with the times
Entrepreneurial mindset - new things
Future line of enquiry *– Links to change in resilience over longer term?*

Values driven enable and disable resilience
Doing the right thing - even if it's not what's popular with some people 'I am going to get these folks to a safe place' / 'stand up for gender media eye' / whistle blew early in career
Values driven from childhood - stand up for classmates
NHS values - not linked to one person, it's systemic
Shared values enable - Working with people sharing same values enables you
Making it better/improved - if you can't do that, it lowers your resilience/motivation
Curious - how to make things better, how it work, people… learn
Empathy - look at it from other people's POV, from others shoes
Values based activities top you up - Seeing patients
Trauma and stress challenge values - Of those around you and your own
Emotional investment, give more than get - in role/organisation/people that may not value your effort.

Values based mindset change in others - drains resilience as don't share or believe in change
Future line of enquiry *– Explore non-aligned values as resilience drain?*
Future line of enquiry *– More on trauma impact on living by your values, or do values keep you going?*
Future line of enquiry *– Values help or hinder? People with different values? - e.g. said how can walk in someone else shoes who is vilifying you about the incident that was values driven.*
Future line of enquiry *– How manage give more than get, that emotional investment?*

Purpose aligned gives motivation
Belief in what you do - gives you resilience, the end product (care). Not care specific (you could believe in perfume shop) but it helps you keep going

Intuition/instinct
Insight to know when to act – when something does not feel right in your gut
Future line of enquiry *– Explore how intuition helped in resilience*

Personality
Very values driven personality - learnt to trust it and personal preference for moral direction.

Connected support network - built around blind-spots
Connection to others helps resilience - of you and organisation, work together, not separate in system
Found and fill blind spots with others - and seek opinions and support from people who fill those
Diverse support network - Coach/mentor/CEO network/friends
Valued feedback - tops up resilience to hear feedback from people respect
People help you actively - when they see you're in bad way/trauma
Future line of enquiry *– How does helping other people help your resilience?*

Pass on resilience, altruism, responsibility to protect others
Helping the vulnerable/people with no voice – e.g. first CEO role wanted to help the people in the organisation to a 'safe place' / media eye due to issue during interview
Stand up for staff - support them, champion their needs, feel should always step forward
Held nurses to account for behaviour (role models) - caused one to come back for help as found respect/trust in them
Future line of enquiry *– Protecting others more vulnerable puts you in personal resilience challenge - is this intentional, or heat of the moment, and what's the impact on you?*

Professional training/power as nurse/breadth of career experience
Clinical experience - curious about how people work
Nurse experience (18 years) - forced to be resilient from beginning of career, learnt team approach an importance of people
Diversity of exec experience - Reputation led to different exec learning opportunities
Professional power - talked down (political figure) and could challenge their perspective using professional power and stories as a nurse, diffused resilience challenge, nurse code of conduct allows you to act beyond public office blocks/ways of conditioned to be
Professional power as nurse – gives a different professional power, dealing with public figures etc.
Future line of enquiry *– How has professional background helped resilience mindset, e.g. emergency team and blocking out negativity to focus on trauma*

CEO/exec focused – potentially unique
Media eye, visible, vulnerable, exposed - you're seen and chastised for every unhappy decision
Emotional investment - in work / the organisation is sometimes only one way
Freedom as CEO - chair is only boss, regulators
Identity with organisation - entwined with organisation
Buck stops with you - you are on your own
Chair/NEDs - can be supportive and enabling or passive/disabling
CEO role changing - as NHS changes, you have to adapt with it

Managing directors is nightmare - 'bag of ferrets / siblings' as they are there to support you, but also each other and their portfolio
Can't learn from role models as CEO - like have done in previous career
***Future line of enquiry** – Explore media eye and vulnerability/exposure, entwined identity with organisation*
***Future line of enquiry** – Explore belonging, as not part of exec and autonomous and impact on resilience*
***Future line of enquiry** – Identity intertwined CEO and organisation*

CEO as 'preferred state of independence'
Not lonely, but never quite belong - you're not part of exec, you are mostly autonomous and belong to the organisation
More comfortable with independence, less need to be resilient - personally always had independence since young.
Some people need others, if you like independence you can be resilient in CEO role
***Future line of enquiry** – Explore gaining comfort with independence and resilience as CEO*

Identity, purpose, values, and people challenge – focus on positive
Being in media eye, challenged values, purpose, identity, clash with other people's values
Dissonance work through trauma, space for positive action
Focus on positive feedback
Park/freeze negative feedback
Look for 'signs' to vilify how feeling (e.g. petrol station nurse said horrible ppl here)
***Future line of enquiry** – How do you work through dissonance as CEO? Link to positivity?*

Personal CEO 'trauma' stories – being exposed in the public eye
1. Traumatised from public meeting disgruntled on [issue relating to services] - learnt from that experience and changed future dealing with similar incidents of public facing
2. Media eye values based fight over values based issue - did what's right, altruistic, stuck up for others, fought off critics, gave others a voice
***Future line of enquiry** – follow up current resilience challenge as CEO to see how this has changed, what it meant to personal resilience, learning etc.*
***Future line of enquiry** – forced to be scared, vs. chosen to be scared and learning through trauma?*

Block negativity, to give space to focus energy on positive action - Remove 'noise' through traumatic experience, reduce vulnerability feeling to cope, allows energy to focus on task at hand
Positive enabling focus - found loads of ways to focus on task, avoid negativity, allowing space to act on the challenge.
Finding space to think/perspective – at all costs especially at times of challenge
Time away from office to focus on difficult tasks. Physical location change.
Focus energy on task - Enables you to be resilient
Listening to people you value - feedback you value tops up resilience
Shut off feedback that's unhelpful e.g. comms scrutinise to give you space to act
Physically avoid situation - e.g. avoid area know bump into people/reminds you of incident
Avoidance survival strategy - to give clear head to focus on past
***Future line of enquiry** – Is this hiding, denial, enabling, coping?*
***Future line of enquiry** – Blocking out negativity, enables energy to focus on positivity?*

Fight, flight, freeze, flex, avoid/park
Fight - if values challenge
Flight - you can walk away from an exposing situation / move on because you feel aren't making a difference or bored and not learning
Freeze - in the moment of trauma, but only short as you work through challenge – gain perspective
Flex - after trauma, learn from experience and don't repeat, or in the moment identity how you need to adapt approach

**Avoid/freeze the moment (not you) - strategically avoided negative feedback, geography to give space to focus on positive actions
Future line of enquiry *– Check this out further especially avoid/freeze negative feedback to give space*
Future line of enquiry *– How quickly get out of freeze? Perspective?*
Future line of enquiry *– Did this avoid negative noise skill come from nurse training/experience? Links to working as a team?*

Resilience as 'concrete' and 'top ups' metaphorically
Concrete – resilience is hard and unbreakable
Top up – Resilience as energy that you top up or deplete
Chipped through the week, emotionally physically intellectually depleted
You find ways to top it up, through these different to different people
Future line of enquiry *– What are your resilience top ups?*

Forgotten/hidden resilience skills
Future line of enquiry *– what about the taken for grandness, the things you may have forgotten about resilience as you learnt to deal? e.g. challenging situations, you can just manage now?*

Fitness
Weight is indicator of stress

Interview impact on current issue described in detail of 'media eye' challenge
Future line of enquiry *– did the interview help with current resilience challenge of media eye*

Appendix 3: Ethical approval form

Application for Ethical Approval (PGR Student)

To be completed by staff and associate researchers proposing to undertake ANY research involving humans [that is research with living human beings; human beings who have died (cadavers, human remains and body parts); embryos and fetuses, human tissue, DNA and bodily fluids; data and records relating to humans; human burial sites] or animals.

Date: 3rd May 2017 **HASSREC Approval Code:** HCA16170025-R

Checklist

		Yes	No
1.	Does your proposed research involve the collection of data from living humans?	☒	☐
2.	Does your proposed research require access to secondary data or documentary material of a sensitive or confidential nature from other organisations?	☐	☒
3.	Does your proposed research involve the use of data or documentary material which (a) is not anonymised **and** (b) is of a sensitive or confidential nature **and** (c) relates to the living or recently deceased?	☐	☒
4.	Does your proposed research involve participants who are particularly vulnerable or unable to give informed consent?	☐	☒
5.	Will your proposed research require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	☐	☒
6.	Will financial inducements be offered to participants in your proposed research beyond reasonable expenses and/or compensation for time?	☐	☒
7.	Will your proposed research involve collection of data relating to sensitive topics?	☐	☒
8.	Will your proposed research involve collection of security-sensitive materials?	☐	☒
9.	Is pain or discomfort likely to result from your proposed research?	☐	☒
10.	Could your proposed research induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	☐	☒
11.	Will it be necessary for participants to take part in your proposed research without their knowledge and consent at the time?	☐	☒

12.	Does your proposed research involve deception?	☐	☒
13.	Will your proposed research require the gathering of information about unlawful activity?	☐	☒
14.	Will invasive procedures be part of your proposed research?	☐	☒
15.	Will your proposed research involve prolonged, high intensity or repetitive testing?	☐	☒
16.	Does your proposed research involve the testing or observation of animals?	☐	☒
17.	Does your proposed research involve the significant destruction of invertebrates?	☐	☒
18.	Does your proposed research involve collection of DNA, cells, tissues or other samples from humans or animals?	☐	☒
19.	Does your proposed research involve human remains?	☐	☒
20.	Does your proposed research involve human burial sites?	☐	☒
21.	Will the proposed data collection in part or in whole be undertaken outside the UK?	☐	☒
22.	Does your proposed research involve NHS patients or premises?	☐	☒
23.	Does your proposed research involve NHS staff?	☒	☐

If the answers to any of these questions change during the course of your research, you should discuss this with your supervisor immediately

Application Details

Details of the research Outline the context and rationale for the research, the aims and objectives of the research and the methods of data collection
Context of the research *Healthcare context:* Reviews into NHS executive leadership by Rose (2015) and Smith (2015) describe the NHS as a stressful, highly pressurised, performance-focused environment, burdened with bureaucratic-regulation, political and public scrutiny. Consequently, this creates a challenging and stressful environment for NHS leaders' to effectively manage healthcare services. Janjua (2014) and Timmins (2016) support these generic views, describing how NHS executive leaders are operating within an adverse, constantly changing, and pressurised environment that emphasises their inadequacies over their successes. Whilst executive roles are described as pivotal to

running NHS services, they also state that due to the highly stressful nature of these jobs, fewer people are aspiring to become executives. This is resulting in the NHS operating with significant executive vacancies.

Hardacre and Keep (2011) state that building the resilience of leaders' is essential to ensure the future success of the NHS. However, literature reviewed as part of this study identifies an absence of empirical research that explores the nature of NHS leaders' personal resilience. Therefore, it is not possible to describe how or why existing NHS executive leaders are able to successfully remain resilient as they lead the NHS within this adverse and stressful environment.

Describing the current situation of the NHS as a 'leadership crisis' Naylor et al (2015) argue that whilst there is much debate surrounding current NHS leadership challenges, few debates examine solutions to enable these leaders to be effective within this stressful environment. Without an increased understanding of what constitutes NHS executive leader personal-resilience, the NHS is less able to develop its senior leaders' resilience and is therefore less able to address this leadership crisis.

Relationship between stress, leadership and healthcare:

The NHS literature above alludes to how stress and resilience are interrelated. The concept of stress can be thought of as a non-specific response to the demands placed upon a person that exceed their available personal resources to cope (Lambert, Lambert and Yamase, 2003; Goldstein and Kopin, 2007).

A review into leadership stress by Smith and Copper (1994) states that organisational culture, poor relationships, lack of work-life balance and role ambiguity affect leaders' stress. Through a multi-sector review of leadership stress, Worrall and Cooper (1995) identified 89% of executive leaders as stressed and 33% experiencing a stress-related illness. Both Worrall and Cooper (1995) and Sutherland and Cooper (1995) found that competition, time pressures, volume of work and performance-targets were the main sources of executive-stress, which ultimately negatively impacts upon their health.

Considering stress within a healthcare context, a recent generic review of stress in the healthcare workplace by Smollan (2015) identified similar themes including; workload, limited resources, conflict, psychological and physiological demands, job-insecurity and limited social support as generic healthcare workplace-stressors. Smollan also states that transition through change is the most stressful aspect of healthcare-work, which is concerning considering that healthcare is now considered in a state of continual-change (Rose, 2015; Smith, 2015). Collins (2006) states that continual-change causes significant stress and anxiety for the healthcare workforce, arguing that the cumulative effect of many smaller stressors leads to general wear and tear on our bodies that eventually manifests itself in physical illness. In fact, there are clearly

researched links between work-intensity stress and negative physical, mental-health and wider wellbeing implications (Sutherland and Cooper, 1995; Collins, 2006; Franke, 2015).

Healthcare specific literature also leads us to consider an added emotional layer of leadership-stress within care-based professions due to the ethical dilemmas faced when delivering care services (Dellve and Wikstrom, 2009; Wicks and Buck, 2013). Whilst supported by Rajan-Rankin (2014) in the context of social-care resilience, this concept is under-explored within healthcare-leadership stress and resilience studies.

Defining personal resilience:

If stress is considered a non-specific response to the adverse demands placed upon an individual, exceeding their ability to cope (Goldstein and Kopin, 2007) personal resilience can be considered as the successful, effective and rapid response that enables individuals to overcome such personal adversity, challenging and stressful situations (McAllister and McKinnon, 2009; Fletcher and Sarkar, 2013; Southwick et al, 2014).

Definitions of personal resilience documented within academic literature often use the metaphor of 'bounce-back' from adversity to one's original state (Tugade & Fredrickson, 2004; Tomassini, 2015). However, researchers also argue that resilience moves beyond bounce-back and that it involves a personal learning experience resulting in an effective and sustainable adaptation that transforms an individual into a new, positive, and evolved state (Zautra et al, 2010; Southwick et al, 2011; Flint-Taylor et al, 2014; Rajan-Rankin, 2014; Tomassini, 2015).

This being said, researchers also struggle to define personal resilience. Henning (2011) and Southwick et al (2014) state that resilience is ideographic in nature, meaning that it can only be defined by each individual based upon their unique life-experiences and perspectives. They argue that resilience cannot be generalised and needs to be contextually explained. In their generic review of resilience literature, McAllister and McKinnon (2009) support this subjectivity, emphasising that wider social and cultural contextual factors impact upon an individuals' personal resilience.

There is also dispute over personal resilience being described as a recovery 'process' in response to an adverse event (i.e. an 'output') or alternatively, if it relates to innate personality 'traits' that individuals' possess that enable them to protect themselves against adverse situations (i.e. an 'input') (Fletcher and Sarkar, 2013; Flint-Taylor et al, 2014; Southwick et al, 2014). Evolving the relationship with personality traits, the term 'psychological hardiness' has been used to describe traits that mitigate stress (Lambert et al, 2003). Shakespeare-Finch et al (2005) McAllister and McKinnon (2009) and Flint-Taylor et al (2014) identify personality traits of 'extroversion', 'agreeableness', 'openness' and 'conscientiousness' linked to increased personal resilience. However, they also call for caution in this area of research due to the complex dynamics between personality and the subjective nature of resilience.

Having access to a social community and support network is important to maintaining personal resilience (Wicks and Buck, 2013; Rajan-Rankin, 2014; Southwick et al, 2014). However, Rajan-Rankin (2014) and McAllister and McKinnon (2009) also state that social support cannot always be guaranteed or relied upon. McAllister and McKinnon (2009) illustrate this by comparing involvement in a public-crisis to an incident of personal-shame; both subjective situations will produce different responses from social-networks and therefore variable levels of social support.

Finding time for self-reflection on life experiences also enhances personal resilience. Rajan-Rankin (2014) and Tomassini (2016) state that self-reflection allows individuals to enhance their personal resilience through 'inner transformational learning' which assists in developing personal identity and self-understanding.

Combining self-reflection and social support, Henning (2011) uses the metaphor of an 'epistemological rear-view mirror' to describe the importance of seeking out and reflecting upon personal feedback to gain personal insight to assist in enhancing personal resilience. Henning also states that whilst historic definitions of personal resilience refer to the ability to avoid stressful situations, individuals should instead embrace uncertainty to learn about themselves, (re)construct their self-identity and personally develop from their life experiences.

Whilst there is significant ambiguity within the literature when attempting to define resilience, agreement is however found in resilience being a complex, multi-faceted, and contextual construct and therefore requires further empirical study to increase our understanding of the phenomenon (McAllister and McKinnon, 2009; Fletcher and Sarkar, 2013; Flint-Taylor et al, 2014; Southwick et al, 2014).

Healthcare leaders and resilience:

The literature review as part of this study identified limited empirical studies exploring the personal resilience of healthcare leaders. Hardacre and Keep (2011) are an exception to this through their review of NHS resilience and engagement with generic healthcare managers and clinical leaders. They identify that the constant uncertainty within the healthcare environment is the most significant stressor to the NHS, correlating with stress-literature (Smith and Cooper, 1994; Collins, 2006; Smollan, 2015). Hardacre states that the resilience of NHS leaders should be better developed to enable them to deal with the ambiguity of this constantly changing environment. Whilst they offer practical advice on developing personal resilience including self-reflection and social support, this advice appears generic and similar to the resilience studies discussed above and lacks differentiation between the resilience of generic healthcare-workers and resilience of senior/executive leaders.

Whilst rooted within NHS leadership development, a study by Turner and Nichol (2016) identified that when aspiring NHS leaders were faced with highly stressful, performance-focused situations, their personal resilience was challenged. Whilst some individuals described surviving and personally developing, others described long-lasting accounts of trauma arising from their experiences.

Executive leaders and resilience:

There are no empirical studies relating to the resilience of executive healthcare leaders, or executive leaders generically. However, there are a number of generic opinion-pieces offering advice to executives to build their personal resilience. For example, Arnold-Thomas (2004) and Shambaugh (2010) suggest flexibility of leadership style, engagement with others and embracing continual personal development helps executive leaders maintain resilience. Whilst not claiming to be empirically based advice, this appears congruent with guidance found within the empirical studies discussed above. Whilst focused within stress literature, Ho (2013) also found that different executive professional backgrounds identified with different stress coping mechanisms, supporting the subjective and contextual nature of executive leader personal resilience.

Gaps in our knowledge:

Whilst resilience is prominent within the academic fields of business management, psychology and more recently nursing literature (McAllister and McKinnon, 2009; Thomas, Jack and Jinks, 2012; Hudgins, 2016) there are no studies that combine these fields to investigate healthcare executive leaders' experiences of personal resilience. This is surprising when considered against the identified need for NHS executives to remain resilient as articulated within the high-profile NHS grey literature and opinion pieces by Hardacre and Keep (2011) Janjua (2014) Naylor et al (2015) Rose (2015) Smith (2015) and Timmins (2016). In fact, there are no studies that explicitly explore the personal resilience of executive leaders more generically.

Literature also identifies that the concept of resilience remains ambiguous. Contemporary researchers within the field including McAllister and McKinnon (2009) Mazzola, Schonfeld and Spector (2011) Southwick et al (2011) Fletcher and Sarkar (2013) Ranjan-Rankin (2014) Smollan (2015) and Tomassini (2015) are requesting wider qualitative and subjective studies to enhance our academic understanding of resilience as a conceptual, context specific phenomenon.

Combining this identified need to enhance knowledge and understanding of NHS executive leaders' personal resilience from NHS grey literature, a lack of studies generically exploring the resilience of executive leaders, and wider resilience literature seeking increased studies to document the subjective nature of personal resilience within different contexts, this study seeks to address these gaps in our knowledge and augment our academic understanding of personal resilience as a phenomenon.

Research aim and questions

To address the identified gaps within our understanding of NHS executive leaders' personal resilience, it is proposed that the aim for this research study is to investigate:

How do NHS executive leaders experience personal resilience?

Any qualitative, inductive, and exploratory research of a given phenomenon is likely to unearth new and unexpected avenues of enquiry (Smith et al, 2009) and the nature of this study may naturally change as new data is uncovered. However, initial questions of this proposed study are to explore:

1. How do NHS executive leaders experience stressful healthcare working-environments?
2. How do these NHS executive leaders experience and define personal resilience when responding to these stressful environments?
3. What is the difference between being resilient, and failing to be resilient for them?
4. How is personal resilience gained, developed, and retained for these individuals?
5. Have their perceptions toward personal resilience changed throughout the duration of their careers (i.e. is there a uniqueness relating to executive leader resilience?)
6. How do they perceive working in a care-based profession impacts their personal resilience as an NHS executive leader?

Proposed methodology and analysis

This study seeks to gain an appreciation of what personal resilience means to the participants, through the contextual focus lens of being an executive leader within the NHS environment. It has been established above that personal resilience needs to be understood at an individual level, and for this reason it is proposed to place this study within the field of phenomenological enquiry.

As a methodology, phenomenology aims to explore and explain the essence of human experience and how people perceive the world around them. It flexibly utilises both descriptive/epistemological and interpretive/ontological methods to achieve this aim (Gibson and Hanes, 2003; Dowling, 2007; Gill, 2014). It is commonly used within nursing, pedagogy and psychology and more recently organisational/management studies, utilising its focus on describing and interpreting human experience (Gill, 2014).

Within the phenomenological field of study, Interpretative Phenomenological Analysis (IPA) has been identified to support this research project due to its flexible approach within an established and prescribed research method. IPA offers an idiographic focus, meaning that it offers subjective insights into how a particular person, in a particular context, makes sense of a

particular phenomenon (Pringle et al 2011; Smith, 2009, 2011; Roberts, 2013; Gill, 2014; Wagstaff and Williams, 2014). This means that IPA appeals to the ideographic nature of resilience already alluded to within existing personal resilience related literature (e.g. Henning, 2011; Southwick et al, 2014).

IPA is used within healthcare studies (Pringle et al 2011; Smith, 2011; Roberts, 2013; Wagstaff and Williams, 2014) more recently management studies (Gill, 2014) and has also been successfully applied in the investigation of social-care workers' personal resilience (Rajan-Rankin, 2014). For the purposes of this study, the IPA guidelines documented within Smith et al (2009) will be followed.

(Please see subsequent sections of this ethical approval form for detailed accounts of; participant sample criteria, recruitment processes, consent arrangements, data governance and wider ethical issues in relation to following this IPA method).

Following engagement, contracting and consent procedures with the identified sample group, participants will be invited to take part in semi-structured interviews where open-questions relating to the research objectives will be presented to the participant until they naturally wish to disengage. These personal narratives surrounding experiences of the research topic, referred to as 'lived experience' within IPA studies (Smith et al, 2009) will be recorded and then transcribed verbatim. Transcripts will then be thematically analysed, and each individual theme will be grouped into an overarching set of emerging meta-themes.

Interpretation forms a core aspect of IPA research, and therefore member checking procedures outlined within Smith et al (2009) will be utilised to re-engage participants to clarify understanding of the emergent themes and increase rigor of the interpretation through deeper exploration of identified themes. This is likely to be in the form of additional face to face interviews where emergent themes, parts of the transcript and their interpretations are played back to the participant to check for correct understanding, and/or to generate deeper understanding. In the unlikely event that re-engagement of participants is difficult, this could also be flexibly achieved by sharing the themes arising from the interview with the participant via email. Participants will then have time to read and reflect on these themes, which can then be shared flexibly through either an email response or through a short phone interview.

Following this analysis phase, a thematic literature review will then be undertaken in relation to the identified themes. This will allow the researcher to explore how the new knowledge gained from these participants relates to established theory.

When writing up the final research piece, participant narrative extracts will be used verbatim to support each of these identified themes and subsequently, all findings will be synthesised into a final research thesis.

RDB progress

My research has already been to the University Research Degrees Board. The Board agreed that my research could progress with no amendments to the proposal outlined above.

Who are your participants/subjects? (if applicable)

Following IPA's purposive-sampling guidelines by Smith et al (2009) it is proposed that a sample group of between 6-10 participants are interviewed.

The inclusion criteria for participation for the study will include individuals who:

- Currently hold an executive leader role within the NHS. An executive in the context of this study is defined as an accountable member of an NHS organisation's executive board with voting rights regarding decisions affecting how their organisation is managed.
- Having experienced the role of an NHS executive cumulatively for at least 2 years. This is based upon NHS grey literature above (e.g. Janjua, 2014) alluding to the average tenure of an executive officer is just over 2 years. Therefore, where participants have spent this length of time in post, it could be argued that the participant is exhibiting resilient signs in relation to their role as an executive.
- Sampling from both a variety of both urban and rural NHS services to ensure coverage of the breadth of healthcare services.
- Establish an even mix of clinical (i.e. nursing/medical) and purely managerial professional backgrounds. This will ensure a variety of professional background perspectives are considered.
- Have English as their first / substantive language, acknowledging IPAs interpretative requirements.

Exclusion criteria will include:

- Close or compromising relationships to the researcher. Whilst phenomenology values the relationship between the researcher and the participant (Gibson and Hanes, 2003; Dowling, 2007; Gill, 2014) very close relationships such as work friendships or those within the immediate organisation of the researcher will be excluded. This is to avoid coercion, in addition to ensuring that these participants do not feel compromised and share inaccurate information to please the researcher because of this close relationship (i.e. they may feel obliged to express that they are personally resilient, as it may be of personal benefit to them to be seen in this way to a very close work colleague or friend).

- Participants who express that resilience is currently a personally challenging topic for them during the contracting phase, or, where the researcher identifies that it may be a particularly challenging topic for them currently. For example, their organisation is going through a high-profile public investigation similar to that of Mid Staffordshire NHS Trust, where participant personal resilience is potentially challenged beyond a normal threshold at the present time. Whilst it is not expected that exploring personal-resilience will cause additional anxiety beyond their day-job for these executive leaders due to their significant experience and development in role, this criteria is primarily in the interest of ensuring participants are not exposed to a situation that may cause them additional anxiety at a particularly stressful time. This is also in the context that this research sits within a phenomenological perspective seeking to explore reflections on experience of resilience, rather than in-the-moment reflections.

How do you intend to recruit your participants? (if applicable)

This should explain the means by which participants in the research will be recruited. If any incentives and/or compensation (financial or other) is to be offered to participants, this should be clearly explained and justified.

Participant selection will follow IPA purposive sampling guidelines outlined within Smith et al (2009).

As NHS executive leaders could be considered an elite group of people, participants matching the sample group criteria will be initially approached via a formal invite letter/email to raise awareness and introduce the purpose of my research, what the research hopes to achieve and how to get involved. This will be a simplified version of my information sheet, which will also be included as a detailed attachment (see attached information sheet).

Dependent upon response rates and with further consideration towards IPA purposive sampling guidelines, I may also approach participants to take part in the study directly. These individuals will be identified from my practice-based knowledge of them within my 'day job' in the NHS for Health Education England, where I am aware of the professional background of these individuals and how they could contribute an interesting perspective on the research topic. This is in accordance with taking a phenomenological perspective and fully utilising the benefits that an 'insider researcher' (Costley et al, 2013) brings to the research, whereby being within the same organisation (i.e. the NHS in this case) will more rapidly allow for a trusting relationship to be built between the researcher and participant, therefore potentially yielding greater insight. As stated above in my exclusion criteria, very close work relationships will be excluded to ensure that these individuals do not feel coerced into participating and/or potentially sharing inaccurate information with me that they think I may want to hear, or holding back information that could compromise our close relationship, rather than sharing their true reflections etc.

(NB - Coercion and transparency are further considered in the context of being an 'insider-researcher' later within wider ethical considerations within this approval form)

With this in mind, I will initially approach participants through my NHS work email address for several reasons. Firstly, building upon the merits that an 'insider researcher' role (Costley et al, 2013) brings from my job-role experience of working with executive leaders, I acknowledge they are very busy and have many emails. They are more likely to read and respond to emails from me in my NHS context. Secondly, from experience of working within tightly governed NHS IT governance, sometimes external emails such as that of my University email address with complex characters will cause these emails to be sent to spam filters and may not get through. When I have established interest in the research topic from participants, I will explain that I will then switch to the University email address for future communications as this complies with University data governance procedures as well as giving them assurance that only I will see their emails.

I will also ask participants which of their email addresses they prefer me communicating with (e.g. their work or personal) to ensure that they feel conformable with me contacting and sharing information relating to my research with them as the research and interviews progress. This is clarified explicitly within the consent form which asks participants to clarify their preferred communication details.

Acknowledging my exclusion criteria above, I am aware that I may have participants contact me to take part in the research who upon closer examination fit within this exclusion criteria. Where this happens, I will work with them to openly explain why on this occasion I am not able to engage them to take part in my research and thank them for their interest (e.g. interviewing a close work colleague is not appropriate as we both work in the same organisation and this is a potential conflict of interest). My participant information sheet also outlines potential exclusion criteria i.e. 'why I may not want to participate…'

How will you gain informed consent/assent? (if applicable)

Where you will provide an information sheet and/or consent form, please append this. If you are undertaking a deception study or covert research please outline how you will debrief participants below

Please see attached research information and consent forms.

Where participants have further questions, or seek more information before committing to taking part, I will offer the opportunity to have a phone conversation with them to discuss the study in more detail and to fully inform their decision in participating. I will be open about all details of the study and any questions they may ask e.g. what participation means for them, the voluntary nature of the research, how I will use their data, confidentiality vs. anonymity, the

voluntary nature of participation, commitments in agreeing to take part, my role as both researcher and how this relates to my job in the NHS etc.

(See wider considerations later in this ethical approval form for how I intend to manage being both a researcher and practitioner in the NHS as part of this study).

Where participants indicate that they agree to proceed in supporting the study, I will ask them to formally read and sign the consent sheet and send this back to me for record. Due to the nature of working with executives across a large geographical area, it is proposed that this will be signed and sent back electronically e.g. as a PDF to my University email address in the first instance.

When consent is formally agreed in this way, I will then liaise with them to plan a suitable date where we can dedicate undisturbed time to conducting an interview. When opening the interview, I will verbally work through the consent form and reiterate the information in it to also gain verbal consent to fully ensure that the participant is aware of the purpose of the study etc. I will also take a printed copy of the electronic consent form and clarify that they did sign this by asking them to review it and re-sign in ink. This will also be recorded verbally as part of the audio recording for the interviews.

I will make it clear through the information sheet and through any pre-consent discussions that participation is completely voluntary, and it is an opt-in, rather than opt-out approach. I will also make it clear that signing the consent sheet does not mean their data is automatically used within the study. I will point out that there is a limited 'cooling off period' of 14 days after the interview before I start to use their data should they decide that they wish to have some elements, or the entire interview excluded from the study after reconsidering the data they shared.

To ensure that participants feel that I am open and transparent about their data, I will also explain member checking activities outlined above where I will re-engage them following my initial analysis. This will offer them further opportunity to review and check my interpretation/understanding of the narratives that they shared with me, explore themes arising in greater detail if relevant, and also reassure them that I understood their meaning.

Confidentiality, anonymity, data storage and disposal (if applicable)

Provide explanation of any measures to preserve confidentiality and anonymity of data, including specific explanation of data storage and disposal plans.

My background, experience and training within the NHS, which has strict data governance procedures due to the firm ethical guidelines of working in an environment that deals with patient sensitive data, helps me to appreciate the importance of data governance and will assist me in applying this experience of handling sensitive data to my study. For example, as an NHS

member of staff I am required undertake mandatory training in, and follow a rigorous NHS code of practice on data protection, governance, management and storage procedures.

Whilst NHS guidelines on data management are robust, for the purpose of this study I will follow the Universities research data management and governance policy as I am conducting the research as a student of the University. Following guidelines within this policy, the main way I will ensure that my data is kept secure and confidential will be organisation and storage on my personal and password protected space on the University secure digital storage space. Using University assured storage provides confidentiality assurances around data governance as it is an approved secure storage service. All of my IT equipment i.e. laptop/desktop that I use to write up my research and access my secure storage files on the University drive will also be password protected. It is unlikely that any data will need to be physically transferred, however if it is this will be achieved through a digital password-protected and security encrypted USB memory stick to ensure confidentiality is maintained.

Primary data relating to the study will be collected through interviews. These will be recorded on a password protected secure audio recording device (e.g. mobile phone or encrypted digital tape recorder). As soon as the interview is complete, these recordings will be transferred to the secure University electronic storage space to limit the time the data is contained within the recording device, limiting any risk of being stolen/lost etc. When the recording is securely transferred, it will then be destroyed on the mobile recording device. Audio recordings will then be personally transcribed by me.

Following the Universities data storage policy including the Data Protection Act, I will only keep the audio data for as long as is necessary. This will mean that when the audio interviews have been transcribed and analysed by me, there is no need for the original recordings and these will be destroyed/deleted from my secure University storage. This means at this point, there are no longer any versions of the original audio recordings.

The narrative interviews from participants form the main part of this study and extracts will be used to illustrate points within the PhD thesis and any publication. Therefore, these narrative transcripts will be securely kept on the University secure storage after the study is complete to allow for use in potential publications. University good data management guidelines state that this transcript data should be kept for a minimum of 10 years' post thesis publication. After this period of time, the data will be reviewed and if it remains unused it will be destroyed.

All stored transcripts will be anonymised and will not refer to any directly identifiable data about the participants. Following the NHS and education ethical guidelines used as part of this study (*see later section of this form for more information on these*) pseudonyms will be used at all stages of writing up my study to differentiate participants (e.g. 'Participant 1 stated that….'). This will be carried forwards into writing the final thesis and for any publications and ensure participant anonymity. Ultimately, this means that when data has been transcribed from audio

to written narrative, it will no longer be personally identifiable to the original individual and only I as the researcher will know who this referrers to.

I will log the pseudonym of the participant on to the hard copy of the participant consent form following interview allowing me to link the participant to the pseudonym. I will keep the electronic transcripts and consent forms separate in order to protect the anonymity of the participants. Hard copies of the consent forms will be kept in a secure locked cabinet in my home which is not accessible to anyone else, until a time that these forms can be destroyed within the 10-year period as outlined in the Universities good data management policy.

For organisational purposes whilst I am actively engaging participants in interviews, I am likely to need to keep a file on my secure University storage area that outlines the participant names, contact details and links them to their pseudonym (i.e. 'participant no. 1'). Using University secure storage means that only I can access this. When I have completed my transcripts, analysis and member checking activities I will no longer need this file and it will be deleted, meaning there will be no way to trace transcripts back to the individual after this point.

It may be necessary to describe certain features regarding the participants' role or type of organisation that they work within (e.g. they work within operations in a community hospital environment). Following the British Educational Research Association (BERA) ethical guidelines which acknowledge this as a challenge to qualitative research, this will be done with care to ensure that the identity of any specific organisation is not revealed and therefore maintain the anonymity of the participants (e.g. rather than stating 'they work for X community trust within central Birmingham with 2,450 staff and…etc' I will generalise this to 'the participant works within a medium sized community care organisation…')

Following good phenomenological and 'insider researcher' practice (Gibson and Hanes, 2003; Dowling, 2007; Costley et al, 2013; Gill, 2014) I may also write field notes within a reflective journal. This poses potential risk of loss of data as I will carry this around. However, these notes will be anonymised and generic in nature, relating only to how different elements of the study (e.g. an interview, a new piece of data, a reflective thought, links between ideas emerging etc.) have had an impact on me personally and reflexively what this may mean to my research topic. Whilst generic in nature and not relating to any individual and therefore low risk, I understand the importance of keeping this data secure. I will therefore keep it in my possession at all times and not allow accessible to others. When not in use, it will be locked within a secure storage space at my home. Although a low-risk item, when the study is completed, written up and published, the journal will be securely disposed of (e.g. confidential waste/shredding service) following similar guidelines as stated above regarding transcripts.

As this study forms part of my PhD, it is likely that I will have to share some of the data with my supervisory team at the University as my study progresses. I will make participants aware of this,

and reassure them that the discussions about their data will be kept anonymous, ensuring that my supervisory team will only know them by a pseudonym.

Although a highly unlikely situation, it is possible that participants share information with me during interviews whereby I may be obliged to share this information wider e.g. causing significant harm to another human being, themselves, or illegal practice. I will make participants fully aware of this clause in the information form and reiterate this at the start of the interview. If this were to happen, I would take this to my supervisory team straight-away for guidance. My supervisory team comprises of both business and healthcare professionals, which means that any ethical decisions will be made respectful of both my business researcher and NHS professional roles.

Potential risks to participants/subjects (if applicable)

Identify any risks for participants/subjects that may arise from the research and how you intend to mitigate these risks.

The research poses no immediate threat or physical discomfort for the participants.

I will ensure that the participant feels comfortable during the interview by making sure that the interview is conducted in an environment that feels safe for the participant and is suitable for interview (e.g. their personal office or a meeting room of their choice). I will draw upon my professional experience as a certified executive coach to ensure that I provide unconditional positive regard to the participant at all times and utilise open and exploratory questioning, sensitive to the topics that the participants share with me.

The topic of personal resilience and seeking personal accounts relating to this area of study could at times make participants feel uneasy when they recall and share their personal stories and past experiences. However, these senior individuals have been selected because it can be assumed that they already demonstrate resilient qualities i.e. having long established leadership careers, combined with achieving a sustained very-senior management/leadership position in the NHS for over two years. From my NHS practice-based knowledge, I can assume that they are highly likely to have been exposed to strong leadership, personal development and coaching in the past that will have already helped them explore many of the topics that they may share with me as part of the interviews. Therefore, it can be assumed that the interviews are highly unlikely to unearth topics that they are not already personally aware of.

In the unlikely event that participants advise me of significant discomfort during the interview, or I see evidence that the participants' wellbeing is visibly in question (e.g. crying) I will check-in with the participant to ensure that they are able to continue and then review their participation/continuation in the study. I will also outline that they are able to disengage at any time. The participant information sheet will outline this and also signpost participants to further

support services should they feel any need to engage with these after the study e.g. NHS counselling, occupational health and wellbeing services.

I am also aware that the quality of the data that I gain in taking a phenomenological approach is dependent upon the relationship and trust that I build with the participants (Smith et al, 2009). Therefore, I will demonstrate unconditional positive regard for their engagement in the study and the insights that they share with me around the topic. My training as an executive coach and the professional principles that I adopt when building relationships with coachees supports me in this area.

Other ethical issues

Identify any other ethical issues (not addressed in the sections above) that may arise from your research and how you intend to address them.

Research in the context outlined above is considered as undertaking an 'insider researcher' style approach (Costley et al, 2013) as I have a practice-based job role and profile within leadership development working nationally/regionally for NHS Health Education England.

As previously stated, this is advantageous to taking a phenomenological style of approach which emphasises the importance of the relationship between researcher and participant. NHS executive participants are likely to build trust with me more quickly as they see that I am part of the NHS and understand the context they are working in, and wish to contribute to making the NHS a better place for leaders as part of my research. My understanding of the NHS context also enables me to add value to the interpretations of the participants' narratives through my own considered reflexivity toward the interpretations.

My organisation / manager within my NHS professional role are also aware and fully supportive of my research studies and see my study as enhancing both my personal development and also what I have to offer the organisation. Therefore, when working with participants I am able to openly share that I bring both myself as 'researcher' and 'NHS leadership development practitioner' in my NHS day-job to the study.

However, I am aware of the potential for coercion and the need for a balance to be carefully considered between my relationships with participants as NHS leadership practitioner and researcher. To avoid coercion arising within IPAs purposive sampling approach, I will be open with potential participants about my own personal interest in the subject and why I believe they may yield useful perspectives on the subject matter. I will explain my belief in how their perspective and data arising from interviews will potentially expand our knowledge of executive resilience in the NHS, and how my aim is to add knowledge to this area which could ultimately lead to better supporting NHS leader development in the future. In doing so, I will openly make reference to how this appeals to both my researcher interests, and practice-based job role interests in NHS leadership development. I have also openly acknowledged this within the

participant information sheet stating my personal motives/interest in the research and how it relates to my role within the NHS.

As stated above, my purposive sampling criteria outlined above also mitigates for the potential conflict of interest here, whereby some individuals may want to demonstrate a false sense of being resilient to me as it better serves them and their working relationship with me in my day-job (i.e. I am purposefully excluding close working colleagues and those from my own organisation, as they may not want to be seen in a negative context).

This distinction between the benefits of being an 'insider researcher' and my 'NHS day job' is important to protect my personal interests too. For example, being an 'insider researcher' means that I am part of and can understand the practice-based context of working in the NHS, which is separate from 'doing my day job' which would mean supporting the personal development of NHS leaders. There is therefore a small risk that participants may engage in the research for their own coercive agenda, such as wanting priority access to NHS leadership development funding or resources that I may bring through my NHS job role. To mitigate such a conflict in the unlikely event that it arose, if the participant asks me a question relating to my practice-based role in the NHS (e.g. "tell me about the leadership development services you offer") I will outline that this is outside the context of this research study, and signpost them to how they can engage in this query outside of the research discussion. If it became evident that the participant had only engaged me in the research for their own means, I would review the quality of their contribution with my supervision team, which may ultimately mean discounting their data from my research study.

Acknowledging the ambiguity that being an 'insider researcher' brings, ongoing personal reflexivity through my personal research journal, as identified as best practice in insider-research by Costley et al (2013) will be used to support me in my reflections around the interaction between researcher and NHS practitioner. My supervision sessions with my University team will be utilised to acknowledge, reflect and take forward any wider ethical considerations that I identify as my study progresses relating to this 'insider researcher' nature of my study. Having a supervisory team comprising of academics from established healthcare and business backgrounds will also help me maintain a balanced perspective in this area.

Published ethical guidelines to be followed

Identify the professional code(s) of practice and/or ethical guidelines relevant to the subject domain of the research.

I have reviewed the following when developing my research proposal and will follow the best practice as identified here:

- University of Worcester - Institutional ethical guidelines
- Department of Health - Research Governance Framework

- British Educational Research Association (BERA) - Ethical guidelines for educational research

These guidelines have been chosen to reflect the hybrid business, NHS and education nature of my research. In-particular the BERA guidelines specifically acknowledge the tension between the hybrid 'researcher' and 'day job' roles as also identified in Costley et al (2013) and provide ethical guidelines on managing this tension.

Although the context of the research is within the NHS staff, from reviewing both the University ethical guidelines, speaking to the University health research lead, and also formally contacting the NHS Research Authority directly, I can confirm that my research will not require wider NHS ethical approval.

In the unlikely event that any information or approaches contained within this ethical approval form change in the future, I will review and update the form with my supervisory team and ultimately make the University ethical committee aware/seek guidance as necessary.

Appendix 4: Participant information sheet and consent form

NHS executive leader personal resilience: Research information sheet

Title and context of the study

Question: "How do NHS executive leaders experience personal resilience?"

Personal resilience can be thought of as the successful response to overcoming a stressful or adverse situation. This study seeks to explore what it means to be personally resilient within the context of being an executive leader working within the professional setting of the NHS.

Why is this study important?

Importance of this Research:	**This research study into NHS executive leader resilience is important because** ▪ The NHS needs its most senior executive leaders to be increasingly resilient within highly challenging and stressful times, as extensively documented within recent NHS related publications. ▪ To date, there has not been any significant research conducted into what it means to be resilient as an NHS executive leader, or as an executive leader more generically. ▪ This lack of knowledge means that the NHS does not clearly understand how to effectively develop and maintain the resilience of both established and aspiring executive leaders.
My Approach:	**My research seeks to address this gap in our knowledge by** ▪ Exploring your experiences of personal resilience and related areas in the context of you being an experienced NHS executive leader. ▪ Appreciating the richness gained from your personal accounts and stories within this area. ▪ Placing your personal narratives in the centre of understanding what it means to be personally resilient within your executive role.
Impact of Research:	**By better understanding what personal resilience means to established NHS executive leaders, I am hopeful that my research will** ▪ Contribute to how the NHS can better support both established and aspiring executive leaders.

	▪ Help NHS leaders to enhance and maintain their personal resilience in the future. ▪ Contribute to wider knowledge within personal resilience and leadership studies.

Who am I looking for?

I am looking for **established NHS executive leaders**, **currently in an executive role** sitting as a voting member on your Board and who have experienced an **executive role for at least 2 years cumulatively**. This will ensure that the participants I engage with have had adequate experience of an executive role and we are able to talk about accounts of what it means to be resilient within this context.

I am seeking an even **mix of varying professional backgrounds** (e.g. both clinical and managerial) and I am also interested in **varied experiences of NHS services** (e.g. rural, urban, acute, community, mental health, commissioning etc.)

What does participation involve and what do I have to commit to?

I am looking to interview participants openly surrounding their experiences of personal resilience in terms of being an NHS executive leader. Participation is completely voluntary.

The areas we will explore will include the following, related to the context of being an NHS executive leader:

- ***Causes of resilience***
- ***Defining resilience***
- ***Developing / maintaining resilience***
- ***Not being resilient***
- ***Longitudinal / changing views on resilience***
- ***Resilience in care-based professions***

Interviews will involve a relaxed, open and exploratory conversation around your experiences of personal resilience in your executive role, related topics and sharing your personal accounts and stories relating to the subject. As I am interested in your personal and natural accounts, it is likely to feel more like an exploratory chat or discussion rather than a formal interview. The exploratory nature of my study will mean that I will not bring any form of preconceptions around the topic as I am interested in your own personal thoughts and stories and where this leads us.

Working within healthcare, I understand the challenging nature of your executive role. Therefore, our interview will be flexible and we can agree how best to arrange this around your schedule. However, to ensure my research is successful I do need a commitment from you to providing enough undisturbed time to fully explore the subject with me.

Ideally interviews will be conducted in a quiet, comfortable environment of your choice that is free from disturbance. I would expect the initial interview to be scheduled for around 2 hours, however I would like us to explore the subject until we reach a natural end-point. This may mean we finish earlier, or, if there is still more to discuss and explore we can arrange to schedule a follow-up interview.

I would also like the opportunity to re-interview you after I have undertaken some analysis on your narrative. This will enable me to check my understanding and interpretation of your narrative, and allow you opportunity to reflect on the narrative you provided me in more depth. Therefore, the follow-up interview is expected to be shorter in duration and last between 1-2 hours maximum.

Is there any reason I shouldn't take part?

I am not able to interview colleagues that I work closely with (i.e. those from my own organisation). I would also discourage you from participating if you feel that you are currently going through an intensively stressful time (i.e. over and above what you would consider normal for you) as I do not want you to feel overly uncomfortable when sharing personal accounts of being resilient as an executive. If you are interested but are not fully sure if you should participate in these contexts, please contact me to discuss this using my details at the end of this form.

How will you use my data and keep it confidential and anonymous?

I will keep your data and your identity anonymous by using pseudonyms, never refer to any names or identifiable data, and ensure that any contextual data utilised does not compromise your anonymity.

I will record our interview conversations on a secure, password-protected device and then personally transcribe these. Once transcribed and analysed I will erase the recording. This means that no one other than myself will hear these original audio recordings.

The resultant transcript of your data will be kept confidentially on secure University IT servers that conform to strict data protection standards. I will keep these transcripts for the duration of my PhD programme (3-5 years) and then in accordance with good data governance procedures, for up to 10 years after this time for potential use in publications. During this time, the data will be reviewed following good data governance procedures and ultimately destroyed when it serves no further use.

To provide additional assurances around anonymity/confidentiality, your participant consent form containing your allocated pseudonym will be securely stored separately from your transcript and only accessible by me. This means that your transcript cannot be linked back to your name.

My approach to the research is to analyse your narrative descriptions of what it means to be personally resilient as an NHS executive, which means that I am likely to quote extracts of your personal accounts from our conversations. These will remain unaltered and in their original form, unless there is any data that could explicitly compromise your anonymity and in which case the quotes will be altered. For example, you may share contextual and demographic information relevant to your role and I may need to share this to add context to your narratives, however this demographic information will be purposely generalised where possible to provide assurances around your anonymity. An example of this could be you state "I am a Director of Nursing within Jo Blogs Community NHS Trust in Smith Town which employs 2,457 staff and have been in the NHS for 31 years having started out in paediatrics… etc" which is likely to be generalised into "The participant is a Director of Nursing within a medium-sized community Trust having worked in healthcare for some time".

I will need to discuss the research with my small supervisory team at the University, however they will not know you by name and only by a pseudonym. This approach will be carried forward into writing up and disseminating the research in the future.

As per good researcher ethical practice, they only possible time that I may ethically have to compromise confidentiality would be in a highly unlikely event that you shared information with me that could compromise safety (e.g. you intend to cause harm to others, yourself or disclose unlawful activity).

Resilience is a personal topic - what if I need support after the interview?

I value your time as a participant and my aim is to ensure that you are comfortable with engaging with my research study. Discussing your personal accounts of resilience could understandably be a mildly uneasy subject. It may bring up past experiences that you may want to explore in more depth after our interview. Should I feel the need to, I will check-in with you during the interview to ensure that you are ok to continue, and equally you are free to disengage at any time. If you feel the need for support following the interview, you can engage with: NHS organisational counselling services, and/or NHS occupational health and wellbeing services.

What if I change my mind?

Participation is voluntary. After our interview, you may reflect on our discussions and decide that you wish to withdraw certain aspects of the interview, or from the research programme entirely. This is understandable and I will offer a 14 day cooling off period to allow for this should you change your mind. Please discuss any concerns with me as soon as possible before this time, as after 14 days I will begin to integrate and synthesise your data into my wider research study and analysis.

As stated above, I will also seek to arrange a follow up interview with you to share my interpretation of your personal accounts and explore deeper meaning. This approach also allows you the opportunity to review the themes from your narrative and feel assured that I have interpreted and reflected your data correctly. If a follow up interview is not possible we can explore alternative options such as phone conversation or email review.

What will you do with the research?

This research forms part of my PhD studies and will form part of my thesis write-up. I will also seek to publish parts of the thesis to share and disseminate findings. Sharing findings is important to the NHS as this will lead to better ways to enhance and develop the resilience of current and aspiring executive leaders and the wider leadership community in practice.

I am hopeful that your accounts will ultimately contribute to increased knowledge in this area which will ultimately support enhancing leadership development practice in the future. If you are interested in my findings, I will be able to share a summary of these with you when I complete my study and/or share any publications resulting from my work. You can indicate your interest in the participant information sheet.

More about me as a researcher and my interests in this subject

My full-time role is working within the leadership and talent development arm of Health Education England. I have a deep passion for the field of healthcare leadership development. Working to support established and developing senior leaders has led me to a personal interest in how both I and the wider NHS can better support our talented leaders to effectively reach and maintain their potential.

In order to challenge myself personally and add rigor to my passion and curiosity within this area, this research piece forms part of my PhD that I am studying with the University of Worcester. I am hopeful that my study will both help me to be a better leadership development practitioner in

healthcare, and also offer insight into how the wider NHS can better support senior leaders in the future.

Whilst I am engaging with you primarily as a researcher, I see that working in leadership development in the NHS helps me engage with and understand the context that you work within as an NHS executive leader, and ultimately helps with my interpretation of your narrative.

I have a few unanswered questions, what do I do?

Please do contact me using my details below if you would like to take part and/or if you would like an informal conversation to discuss any aspects of my research in more detail.

What happens next?

If you agree to take part in the study, I will liaise with you to arrange a suitable date and time to schedule our informal interview. I will also ask you to **complete and sign a consent form** that acknowledges your agreement to take part in the research and to send this back to me scanned/electronically to allow us to progress.

Contacting me for next steps

To indicate your interest in taking part in the study, or for any other queries please contact me at my University email address, indicating the best way of contacting you. You can also call me directly on my mobile phone: **[Contact details]**

*NB – Once you agree to take part in the study, **I will only use my University email address** to provide you with assurances that communications with me are confidential as no one else can see this address. This also allows me to easily differentiate my research work from my job role within Health Education England. The consent form also asks you to clarify how you wish me to communicate with you e.g. personal or work email.*

What if I want to talk to someone at the University?

You are able to discuss any aspect of my research with my PhD supervisor at the University of Worcester **[Contact details]** or, the Deputy Pro Vice Chancellor for Research Studies at the University of Worcester: **[Contact details]**

Consent agreement for the research project:

How do NHS executive leaders experience personal resilience?

***When completed**: Please sign, electronically scan (e.g. PDF) and send this form back to me at my University email address:* **[Contact details]** *which will allow me to formally proceed working with you. I will also bring the form with me at our interview to clarify consent.*

I, the undersigned, confirm that (please initial boxes as appropriate):

1.	I have read and understood the information about the project, as provided in the **Information Sheet**.	
2.	I have been given the **opportunity to ask questions** about the project and my participation to my satisfaction.	
3.	I **voluntarily agree** to participate in the project.	
4.	I understand that I can **withdraw at any time before the interview** without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn. **Following interview, I understand that I have a cooling off period of 14 days**. Should I wish to withdraw elements of my interview, or it in its entirety, I must contact the researcher within this timeframe to do so. I understand that outside of this timeframe, the researcher may have begun to synthesise my data into the wider research piece.	
5.	The procedures regarding **confidentiality and anonymity** have been clearly explained to me (e.g. use of names, pseudonyms, anonymisation of data, etc.).	
6.	Forms of **data collection and storage** (i.e. interview recordings and transcripts) have been explained to me.	
7.	The **use of the data** in research, publications and wider dissemination has been explained to me.	
8.	I would like to be **kept informed of the outcomes** of the research study?	
9.	My **preferred email address** and **contact number** for all communications as part of this study is _____	

I, along with the Researcher, agree to sign and date this informed consent form:

Participant

_____	_____	_____
Name of Participant	Signature	Date

Researcher

_____	_____	_____
Name of Researcher	Signature	Date

Participant chosen pseudonym

For reference only, to be discussed at interview _____