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FEATURE ARTICLE

Nurses' experience of adjusting to workplace violence: A theory of adaptation

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ABSTRACT: *Workplace violence directed at nurses working in both the mental health and general areas of the hospital is a common occurrence and the impact of these events on all parties may be severe. A consequence of these confronting situations is the possibility that nurse victims will leave the profession. To help administrators facilitate nurses' psychological recovery, this qualitative study identified how nurses in several areas of a hospital setting adapted to workplace violence, research which has been previously unexamined. This study was the first of its kind to use a theory of cognitive adaptation to explore nurses' experiences of workplace violence. Participants were found to use the cognitive processes of* finding meaning, gaining mastery *and* enhancing the self *to adapt to workplace violence. Critical incident debriefing may facilitate the nurse victim's psychological recovery following an episode of workplace violence.*

KEY WORDS: *adjusting, cognitive adaptation, nurses' experience, workplace violence.*

INTRODUCTION AND BACKGROUND

In recent years there has been increased interest in workplace violence (WPV) toward health care providers both internationally and nationally with studies showing that nurses routinely encounter these events (Di Martino 2002; Henderson 2003). Acts of WPV include such things as verbal threats, verbal abuse, sexual harassment, physical intimidation, physical assault, racial discrimination, and property damage (Farrell *et al.* 2006; Mayhew & Chappell 2003). The impact of WPV to all parties is substantial and includes physical and psychological injury, disruption to patient care, and staff resignation (Armstrong 2006; Farrell *et al.* 2006). For a more detailed review of WPV directed at nurses see Chapman and Styles (2006), and Woods and Ashley (2007).

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Nurses frequently experience incidents of WPV (Di Martino 2002; Henderson 2003), however, although some leave the profession (Farrell *et al.* 2006) many continue to be part of the health workforce and care for those people that are the most common offenders in these acts, namely, patients (O'Connell *et al.* 2000). To understand how nurses remain in employment in the health sector and continue to care for the perpetrators of these stressful events, this study explored how nurses adapted their view of themselves and the incident of WPV.

The goals of adaptation may be different for the profession, organization and the individual. However, it is safe to assume that all parties want nurses to remain in the health care profession, and to continue to be competent and happy in their work. In this paper we focus only on the adaptation strategies nurses use to achieve and maintain the integrity of their psychological self and maintain emotional well-being (self-protection) following an episode of WPV.

Understanding the strategies nurses use to maintain and enhance their emotional well-being may enable organizations and educators to develop policies and programs to support nurses and reduce the impact of WPV.

In addition, understanding nurses' adjustment to and their perceptions of being involved in WPV can help practitioners capitalize on opportunities to promote positive adaptation.

Research has shown that following a threatening event, an individuals' psychological adjustment is dependent on their ability to cognitively process the experience, develop strategies to help them understand, and then adapt themselves in some way (Grossman *et al*. 2000). Effective coping strategies are directly related to a person's ability to find meaning in and make sense of negative, unexpected, or threatening events (Fjelland *et al.* 2007).

Studies have shown that finding meaning in a threatening event has been associated with positive psychological and mental health outcomes (Draucker 2001). We were able to locate only one study that explored the meaning that nurses ascribe to acts of WPV (Luck *et al.* 2007). Luck *et al.* (2007) examined the impact of WPV on one group of Australian emergency department (ED) nurses and their responses to these situations. The authors found that their participants judged episodes of WPV along three dimensions: personalization of the violence; presence of mitigating factors; and the reasons the perpetrator attended the ED. Luck *et al*. concluded that these factors informed how the nurses responded, how they chose to manage the episode of WPV, and whether they reported the event. Although Luck *et al*.'s study demonstrated that ED nurses make complex interpretations following an episode of WPV, they focused on just one cognitive process (the search for meaning) and on only one group of nurses (those working in the ED). Our study builds on Luck *et al*.'s research by extending the range of cognitive processes employed to adjust to WPV and by including nurses working in several areas of a hospital.

Although it is widely accepted by researchers and clinicians that violence exists in the ED and psychiatric areas, it appears that there is an assumption that this phenomenon does not occur in other areas of the hospital (Winstanley & Whittington 2004). Although most researchers have investigated these events in discreet areas of the health care setting (ED and psychiatric areas) very few studies (Lam 2002; O'Connell *et al.* 2000) have investigated the problem in the general hospital setting as a whole (O'Connell *et al.* 2000) as was the intention of the current study. Therefore this study explored the perceptions and experiences of nurses working in several areas of the hospital including the ED and psychiatric setting in regards to WPV.

In addition to finding meaning, researchers have shown that establishing personal control or mastery is another cognitive process that has a positive psychological effect. Perceptions of mastery reflect individuals' expectation of their ability to influence or control current or future events and those people with greater perceived mastery experience less psychological distress (Townsend *et al*. 1989). When people fail to gain mastery (that is, control their thoughts, emotions and actions) and feel unable to influence their life circumstances, they are at greater risk of psychological stress (Bengtsson-Tops 2004). Furthermore, to feel better about themselves after a threatening event, individuals will often make cognitive efforts to improve their self-esteem (Dewar 2003).

This study utilizes a theory-before-research approach (Berg 2009). We use the theory of cognitive adaptation (Taylor 1983) to understand nurses' perceptions of being involved in WPV because the focus of the model is on how individuals adapt their views and thinking following a threatening event. An assumption of this study is that nurses who have been recipients of WPV have experienced not only an act or threat of physical abuse but also an assault on their psychological self. Thus, to understand the event of WPV and to deal with its consequences, nurses will aim to preserve and enhance their self-identity. While Taylor has developed this model further (Aspinwall & Taylor 1992; 1997), because the original model was more parsimonious and appeared more relevant to WPV we considered that the fundamental framework was better suited to our purpose. Therefore, Taylor's (1983) model was chosen to examine whether the model could adequately explain nurses' experience of coming to terms with an incident of WPV in a non-teaching hospital context.

To our knowledge this study is the first of its kind to use a cognitive adaptation framework to explore nurses' adaptation and adjustment to WPV. As a result, the findings from this study will not only build on the literature of WPV but also add new knowledge regarding this phenomenon.

AIM

This study aimed to explore how nurses adapt to WPV and to examine whether Taylor's (1983) theory of cognitive adaptation could be used as a framework to understand nurses' perceptions of being a recipient of these events. Taylor's framework may enable researchers to identify those resources that nurses use to enable them to return to their previous level of functioning on their wards or departments and to provide effective patient care following an episode of WPV.

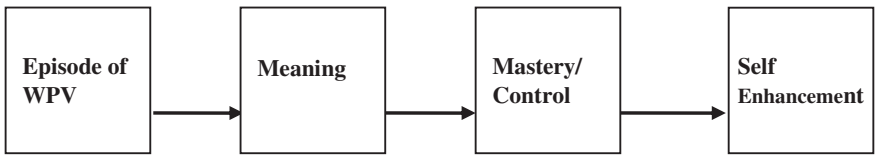

FIG. 1: *Conceptualisation of Taylor's model of Cognitive Adaptation.*

CONCEPTUAL FRAMEWORK

Taylor (1983) developed a theory of cognitive adaptation to life threatening events following work with cancer patients, rape victims and cardiac patients. She proposes that to achieve a quality of life that is equal to or exceeding that which the person experienced prior to a personally threatening event, the individual is required to engage in a readjustment process. This process focuses on three main themes: the search for meaning, gaining a sense of mastery or control over the event and its consequences, and self-enhancement (see Fig. 1). To protect the integrity of their psychological self and maintain emotional well-being (self-protection), individuals use the adaptive process of finding meaning in and gaining control over the event.

The search for meaning requires individuals to make sense of the event to understand why the catastrophe occurred and what impact it will have on the rest of their lives. Mastery entails the person regaining control over this and future events. Following an event individuals will usually experience diminished self-esteem and, in order to recover, they are required to find ways to feel good about themselves. According to Taylor, self enhancement is achieved by comparing oneself to others who have not fared as well in a similar situation, and thereby bolstering one's self-esteem. Moreover, Taylor argues that to successfully resolve these three processes the individual is required to form and maintain a set of illusions (which other people may or may not consider 'true' or 'correct'). These illusions necessitate individuals to view the known facts in a light that will enhance or maintain their view of themselves.

DESIGN

The explorative study involved the collection of qualitative data through interviews. All 322 nurses working in the ED, restorative, medical, surgical, maternity, paediatric and mental health areas of a non-teaching metropolitan hospital in Western Australia, and who had direct patient contact, were sent letters explaining the purpose of the study and inviting them to participate. As a result 35 nurses who had experienced an incident of WPV agreed to be interviewed in 2006. Theoretical saturation was reached after twenty interviews, that is the researcher failed to obtain any new information and all categories and themes appeared to be complete (Sandelowski 1986). Ethical approval was obtained from the ethics committees of the case study hospital and a university. All nurses participating in the study were given an information sheet about the study and gave written informed consent prior to participating in the interviews.

While it was not envisaged that any participant would experience distress from being interviewed, the researchers still planned for the management of participant distress in line with the university risk management policies. Following the interview the researchers undertook a 'debriefing' period with the participant to ensure that they were not experiencing any distress from the interview.

The participants in this study were mainly female (three of the 20 participants were males), in their early 40s, had been registered in the profession between six months and 40 years (with a mean of 17.8 years), and mainly worked part-time. Their roles within the hospital included enrolled, registered and clinical nurses and management positions.

Interviews

Semi-structured interviews or 'conversations' were conducted to explore nurse participants' experience of WPV and to gain an understanding about the meaning and interpretations of these events (Llamputtong & Ezzy 2005; Speziale-Streubert & Carpenter 2003). The interview questions were derived from the aims of the study, were open-ended, and directed towards uncovering the meaning of the nurse participants' experience of WPV (Fontana & Frey 2000). An interview guide was used in each interview with a set of questions and prompts to reduce any researcher bias.

Some examples of the questions asked are: Can you please tell me about a time when you experienced a violent encounter during work? Can you describe as specifically as possible this event/s? Can you share your thoughts, feelings and perceptions about the situation? The interviews began with the researcher developing trust with the participants: this process was assisted by providing a quiet environment, without interruptions, by being receptive, and by listening non-judgmentally

(Llamputtong & Ezzy 2005). All of the interviews were tape recorded and then transcribed verbatim.

DATA ANALYSIS

Data were collected and analyzed simultaneously. The interview transcriptions were analyzed using the standard processes of qualitative analysis: coding; finding categories; clustering; and identifying patterns and meaning (Speziale-Streubert & Carpenter 2003). The transcribed data were reflected on and coded line-by-line to identify significant meanings, the coded significant meanings were then clustered and the relationship between them identified. This method confirmed that the themes which emerged from the data were adequate and informative (Morse & Richards 2002; Strauss & Corbin 1990). While we used the three major processes of the conceptual model to analyze the data, we were also alert for other unexpected or novel categories that may have emerged.

Rigour was ensured by establishing trustworthiness (Berg 2009; Fossey *et al.* 2002) and was achieved by addressing credibility and transferability of the data (Lincoln & Guba 1985). Credibility was ensured by giving a sample of the transcripts to two experts in qualitative data analysis. These experts coded and categorized the data individually. There was overall agreement and consistency between the experts' analysis and that of the researchers. Furthermore, participants were contacted to verify the findings (Lincoln & Guba 1985; Sandelowski 1986) and all agreed that the findings reflected their experiences. Transferability was established by developing rich descriptions and maintaining an audit trail to allow comparison of our study with those conducted in similar contexts.

Following data analysis, 28 descriptions or narratives (four of the interviews provided the researchers with more than one account of an experience of WPV) of the participants' experiences of WPV were developed. The following section presents the findings from our study and includes pertinent literature that directly relates to the categories and subcategories. The discussion section of the paper will interpret the results more broadly.

FINDINGS

The three cognitive processes that form the conceptual framework were identified in the data: finding meaning, gaining mastery and self-enhancement. The findings demonstrated that all nurses in our study used these cognitive adaptive processes to adjust to their experiences of WPV.

Table 1 presents a summary of the original three processes from the conceptual framework, the frequency with which they were used and examples. In addition, it provides evidence of the subcategories (or finer level processes) that emerged from, and which afford a better understanding of, the data.

The following section focuses on the evidence for each of these processes in turn. In the quotes used in the following sections phrases pertinent to the cognitive process being discussed are italicized.

Finding meaning

As demonstrated in Table 1 all of the participants in our study sought meaning by describing the event in a logical, step-wise fashion (sequencing) and explaining why it happened: these were identified as two aspects of finding meaning. The explanations attributed causes or reasons for the episodes of WPV and usually related to trying to understand the behaviour of the perpetrator. The predominant external cause attributed to WPV was physical and/or psychological illness and the most frequent internal reason was the inexperience of staff.

Finding meaning therefore constituted making sense of these events by presenting the experience in a sequential way and assigning cause. For example, a junior nurse recounted the time when she:

> . . . was showering an elderly patient who was known to be aggressive. *I was inexperienced* and *thought that I could handle the patient* and *became over-confident*. . . . I bent down to help him assist with his socks and while my head was down like low he swatted me around the head and knocked me sideways. . . . because *this gentleman had dementia* there was no blame towards him . . . (Mia)

Finding meaning has been shown to assist victims of hate crimes to heal. For example, Willis' (2008) phenomenological study of gay men who had been victims of one or more hate crimes found that to effectively heal from these events the victims found meaning and ultimately achieved a balanced perspective on the experience.

Gaining mastery

As shown in Table 1, the nurses used mainly psychological but also physical strategies to achieve control or mastery of these events. Some of these strategies occurred during the incident and others at a later date.

A sense of personal control, or mastery, is central to achieving psychological adjustment (Bengtsson-Tops 2004; Marshall & Lang 1990). There is evidence that the nurses in our study regained control of their situations by employing strategies such as attending counselling,

TABLE 1: *Summary of the cognitive processes, categories and subcategories within each, frequency of mentions and examples*

Cognitive process	Categories	Subcategories	Frequency	Examples
Finding meaning				
Sequencing			28	
Attributing cause	Internal	*Inexperience*	7	Young, not picking up cues, over confidence
		Seniority	4	Coordinating, being a manager
		Rapport	3	Believing rapport was established
		Philosophy of care	3	Duty of care for others
		Displaying anger	2	Being cross
	External	*Substance abuse*	6	Alcohol and/or drugs
		Illness	14	Dementia, infection, delirium, mental illness
		Lack of care	7	Lack of care for family member or patient attributed to nurses
		Refusing care	7	Absconding, not cooperating, refusing medication
		Organization	8	Lack of staff, busy shift, long wait times
		Mood of perpetrator	2	Tired, impatient
		History of aggression	3	Groups fighting prior to admission
Mastery	Physical control	*Calling authority*	8	Police, security, senior colleagues, code black
		Avoidance	6	Walking out, discharging aggressor, refusing to care for them
		Restraint	5	Physical and chemical
	Psychological control	*Debriefing*	5	Counselling, talking to colleagues and friends, talking to police
		Diffusing	7	Talking them down, distracting, explaining, reassuring, apologizing
		Assertiveness	11	Raising voice, verbalizing, demanding respect, giving ultimatum
		Nurturing self	5	Humour, tea or coffee, deep breathing, going for a walk
		Perception of blame	4	Not personalizing event, not perpetrators fault
Self-enhancement	Comparisons		20	More competent, more experienced, more assertive, being bigger, male
	Positive view of self		9	Experienced, knowledgeable, emotionally strong, willing to confront
	Finding benefit	*Self*	26	Learning, more confident, better prepared, more assertive, better clinician, better father, more mature, less arrogant
		Others	2	Protecting inexperienced staff
		Organization	3	More security in place, better processes

reporting the event to the police, initiating physical and chemical restraint and avoiding similar situations until their confidence had been rebuilt. For example Mia explained that 'I actually *avoided the patients* who I felt were risky for a few weeks until I built my confidence back up'. Sally was more proactive in her pursuit to regain personal control over her situation:

> . . . *I called security for help* and afterwards *I talked about it* [WPV] . . . we talked it out . . . one of the girls made me a cup of tea and we calmed down and sat down and lucky it wasn't busy on the ward. And *we just talked it through* and by talking it through it *made us calm down* . . .

Studies investigating mastery in the psychological and nursing literature have found that a perceived sense of mastery positively influences one's psychological and behavioural adjustment (Bengtsson-Tops 2004; Marshall & Lang 1990). Although we were unable to locate any literature that investigated nurses' use of mastery following an episode of WPV, the findings from our study suggest that this process is part of their psychological adjustment following these events.

Self-enhancement

We found that the participants in our study used three strategies to boost their self-esteem. As shown in Table 1, they compared themselves favourably with their colleagues, evaluated themselves positively and found benefit to themselves, others or the organization. For example Frank compared himself with a junior doctor:

> I've seen one of our . . . [junior] medical officers, *she's . . . not picking up any clues* that she was about to get her head knocked off, she's just too sweet a person and has no experience . . . this guy was getting that close, he's raising fists and screeching at her and he's going to hit her . . . because *I have 40 years life experience and a lot of work experience I would have managed the situation better* . . .

Although all of the senior nurses in our study used downward comparisons and considered that they were better able to manage WPV than their less experienced colleagues, some of the more junior participants (less than three years experience) were more sceptical of their senior colleagues. These nurses believed that after observing senior nurses managing situations of WPV they themselves would have handled the circumstances better. For example, Alice observed an aggressive interaction between her patient and the shift coordinator and thought she would have handled the situation much better than the coordinator:

> . . . he'd [patient] been told he'd be moving into a four bed room, he just snapped within five seconds . . . *the co-coordinator that went in there* [patient's room] *had a different tack to what I would have had . . .* because of the way he'd behaved previously . . . . I would have picked that he'd behave that way. *If I had been the one telling him he was moving I wouldn't have even gone into any of that . . .*

We are not sure why the junior nurses in our study believed they could have better managed the events of WPV that they had observed. Maybe they did indeed have better communication skills or their education prepared them to control the situations more effectively than their senior colleagues. On the other hand, when one is observing WPV from the sidelines and not taking responsibility for the outcome, it may be easier to inflate one's ability and effectiveness. While it is beyond the scope of this paper to investigate this phenomenon, future research could address nurses' education and communication requirements to enable them to manage WPV more effectively.

The second strategy identified in the literature to restore or enhance one's self-esteem is construing personal benefit from a negative or threatening experience (Davis *et al.* 1998; Taylor 1983). The participants in our study considered themselves to be personally and professionally better off than they were prior to the experience/s of WPV. For example, because Jenny has been involved in many episodes of WPV she now considers herself to be better able to manage these events '. . . . I've had to physically deal with it [WPV] many times in my practice . . . I have [a] *better understanding of it* [WPV] . . . and [as a result] I'm *much better at dealing with it* [WPV] now . . .'. In another example Frank thinks he is a much better family man and clinician as a result of being involved in several incidents of WPV because he is more aware of his feelings '. . . I *recognise things* [now] *much more quickly* and try and spend and do more things at home . . . I think *I'm a better clinician and father* because *I'm more aware of my own feelings . . .'*

We argue that being a recipient of WPV is traumatic and has significant impact on a nurse's psychological self. The literature has shown that finding benefit can minimize the negative implications of a traumatic event and is one way a person can assign positive value or significance to their life (Taylor 1983). Our participants considered that they were better clinicians (in one case a better father) as a result of experiencing WPV. According to Taylor both the cognitive restructuring of favourable comparison and construing personal benefit are based on the individual's ability to maintain a set of illusions.

Contrary to the view that positive mental health requires an individual to be in touch with reality, Taylor (1983) contends that not only are illusions necessary but that they are dynamic and can 'simultaneously protect and prompt constructive thought and action' (p. 1171). Positive illusions may be adaptive for one's mental health and well-being (Taylor 1983). In particular those illusions of positive self-evaluation and optimism, and an exaggerated perception of control or mastery, have been suggested as leading to effective cognitive adaptation (Taylor & Brown 1988).

DISCUSSION

Our study provides a 'snap shot' of nurses' experiences of adapting to WPV in one non-teaching hospital and thus the ability to generalize our findings to other contexts may be limited. However, this study is the first of its kind to explore in some detail nurses' cognitive adaptation processes following episodes of WPV and as such offers new knowledge and insights into this phenomenon. Our findings indicate that nurses' reactions to their experiences of WPV can be explained in terms of Taylor's (1983) theory of cognitive adaptation to traumatic events. All of the clinicians in our study (all of whom had continued to work) had adapted to their experiences of WPV by finding meaning, gaining mastery and enhancing themselves.

Finding meaning required our participants to be able to tell of their experiences in a sequential way and make direct attributions as to what caused the episode of WPV. These included what and why the event happened, and who was to blame. On most occasions the nurses ascribed blame to others (usually the patient) as a cause of the event.

It is noteworthy that except for their lack of experience, the nurses in our study ascribed causes that they considered they had little or no control over. For example, the nurses felt that they could not control which patients

were admitted to the hospital, long wait times for patients to be seen by a health provider, inadequate skill mix of staff, or the offenders' substance abuse. This is contrary to Taylor's (1983) findings where the cancer patients in her study attributed causes of their disease to factors that they had some control over such as stress and diet. Taylor asserts that individuals identify causes of life threatening events that are controllable, either immediately or in the future. We argue that this assumption is not necessarily correct because even though the nurse participants in our study considered that they could not control many of the actual causes of WPV they still managed to find strategies that enabled them to regain mastery of the event such as seeking counselling and reporting the incident to the police.

A self-enhancement strategy used by the participants was to compare themselves favourably with others. All of the nurses believed that they were better able to manage or deal with WPV than their colleagues. This strategy allowed the participants to maintain their self-esteem and was therefore central to their adjustment and adaptation to WPV. Downward comparison (comparing themselves with people who they consider less able to manage WPV) is a reasonably vigorous method of self-protection against threat (Taylor 1983). Our study affirmed Taylor's assertion that 'everyone is better off than someone' (Taylor 1983; p. 1166). For example, the senior nurses compared themselves favourably with junior and less experienced clinicians. However, those junior staff that observed their more experienced colleagues manage an event of WPV considered that they themselves would have handled the situation better if they had been in charge.

We would argue that our junior nurses are selecting their social comparison targets to enable them not only to validate themselves but, because their management of these events was hypothetical and untested, also to construct a favourable view of themselves and their abilities. An additional reason for this finding could be that nurses may be wearing their experiences of WPV as a 'badge of honour' and that this strategy may also be a part of their adaptive process. If this interpretation is correct, what are these medals demonstrating? Could they be evidence of their bravery, knowledge, ability or their qualification to be a member of the nursing profession? If the latter is the case then this may be a further reason that our junior nurses hypothesized positive abilities to manage WPV.

It is important to note that we did not interview nurses who had left the profession because of WPV and therefore it may be that our participants were unusually well-adjusted following their experiences of WPV. To gain a comprehensive understanding of nurses' adaptation to WPV future research should focus on those clinicians who have chosen to leave the profession because of these events.

Although we have presented our findings of meaning, gaining mastery and enhancing self in mutually exclusive categories, many of these cognitive processes may serve more than one function simultaneously. For example, believing one has control (mastery) or making downward comparisons (self-enhancement) may both enhance the self. In our study most participants cognitively adapted to WPV by finding meaning, gaining mastery and enhancing their self-esteem, however, to achieve an effective level of functioning all of these processes appeared to be recursive. We postulate that participants may revisit and continually reflect on their experiences, reframing them to achieve self-enhancement and self-protection. These techniques may work toward gaining control of the event and may help guide behaviour in future situations. As a result of these observations we have re-envisaged the theory of adaptation as presented in Figure 2.

Although we argue that adaptation to WPV is critical to an individual's psychological adjustment, many questions remain, such as: Are there long-term negative effects for nurses, organizations and the society at large of adapting and adjusting to WPV? Does a person's belief that they can control and master WPV make them more vulnerable to these events? In fact, do those individuals with unrealistic optimism regarding their abilities lead them to ignore the warning signs that an event of WPV is likely to occur and to take unacceptable risks? To build on the understandings of the process of adaptation evident in this study, and answer these questions, further research is needed.

The results of this study have demonstrated that on the whole the nurse participants cognitively adapted to their experiences of WPV. This outcome was achieved by utilizing such strategies as finding meaning, gaining mastery

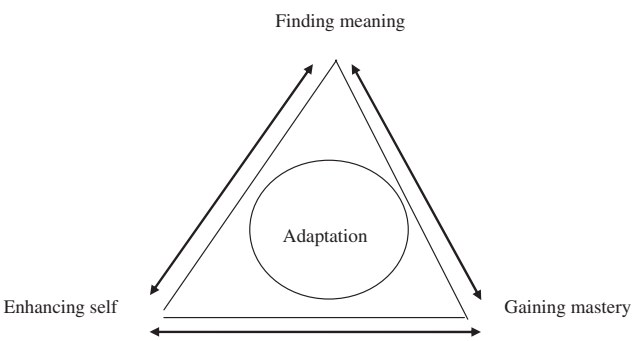

FIG. 2: *Model of cognitive adaptation to WPV.*

and enhancing the self through social comparison and maintaining a set of positive illusions. Therefore, we contend that to assist nurses through the process of cognitive adaptation, organizations are obliged to develop policies and practices that provide staff with formal and informal counselling and support services (Dean 2004). In this way nurses may be enabled to reflect on events of WPV shortly after the incident and their psychological recovery will be accelerated (Cembrowicz & Shepherd 1992). This strategy will guide nurses through these distressing incidents and hopefully help them find meaning, take some control and feel better about themselves following an event. These policies and interventions would assist hospitals and health agencies to fulfil occupational health and safety requirements that oblige them to mitigate WPV and support staff following these events (Morrison & Love 2003).

CONCLUSION

All of the participants in this study had experienced WPV perpetrated by either their patients or their friends and family. As a consequence the participants adjusted to their experiences of WPV by using strategies in an attempt to overcome such situations.

Our study shows that Taylor's (1983) theory of cognitive adaptation can improve our understanding of nurses' experiences of WPV. However, we have refined this theory. Firstly, by detailing specific types of strategies which constitute each process and secondly, by arguing that these processes are not functionally mutually exclusive. Further, we have suggested that the cognitive processes involved in adapting and adjusting to WPV are not linear but recursive. Future longitudinal research could address this issue.

In considering the implications of the present study we have argued that to facilitate nurses' psychological recovery following an episode of WPV administrators, educators and nurse colleagues are required to implement therapeutic interventions strategies such as critical incident debriefing to assist them to cognitively adjust to the event.

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