From the Editor's Desk

As with many aspects of life during the age of covid-19, the summer issue of the Grounded Theory Review has been delayed. We are pleased to publish, however late, this issue. The Grounded Theory Review is dedicated to supporting researchers who conduct classic grounded theory research. Classic grounded theory is a unique method of discovering never before recognized processes and patterns of human behavior, a method well-suited to studying current issues and processes.

These are troubling days of pandemic illness, cultural upheaval, racial animus, international disruption, and political turmoil. Although politicians and opinion journalists predict the future, the coming months are uncertain. We are in uncharted territory. In response, particularly to covid-19, structural and psychological social processes are changing. Education, family life, health care, work life, business, consumerism, sports, trade, entertainment, government institutions, and travel are all changing. People are assuming new roles or are adjusting their roles to fit new life circumstances. This is a time of great upheaval—a time particularly ripe for grounded theory research.

The beauty and value of classic grounded theory is the nature of honest, unbiased discovery of social processes. Proper classic grounded theories cannot be preconceived or conjectured. Unlike verification research, grounded theories provide insightful, enlightening, and often surprising revelations—discoveries. As data is gathered, conceptualized, and organized by the investigator, concepts and processes emerge.

Emergence is the key to the discovery of grounded theories. Researchers who use other, usually deductive, methods are sometimes confused by the idea of emergence, which is mostly inductive. We can compare the concept of emergence in grounded theory with how we have learned about covid-19. Since it was a newly discovered virus, there were no textbooks to guide health professionals as they tried to combat the virus early on. Facts have emerged from data as a cascade of covid-19 patients has appeared in hospital emergency rooms in the intervening months. Although it was thought at first that serious cases of covid-19 generally presented as pneumonia for a relatively short duration, we now know that the virus can affect many different parts of the body in unusual ways for an unknown duration. Months later, facts and patterns are still emerging. The process of learning about the disease can be compared to the use of grounded data to discover conceptual theories. In the same way that physicians with open minds collected, organized, and examined medical data to guide their diagnosis and treatment of covid-19, grounded theorists can gather, organize, and interpret data that will help us to understand and navigate the many social changes that are occurring.

Explaining grounded theory, Glaser tells us to ask "what is going on" in a substantive area. Today, we have few referents to help us understand what is going on. As a family member who suddenly took on the role of home schoolteacher, I know that traditional ideas about family and school have been turned on their heads and I wonder about other changing social processes. Thinking about grounded theory research projects in the age of covid-19, researchers whose curiosity is sparked might ask questions such as, "What is going on in a given population when suddenly:

- teachers who are accustomed to classroom teaching are thrust into distance learning modalities?
- breadwinners lose jobs due to covid?
- farmers cannot find a way to gather or move their produce to markets?
- parents work from home while caring for children?
- physicians must ration care because of high demand and a scarcity of equipment or supplies?
- business owners are forced to close businesses or lay off employees?
- social activists participate in protest activities they strongly support during a raging pandemic?
- political leaders face mutually exclusive pressures from different constituencies?
- nurses must care for patients even though they have insufficient personal protective equipment?
- judges or prosecutors face potential disease transmission in the courtroom and prisons while adjudicating cases?
- families at risk of domestic violence are quarantined at home for long periods?
- teens' are unable to socialize with peers in the usual ways?
- researchers must gather data and otherwise conduct research while social distancing?

These questions are among are hundreds of potential questions that might stimulate curiosity as our world changes. They are ripe for investigation. I urge experienced and novice grounded theorists and PhD students to turn aside from tired and over-studied phenomena and consider this wide-open opportunity to advance important knowledge. In the first paper in this issue, *Getting Started*, Glaser discusses how to get started with grounded theory research. He examines the unique manner in which research problems and research questions are approached in classic grounded theory. New grounded theories can open doors of understanding. As Glaser has suggested, grounded theories can explain what is happening, predict what will happen, and interpret what has happened. Therefore, the knowledge gained from examination of today's social processes will help others to understand and deal with similar ones as they occur in the future—no longer uncharted territory.

Alvita Nathaniel, PhD

Editor

Getting Started

Barney G. Glaser

Editor's note: Especially helpful for those thinking of beginning new research projects, this paper addresses common questions about the particular way in which grounded theorists identify a research problem and craft a research question appropriate for classic grounded theory. Getting Started was first published by Sociology Press in Glaser's *Emergence vs Forcing: Basics of Grounded Theory Analysis* (1992). This important chapter has been excerpted and lightly edited for clarity and context.

It may sometimes be said that one of the most difficult parts of doing research is to get started. The making of choices and commitments to a research problem seem less secured and structured when doing descriptive research in quantitative or qualitative research. This occurs because the research problem is chosen beforehand and therefore forces the data, thus the yield may be small or nothing since the problem, in fact, may not be relevant. A "thought up" problem may sound juicy, but the preconception leads nowhere.

The underlying principal in grounded theory, which leads to a researchable problem with high yield and relevance, is that the research problem and its delimitation are discovered or emergent as the open coding begins on the first interviews and observations. They soon become quite clear and structured as coding, collection, and analyzing begin and a core variable emerges, and saturation starts to occur. In short, getting started in grounded theory research and analysis is as much a part of the methodological process as are the ensuing phases of the research.

The researcher should not worry. The problem will emerge as well as the manner by which the subjects involved continually process it. As a matter of fact, it emerges too fast most of the time and the researcher must restrain herself until sure if it is core and will account for most of the variation in the action in the substantive area under study. As categories emerge in open coding, they all sound like juicy problems to research, but all are not core relevant. Only one or at most two. Remember and trust that the research problem is as much discovered as the process that continues to resolve it, and indeed the resolving process usually indicates the problem. They are integrated.

Area vs Problem

There is a significant need to clarify the distinction between being interested in an area compared to a problem. A researcher can have a sociological interest which yields a research problem and then look for a substantive area of population with which to study it. But this is not [classic] grounded theory. It is a preconceived forcing of the data. It is okay and can produce good sociological description, but it usually misses what subjects in the substantive area under study consider, in their perspective, the true problems they face. This kind of forcing with the support of advisor and colleagues can often derail the researcher forever from being sensitive to the grounded problems of the area and their

resolutions. A missed problem is a problem whether the researcher discovers and attends to it or not. It does not go away. We find, as grounded theorists, so often in preconceived research that the main problem stares us in the face as the researcher just attends elsewhere and misses it completely in an effort to describe what is going on. Squelching it from focus does not remove its relevance.

In vital contrast, the grounded theory researcher whether in qualitative or quantitative data, moves into an area of interest with no [pre-identified] problem. He moves in with the abstract wonderment of what is going on that is an issue and how it is handled. Or, what is the core process that continually resolves the main concern of the subjects. He discovers that truth is stranger than fiction. If he moves into an area with an interest in studying people in pain, he will discover what problem pain produces and how it is resolved or processed. The social structure of each substantive area can make this resolution quite different. The grounded theorist keeps his mind open to the true problems in the area. A forcing researcher may study risk taking in steeplejack work; a grounded theorist will probably discover that the main problem is negotiating the day's voyeurism, with the risks involved as a minor consideration.

As mentioned in *Theoretical Sensitivity* (1978), it is most advisable to the grounded theorist, when at all possible, to choose an area with a life cycle interest to gain enough motivation to get her through the research to the end product. But, even when a researcher has to study an area of lesser interest, it is likely that the conceptualization of it will still be of interest as a general sociological concern and process. Thus, if one has [grant] money to study meatpacking, he may be able to study on an abstract level the style of eating patterns in diverse social classes.

Areas of interest are not hard to come by. They abound, and with grounded theory, the research problem emerges easily. Whereas a preconceived problem is hard to come by with the surety it will both yield findings and will be supported by enough data. When a research problem is elusive or hard to come by, a lot of people tend to give advice. However, the grounded theorist should be wary, since his approach to the research problem is both grounded and easier. The researcher's search for the preconceived problem is subject to the whims and wisdoms of advisors with much experience and of colleagues. He should be careful as he may just end up studying his advisor's pet problem with no yield for him and data for the advisor. And, he will likely miss the relevance in the data.

Preconception using the technical literature can have a level of groundedness in it, especially at the end of a piece where the author "appeals to future research." This is, of course, a good lead and the grounded theorist should consider these issues but be careful that they are born out in his own emergence of problems in the area, as later date conditions may have changed relevancies. Thus, for [some] women, women's liberation may not be an issue when they would rather [quit work and stay at home while others] wish to get away from [home]. Personal experience and/or professional experience associated with it can produce strong, life cycle, substantive area interest. But the grounded theorist must be careful not to force data with his or her own problem and keep an open mind to the emergence of the subjects' problem. The researcher's personal problem may be idiosyncratic, but once the general concern emerges, it is almost sure to integrate as a

varying property of it. The life cycle interest will be taken care of and be enhanced with understanding coming from the emerging theory.

The Research Question

The need to preconceive is strong when there is no trust in discovery of a problem. The researcher should fight this and learn not to know, when telling himself or others what he is studying. Do not say anything until the core problem has emerged and proves to be a stable focus of the research.

In comparison to preconceived description, there is no dilemma when choosing the grounded theory methodology as to when the problem may become known, whether with quantitative or qualitative data. There is no need to waste time on the debate as to whether or not the research question should dictate the method or the method the research question. The researcher need not be concerned whether or not the data should be collected quantitatively or qualitatively or in what combination, as required when studying the preconceived problem.

Once grounded theory methodology is chosen, this debate is moot. The methodology process [uncovers] the emergent problem and all data of whatever type is grist for the mill of constant comparison…. The emergent research problem will core out and be delimited by diverse conditions such as the researcher's training, the locale of subjects, funding, etc. Boundaries to the problem will emerge and the one criteria of grounded theory, modifiability, says that is a good grounded theory should be readily modifiable to new conditions, new subjects, and perspectives on the same problem, provided that the same problem is relevant in the new area.

Remember that grounded theory research is the study of abstract problems and their processes, not units. Unit analysis is for description. Thus, studying women managing pregnancy is not to focus on women, but to discover their emergent problems and their resolutions for managing the pregnancies. These problems will likely vary considerably with studies in different areas. The problems of middle-class women trying to communicate with [physicians] who do not favor natural childbirth are far different than those of lesbians trying to communicate with macho, male [physicians].

The Specific Research Question

To repeat, the research question in a grounded theory study is not a statement that identifies the phenomenon to be studied. The problem emerges and questions regarding the problem emerge by which to guide theoretical sampling. Out of open coding, collection by theoretical sampling and analyzing by constant comparison emerge a focus for the research.

Even then, when specific questions can be asked without forcing the data or its collection, the researcher never, never asks the question directly in interviews as this would preconceive the emergence of data. Interview questions have to relate directly to what the interview is about empirically, so the researcher maximizes the acquisition of non-forced data. These specific questions are in the thoughts and the analysis of the researcher, to be

reviewed later. Think theory, talk everyday common [language]. And this method of qualitative analysis is the same for qualitative as for quantitative collection of data. In grounded theory there is no preconception of being too broad or global or narrow at whatever stage; the grounded theory process steers the path to bounded focus. And with grounded theory there is also no preconceived relevance as to whether questions to subjects are interactional, organizational, biographical, psychological, or whatever. The emerging questions simply tap the variables that work, whatever the field. Obviously, a researcher is trained in the sophisticated use of one or the other variable and will be more theoretically sensitive in his own area. If a major variable occurs in an area outside his training, he may have to call in a consultant. At minimum, he will have to report this grounded fact in his theory, not ignore it as having no relevance. Thus, a sociologist may have to consult with an economist or psychologist or political scientist at times to better understand processes in their fields.

In sum, when a researcher flounders in getting started on a research project, it is quite often the result of forcing on the data a preconceived problem that ought to take the data apart and give yield, but does not, because of lack of relevancy. The researcher is lost and sees the data as recalcitrant. The grounded theory researcher bypasses this problem in getting started by simply studying what is to be studied with no preconception of what should be in advance of its emergence. He has the patience and security and trust to wait for its emergence. Also, he trusts himself not to know in advance and forces himself not to pontificate that he knows better than the subjects involved what is most relevant to them.

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Strengthening Devotion: A Classic Grounded Theory on Acceptance, Adaptability, and Reclaiming Self, by Parents of Children with Autism Spectrum Disorders

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Abstract

The experiences of parents rearing an autistic child(ren) framed an exploration of caregiver well-being using Glaser's classic grounded theory. The theory delineates struggles, stress, and self-growth through service. Viewed as a roadmap, *strengthening devotion* guides caregivers through a fear-driven landscape of altered perceptions that fuels evolution in awarenss about what it means to love nonjudgmentally with unqualified faith not only in a child(ren) but in one's own resilience. Acceptance, adaptation, and a reclaiming of relinguished self-focus define strengthening devotion. In accepting, entrapment wanes as emotions signal reengagement; in adapting, self-esteem develops with emotion regulation; and in reclaiming life, resilience signals reimagining of self. As uncertainty and reactivity are delimited through activities of service, devotion evolves, conceptualized as a stage-dependent growth continuum, namely: Strengthening Parental Devotion, Strengthening Relational Devotion, and Strengthening Personal Devotion. Ultimately, parents may use the strengthening devotion roadmap to corroborate where they have been, how far they have traveled, and chart proactively to lower stress, improve health outcomes and re-engage with life's unlimited potential.

Keywords: caregiver, autism spectrum disorders, devotion, classic grounded theory, parenting, presence

Introduction

One in 45 US children exhibits behaviours representative of autism spectrum disorders (ASD) (Zablotsky, Black, Maenner, Schieve, & Blumberg, 2015). These behaviours produce post-traumatic-stress syndrome-conditioned reactivity in parent caregivers. This research offers caregivers a pathway to thrive rather than survive on the frontlines of daily caregiving.

Glaser's classic grounded theory (CGT) method provided the systematic structure through which *Strengthening Devotion* emerged as a roadmap for parent caregivers' experiences of self-growth through service. *The Basic Social Process* (Bigus, Glaser, & Hadden, 1982; Glaser, 1978) that arose is grounded in data, conceptualizing experiences of parent caregivers for wellness professionals engaged with this population. Source data integrated 33 items, including first-person published accounts in books, web pages, blogs,

and direct interviews of parent caregivers responding to the *grand tour* question: "Tell me about your experience as a caregiver."

Method

The purpose was to develop a theory to explain and to categorize the experiences of parents who provided caregiving to their children with ASD. Varied perspectives were sought. Classic grounded theory was used to analyze data systematically. Discovery of underlying patterns of behavior that might lead to escalating levels of abstraction and conceptualization was the goal (Glaser, 1978).

Participants were adults 21 years of age and older, who are parents and primary caregivers for a child with ASD and adults identified through theoretical sampling prepared to share experiences of caregiving for a child. Years of caregiving ranged from a minimum of eight to a maximum of several decades. Study participants were also single or married and provided caregiving in situations that included neurotypical children and multiple children with ASD families. Establishing the boundaries of the emergent theory required interviews with participants outside the primary study group (e.g., caregivers of neurotypical children).

Recorded participant experiences were transcribed into digital data and then underwent considerable and deliberate fragmentation through conceptual coding, the core CGT process (Holton, 2007). Constant comparison of incident with incident, and incident with concept, etc., initially generated substantive descriptors and later theoretical categories (Glaser, 1992). Incidents were identified line-by-line within the empirical data and then assigned a code. Codes were grouped and compared when patterns or variations on patterns were recognized.

Two types of CGT coding procedures were utilized: *substantive coding*, which collectively comprise *open* and *selective coding*, and *theoretical* coding. Open coding supported the early work with the raw data. Categorization occurred through fracturing and analysing raw data for the emergence of a core variable and its related concepts. Thereafter, selective coding saturated the core variable and its related concepts. Theoretical coding followed substantive coding and conceptualized the emerged relationships between groups of substantive codes (Glaser, 1978). The process of constantly comparing incidents with substantive codes continued until no new properties or dimensions emerged, a state Glaser (1998) referred to as interchangeability of indicators.

The activity of constant comparison during initial substantive coding paved the way for the identification of this study's core variable, *strengthening devotion*. Strengthening devotion impacted theory categories at all levels and explained how ASD parents experienced their lives, and reflected change with at least two stages; the theory is a Basic Social Psychological Process (BSP; Bigus et al., 1982; Glaser, 1978).

There was a deliberate focus on the development of a minimum of three levels of conceptual abstraction (Glaser, 2001). Categories (higher level concepts that identified underlying patterns in the data) and their properties (a concept that captures a variation in a category) emerged organically as data abstraction progressed. Theoretical concepts emerged thereafter, concepts that subsequently resulted in theory generation. Strengthening devotion was the endproduct of an overall inductive process that produced a series of tightly integrated hypothetical probability statements (Glaser, 1992, 1998) which interpret, explain, and predict how parent caregivers resolve concerns and continually process the impact of their caregiving experiences.

Strengthening Devotion

The researcher investigated the core variable strengthening devotion and how it explained the parent's life journey caring for a child with autism. The significance of strengthening devotion lies in its predictive capacity, most particularly for those parent caregivers just entering into this potentially life-time commitment of caregiving. Strengthening devotion presents a pathway that informs caregivers how to optimize their health profiles. This crucial benefit bestows much-needed choices to parent caregivers at all stages of their caregiving horizons and allows for the adoption of best practices for personal management of long-term caregiver well-being.

The Core Variable

The core variable, strengthening devotion, emerged from open coding, a process that conceptualizes descriptive incidents within the raw data on a line-by-line basis and compares them to each other. The goal is to transcend descriptive details and focus on patterns among incidents that then yield codes. Data from the open coding phase of the CGT research included transcriptions of five live interviews, and two personal narratives in book form. As a unit, the data presented a compelling exposé of personal transformation through the conditioning impact of ASD.

Parents who provided data for this study encountered many challenges. All recalled emotions of dread and worry prior to the diagnosis. Post-diagnosis, feelings of loss were universal and provided the seeds of change that eventually germinated in a willingness to sacrifice personal futures to focus resources on their ASD child(ren). In so doing, parents battled fear daily and fortified resilience while they constructed the necessary connective human network to improve their capacity and capabilities as caregivers. An eventual reengagement with renounced personal goals was experienced by a small ratio of parents who after years of caregiving decided to explore anew relinquished personal careers and talents, via deliberate appropriation of energies away from caregiving and toward individual expression of personal interests.

Parents did not consciously attribute caregiving activities to a desire to strengthen devotion. Attention focused primarily outward toward the ASD child, and secondarily on other neurotypical siblings. Concerns for self received occasional attention. Nevertheless the constant struggles, unrelieved stress, and sustained self-growth experienced by caregivers represented a stage-dependent awareness-continuum conceptualized as a strengthening of devotion. In addition, as the core variable, strengthening devotion was

transformative over time and exhibited stages (Glaser, 1978): *strengthening of parental devotion*, *strengthening of relational devotion*, and *strengthening of personal devotion* (see Figure 1).

Via selective coding (data collection delimited to that which is relevant to the emerging core variable), *unqualified fidelity* and *nonjudgmental love* emerged as defining properties of the core variable. Each of the three stages of strengthening devotion (the *stage of accepting*, the *stage of adapting*, and the *stage of reclaiming life*) (see Figure 1) encompasses experiences, skills, and strategies that contribute to the unfolding of fidelity and love. In Stage 1, which focuses on the emotional journey through loss, fidelity manifests for parent caregivers as the desire to re-engage after the shock of the ASD diagnosis; love manifests as sacrifice of self to support the ASD child. In Stage 2, which focuses on structuring uncertainty, fidelity fosters for parent caregivers a commitment to engage with others for the benefit of the ASD child; love expresses as patience. In Stage 3, caregiver proficiency promotes desire to grow beyond this role, transforming fidelity into openness to explore a broader self; love transforms into tolerance that supports a developing facility with living in presence.

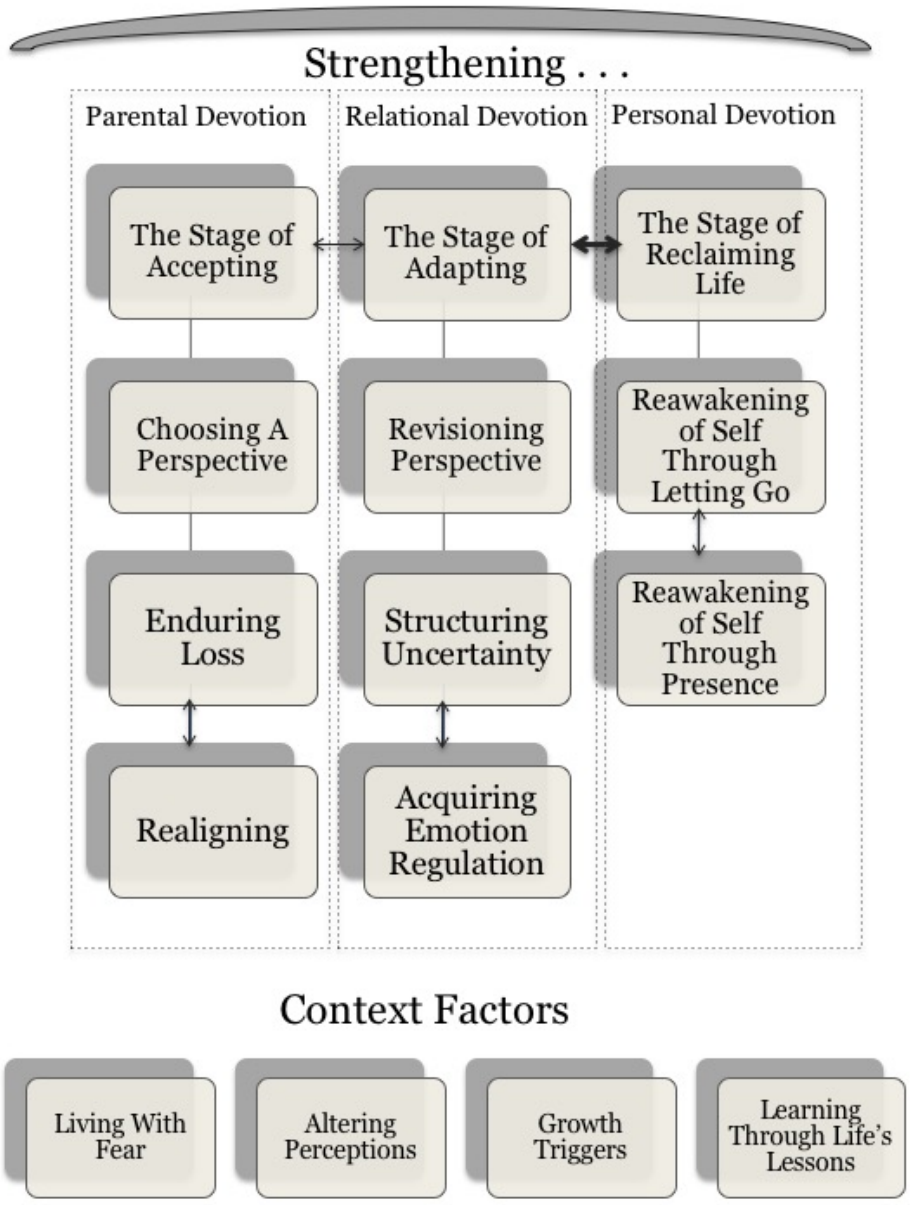


Figure 1. The Theory of Strengthening Devotion is a classic grounded theory on acceptance, adaptability, and reclaiming of self for parents of children with Autism Spectrum Disorders. Devotion presents as unqualified fidelity and nonjudgmental love. Devotion strengthens progressively within and between three stages; namely, the Stage of Accepting, the Stage of Adapting, and the Stage of Reclaiming Life. In addition, three aspects of devotion—Parental Devotion, Relational Devotion, and Personal Devotion—each respectively conditions the first, second, and third stage of the theory. Identified factors of context impact each mode of the theory.

The Context

Parents, by virtue of their distinct uniqueness, perform caregiving through unique filters which differentiate experiences, expectations, and needs. Nevertheless, striking similarities encapsulate physical, emotional, mental, and spiritual narratives. Strengthening devotion suggests that the parent caregiver's life undergoes a permanent restructuring. The context of that restructuring is delineated by properties under which the core variable operates and the stages unfold: *living with fear, altering perceptions, growth triggers, and learning through life lessons.* (see Figure 1).

Living with fear depicts a parent caregiver's ongoing dread and ever-present anxiety that exasperates feelings of vulnerability and overwhelm. Altering perceptions describes the changes in parent caregivers' habitual ways of understanding people and events after their child's(ren) diagnosis of ASD. Daily life takes on a quality of unpredictability that forcibly rewires rigid thinking and exposes caregiver behaviors that both calm and excite a child(ren)' ASD symptoms. Attunement with the ASD child takes center stage. Growth triggers are stimuli of emotional, physical, mental, or spiritual origin, often traumatic or euphoric, that spur within the ASD parent, the development of capabilities, potentialities, and self-awareness. Learning through life lessons conceptualizes the common distillation of daily life into a parent caregiver's scaffold of wisdom.

Stage 1: The Stage of Accepting

Strengthening parental devotion. The properties of devotion, namely unqualified fidelity and nonjudgmental love, symbolize endpoints of a continuum of transformation commencing in Stage 1 with the dimensions of *re-engagement* (for fidelity) and *sacrifice* (for love). In addition, the theory proposes that the core variable strengthening devotion also matures through three stage-specific expressions, the first of which is *strengthening parental devotion*. As the parent caregiver moves through Stage 1, *choosing a perspective, enduring loss, and realigning*, conceptualized as subcategories, encapsulate experiences with caregiving that condition parent responses.

Choosing a perspective. Parent caregiver reflections on early memories with ASD clearly indicate the choosing of a perspective (see Figure 2). As the lens through which fulfillment of responsibilities occurs, the choice of a perspective impacts self-reported satisfaction with life, most especially early on in the ASD journey.

Two perspectives are available, namely, *accepting via force* or *accepting through trust*. Accepting via force views life-from-now-on from the viewpoint of compulsion. The advent of ASD replaces a parent's personal life choices with a mandate that threatens the status-quo of the family unit for the foreseeable future. A respondent remarked, "It kills people's family."

The second choice is to accept the new situation from the vantage point of trust. Whether an individual belief of capability supports the choosing through trust or alignment with a religious faith, this choice ballasts against the inevitable range of emotions that life-from-now-on with ASD creates. A mother remarked:

> It's kind of like, well here it is, and let's just embrace it and keep going forward, even though you don't know where that forward is. To me it's a trust thing, you just have to trust that as a mother and as a caregiver you're doing the right thing. And that you're trying your hardest.

Analysis suggests that the journey with ASD usually begins via force, particularly for first-time parents. For those with neurotypical children prior to the birth of an ASD child, choices range more broadly, generally focusing on a trident of options: force, trust via religious adherence, or trust via self-sufficiency.

Enduring loss. The impact of ASD beyond an initial choice in point of view (i.e., perceiving by force or by trust), involves experiencing four subcategories of experiences (see Figure 2): (a) *shock and denial, (b) pain and guilt, (c) anger and bargaining,* and *(d) depression, reflection, and loneliness*. Experience with enduring loss is unavoidable, even for parent caregivers who divorce themselves from responsibility. Movement through these subcategories is unique and personal. Enduring loss is, therefore, a framework for the categorization of the physical, emotional, mental, and spiritual occurrences relating to incidences of bereavement.

Enduring loss, as a framework, allows for the generalization of common experiences. The identified experiences occur simultaneously, in random order, and loop, as lives move inexorably forward. However, the degree of emotional reciprocity between the caregiver and the ASD child profoundly impacts caregiver feelings of loss. A mother highlighted the cyclic nature involved in her own personal growth, as she encapsulated her experience over an eight-year-period, “I go through the grieving process at least once a year, to some extent.”

Realigning. Realigning addresses change (see Figure 2). As a theoretical concept that wefts into the weave of strengthening parental devotion, realigning encapsulates an inexorable human need for personal progress and associative growth. Two subcategories of realigning emerge: *redefining personal reality* and *redefining relationships*. Exposure to the growth experience of enduring loss provides the parent caregiver with seeds that eventually motivate realignment. A parent’s personal reality has no choice but to change. Relationships in the world of life-from-now-on redefine or die. Realigning, then, becomes the conceptualized placeholder within the stage of accepting that provides the space and the time for the necessary shifts in alliances to take place, and culminates in a decision to move beyond the stage of accepting towards the stage of adapting.

Decision point. Strengthening devotion proposes that the first of three stages culminates in a decision point that focuses parent caregivers on whether or not to move beyond the stage of accepting into the stage of adapting (see Figure 2). How quickly this decision point comes into prominence depends upon a biopsychosocial readiness for change that is unique to each family, each individual parent as well as to the ASD child. Resilience matters, as does willingness to sacrifice, engage, embrace change, and let go of patterns of behaviour that weaken rather than strengthen parental devotion. Spiritual and religious affiliation also impacts preparedness. At any time, the ongoing activities that steer a parent

caregiver toward choices of perspective, new experiences, or memories of loss, may cause a cycling between subcategories of enduring loss and realigning that lasts until revealed issues find self-determined and accepted resolution motivating a decision to move toward wellness.

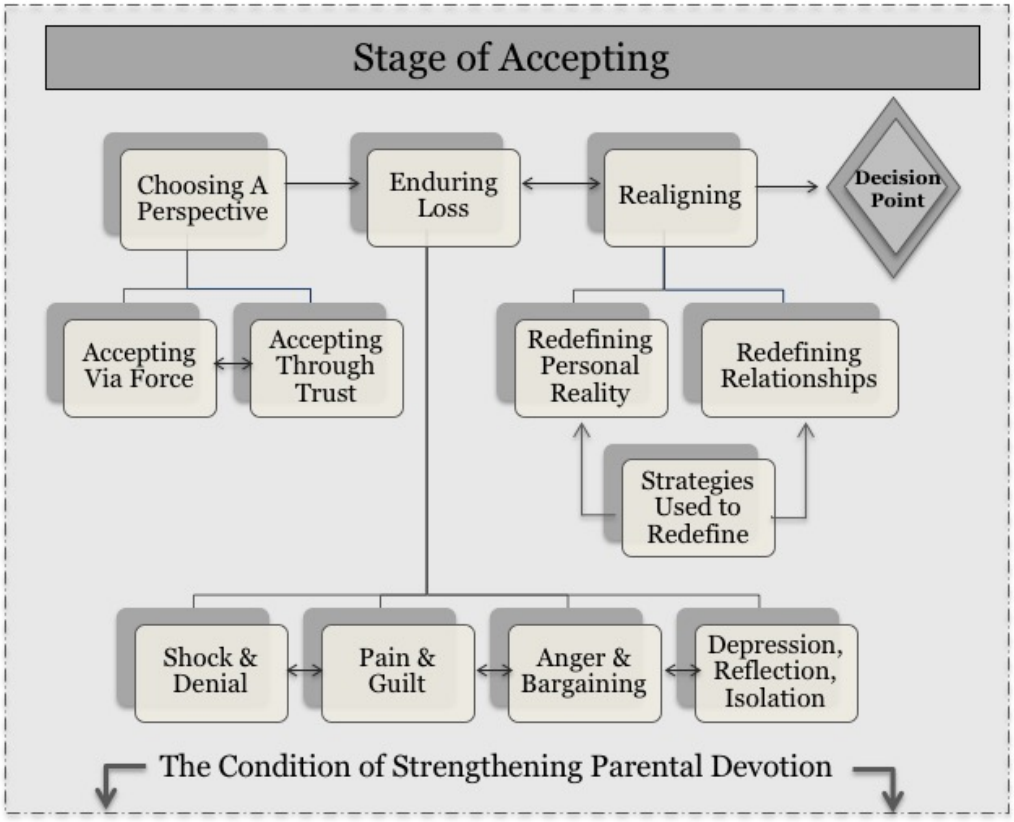


Figure 2. The first stage of the Theory of Strengthening Devotion is the Stage of Accepting. Three theoretical concepts comprise this stage; namely, Choosing A Perspective, Enduring Loss, and Realigning. A Decision Point marks readiness to move to stage 2, the Stage of Adapting. Strengthening Parental Devotion, the first of three aspects of devotion, conditions this stage with three skills and one strategy. For context factors see Figure 1.

Stage 2: The Stage of Adapting

Strengthening relational devotion. The properties of devotion, namely unqualified fidelity and nonjudgmental love commence in Stage 2 with the dimensions of

commitment (for fidelity) and *patience* (for love). In addition, the theory proposes that the core variable strengthening devotion also matures through three stage-specific expressions, the second of which is strengthening relational devotion. Now life takes on a constructivist focus conceptualized as *revisioning perspective, structuring uncertainty, and acquiring emotion regulation* (see Figure 3).

Emerging from the habituated isolation of Stage 1 requires the bolstering support that the willingness to sacrifice (a dimension of fidelity) and re-engage (a dimension of love) provides. Initially hesitant forays gain confidence as facility with discourse (whether with others or through a Higher Power) opens pathways to understanding and therefore guides a choice of perspective (see Figure 3). The desire to alleviate the unpredictable nature of life with ASD, eventually, and with patience (the Stage 2 dimension of the property of love), motivates a throwing off of limiting fear and vulnerability. Commented a mother, “I have to keep learning about my son, and how to help him, and not feel like I’ve learned it all.” Patience with self also sets the stage for acquiring emotion regulation. Commitment (the Stage 2 dimension of the property of fidelity) fosters exploratory excursions into the ASD community for answers and associations that help to structure uncertainty.

Revisioning perspective. In this second stage of strengthening devotion, the painful first experiences of loss ease. Reality realigns, a revisioning of perspective occurs, and adaptation to life-from-now-on begins in earnest (see Figure 3). As in Stage 1, the stage of accepting, a lens of perception focuses the events and experiences of Stage 2, the stage of adapting. The Stage 1 perception of adjusting via force, while still present, no longer engages parent caregiver emotions with an intensity that controls decision-making. The viewfinder redirects in the stage of accepting to a perspective that focuses the parent caregiver on relational growth. Nevertheless, as in choosing a perspective (Stage 1), the concept of revisioning perspective also offers choices that impact the quality of perception and self-reported satisfaction with life. Two choices emerge. They are conceptualized as *adjusting through growth,* and *adjusting with spirit*.

Choosing to perceive through a lens of adjusting through growth initiates an evolution in self-sufficiency that impacts relational dynamics. A mother described her growing comfort with the unknown:

> So in this last week I've noticed he seems hungry. I don't know. It's kind of like, I don't know. I don't know if the milk and the beef, it's just not doing it. But yet he still won't eat fruit. So like always, it's one day at a time.

Choosing to view the stage of adapting through the lens of adjusting with spirit incorporates learnings from adjusting through growth and adds into the quality of perception the distinguishing feature of belief in a Higher Power. As with Stage 1, this choice reduces stress and emotional reactivity. Belief in a Higher Power provides a perceived personal and family protection. Belief surrenders control and ballasts against self-blame. Belief focuses actions and activities so that they align with spiritual and traditional compassess of morality. Adjusting with spirit activates the Stage 2 commitment dimension of the property of fidelity as the relationship with a Higher Power deepens. "I'm gonna keep trying to access the help I need to mentally, psychologically deal with that [fear

and worry]. I'm gonna keep my relationship with God strong," commented a parent. Both choices in revisioning perspective (i.e., adjusting through growth and adjusting with spirit) involve an evolution in attitude, self-understanding, and self-in-relationship.

Structuring uncertainty. Structuring uncertainty addresses decision-making with adaptation in mind (see Figure 3). As a theoretical concept that aligns with strengthening relational devotion, structuring uncertainty involves a willingness to communicate with people, and to engage skills and strategies in order to bring under control an inner unease with unpredictability. Commented a mother, “You have to start transforming your resources to look towards the future.” This unease compels movement, perhaps back through subcategories of Stage 1, but eventually forward toward growth through this section of the stage of adapting. Emotions of isolation diminish as parental advocacy increases.

Acquiring emotion regulation. Acquiring emotion regulation addresses restraint with adaptation in mind (see Figure 3). As a theoretical concept that aligns with strengthening relational devotion, acquiring emotion regulation supports parent caregiver recognition that intensely emotional events adversely impact personal short- and long-term health horizons and also the health horizons of relationships with the ASD child, family, and community of support persons. Recognition may be a decades-long journey through the stage of adapting. A single parent commented, “Whether it be right or wrong or people just thinking I’m a complete lunatic, I don’t really care. I’ve reached that peace a long time ago with people judging me.”

Eventually, a confluence occurs of emotional pathways towards growth and parent caregivers experience an easing of obsessive vigilence, improved and consistent self-care, release from dysfunctional attachments, and acknowledgement of the need for self and relational empathy. This convergence is unexpected, significant, uniquely personal, and entirely internal. It portends the end of the stage of adapting and the arrival of a redefined self. An energetic readiness infiltrates caregiver activities. A rekindled optimism spurs the emotional move into Stage 3, the stage of reclaiming life.

Tipping point. In strengthening devotion, the second of three stages culminates in a *tipping point* that redefines self (see Figure 3). How quickly this tipping point comes into prominence depends upon circumstances unique to each family, each individual parent, and each ASD child. Reductions in negative self-judgement decreases physical (e.g., insomnia, heart palpitations), emotional (e.g., anxiety, outbursts), and mental (e.g., confusion, depression) stress reactions. Engagement with self-care activities motivates improved caregiver well-being allowing laughter, as a coping mechanism, to improve satisfaction with life. Nevertheless, acquiring emotion regulation is a lifelong task. Acquiring sufficient emotion regulation to move through the stage of accepting into the stage of reclaiming life requires a temperament and willingness to embrace change that focuses on self-improvement. The motivation to reclaim life also depends upon the degree to which the parent caregiver has evolved facility with the two emergent properties of devotion, that is, fidelity and love.

Achieving this tipping point may depend upon the conditioning impact of strengthening relational devotion. A caregiver’s perception of her resiliency, whether

developed via improved self-sufficiency (adjusting through growth) or faith-based communion (adjusting with spirit) impacts the rate of travel towards the tipping point as well. At any time, the pressures inherent in any part of the journey through structuring uncertainty and acquiring emotion regulation may cause a cycling that lasts until revealed issues find self-determined and accepted resolution that culminates in a redefined sense of self. A mother summarized her journey through the stage of adapting:

> This whole business… it IS a journey. That is exactly how I have tried to describe it to others. I think most people honestly never give Autism much serious thought until one of their own (or more – 2 in my case) children ends up on the Spectrum. That is when you really come face to face with how much you thought you knew, how well your emotions will stand up to the task, and how ready you are to discard all your previous notions of what parenting meant, and start adapting to a new way of developing relationships with your children. I am in a different place today then I was a year ago, which was different from the year before that. All I can do is try to keep my head, see everyone's point of view, explain myself calmly, try not to get defensive, and take everything people say to heart (and perhaps with a little grain of salt). (Phillips, 2013, March 29)

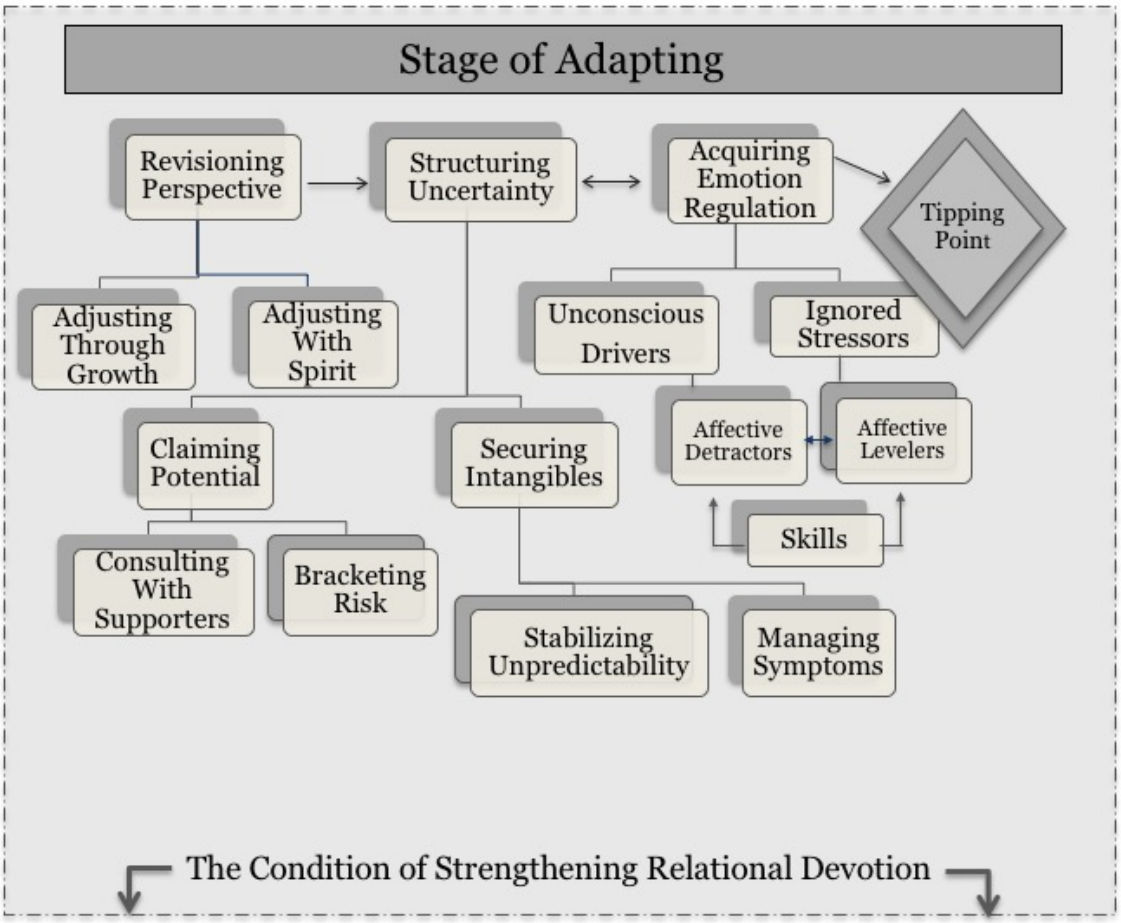


Figure 3. The second stage of the Theory of Strengthening Devotion is the Stage of Adapting. Three theoretical concepts comprise this stage; namely, Revisioning Perspective, Structuring Uncertainty, and Acquiring Emotion Regulations. A Tipping Point marks readiness to move to stage 3, the Stage of Reclaiming Life. Strengthening Relational Devotion, the second of three aspects of devotion, conditions this stage with three skills and four strategies. For context factors see Figure 1.

Stage 3: The Stage of Reclaiming Life

Strengthening personal devotion. The properties of devotion, namely unqualified fidelity and nonjudgmental love commence in Stage 3 with the dimensions of *openness* (for fidelity) and *tolerance* (for love). In addition, the theory proposes that the core variable strengthening devotion also matures through three stage-specific expressions, the third of which is strengthening personal devotion. Now life takes on a drive to express everything authentically, conceptualized as r*eawakening of self through letting go and reawakening of self through presence* (See Figure 4).

A mother expressed her authentic self when she matter-of-factly revealed, “He’s [her son with ASD] hard to have a relationship with ‘cause he gives you nothing.’” Reawakening to the potential within self, without the heaviness of emotional baggage and limiting expectations, nudges open previously restrictive attitudes with compassion and empathy for self, born of acquired emotion regulation. For parent caregivers, the redefining of self that occurs, as Stage 2 moves forward into Stage 3, motivates a desire to let go of past attachments and move into ever more frequent experiences of presence (i.e., a state of unlimited personal potential, free from past emotional burdens and future expectations).

Reawakening of self through letting go. Reawakening of self through letting go addresses the external activities that support the attainment of autonomy and the impact of those actions on the evolving self (see Figure 4). The revisioning of perspective in Stage 2 continues to hold true in Stage 3, the stage of reclaiming life, as emotional development through self-sufficiency (i.e., adjusting through growth) or in concert with a religious or spiritual outlook (i.e., adjusting with spirit) supports the evolution of self beyond the all-encompassing and ever-present identification as a caregiver. Two subconcepts support reawakening of self through letting go: *tempering control behaviors* and *reaching toward detachment*.

Tempering control behaviors focuses the parent caregiver on the achievement of equanimity. Reawakening, in its expression of reawakening of self through letting go, suggests a reemergence of a connection with a felt sense of autonomy. Control behaviors (e.g., guilt) restrict the blossoming of that reawakening and so the tempering utilizes internal emotional strategies (e.g., reappraising) to bring the existence of control behaviors to conscious awareness, and then moderates their dampening influence on the burgeoning enthusiasm culminating in a Stage 2 tipping point, redefining self. A mother with one neurotypical child and an older ASD child reappraised how their presence in her life tempered a self-admitted perfectionism, "Well they've taught me not to say, why me. Certainly they've taught me to have more compassion and empathy. Maybe in general for everything, but specifically the areas that have been hard for me."

Reaching toward detachment focuses the parent caregiver on learning to be detached, but not disinterested in the activities of life with ASD. It is about engaging emotion regulation in activities that engage the mind and the body in such a way that doing transforms into a new understanding of being. Activities focus on broadening the felt-sense of autonomy through a variety of means that improve safety for the ASD child in the long-term, and anyone who comes into contact with the ASD child at home or when in public.

Activities also focus on the increase in autonomy that occurs as a result of the development of a transition plan for an ASD teen moving into adulthood. Over time, these activities impact the intensity of the felt sense of ever-present anxiety, and as plans coalesce, a detachment occurs that improves autonomy. A 50-year mother commented after decades of caregiving, "We are close to retirement and wondering what sacrificies we will make in the next few years. Will our son be able to be semi-independent in a group setting or will he be still be dependent totally on us."

Reawakening of self through presence. Presence describes a state of being in which the events of the past (e.g., memories, emotions, judgments) and hopes of the future (e.g., expectations) do not restrict the unlimited potential for growth within each moment of experience. This ability to slow focus sufficiently to be aware of the physical and the emotional self in-the-moment is an extension of years, and in many cases decades, spent developing the capacity to narrow focus on the in-the-moment needs of the ASD child.

Developing proficiency with emotion regulation strategies (e.g., reappraising) in Stage 2, the stage of adapting, provides in Stage 3, the stage of reclaiming life, a clarity of perspective through increasing distance (i.e., detachment) from highly emotion-driven events. Parent caregiver stress responsivity diminishes as facility with caregiving has matured. The emotional distancing from immediate reactivity allows for a more balanced and authentic self to emerge, a self in which a decades-long identification with the role of caregiver recedes in prominence, as interests once laid aside reemerge or new interests excite sufficiently to develop the desire to grow into roles other than caregiver. A mother described her realization that she was ready for an expanded role for herself in her life:

> I had reached the point where I no longer wanted to be the person who pushed Justin to be independent and learn new skills. I had grown tired of being his teacher, case manager, and advocate rolled into one. I wanted someone else to assume those roles and let me just be his mom. (Morrell & Palmer, 2006, p. 198)

The confidence to express a more authentic self develops in part through changes that result from acquiring emotion regulation. These changes spur self-reflection, empathy, compassion, warmth, and respect for self and of others. Choosing to interact with people and life events via a present-moment approach suggests an evolving understanding of and reverence for values like respect, compassion, and empathy, and their role in optimizing well-being.

The confidence to articulate authentically allowed a father of four autistic sons and a wife with critical medical issues to express the compassion that resulted from his empathic connection to his family:

> Emmett and Elliott [his sons] were melting down. Lizze [his wife] was past her physical and emotional limit. Gavin [his son] was only concerned about showing me his castle. When things like this happen, my heart shatters and I feel like I can't breathe. The only thing in the world I want to do is make everything better for each of them. At the same time, there's this part of me that's screaming and wanting to run away from that moment and catch my breath. The really sad part is that I am fully aware of the fact that what I'm going through pales in comparison to what my

> wife and kids survive every day. When I realize or remember this, I'm overwhelmed with guilt. It's an endless cycle. (Gorski, 2014)

Releasing expectations as a strategy clears behavior of beliefs that stymie the ability to live in-the-moment. Releasing expectations of self and others improves empathy, develops compassion, and deepens devotion, paving the way for a new lens of present-moment living to guide caregivers to explore their own potentials beyond their roles as caregivers. Recognizing ways of relating to others, to the ASD child, and to oneself that restrict connection to what is happening in-the-moment helps to spur letting go and to optimize well-being. The reward will be a reawakening that builds upon a Stage 3 foundation of devotion that delights in openness (the Stage 3 dimension of the property fidelity) and non-judgment (the Stage 3 dimension of the property of love). An uncle who was named guardian of his deceased sister's teenaged autistic son described how adopting an open and nonjudgmental perspective helped him succeed in releasing expectations:

> J. was diagnosed as being low–range mentally retarded, with no chance of ever speaking, or having a life beyond mere existence. But, we *never* gave up on his potential. We've found that diagnoses are little more than labels, stuck to people so that others feel comfortable in dealing with them. J. has taught us as much about ourselves and the "system" as we have taught him. He's made his transition to adulthood like a true champ! (McDonald, 2012, p. 170)

The advent of ASD, which in Stage 1 presents an overwhelming challenge, causing some caregivers to abandon faith-based tenets, transforms, by Stage 3, into an understanding that the advent of ASD has been a gift of a transformed self through a deepening of devotion.

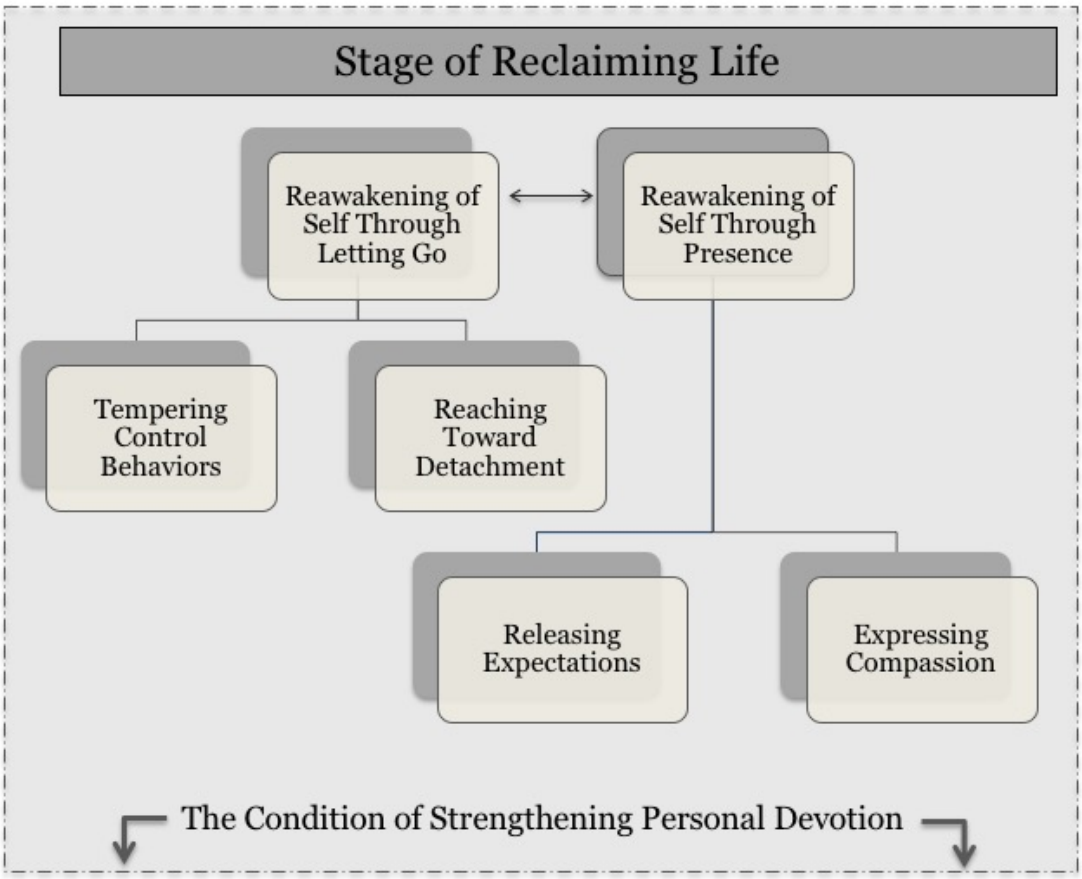
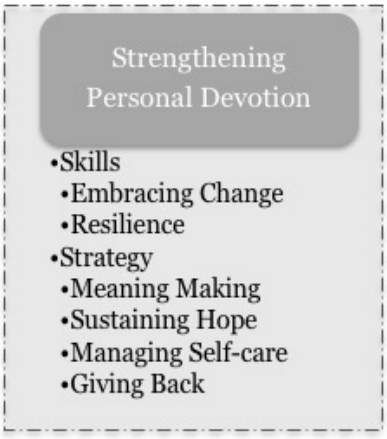


Figure 4. The third stage of the Theory of Strengthening Devotion is the Stage of Reclaiming Life. Two theoretical concepts comprise this stage; namely Reawakening of Self Through Letting Go, and Reawakening of Self Through Presence. Strengthening Personal Devotion, the third of three aspects of devotion, conditions this stage with two skills and four strategies. For context factors see Figure 1.



Discussion

Though we don't have a cause, autism, and its spectrum of disorders, is becoming increasingly prevalent. Given that one in 45 US children have some form of autism (Zablotsky et al., 2015), identifying concrete opportunities to support parent caregivers is critical. That means we need to delve into their journeys to pinpoint commonalities such as post-traumatic-stress syndrome-conditioned behavior. The theory of strengthening devotion focuses on their lived experiences. It not only provides caregivers with a scaffold of acceptance and support but also offers governments (with their legal obligation), healthcare and other professionals (with their ethical and moral obligations), and advocates like me (with my human obligation) with an opportunity to identify, conceptualize, and generalize parent caregiver experiences such that aid is targeted and ultimately useful.

The theory offers a roadmap, grounded in data, populated by the three weigh-stations of accepting, adapting, and reclaiming life. While in the weigh-station of accepting, parent caregivers confront feelings of loss and entrapment until emotions signal readiness to sacrifice self and adapt. In the weigh-station of adapting, parent caregivers begin cultivating community connections, developing the relational competencies and emotion regulation they'll need to problem-solve the myriad issues that present through the decades. And lastly, for those parent caregivers who develop a deep willingness to embrace change that focuses once again on self-improvement, reclaiming life conceptualizes what that would look like, and how letting go and detaching helps reawaken personal competencies through a focus on living life in presence.

Accepting, adapting, and reclaiming life may be identified as growth-related stages that actually occur. They may be identified in a predictive manner by physicians, psychologists, social workers, and family therapy counselors among others who intimately work with this population. But first and foremost, they may be used by caregivers to chart their personal courses in concrete and practical ways that support a plan which harnesses the often overwhelming stress, emotions, unpredictability, and uncertainty that cloak each parent's journey. Parents who can find themselves on the strengthening devotion roadmap not only can corroborate where they have been and how far they have come, but also chart their course to the next stop with an idea of what they may encounter along the way.

For parents, love fueled the desire to be of service and compelled most caregiving. Bumagin and Hirn (2006) agreed, adding that love motivated parent caregivers to devote themselves to *being* a caregiver, whereas non-parent caregivers' motivation focused on *doing* caregiving. Within the theory of strengthening devotion, unqualified fidelity and nonjudgmental love arose as defining properties of the core variable, strengthening devotion. Caregivers in the stage of acceptance grappled with readiness to re-engage and sacrifice; in the stage of adapting, caregivers focused on developing commitment and patience; and in the stage of reclaiming life, caregivers deliberately let go of their old restrictions and expectations in order to engage new possibilities with openness and tolerance. According to Pipher (2000), fidelity and love represent malleable sociopsychological values that strengthen devotion in a dynamic way every time a parent

caregiver either makes a choice (Bernstein,1990), or overcomes a struggle (Anandamoy, 2013).

Caregivers defined their struggle as longlasting. Fears (e.g., medical: “What kind of doctors will be needed?”; financial: “How will I pay for care?”; big picture: “What happens if I die?”) altered perceptions of their futures; grief for their child(ren) and themselves initiated reoccurring periods of pain and loss; waning friendships crumpled confidence and produced sensitivity to rejection; isolation from family and friends undermined resilience; and lack of knowledge about autism fueled monetary distress and bewildered questions like ‘why me?’ and ‘what do I do now?’ Caregiver struggles emerged then, as catalysts dissolving fear into commitment (Pierce, Lydon, & Yang, 2001), and willingness to sacrifice self (Van Lange et al., 1997). According to grief researcher Kübler-Ross (1997), acceptance of a traumatic announcement like the reordering of life after a doctor informs parents their child has autism, occurs when fear-distabilized emotions settle sufficiently for the attachment to life-as-it-was-supposed-to-be wanes. How long that takes is up to the caregiver. The theory of strengthening devotion suggests that the easing of grief emotions portends a caregiver’s arrival at a decision point where forced compliance with caregiving responsibilities subsides as a willingness to sacrific emerges. Rolle-Whatley (2014), who researched how active parenting transformed parents themselves, agreed, adding that when loyalty to a child is reinforced, a parent’s resistance to caregiving gives way.

So while the struggle was ever-present, unexpected moments of triumph and sweetness made parent caregivers regard their decision to sacrifice, accept, and adapt ultimately rewarding. Developing the necessary skills and strategies needed to provide for the ASD child successfully clearly played a pivotal role in the positivity of a caregiver’s outlook. The theory suggests that a different aspect of devotion is strengthened during each stage. In accepting, parenting skills are strengthened; in adapting, relational skills come into prominence; and in reclaiming life, releasing expectations and the development of compassion take center stage. For caregivers, that means, for example, learning to decode how the ASD child communicates her needs (in accepting), or how smart handling of the ASD child’s temperament can defuse explosive public episodes (in adapting), or how practicing present-moment focus can facilitate an embrace of potential (in reclaiming life). Learning to apply strategies has similar positive results. For example, choosing to let go of behaviors that no longer serve the new paradigm (in accepting), providing sufficient emotional support for neuro-typical siblings (in adapting), and also making a commitment to regular self-care (in reclaiming life).

The theory suggests that caregiver health and well-being may remain compromised until caregivers acquire proficiency with a variety of skills and strategies necessary to regulate their emotional response to stress events. Caregivers encounter emotion regulation skills (e.g., deep breathing, meditation) and strategies (e.g., regular self-care, seeking opportunities to laugh) in adapting. Nevertheless, personal emotion regulation remains a huge hurdle for caregivers as behaviors exemplary of autism don’t generally diminish, though they may be moderated via methods like mindful parenting (Singh et al., 2010), an emotion regulation technique. Canning, Harris, and Kelleher (1996), who examined parental reactivity to caregiving for children with diverse medical conditions, suggested that factors of lower family income, degree of child impairment, and age of the parent caregiver

contributed to heightened emotional distress. Theory data suggest that sleep deprivation, fatigue, heart-rate elevation, loss of appetite, irritability, all-over body pain, inflammation, isolation, grief, and frequent colds are a few of the many stress responses caregivers identified that adversely impact their ability to regulate emotions. Given that many caregivers will be providing service for the entirety of their lives, disciplined and dedicated practice of emotion regulation stands out as one critical component in a parent's action plan designed to make accessible a future filled with individualized potential.

Additional opportunities available to parent caregivers wishing to concretize theory observations may be found in tempering guilt behaviors, developing actionable emergency care plans, identifying and then developing cordial relationships with critical gatekeepers in the ASD medical community, and accepting offers of respite relief.

Hope does exist. Those parents, who committed to a practice plan that included disciplined mastery of the opportunities outlined earlier in this article, moved beyond adapting to reclaiming life. Self-sufficiency, a growing autonomy, and a deepening compassion allowed their devotion to strengthen and blossom. An excited openness about life's potential re-emerged and with it the tolerance born of self-confidence. Parenthood is a process of metamorphosis in which children foster in parents new understandings that ultimately lead parents to discovery of their own beingness (Rolle-Whatley, 2014). According to the theory of Strengthening Devotion, the lives of parent caregivers take on an aura of grounded and authentic self-hood that lends them the necessary courage to confidently step into their futures.

Limitations, Unique Attributes, and Implications for Future Research

Culture, religion, family income, degree of child impairment and the age of the parent all produce diverse perspectives on life's experiences. Parent caregivers with varied backgrounds were limited in the study and incorporation of broader viewpoints is necessary.

The uniqueness of strengthening devotion lies in (a) the revealing of a Basic Social Psychological Process (Bigus et al., 1982; Glaser, 1978) that leads parent caregivers of children with ASD through a distinctive process of self-growth via service to others, (b) the detailed explication of the stages of this process, and (c) the proposal that until and unless a parent caregiver reaches the emotional stage in the adapation process where the experiences of service are recognized as catalysts for personal transformation, the fullness of the opportunity offered to a parent caregiver through a strengthening of devotion remains unrealized.

Several topics emerged for future research (Author, 2014), such as whether and to what extent can caregiver health indicators related to stress (e.g., sleeplessness, immune system degredation, mental fatigue, confusion, and irritability) improve emotion regulation via techniques such as meditation. Parent caregivers would benefit from such research.

Conclusions

This CGT study began with, "Tell me about your experiences as a caregiver." From this question, strengthening devotion emerged as the core variable representing how parent caregivers of child(ren) with autism spectrum disorders may sustain health and a positive outlook as they manage their highly emotional and stress-filled lives. A roadmap charts a course that begins with acceptance, moves through adaptation, and forward into a reclaiming of religuished self-focus. Caregiving struggles fuel parents' evolving understanding of what it means to love nonjudgementally and to experience unqualified faith not only in a child(ren) but in themselves. Devotion strengthens as emotional reactivity is regulated over time, motivating and sustaining self-growth through service.

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Self-Balancing Sanctuarying: A Classic Grounded Theory of Relaxation

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Abstract

This author aimed to set out a grounded theory (GT) of relaxation as it is carried out under the normal pressures and tensions of everyday life. After switching from using the Corbin and Strauss grounded theory (2008) design to classic grounded theory, the author discovered a five-step theoretical causal-consequence model emerged from the analysis of what 21 non-anxious-to-slightly-anxious people from the community said what they do to relax. Their main concern is self-balancing. A disturbed sense of ease (cause) arising from internal and external threats (context) leads to resolution by switching (core category) in safety (condition). The chosen switching activities are self-emergent. Their continuing use depends upon transforming hindrances and integrating feedback to the process to maximize benefits (contingencies and consequences). Three switching strategies are central. Benefits not consciously or analytically generated are restoring, refreshing, and re-energizing me; maintaining and building me; and growing and developing me. Restoring, refreshing, and re-energising me is characterized by a sense of well-being and lifted mood; maintaining and building me is characterized by integrating and strengthening the core self and connecting to the community; growing and developing me is characterized by expanding self-discovery. Theoretically situating extant descriptive and conceptual models of relaxation is one of the many contributions this research makes.

Keywords: anxiety, classic grounded theory, relaxation, positive psychology, interacting cognitive subsystems model.

Introduction

Prior to this research, relaxation has been viewed as a process of letting go of all tension not only in the body, in the sense of micro-factors of muscle physics and electrical activity (Jacobson, 1964), but also of macro-factors of such as those arising in the environment (Selye, 1946), the mind, and the spirit (Benson, 1975). The debate about psychophysiological relaxation that took place in terms of Claude Bernard's abstract concept of the constancy of the milieu intérieur (Modell, et al., 2015) and which was made more concrete and practical by Cannon (1932) and then by Selye is now taking place in terms of allostatic balance, load, and overload (Chuang, Glei, Goldman, & Weinstein, 2007). This historic focus on release of muscle tension was driven by a mechanistic medical view of how humans "work." This means that active relaxation

activities have rarely been studied together with passive ones, and that neither have been studied in the context of life as lived.

Theoretically, while relaxation is mentioned in related disciplines which do include contextualised activities involving significant body movements, such as in Csikszentmihayli's extensive empirical, conceptual, and theoretical work on "flow" in work and play (1975), the largest body of recent empirical work directly focusing on relaxation, per se, is Smith's (1990, 1999) which focuses on passive relaxation activities. Smith (1990) developed a set of structured inventories using factor analysis of words and phrases culled from passive relaxation therapy text books. These questionnaires were then used to develop "R[elaxation]-State" concepts which are said to be emotional, mental, and physical states. Smith (1990) first hypothesized a hierarchical linear model of how people progress through the R-States and later a "dual path" (Smith, 1999, p. 45) model, with the suggestion that any sequence through the R-States may be possible. As mindfulness took hold in the United States, the dual-path model has been re-framed in a mindfulness context and re-named "window of renewal" (Smith, 2007, p. 41). "Core mindfulness" and "transcendence" were then hypothesized to be anchoring concepts in the new conceptual model, which focuses on the activity itself and not on its drivers, antecedents, or long term outcomes.

Thus, for the present research, it was a logical first step to talk with people about all forms of relaxation without pre-conceived questionnaires and without a single focus on passive activities. This shift was to discover the main concern and how it is continually resolved when people say they relax, regardless of how they do it. Also, as "anxious" people are often unable to relax by their own self-report, the focus of this paper is only on "non-anxious" people's reports.

Methodological Concerns

Methodologically, Smith's conceptual model along with mechanism of action models made by proponents of specific therapeutic activities, such as Jacobson (1964, 1977) for progressive and applied relaxation, Kabat-Zinn (1991) for mindfulness based stress reduction, and Schultz (1972) for autogenic training, had to be set aside.

Purposive sampling began with recruiting people from the wider community who were not more than 'mildly' anxious to talk about relaxation. Eleven attendees at a public meeting called "Psychology for All" which was sponsored by the British Psychological Society and held in London in March 2009, volunteered for interview. They reviewed and signed a consent form which had been approved by Canterbury Christ Church University's ethics committee along with a semi-structured interview in February 2009. The interview format, the ethics approval, and the participant recruitment processes were designed to follow the Corbin and Strauss GT method (2008) which was advised by and approved by the dissertation committee.

Volunteers talked for twenty minutes and handwritten notes were taken as verbatim as possible. At the end, to assess participant anxiety levels, a 5-point anxiety scale was used which read "Are you? Very Well, Well, Worried Well, Unwell, Very Unwell". For ethical reasons the word "anxiety" was not used in this scale; instead, wellness concepts (Pontious, 2002) were substituted with answers of 'very well' and 'well' equating to 'none' to 'mild' anxiety levels. This scale was used to rule out any

participant who was not ‘very well’ or ‘well’ by self-report; one participant was in fact ruled out.

Following the Corbin and Strauss comparison method (1990), coding and analytic memoing began immediately after interview using MAXQDA software (Peters & Wester, 2007). Three theoretical issues emerged: (1) relevance of relaxation activity levels, (2) relevance of gender, and (3) relevance of opportunity recruitment factors.

The idea of energy expenditure being central to benefits of relaxation was spontaneously mentioned by participants. Jetté, Sidney and Blümchen’s (1990) metabolic equivalency tasks (METS) tables which quantify the “energy expenditure values for numerous household and recreational activities [as a multiple of] the amount of oxygen consumed while sitting at rest” (p. 555) were used to assess activity levels of all the activities mentioned. Stress management authors (Woolfolk, Lehrer, & Allen, 2007) suggested activity levels and gender could be relevant variables. A further question had arisen. Could the relatively high level of knowledge of psychology common to the volunteers have biased the data?

To assess whether these variables were relevant and to ensure theoretical saturation of concepts, attendees of the Surrey Economic Business Partnership breakfast meetings held in Guildford, Surrey, and members at the Blackhorse Apiaries, St Johns, Woking, Surrey were told about the research and asked to participate, if interested. With permission, all interviews were audio recorded. Participants from the whole set who were willing to be re-contacted were contacted again for further discussion of concepts relating to activity levels and to the switching processes within them.

Whilst no specific occupational categories or gender were targeted, by the end of theoretical sampling there were 21 participants, 7 men and 14 women ranging in age from 19 to 65. They came from these fields: psychology, teaching, coaching, management, education, garden construction, entrepreneurship, journalism, and financial services. And, participants had talked about a variety of activities which they undertook from three times a day to once or twice a year. These activities ranged from low to high METS: hot bathing, working, gardening, guided Pilates, guided relaxation, listening to books, meditating, playing a musical instrument, reading self to sleep, scuba diving, shopping, steam bathing, swimming, taking days off, walking with a friend or alone, watching funny films, watching TV and playing Sudoku, working out, and yoga.

Ultimately, over 200 codes with memos were captured in the MAXQDA database using the Corbin and Strauss method (1990, 2008). Initial sorting of theoretical memos yielded a preliminary description, not a theory. At this point of being overwhelmed with data and of realizing a description and not a theory was emerging that two of Glaser’s books (1978, 1992) were discovered.

Attending to verbal direction given by the Grounded Theory Institute (GTI) in 2010, it became clear that the data overwhelm could have easily arisen because interviews were taped (1997) and database software was used instead of pencil and paper. With advice from the GTI faculty, all previous coding and memoing was set aside. Paper and pencil only were used to re-do the analysis from start to finish. Interviews were open coded again. Memos were written. The number of codes reduced by almost two-thirds and conceptual and theoretical memo output increased. At this point, it was clear that no further theoretical sampling was required. Theory that emerges from this

simple, iterative, inductive process is an extended hypothesis which can and should be altered as and when new data and information suggest that it no longer works and fits as it stands.

Theory: Self-balancing Sanctuarying

On sorting memos, it became clear that Glaser's (1978) generic "Six-C Model" (p. 74) of a cause-consequence process, doing an activity in its ecological, or "inter-being," context, worked and fit. There are five variables: a self-chosen, self-emergent, self-balancing relaxation activity (assessing, arranging, using switching strategies) is placed within a context (internal/external), with a condition (safety), a cause (actual or threatened dis-ease), consequences (benefits), and contingencies (hindrances and enablers). There are no co-varying factors.

Self-balancing sanctuarying is an iterative, and at times recursive, switching process. The self-balancing activity involves taking action in a three-stage switching process; these stages may progress in moments or over an extended period of time.

- Stage one requires a realistic assessment of the external context of objects, people, and ongoing life and of the internal context, the self's "felt sense of ease" (FSE).
- Stage two involves arranging these externals and internals to develop and maintain safety.
- Stage three involves doing the activity using up to three switching strategies.

Contextually, and at the start, anticipating benefits and/or ignoring distresses are tactics which may be used to maintain current state or to deal with distress in the near term if circumstances do not permit self-balancing in the moment. Hindrances must be managed and benefits must be integrated at each stage to optimize self-balancing and give motivation and meaning to the overall process. Past experience and selected family, friends and others in the community are important supporters of this self-balancing process. Significantly, for the process to proceed, a condition of safety must be assured during assessing and arranging and then throughout the activity itself. Once benefits accrue, these are integrated into the process at each step, giving motivation and meaning.

Main Concern: Self-Balancing

Participants talked about their concern this way: "When I unwind I am detaching from my work day commitments, I process the day, think about the next day, I have time and space to clear my head:" unwinding from stress re-balances. "The first thing would be noticing that I feel tense and not plowing on through that, making the choice to do something constructive to relax, taking the time for myself, allowing myself time:" letting go of stress brings balance.

> I have had periods in my life when I have been extremely stressed, so I avoid that, and in order to avoid that it is essential I have relaxation time, I relax with friends, and family, but also have to carve that out as a bit of time for me."

We see avoiding accumulating stress as a way of staying balanced.

Core Category: Switching

The context for self-balancing sanctuarying is the internal and external life milieu–is it balanced or is it loaded or overloaded with dis-equilibrating factors and forces? Constant monitoring by the felt sense of ease answers this question. Switching begins with realistic assessing of the real time or anticipated possible disturbances in the felt sense of ease. If motivated, attention and action are re-oriented toward adaptive arranging, and then participants start a chosen self-balancing activity using one or more of three switching strategies. The consequences of switching are a restoration to balance and a restored felt sense of ease with experience, along with other multiple benefits. Two contingencies impinge on the process: (1) transforming hindrances that dampen the process in a negative causal feedback loop, and (2) integrating feedback to the process in an amplifying positive causal loop. These contingencies may happen over short (seconds) or long periods (hours).

Cause and Context: Self and 'Felt Sense of Ease' (FSE)

Participants acted upon and made meaning of their experiences of ease or disease through their felt sense of ease or dis-ease (FSE). This acts as a barometer to let them know if they are balanced or loaded (context variable) and also acts as a trigger (cause variable) to begin self-balancing. One participant put triggers to relax this way: "[it's] a combination of overload and frustration." From the theoretical perspective, this felt sense of ease or dis-ease functions in two ways: as a sensing device and as a gatekeeper. This felt sense appears to align with Gendlin's (1997) discussion of a "felt sense" of knowing. Gendlin theorised, from a philosophical and clinical perspective, that humans have "a thinking that employs more than conceptual logic, rules, or distinctions . . . a wider process of human sense-making" (p. xii, xvi). Sense-making for Gendlin (1997) is meaning making which arises pre-cognitively within the body as a felt sense.

The FSE is a body based "voice" which communicates non-lexically, implicitly, subjectively, and concretely, even though it is lexically blank, by pointing to the implicit that must become known. It has a "language" and a "voice" that make and validate meaning by the subjectivity of experience. The FSE has a balancing set point that ranges from inflexible to flexible; it has a tipping point and a safety range which is narrow to wide, and it responds to perceived threat load. To explain why they engage in relaxation activities at specific times, participants use a combination of common-sense logic and a felt sense of knowing. "If I am confident and comfortable in the situation, like I am supposed to be there, then I am relaxed." They have attributed causality to a number of distal and proximal incidents arising from internal and external contextual sources, like accidents or work stress. For example:

> My job is hard, it is long hours and dealing with difficult people, with little in way of breaks during the day… it's illegal, I'm sure, so [yoga and relaxation once weekly] help me unwind the thought which goes on in my head constantly the other four days of the week. . . .

And, "I think it's more an overload thing with me, I've got an overload going on up here [in the mind], which is rationalized [internal threat]."

The FSE is felt as either a juggling or a flowing state which has a set of distinct self-balancing objectives: getting back to me, being me, and becoming me. "It is something I do to relax [play an instrument], or something I do, full stop . . . it is part of a routine, so ingrained in my life over decades." And, the listening self modulates

awareness of the felt sense of ease, either pre-consciously or consciously, asks itself questions about its state, and decides what to do next. For example, one consciously aware participant who does not manage hindrances well says: "I am aware of the fact that it [meditation] would help, I would like to do it, but it is genuinely a time constraint… I do know I need to do it more now, clearly, but clearly is not enough!" Another participant who is pre-consciously aware and has integrated a positive feedback loop into ongoing life says: "I find that I am relaxed most if I can do something at a set time of day, then there is no stress involved, you just get yourself ready and you do that activity and it's relaxing."

Condition: Safety

Switching proactively or reactively is done in a safe and unhindered way. "I am wanting to concentrate – to do it in the best way, I need to be physically relaxed and comfortable. My space is very calm and light, it's my retreat." "Maybe it's a very pleasant place to go to." "It's a haven, it's safe, it's my own space, nothing else, no one invades it, if you want, unless I chose to let them." Sanctuaries are places and spaces in which the outer world is controlled and inhabited by the self and trusted others only, distant from threats. A sanctuary can be a place:

> I love water, if I could I would spend all day in the bath. Also, I know that when I am in the bathroom no one else has access to me, I don't have any distractions from the outer world, I am in my enclosed private space.

It can be an inner space: "It's just a sense of calmness, connection and safety, I feel safe. I feel cared about." And, it can be a place where others participate: "The yoga teacher has a voice like liquid chocolate… her voice is very relaxing, which is why I have stuck with that particular class."

Activity

An effective self-balancing activity is incorporated into the life through a learning and repeated doing process. People do the activity in their own individual way, not in a forced way, but because they like it and it works for them over time: they have made it their own. In essence, their chosen activity has emerged into their life during a time of confluence of interest, ability, social support, and a growing felt sense of ease that the activity serves its purpose.

Stage One: Realistic Assessing. This is the first step. It can be an automatic process wherein challenges to starting are easily and seamlessly met. "I don't think anything like, 'I have to relax, I will do x'. I don't ever consciously think 'I have to relax'… it is part of my routine." Some challenges are noticing cues and accepting present reality. If self-balancing is not a habit or routine built into the life, assessing requires developing adaptive processes for countering resistances and hindrances, appreciating, and integrating benefits. At the point in the process where challenges to assessing must be surmounted, the felt sense of "flowing" may be low to non-existent, and the felt sense of "juggling" may be high.

To notice in time and respond accordingly the person must be vigilant and honest. "I think the biggest obstacle is actually recognizing that I am feeling something that is making me feel uptight or stressed, anxious." Vigilance and honesty can be impeded by factors in the external and the internal milieu. Where work or other activities

are demanding, and when it is felt that time cannot be taken to self-balance may attract attention from or may mask disturbances in felt sense of ease that are signaled through the body. Early childhood training, which may have functioned adaptively within the family, can extend to developing a very strong work ethic, to hiding some kinds of emotions, feelings, and sensations, and to putting responsibility to others above duty to and responsibility for the self. For example, devotion to others before self-care may be a hindrance: "I am not very good at relaxing when I'm at home, I don't sit down and do nothing… when I do, I feel guilty, I think there are other things I ought to be doing or could be doing;" and "I have had two heart attacks… Relaxing on a day off from work, I have a host of jobs to do on a fine day, and I feel guilty not doing them, or not starting them."

Hindrances like these must be overcome before the internal and external milieu can be made safe by adaptive arranging. The degree of honest appraisal of current state, and acceptance of self as worthy of self-care, whether clearly articulated or not, and as reflected in the action tendencies, are therefore key adaptive factors.

For people who accept, trust, and are honest with themselves, as well as vigilant and committed to self-care, assessing is rarely a challenge. Assessing happens all the time, and may or may not be done at the center of awareness, even when the felt sense of ease is disturbed. Pushed by external or internal threats, the person thinks or has a felt sense of needing down- or me-time, or needing to switch activities. The process flows when people have control over the environment and when they easily respond to subtle internal cues arising through the body. They are able to switch automatically to micro or macro sanctuarying activities as needed.

Some cues have strong associations, as in the starts of rituals and habits that are time dependent and well entrenched. Here, anticipating doing the self-balancing activity at a future time can reduce the felt sense of threat in the present, thus helping maintain self-balance in the present. One participant put it this way:

> It's a longing to be in the zone, in flow, and anticipating it might happen [that takes me back to the jazz making]. [Without this way of relaxing, I] would have to find a way of living, but for me I cannot imagine it, I believe it would be like a very serious amputation, very serious effect on me psychologically.

The felt sense of anticipation of a future experience (near or distant) can be a micro self-balancing sanctuary in and of itself and anticipating can be a form of responding in time, as habitual ways of relaxing are known through repetitive experience to work effectively, to fit the life and to be integral to "being me."

When people who say they are not naturally relaxed seek a release of tension, they may be challenged to bring awareness of subtle internal cues to center stage to trigger a self-balancing process before they get loaded or overloaded. This is particularly true when external threats are increasing the load. Juggling of pros and cons over a long period of time and carrying on regardless by ignoring cues instead of responding to them prevents self-balancing and is psychophysiologically counter-productive, thereby increasing allostatic load. As one participant put it, "actually, I will end up feeling ill, I think my body finds a way to say 'you are going to stop, even if we have to make you.'"

Stage Two: Adaptive Arranging. This is the second step. "It's about being comfortable in what you are wearing . . . the right shoes. The wrong shoes change the experience entirely." Arranging is a two-staged adaptive structuring process: (a) some arrangements have become part of the fabric of ongoing life, and (b) some may be consciously made as the activity is taken up. For all participants, arrangements are already integrated so minimal efforts with few surprises are needed to take the activity up in real time.

Arranging involves choosing from amongst the culturally available repertoire of relaxation activities (content), placing this choice in a setting with boundaries and ensuring physical comfort in support of the doing the activity (contextual safety), and pacing the activity (taking time). Choosing and committing to the process may or may not take considerable effort as there is a wide range of objects from which to choose, and the choice depends on the self-balancing goal at the time. Successful arranging also requires organizing people and things so a safe haven is created in the right time and place, and so boundaries and physical comfort can be maintained while the activity or process continues without interruption, if possible, as in this example:

> Switch off my mobile, obviously first communicate with everyone and do all that needs to do, get all the jobs finished, my dinner, call my husband, call all my friends, then switch off the phone, and be just on my own.

Metaphorically, the body is the container of the mind. So, as long as the body is perceived to be and experienced as being comfortable and not under threat, arranging continues with setting further boundaries. For example, people say a prayer, process and/or set aside worrying thoughts, talk with loved ones beforehand, close doors, look away, put the phone on silent, and so on. The posture and place people actually take varies as widely as the activities they are preparing to do, ranging from sitting still in a home or office environment, to meandering or jogging down paths outdoors, to sitting in the garden talking with chickens and bees.

Arranging also involves pacing. When self-balancing is high on the priority list, and the tolerance range for deviations from an acceptable felt sense of ease is low, action is taken more quickly to dispel impediments to switching to the relaxation activity itself, and where action cannot be taken immediately, anticipation of relief in the near future tides over. Alternatively, the activity is placed and paced in life habitually. In any case, this repeated adaptive behaviour couples self and action in synergistic ways so that the timing of self-balancing relaxation activities is optimised.

Stage Three: Switching. The third step involves using one or more switching strategies: distracting/blocking, managing/controlling, and, letting go/allowing. Most participants used more than one strategy in the same or separate activities, and their use depended on the immediate goal. One participant put it this way: "I go to the gym for mental relaxation, because that just clears my head [for epiphanies] . . . if I just want to literally not think at all and not doing anything I would read a novel."

Distracting/blocking is an escaping/maintaining me strategy. It serves an immediate re-balancing function by applying narrowly directed thought and action. There is an active disengagement of attention from detractors or disablers in the environment and in the inner world and an active focusing of attention exclusively on a limited set of inner and outer objects. Physical activity levels and interaction with social supports may

vary, but the mental escape is the same. One set of thoughts and feelings is completely set aside and the entire experiencing space is actively replaced with another more desired set for the time being, a set which is made in dialogue with the external object. An example would be attending to characters in a book or enacted stories or playing online computer games.

When using distraction/blocking to switch, the switching process itself and the state it induces are experienced as the "opposite of stress" or an "antidote to stress." One participant put it this way: "I am on Facebook. That would make me smile, it terms of state of mind, I am relaxed, and happy." The immediate emphasis is on the process itself, on being in it, and on doing it voluntarily and repeatedly. The emotional states most likely to emerge are either neutral or intermittently positive (enjoyment). With this type of switching there is no intention to broaden habitual ways of thinking, feeling or acting, so that neither the broadening nor the building that Fredrickson (2001) hypothesized are part of the near-term benefit–even if positive emotions actually emerge. There is, however, a release of mental tension, a strengthening of current distraction/blocking skills, and a self-soothing time out from normal stresses and strains of everyday life.

Managing/controlling is a filling/building me strategy. It requires filling the mind with specific thoughts and inputs using open, congruent judgmental criteria. Whilst giving time out from problems that cannot be immediately resolved, it is an additive strategy fostering positive emotions, requiring thoughtful action, and adding to knowledge stores. One participant puts it this way: "Taking my mind off anything stressful, to get my mind away, so I don't have to think about it, normally that's work, I decide to sit down and read magazine articles that interest me." The objects and processes used may be instrumental in seeking and finding solutions to current problems by building on interests and strengths. The cognitive and emotional content of the activity, which can range from light to heavy METS, is not as thoroughly specified in advance as in distracting/blocking. Thus, the experiencing space is more open for something new and unexpected to come in or to arise from within. For example, the space can be filled by learning something specifically relevant to hobbies or career (light METS), by responding with a full range of emotions while making music with others (moderate METS), or by taking on physical challenges that have very high attentional demand and build the body (heavy METS).

Letting go/allowing is an opening up/growing me strategy. It affords a different viewpoint on challenges, offering opportunity for engaging with mental and emotional contents of the inner world head-on, as they arise consciously and pre-consciously both during and/or after the switching process. As one participant put it:

> Something might suddenly pop up that I hadn't realized would pop up, something that I wasn't consciously thinking about... or sometimes I bring something consciously to mind that I'm thinking about, that I might be in a box about, and I let it drift.

This switching strategy involves a non-judgmental attitude of unguarded hopefulness and trust regarding the full range of inner experience. Emotions and thoughts are experienced in a "still" way; reactivity is lower or non-existent; thoughts are viewed in a more detached way. Room is made for whatever arises to arise during or after the activity.

Consequences: Benefitting

Chosen activities, whether active, passive, or a combination of both, involve a coordinated series of steps and induce self-emergent positive changes in at least two of four arenas–body, mind, emotion and action.

> Relaxed means that you are not stressed at all . . . . Enjoying life. [Reading] clears your mind . . . makes you forget about some things, fills your mind with something interesting and new. I like to know new things all the time.

Relaxation is thus an experience where life is as it is in the moment, and is freely chosen and experienced within arranged parameters for exactly what it is. One participant put it this way:

> In the sense of being comfortable with your situation, could be very active… and can be resting to go to bed, so it is context dependent – yes, if I am confident and comfortable in the situation, like I am supposed to be there, then I am relaxed.

Successes throughout the process feed back into the system automatically or upon reflection, and then become foundational elements, amplifying the energy for developing and maintaining chosen activities, habits, and rituals. The whole process brings a person in touch with and allows them to understand and express their essential self in authentic, grounding, and often joyful ways. “After a stressful day at work, I would dive in into the deep 12-foot end of the pool, hang out there 2-5 seconds in the water, being free, totally away from everything underwater hanging upside down. Incredible!” It can be experienced as a “flow.” And it offers opportunity for growth and development of strengths. Emerging insights, creative epiphanies, and peak experiences arise, and there is reduced emotional reactivity to and increased objectivity about problems and worries along with an enhanced ability to see what is important and meaningful in life. Benefitting happens all along the way, as each of the three steps present different opportunities for learning about the self and for what Fredrickson (2001) called broadening and building positive thought-action repertoires, thus increasing resilience and commitment to self-care.

One benefit of switching is that switching offloads stress and is comfortable and self-soothing. It conserves resources by restoring, refreshing, and re-energising them, and by lifting the mood in the near term. When self-balanced, the felt sense of ease settles with feelings of returning to me, being me, and maintaining me. This benefit holds no matter which switching strategy is used. In the longer term, consistent self-balancing practices using managing and letting go switches yield a felt sense of ease not only of being me, but also of and growing me, respectively.

Benefits from switching by managing/controlling offer a direct way of experiencing a series of positive emotions: interest, enjoyment, calm, amusement, satisfaction, and peace. Self-balancing this way not only accomplishes blocking/distracting if that is sought, it also teaches or supports, for example, new trains of thought along desired and specific lines. As it builds on current interests and strengths in directed ways, this strategy fosters growing me. Managing/controlling restores, builds, adds knowledge, increases self-confidence, and brings well-deserved pride in personal accomplishments.

Switching by letting go/allowing gives a further benefit of expanding self-discovery through transforming and growing by connecting. It can be by connection to a sense of wholeness: “To connect with my god, my higher self, the universe . . .There’s also, oneness, maybe, sensing a unity, as the goal.” It can be by a connection to what is valued: “Really, it’s an internal NO. I think breathing is a big one, imagining when you exhale you are getting rid of everything negative.” And it can be by a connection to one’s place in nature: “I think too often we are only using . . .. well, focused on one sense, and gardening and nature make me aware of all of them, and I can actually be still in a garden . . . so it is being in nature, doing that.”

Both managing/controlling and letting go/allowing offer the benefit of changing appraisals. The scope of problems can be clarified: “So it’s like prodding the part of me that is feeling a bit anxious, this helps me get in touch with it.” Approaches to problems can be reformulated: “I think I can get quite reflective, maybe more philosophical, more spiritual–more accepting, perhaps having insights, yes, it’s almost about being a bit more reflective on life, people and events” and, premises and presuppositions can be examined again–“So it is partially the idea, if something is that easy to erase from your mind, then whatever was stressing you out isn’t that important.”

Epiphanies, solutions, and connections with regard to whatever may have been pre-reflectively or consciously offered up or with regard to whatever emerges may surface and be recognised in amplifying causal feedback loops. Transformation may take place without consciously seeking it. It is initiated by and arising through the felt sense and the body. Presenting itself without conscious reflection, it gives rise to a consciously known course correction. It involves “breaking the circle of conditioning” such that underlying framing and appraising processes and meaning structures–including assumptions about how the life world is to be interpreted–are reformulated.

Contingencies: Managing Hindrances and Integrating Enablers

Wherever and whenever self-balancing takes place, and whatever activity is undertaken, there are two contingent feedback loops integral to entering into and maintaining immersion in the activity: dampening negative causal loops which are activity hindrances and amplifying positive causal loops which are activity enablers. For example, negative causal loops emerge when hindrances to choosing, starting and staying in the switching process arise, and they must be adaptively transformed. When hindrances are not transformed, the necessary condition, safety, is impaired, the felt sense of ease is disturbed, the self-balancing process is dampened, and the activity may either stop or be less beneficial. This is what happens, for example, when noticing and responding are dampened by childhood training or by the particularly onerous demands of high-pressure work.

Arranging is hindered where the assessing process may not be as honest as needed, as when a strongly felt sense of devotion to duties and responsibilities causes people to place a higher priority on others than on self-care. The correct match of activity to the self-balancing need may not be made or non-sanctuarying activities may also easily take priority. Once assessing is honest, and hindrances to arranging are adaptively managed and set aside, along with the guilt which may arise when a set aside effort is made, switching to the appropriate activity may still begin with reluctance. This does not mean that reluctant relaxers do not have an overall felt sense of ease about themselves or that they are not balanced for the most part. Instead, it means that they

justify to themselves and others their priorities by referring to upbringing and to their essential nature–being planful and responsible people. It means that they plan their sanctuarying activities and that they are structured into the lifestyle in such a way that they can justifiably set a duty or a feeling of guilt, feelings which would otherwise be a hindrance (contingency), aside. For an example, when of a hindrance to remaining switched arose, the daily walker whose managing/controlling switching process no longer worked because of guilt had two choices: add content to the managing/controlling switching process; or, change to a letting go/allowing switching strategy. An example of adding content is here: "daily was going for a walk, the walk got boring, so I got the MP3 player with audio, so this is how it evolved. I am not a person who can switch off and think about nothing."

At the other end of the spectrum, where positive feedback loops have been consistently strengthened, people who place a high value on self-care enter and exit sanctuarying activities either on the spur of the moment, dipping in and out of micro-sanctuaries almost automatically, or by entering consciously designed, more time extensive habits and rituals such as macro-sanctuaries are needed. In either circumstance, knowing what to expect, or knowing that the conditions of safety and trust are arranged, is a central feature of the positive feedback integration process.

In summary, for a hindrance to be managed and transformed at each stage, being vigilant and honestly recognizing objections to assessing realistically, to arranging adaptively, and to switching are done consciously. Recalling the attractors and the values of self-balancing, recalling past positive self-balancing experiences, and reminding oneself of relevant life goals lead to transforming disablers into enablers and to allowing positive movement are required. In this transforming process, an activity can be adjusted so that it is more enjoyable or easier to do, so that impediments to starting and staying committed to the process are minimized and positives from benefits arise to take their place. Positive causal loops arise in a narrow and a broad sense. In the narrowest sense, these loops include ideas arising from how to improve the activity and make it work and fit even better. In the broader sense, benefits arising during and after the activity amplify the desire to continue or resume the activity at a later time, make it easier to get benefit from doing the activity, and make it easier to transform other hindrances to doing the activity, thus supporting its integration into the life.

Discussion

The current study breaks new ground in relaxation research by using a classic grounded theory research design and by considering with equal weight passive and active relaxation processes. It aligns with Gendlin's (1995, 1997) philosophical model of meaning making by and through the body's non-lexical voice which functions as a context and cause variable, and aligns with his theorizing from a philosophical and clinical perspective about how and where thought arises in fully embodied persons. In the positive psychology tradition of Seligman and Csikszentmihalyi (2000), gathering data about positive subjective experience and about the emergence and evolution of positive personal traits over time takes place.

This current study also supports Teasdale and Bernard's (1995) Interacting Cognitive Subsystems macro-theory of the non-mediated, non-linguistic synchronization of body-based information with memory making and the development of schematic mental models (Cowdreya, Lomax, Gregory, & Barnard, 2017). During self-balancing

sanctuarying, new meanings are created and made accessible to lexical consciousness at metacognitive and implicational levels. These are the levels at which Teasdale and Barnard (1995) and Park, Dunn and Barnard (2011) proposed that schematic implicational models be held. These models can be changed by proprioceptive information arising from the body without conscious lexical thoughts as mediators; they are models of meaning that positively construct an objective and a subjective self.

The state of consciousness people enter when using all three switching strategies closely aligns to Csikszentmihalyi's (1975, 1990) model of the autotelic self and his concept of flow with the process itself having its own reward. The benefits directly align with the broadening and building theoretical concepts proposed by Fredrickson (2003) who urged that "we need to develop methods to experience more positive emotions more often" (p. 335) not only in the best experiences of daily life, but also in neutral and negative experiences. With a managing/controlling switching strategy interest precedes the activity and is one of many motivators for choosing it; and, the enjoyment and sense of lightness and freedom that emerge when doing what one wants to do in a safe space, carry on often for hours after the relaxation activity is over. The question of which comes first arises: the anticipation of positive emotion as an outcome and benefit, or the desire to learn more by doing the activity more. When the managing/controlling switching strategy is used the two factors serially and mutually enhance and reinforce each other over time. This supports Fredrickson and Joiner's (2002) finding that "positive affect and broad-minded coping reciprocally and prospectively predict one another" (p. 172) and Fitzpatrick's and Stalikas's (2008) assertion that "positive emotions are not just indicators [of change] but [are] also generators of change" (pp. 137, 151).

Implications

People have implicit health maintenance models and beliefs about whether, why, when, where, and how to stay balanced. The self-balancing sanctuarying theoretical model can function as a guide that may be used to assess and motivate people who need to self-balance yet who do not consistently do so for a variety of reasons. This model identifies enablers and disablers to all variables in the self-balancing process and clarifies that both active and passive activities can be successfully used to refresh, restore and re-energise.

To uncover, assess, and support a person's situational and motivational hindrances and enablers to self-balancing with regular relaxation, it may be beneficial for laypeople and professionals to use the metaphors community participants used. Unwinding and loosening (threads, strictures), moving away from (threats) or toward (safety as in a journey), and diluting (density, saturation as in a fluid container) are examples of the many metaphors.

Limitations and Future Research

Time and access to participants constrained study of "well" people's relaxation process such that saturation of concepts was not achievable in every area. Specifically, for the distracting and blocking switching strategy there may be a behavioural addiction quality to the use of the strategy in some circumstances. Saturation of the concept "addictive focusing" was not achievable during this stage of the work. Whilst two participants talked of extensive periods of time spent doing repetitive tasks that functioned in a maintenance fashion, further study of the use of this strategy is needed, partly as the

repetitive tasks may function to block relaxation induced anxiety (Newman, LaFreniere, & Jacobson, 2018).

This current theoretical understanding of relaxation as a self-balancing process has many common elements with Csikszentmihalyi's flow theory at personal, place, and social levels (Bonaiuto et al., 2016). It may be important to embark on studies to differentiate relaxation from flow and from other waking states of consciousness in terms of relationship to the self, in terms of the Massimini and Carli (1988) skills/challenge matrix, and in terms of finding flow in online gaming (Weber, Tamborini, Westcott-Baker, & Kantor, 2009), for example. Another question is: Does this theory of relaxation work and fit for people who are moderately to severely anxious, where positive transformations arise out of negative or traumatic life experiences which may "shatter the assumptive world" (Tedeschi, Calhoun, & Cann, 2007, p. 399) and may for some people eventually result in post-traumatic growth? Using this theory of self-balancing sanctuarying on an "emergent fit" basis, the researcher investigated what anxious people do to relax and this will be set out in a subsequent report.

Conclusions

Twenty-one people who reported feeling "well" or "very well" and who lived and worked in the community talked about 22 activities they do to relax in their daily lives. A consistent pattern emerged: a main concern and core category of self-balancing whilst in safety. Realistic assessing and adaptive arranging happen before using switching strategies to move into full engagement in self-emergent, self-chosen relaxation activities. This process seems to come more or less easily, and transforming hindrances to starting the process, to staying relaxed and to integrating positives into the process are contingencies that are routinely managed proactively.

People use different switching strategies in a variety of combinations: distracting and blocking, managing/controlling, and letting go/allowing. Each of these strategies restores, refreshes and re-energizes. Benefits from managing and allowing strategies can also include a subjective sense of being and becoming oneself, of integrating and strengthening the self, of expanding self-discovery, and of connecting people to nature and the world around them.

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Rolling with the Punches:

Clinician Resistance in a Managerial NHS Hospital

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Abstract

The substantive area explored in this article is hospital consultants in an English Acute NHS hospital dealing routinely with increasing managerialism. Data were drawn from 49 interviews with hospital consultants, at one English Acute NHS hospital Trust. The classic grounded theory named “Rolling with the Punches” that emerged was enriched by literature relating to everyday resistance, labour process theory, institutional complexity and organisation studies by considering public and private (internal) scripts. Interpretation of the emergent theory also drew from everyday resistance narratives from rural peasantry applied to the highly qualified public sector hospital professionals. The theory reiterates the role of discursive resistance in the workplace.

Keywords: hospital, managerialism, resistance, NHS, workplace, resistance, professional, doctor

Introduction

The National Health Service, NHS in the United Kingdom has come into its own as crown jewel of the public services. What happens in the NHS affects the entire UK. For the past 30 years, the NHS has experienced radical changes in its organisation structures and managerial regimes (Ackroyd & Thompson, 2003b; Thompson & Ackroyd, 1995). Healthcare delivery has been transformed with metrics-based performance management, electronic monitoring (Farrell & Morris, 2003), and enhanced audit and accountability (Ferlie, McGivern, & FitzGerald, 2012). Work intensity increased. Changes in the modes of control have resulted in shifting power relations between non-clinical managers and clinicians, especially hospital consultants.

There is a lack of understanding about how clinicians and non-clinical managers routinely interact (Kuhlmann et al., 2013b). These changes mean that professional agency within a managerial context should be clarified (Correia, 2013; Muzio, Brock, & Suddaby, 2013). Dissatisfaction is evident (Dickinson, Ham, Snelling, & Spurgeon, 2013; Exworthy et al., 2010; Morris & Farrell, 2007; Spyridonidis & Calnan, 2011); however, the repertoires of dissatisfaction in such a context are not well-studied (Reay & Hinings, 2009) (Bélanger & Edwards, 2013), highlighting an opportunity for exploration.

This study goes beyond a simple binary of non-clinical managers versus hospital consultants. It shows that the responses of doctors are socially constructed, situated, complex and complicit. Managerial initiatives shape, constrain and stimulate clinical practice in non-hegemonic ways and doctors find spaces to evade managerial control (Ackroyd & Thompson, 2016). Clinicians do not have grand visions of resistance, but they do whatever they can, as *bricoleurs* (Levi-Strauss, 2004), using the tensions between structures that constrain and those that enable (Giddens, 1984). This study illuminates the routine responses of doctors as they encounter managerialism in their clinical practice in an acute hospital setting.

Methodology: Classic Grounded Theory

The researchers followed classic grounded theory procedures during data collection, coding, and analysis. The emergent grounded theory and its constructs were the basis of the literature review that followed. We conducted 49 interviews that were recorded in mind-map format and written up as field notes immediately after the interview. Audio recording and transcription were deemed unnecessary (Glaser, 1998), and the participants were unwilling to be recorded for fear that the recordings, with their recognisable voices, may fall in the wrong hands. In addition to the interviews, 20 observation encounters were captured, also in mind-map format. These observation sessions allowed the researchers to view the participants going about their everyday work within the research context (Barley & Kunda, 2001; Zilber, 2002). The observation sessions were those of a “complete” (or detached) observer (Burgess, 2006).

Documentary evidence from the Trust website and other relevant NHS bodies were also studied. “All is data” (Glaser, 1998, p. 8) is a basic grounded theory tenet and the data for this study came from interviews, observations, and official documents.

Data were coded line by line as they were collected (open coding), and the maxim of “all is data” (Glaser, 1998, p. 8) was kept top of mind, so everything was coded as it came up and initially captured in memos and mind-maps before being transferred to a computer database. Five questions had guided the early coding process i.e. a) what is this data about? b) what category could this code belong to? c) what is happening in the data? d) what is the main concern of the participants? and, e) what are they doing routinely to resolve their main concern? (Glaser, 1978, 1998). The core category is the emergent theoretical code from the underlying empirical data, indices, concepts, and categories.

The initial participants were selected purposively using the network of one of the authors of this publication, and, as data collection and analysis proceeded with detailed memo writing, emerging insights informed the choice of the next participants. It soon became clear that some analyses steered the choice of the next participants in a few different directions, leading to different concepts emerging, all of which needed to be followed up on and kept track of. This initial divergence of concept emergence added detail to the categories and progressed towards saturation of the categories. As data were collected, the new data were compared to and contrasted with data and emerging categories and themes already collected and constructed (Glaser, 1998; Suddaby, 2006).

The earlier inductive phases of coding, namely open and substantive coding were greatly iterative, and levels of coding were constantly tweaked and refined as the codes coalesced into categories relevant to the substantive area. Once this happened, we were able to become more selective and think theoretically (Glaser, 1978, 1998) in considering how the categories

could relate to one another and form explanations about how the population in the substantive area behaviourally dealt with workplace managerialism. Inductive coding ended when the core category emerged, after which selective coding was delimited by the core category. As the coding and participant selection became more theoretical, the interview questions shifted to exploring more abstract concepts with the theoretically selected participants to build and clarify the emerging theory.

Throughout the coding process theoretical ideas were written up as memos. During the theoretical coding, piles of memos about the core category and its sub-categories were sorted. Since a fundamental component of a theory is the relationships between the concepts, constructs, and categories, care was taken to make these relationships explicit. Theoretical codes can be, but are not necessarily, a basic social process (Glaser, 1998, 2013). In this case "Rolling with the Punches" is the core category; the theoretical code and is also a basic social process. The name of the theory was a phrase uttered by one of the consultants in describing his coping strategy; the term is based on a boxing metaphor "to reflect the way a fighter moves with the opponent's punch, stepping back or to the side, and, while still getting hit, avoiding the full impact of the blow; this action alludes to the continuous process of adaptation to a changing reality" (Kristensen, 2010, p. 9).

Rolling with the punches

As the codes and categories surfaced from the data, the following major categories and sub-categories were formed:

Phase 1: Weighing up

Weighing up is the doctors' initial reaction to imposed managerial decisions. When managerial measures such as record-keeping and performance management were imposed on doctors, they process the requirements and work out what they might mean for their clinical practice and clinical identities. Weighing-up goes on all the time. The immediate clinical group play a significant role in how doctors understand their environment. Hence, weighing-up is an individual process with inter-subjective input.

When weighing-up, doctors seek to understand what is happening and evaluate their current mode of coping behaviours; weighing-up can, but does not always, lead to a change in behaviour. The weighing-up phase consists of two sub-categories, that is, making sense and deciding what to do.

Making sense. In the process of considering the new managerial requirements, doctors try to make sense of the new requirements within the context of their professional practice. If their mode of behaviour changes, it can result in erratic vacillations in a non-linear manner. A doctor might adopt contradictory behaviours to the same stimulus at different times, depending on what else is happening at the time. Different mode-shifting triggers could be present in each mode.

Doing something. Doctors as a group are highly individualistic. They are trained to assess and intervene as unique and complex situations emerge. To a large extent, doctors are knowledge workers, and getting them to act in solidarity can be difficult, especially on non-clinical matters, where there is not the professional practice glue which defines appropriate actions. The doctors are also not inclined to take decisions that they might view as potentially

harmful to patients. Thus, they may easily be conflicted in deciding the best course of action when two choices seem to be mutually exclusive and there are often constraints on what they could do to cope with managerialism. However, they must decide and take a specific course of action; in other words, they must do something which means choosing a response behaviour to cope with the imposed (as they see it) restrictions.

Phase 2: Coping behaviours

The forms of coping taken by doctors towards managerialism include efforts to absorb the new requirement and get through the issue in the short term, a temporary stabilisation of the situation. The sub-categories of the coping mechanisms are described below.

Stabilising temporarily. This is a mode of behaviour that is adopted by many newly-qualified hospital consultants. Invariably, they struggle with the non-clinical issues associated with the transition from being a registrar (trainee hospital consultant) to a fully qualified specialist consultant. They work extra hours, often under unrelenting pressure, to get the job done; being trusted as a clinically reliable doctor is important. However, their stress levels increase and their work-life balance suffers. The next step is that the doctors resist the managerial imposition.

Resisting. Resisting means opposing managerialism in various, usually subtle, ways. Given professional and social constraints, hospital consultants do not go out to the picket line, but are hard at work. Overt resistance is disguised, and takes two main forms; *subverting* and *quibbling.*

By *subverting,* the hospital consultant will use the managerial system against itself. A doctor who is frustrated with efficiency measures and cost savings could use the clinical governance processes to highlight the dangers posed a lack of readily available bedside equipment. The subversive uses the clinical governance logs to record clinical concerns, and managers are obliged to respond since the recorded concern is now effectively in the public space and cannot be ignored.

Quibbling means raising hair-splitting concerns. Whilst the subversive attacks managerialism using large measures, the quibbler does very many small things to achieve the same goal. The quibbler uses the knowledge that managers must achieve targets within specified time frames and seeks to undermine them, slowing down specific managerial initiatives and frustrating managers, as they themselves are frustrated.

Limiting the impact. Doctors eventually come to terms with the reality of the managerial impositions and take steps to limit its impact on their lives. They say, in effect, “we are where we are. I have to do the best to insulate myself.” There are two ways of limiting the impact: *lying low* or *faking it.*

Lying low involves avoiding and staying out of sight of colleagues and managers in trying to find ways around the managerial initiatives. Despite the move towards multi-disciplinary teams (MDTs), there is still enough room in the one-to-one doctor-patient encounter for avoiding tactics to be at least partially effective.

Faking it is about keeping up appearances by being in the right place, at the right time and saying the right things. This is a positioning tactic and is arguably less obvious than lying low.

Faking is a mode of behaviour for the consultants to buy enough time to remove themselves from any unwelcome attention and cement their position in the professional environment. Many hospital consultants are skilled in adopting this pattern of coping behaviour.

The unending chain of managerial initiatives creates opportunities for various coping behaviours. The relationship between managerial events and behavioural responses on the part of the doctors is ongoing and iterative, as though they were engaged in an unending and somewhat erratic dance, continuously jostling for a superior position relative to one another.

Phase 3: Adjusting to/Living with

Adjusting to/living with is a mode where an uneasy state of equilibrium is established, although it may be of short or long duration. The behaviour is essentially that of compliance, or at least apparent compliance. For these doctors, the managerial hospital is a reality which they are exhausted from fighting and they take respite in one or more of four tactical positions: *going with the flow, complying substantially, complying fully* and *waiting it out*.

Going with the flow. Going with the flow is evident when individuals keep aligned with whatever seems easiest at the time, with the appearance of being cooperative; yet these behaviours may simply be to take attention off themselves so that they may engage in more self-serving activities such as significant private practice interests. Going with the flow is like faking it, but they feel no obligation to position themselves strategically. Justified self-interest can be a strong motivator.

Complying substantially. When doctors comply with a heavy heart, they do enough to get the managerial job done, but without any enduring commitment or belief in the value of the project. They do their work and go home.

Complying fully. Complying fully is a pattern of behaviours is used by those hospital consultants who are meeting the demands of the managerial hospital, almost completely and without resistance. However, motivations for doing so might differ. Some comply fully because when things go wrong (possible malpractice litigation), as increasingly happens, they find refuge in having followed protocols and clinical guidelines. Other consultants do what the managerial project demands; however, following protocols and managerial directives often results in things taking longer than expected. Thus, complying fully can be like quibbling although the latter is a resistance pattern of coping behaviours. Complying fully takes more time than is necessary with every step of the managerial process whilst still being fully compliant. Both tactics set out to achieve the same goal (slowing down the managerial project) but the orientations of the subjects differ depending on the agency of the specific protagonist.

Waiting it out. Waiting it out is also a is also a compliance-oriented behaviour and is effectively being present physically but not present mentally or emotionally. Doctors can become incrementally demotivated with change fatigue. They are waiting out their time until retirement, and simply do their work, support their colleagues clinically but do not contribute much more than that. It is part of an exit strategy, although it is a tragedy when the exit may be two or more decades away.

The Grounded Theory: Rolling with the punches

Data analysis led to the emergence of dealing with managerialism as the main concern for hospital consultants. Doctors believe that patients come to hospital for treatment by clinicians, and managers should not interfere with the doctor-patient relationship or the clinical decision-making process.

However, doctors perceive that managerialism detracts from their professionalism and they respond by behaving in a variety of ways to avoid, minimise, or otherwise deal with this perceived interference in a manner reminiscent of the avoiding actions taken by participants in the sport of boxing. The name of the theory was chosen based on the boxing metaphor, rolling with the punches, which "reflects the way a fighter moves with the opponent's punch, stepping back or to the side, and, while still getting hit, avoiding the full impact of the blow; this action alludes to the continuous process of adaptation to a changing reality" (Kristensen, 2010, p. 9).

Rolling with the punches begins with a *weighing-up* process in which the doctor reflects on the managerial imposition (*making sense* of the situation) and decides what course of action to take in response (*doing something*). Most of the doctors cope initially by *stabilising temporarily* to maintain the status quo, before taking steps to either *resist* by means of *subverting* or *quibbling*, or *to limit the impact* of the managerial action by either *lying low* or *faking it*.

Sooner or later, most doctors will adjust to the reality of the managerial requirement and act to live with the situation (*adjusting to/living with*). They most frequently choose one of*, going with the flow, complying substantially, complying fully* or *waiting-it-out.* Each of these phases, behaviours or steps do not happen in a unidirectional manner as described here, but are mutually constitutive and constantly iterate, creating a complex web of actions, interactions, responses, behavioural adjustments and retaliations.

Literature review and discussion

The literature review was delimited by the grounded theory. Hence, literature was consulted only to the extent that it contributed to a better understanding of the emergent grounded theory.

Phase 1: Weighing up

Managerialism has significantly changed the acute NHS hospital (Farrell & Morris, 2003; Flynn, 1999) with a possible reconfiguration of the doctor-patient encounter and the subjectivity of doctors. That is when weighing-up is needed (Ancona, 2012). Doctors act without having a clear, or grand, vision of the future in mind (Klein, 1999) with situated responses (Smets & Jarzabkowski, 2013).

Rolling with the punches as a conceptual model suggests complicity between managerialism and medical professionalism. Professional resistance seems to be on a compliance-resistance continuum (Vinthagen & Johansson, 2013). Hospital consultants cannot step outside of the managerial framework and must find spaces to turn the managerial logic in their favour. Their everyday clinical behaviours must be institutionally validated so the doctors continuously (re)frame the relationship between managerialism and medical professionalism in their everyday practice.

Doctors are not culturally insensitive (Garfunkel, 1984) mindlessly following the managerial cultural scripts (Blomgren & Waks, 2015; Waring, 2014). The managerial project

and clinical professionalism make potentially conflicting demands on the hospital doctor. The observed behaviours are underpinned by interpretation, agency, effort, and intentionality. Agency (Emirbayer & Mische, 1998) frames the routine behaviours that can either facilitate or impede managerialism. Weighing-up is the connective link between the different modes of everyday resistance behaviours i.e. stabilising temporarily, resisting, limiting the impact and living with/adjusting to. Despite the duration of the managerial project, everyday resistance has largely kept the acute NHS hospital as a professional bureaucracy (Dickinson et al., 2013).

Weighing-up, which goes on all the time, can lead to any of the modes of coping behaviour.

Phase 2: Coping mechanisms

Stabilising temporarily. This study confirmed the difficulties of newly qualified hospital consultants in the transition to duty consultant (Brown, Shaw, & Graham, 2013; Morrow, Burford, Redfern, Briel, & Illing, 2012). They find themselves managerially unprepared to be the senior clinician. Younger consultants work hard but also seek a better work-life balance (Dacre, 2008; Thomas, 2014). Their goals involve getting through work and not overtly resisting the managerial project. Their agency is not projective but mainly practical-evaluative (Emirbayer & Mische, 1998). They get through their work lists (which are determined by management) in ways that maintain the existing ways of getting work done. They weigh up what management wants versus the accepted clinical practices of their senior colleagues in their areas of speciality. Therefore, they do not merely follow cultural scripts (DiMaggio & Powell, 1991; Garfunkel, 1984), but effortfully work towards accomplishment of the task at hand (Smets & Jarzabkowski, 2013). Thus, practical-evaluative agency has iterative consequences and clinical priorities ultimately prevail.

Despite concerns with the distinction between the public and hidden modes of coping, particularly resistance (Scott, 1989) one could still use the points of difference as an analytical tool. The public script of the newly qualified consultant is one form of compliance with the requirements of the managerial system. The hidden transcript is the shared understanding within the immediate clinical speciality of the doctor, determined largely by the senior hospital consultants in the department. This is the text that legitimises the public behaviour of the newly qualified consultant. Stabilising temporarily is an early, hidden mode of everyday resistance. For newly qualified consultants, disguise is an important survival tool. Their mode of coping behaviour serves to strengthen the professional bureaucracy rather than support managerialism.

Resisting. The concept of routine resistance can easily be found in situations where interpersonal power is present (Correia, 2013; Scott, 1989; Thomas & Davies, 2005). This study answers the question of how hospital doctors routinely resist whilst still accomplishing everyday work with patients.

This grounded theory study confirmed that a small number of doctors resist managerialism by framing the relationship between managerialism and medical professionalism as incompatible. This is an intentional and active process (Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013) in a drive to be true to clinical professional values, which have been shown to be resilient (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006).

Subverting is the delinking of a managerial technology from its stated purpose (Hirsch & Bermiss, 2009; Levay & Waks, 2009). Doctors confirmed subversion as found in the literature

(Ferlie et al., 2012; Miller & Rose, 2008) and use managerial tools for clinical purposes. Where they cannot turn the managerial logic around, doctors engage in discursive resistance and attempt to discredit managerially-inspired clinical protocols and clinical guidelines as "cookbook medicine" (Timmermans & Berg, 2003, p. 19).

Subversives adopt mainly a practical-evaluative agency, as they do not have an option but to get through the managerially controlled work lists as well as attending to their patients. They do not support the change of the hospital from a professional bureaucracy to a managerial hospital. Their agency has iterative consequences and the professional bureaucracy prevails.

Quibbling agency is mainly practical-evaluative, but with no projective dimension, thus having iterative consequences. There is enough in a day for the quibbling resistor to stall the managerial transformation programme.

Resisting is a pattern of situated non-dramatic responses to managerial power in the manner described by Scott (Scott, 1985, 1990). The public transcript affirms managerial status but doctors use institutional spaces within which to conduct ambiguous acts of resistance. The hidden transcript that sustains these individual acts of defiance is an alternative clinical professional subjectivity (Noordegraaf & Steijn, 2014; Spyridonidis & Calnan, 2011; Spyridonidis, Hendy, & Barlow, 2014).

Although weighing-up is described as an initial step, it reappears constantly as doctors evaluate new situations and requirements as they arise, and change their responses depending on specific circumstances.

Limiting the impact. This study confirmed that some doctors coped by trying to find ways around managerialism and limiting the impact. These impact-limiting behaviours came predominantly in the form of *lying low* or *faking it* tactics.

Lying low is an avoidance tactic (Endler & Parker, 1994; Lazarus & Folkman, 1984, 1987)--an effortful and intentional response (Giddens, 1984). Since doctors have to complete their work-lists as set out by managers, their agency is primarily practical-evaluative (Emirbayer & Mische, 1998) with inverse-decoupling (Levay & Waks, 2009) of the relationship between the managerial initiative and actual clinical practice. Lying low is about finding spaces from which to resist whilst being in the shadows. In this tactic one could have someone becoming a clinical manager with the objective not to advance the managerial project, but to defend the clinical project (Dickinson et al., 2013; Waring & Currie, 2009).

In lying low, agency is mainly practical-evaluative with iterative consequences, with some projective agency. The latter is often only to gain credibility with management in order not to draw attention to what is fundamentally a defence of clinical logics. So, effort, intentionality, and agency are geared to find ways around managerialism. Clinicians sometimes seem to have no choice but to cede ground to managers with the emergence of hybridity.

Faking it is a positioning tactic. The fluidity of the professional identity (Ashforth & Johnson, 2001; Waring, 2014) allows for a wide range of acceptable behaviours. Two issues remain non-negotiable. First, doctors cannot put patients at risk. Second, they must complete their work-lists as prepared by managers. Hence practical-evaluative agency primarily underpins their behaviours. Since they are faking it, they aim at keeping managerialism and medical

professionalism apart and decoupling (Levay & Waks, 2009) the managerial technology from its purposes. So, when it comes to job planning and clinical audits (McGivern & Ferlie, 2007) and quality enhancement (Levay & Waks, 2009) they adopt the managerial initiative and discourse and do enough to be seen by management as being cooperative. They then get notice of any future as they see the right people, sit in the right meetings and say the right things – without necessarily walking the walk.

Phase 3: Living with / Adjusting to

Ultimately long-term adaptation is necessary in some form. In this mode there are four predominant types of behaviour: *going with the flow, complying substantially, complying fully,* and *waiting it out*. A different combination of agency, intentionality and effort underpins each of the tactics thus reframing the relations between managerialism and medical professionalism.

Going with the flow is a pattern of coping behaviours that blurs the boundaries between managerialism and medical professionalism resulting in a hybrid professionalism (Blomgren & Waks, 2015; Noordegraaf, 2016).

Agency is mainly practical-evaluative (Emirbayer & Mische, 1998) with iterative consequences as well as a degree of projective agency. Such projective agency makes them somewhat attractive to management but causes tensions with their colleagues (Spurgeon, Clark, & Ham, 2011). Because the doctors do not fully commit to the managerial project, the non-clinical managers are suspicious (Greener, Harrington, Hunter, Mannion, & Powell, 2011), and trust is somewhat shaky. The managers see hybrid professionals as operating in the managerial zone but with a salient professional identity within other nested identities (Ashforth & Johnson, 2001; Spyridonidis & Calnan, 2011; Spyridonidis et al., 2014). The doctors sit on the clinical-managerial fence and self-identify as two-way windows (Llewellyn, 2001). However, doctors often feel ill-prepared for the management tasks that they do assume (Ham, Clark, Spurgeon, Dickinson, & Armit, 2011; Spehar, Frich, & Kjekshus, 2012). Going with the flow behaviours could be said to be the practicing of soft bureaucracy (Courpasson, 2000) with practice-situated improvisations (Smets & Jarzabkowski, 2013).

Going with the flow involves sitting on the fence in a very public way and can be a challenge to both their clinical and non-clinical management colleagues. Hence, it can be a lonely space to occupy.

Complying substantially is compliance in a qualified way, demonstrating practical-evaluative agency without any commitment to shifting their professional priorities towards managerial criteria. So, their agency has iterative effects. If they are obliged to adopt managerial technologies, they do so with a heavy heart and discursively justify their choices (Anderson, 2008; Mumby, 2005), at least to themselves. They do their work, comply as required, and often complain. Frustrations are usually kept private or shared outside the workplace; the doctors do not readily reveal their true feelings at work.

Complying fully is the coping behaviour of a handful of hospital consultants, those with a future-orientated intentionality (Emirbayer & Mische, 1998). These consultants believe that the doctor as a practitioner only is out-dated and not practical, that the new medical professionalism should incorporate transparent accountability (Power, 1999), metrics-based performance management (Farrell & Morris, 2003), and self-management (Miller & Rose,

2008); in fact, it is a strategic hybrid (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015) that is necessarily a salient part of their new professional identity. Those who are complying fully engage in significant discursive justification to legitimise their hybridity.

Projective agency is important for this group as they are committed to a reconfiguration of the medical profession and are happy to get the job done. However, their projective agency still operates in a healthcare delivery environment characterised by wicked problems and complexity (Nelson et al., 2003; Shiell, Hawe, & Gold, 2008). Even their enthusiasm for change does not suggest a grand vision of an alternative medical professionalism but mere situated improvisations (Smets & Jarzabkowski, 2013) that congeal on the margins of the discourse of medical professionalism.

Nearly half the respondents are *waiting it out* and this group comprises the most experienced hospital consultants. Some may have been strategic hybrids at some time earlier but the role has exhausted them (McGivern et al., 2015), and they disengage, hungering for the time when clinicians operating had a high degree of clinical autonomy. Their agency and behaviour might be congruent with those consultants who are going-with-the-flow, but given that they are often mid-career or nearing retirement consultants, their efforts, intentionality and agency differ.

Many doctors have become incrementally exhausted and have adopted a detached state of mind which may have led to marginalisation (British Medical Association, 2013). The consultants do their work in established ways without significant regard for management control systems, metrics-based performance management and competitiveness (Farrell & Morris, 1999, 2003). Having a detached state of mind takes effort and discursive justification. It is hard to look the other way when one has so much more to give to a system that does not value clinical input as it should.

Conclusion

Rolling with the Punches is a complex theory of routine resistance as hospital consultants navigate the fine line (Clifford, 1981) between managerialism and professionalism. Our research suggests that resistance is a complex phenomenon with multiple modes and levels of expression. Close examination of the discourse, justifications and behaviours of the participants gave us an insight into a subtler understanding of resistance within a context where the maxim “first, do no harm” is non-negotiable.

Managerialism has shifted power relations within the acute hospital. Trust and collegial professional integrity have been replaced by audits, accountability, performance metrics, and quasi-competition. These managerial methodologies pose substantial challenges to the hospital as a professional bureaucracy. Managerial decision-making in the complexity of the healthcare delivery system pressurise professional discretion and many consider that the managerial operating logic of the hospital challenges medical professionalism.

Doctors are trained to put the welfare of patients above all else. Hence, resistance potentially putting patients at risk is difficult for doctors to contemplate. Acting in solidarity with other hospital doctors is almost alien to them. Hospital consultants seldom have the political awareness and skills to resist managerialism efficiently, but this does not mean that they do not resist.

What is clear is that doctors care about patients. Managerialism is an issue when it interferes with that clinical orientation. Thus, doctors constantly reframe the relations between the two main logics of managerialism and medical professionalism (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011; Smets & Jarzabkowski, 2013). They are not on a picket line but the hospital consultants often resist managerialism in the small crevices in managerial technologies at the clinical frontline (Barley, 2008), yet at the same time integrating that very managerialism into their everyday behaviours (Noordegraaf, 2016).

Institutionally complex (Greenwood et al., 2011), highly fragmented, and complex organisations like hospitals (Goodrick & Reay, 2011) require agency to routinely get by (Kraatz & Block, 2013). The sense-making process in agency explains contingency of their routine resistance behaviours at the clinical frontline. The routine resistance behaviours of the hospital consultants show that the hospital remains a contested space with a professional bureaucratic bias (Dickinson et al., 2013), despite the huge investments in managerial reforms. Institutional and organisational complexity creates room for agency and misbehaviour (Thompson, 2016). However, it should be noted that the fluidity of micro-institutional behaviours show that managerialism and medical professionalism are not definitively incompatible (Besharov & Smith, 2013; Noordegraaf, 2016; Noordegraaf & Steijn, 2014).

The hospital consultants routinely frame relations at the intersection of competing logics at a micro-institutional level (Reay & Hinings, 2009; Smets & Jarzabkowski, 2013) in the tradition of everyday resistance (Scott, 1985, 1990). We know that the managerial hospital aims to shape both the subjectivities of the hospital consultants and the work environment. Rolling with the punches is a theory of how their routine resistance reclaims that subjectivity and reshapes the social environment in the process of accomplishing routine work. This is the arena of the micro-politics of resistance (Thomas & Davies, 2005).

The ideas on agency, the social construction of meaning (Berger & Luckman, 1967; Blumer, 1971; Giddens, 1984) overlap with Scott's (1985, 1990) ideas on transcripts and discursive resistance. This paper supports the idea that employee resistance is not dead (Ackroyd & Thompson, 2003b, 2015; Thompson, 2016). By focusing on the viewpoint of employees one gains insight into how they make sense of the complexities of the workplace (Thomas & Davies, 2005; Weick, 1995) and how the messiness created by pulling in opposing directions is managed in everyday, informal and spontaneous ways (Knights & McCabe, 2000).

The managerial hospital concentrates organisation power in the hands of mainly, but not exclusively, non-clinical managers. Hospital consultants also have power in the form of clinical expertise and social status, and the ebb and flow of power between clinicians and non-clinicians is evident. This classic grounded theory study gives a conceptual account of everyday behaviours of hospital consultants in a managerially-run acute hospital. It shows that resistance by hospital consultants is taking place and explains why and how the hospital remains largely a professional bureaucracy (Dickinson et al., 2013).

This study illuminates the gaps in understanding between doctors being neither "cultural dopes" (Conroy, 2010, p. 61) nor heroic change agents (Battilana & D'Aunno, 2009). A close examination of the diverse responses of doctors answers the call for a more nuanced account of the complexity of professional agency (Hwang & Colyvas, 2011, 2014).

Directions for future research

Organisational misbehaviour is alive and well. One needs to look in the right places and pay close attention to the empirical context (Ackroyd & Thompson, 2015; Thompson, 2016). A focus on individual agency is needed because macro-logics do not determine frontline behaviours (Barley, 2008). By starting to look at the organisation from the perspectives of the medical staff, as we have done in this paper-–rather than management--we might get a better idea of everyday resistance in organisations.

Other professional groups, within the same empirical context, could be studied. This should be interesting because hospital consultants are the most powerful clinical group within the hospital. How do other, less powerful professionals react to the managerial transformation of the acute hospital? Then, one could have a comparison between the findings of this and the new study. The comparison could have implications for theory and practice.

One could also do a study of professionals in other empirical contexts who are subject to managerial transformation. A formal theory of professional coping under managerial transformation could emerge over time.

Practice implication

Managers generally have an idea that doctors resist change but do not always have a nuanced understanding of the phenomenon. This study could assist practitioners in this regard.

Originality

This study develops links between classic grounded theory, routine resistance in the workplace, management studies, and organisational development. It contributes to the emerging stream of micro-institutional research as to what is happening within organisations as they respond to external pressures.

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Positioning: A classic Grounded theory on nurse researchers employed in clinical practice research positions

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Abstract

The purpose of this classic grounded theory was to discover the general pattern of behavior of nurse researchers employed in clinical hospital research positions. Internationally, efforts have been made to strengthen evidence-based practice by hiring more nurses with a PhD for research positions in clinical practice. However, these nurse researchers are often left to define their own roles. I used data from a Danish anthology of six nurse researchers' experiences of being employed in clinical hospital research positions. The theory of Positioning emerged as the general behavior of the nurse researchers, involving seven interconnected actions of building an identity and transformations of self, which varied in intensity and range of performance. Positioning characterized nurse researchers' actions of following and connecting two paths of working as a postdoctoral researcher in clinical practice and moving towards a career in research, both guided by their personal indicators.

Keywords: nurse researchers, grounded theory, positioning, clinical hospital research, building an identity

Introduction

Traditionally, nurses with a PhD degree are employed at Universities, where they educate nurses in scientific and academic programs, supervise PhD students, and conduct research (Orton, Andersson, Wallin, Forsman, & Eldh, 2019). However, times are changing and the paths into hospital positions are steadily growing worldwide for nurses with PhD degrees. In Denmark, we see an increase in nurses with a PhD in clinical hospital settings, where they are employed in academic positions such as clinical nurse specialists, postdoctoral researchers, senior researchers and clinical professors (Berthelsen & Hølge-Hazelton, 2018a). However, academic nurses holding Master's degrees are also finding their way into hospital and primary care settings as clinical nurse specialists, advanced practice nurses, and PhD students. Due to the low level of evidence-based practice in nursing, academic nurses are needed as role models and leaders of research and development in clinical practice (van Oostveen, Goedhart, Francke, & Vermeulen, 2017; Orton et al., 2019).

Even though nurse researchers, holding PhD and/or Master's degrees, are multiplying in clinical practice, their roles and specific tasks are somewhat ambiguous, which can create

insecurity and confusion about how to perform at their best (Berthelsen & Hølge-Hazelton, 2018c). This aspect was seen in an intrinsic single case study of nurse researchers in clinical hospital positions, where the main theme of being "Caught between a rock and a hard place" identified the nurse researchers' experiences of being in clinical practice in hybrid roles, feeling that they did not fit in anywhere (Berthelsen & Hølge-Hazelton, 2018c). The nurse leaders play a particularly important role in the integration of nurse researchers in clinical practice, as they can help to create and support the optimal environment for research in the department (Bianchi et al., 2018).

Data from a Danish anthology of six nurse researchers' narratives about being employed in clinical hospital research positions were used in an attempt to discover the actions, processes, and behaviors of nurse researchers in clinical practice (Hølge-Hazelton & Thomsen, 2018). The aim of this study was to generate a classic grounded theory on the general pattern of behavior of nurse researchers employed in clinical hospital research positions. The research question that guided the study was: What are nurse researchers' main concern in their clinical hospital research positions and how do they resolve it?

Methods

Classic grounded theory, based on Barney G. Glaser's (1978, 1992, 1998) methodology, was chosen in order to discover a substantive theory on the general pattern of behavior of nurse researchers employed in clinical hospital research positions. Classic grounded theory aims at generating conceptual theories that are abstract from time, place and people (Glaser, 1992) through an inductive-deductive process of data collection, analysis and constant comparison of incidents (Glaser, 1978). This paper was written in adherence to the GUREGT-guidelines for writing and reporting grounded theory studies (Berthelsen, Grimshaw-Aagaard, & Hansen, 2018b).

Materials for data collection

Glaser's dictum of "all is data" (Glaser, 1998, 2001) inspired me to use a Danish anthology of nurse researchers' narratives about being employed in clinical hospital research positions (Hølge-Hazelton & Thomsen, 2018) as the basis for data collection, constant comparison (Glaser, 1998) and a secondary analysis (Glaser, 1962). The anthology consists of seven narratives where researchers in hospital positions describe their experiences of working in clinical practice settings (Hølge-Hazelton & Thomsen, 2018). The narratives are written by the researchers and are displayed in chapters. One narrative was excluded, as it described a midwife's experiences, but the remaining six narratives by six nurse researchers (five PhDs and one PhD-student) were included as data (Table 1).

Table 1: Education and employed positions of the participating nurse researchers

	Qualified as a nurse in year	Completed PhD in year	In current hospital position since year	Combined with university position
A	1984	2011	2012	-
B	1985	2012	2017	Post doctoral researcher

C	1997	-	2015	Assistant professor
D	1988	2012	2018	Assistant professor
E	2008	2017	2017	Assistant professor
F	1983	2015	2016	-

All six nurse researchers were employed in research positions in hospitals and four of them were employed in dual positions at a University. The number of years they had been qualified ranged from 12 to 37 years (median=33.5 years; mean=29.1 years) and those with PhDs had completed their PhDs in the previous 3 to 9 years (median=8 years; mean=6,6 years). Owing to the choice of data materials of narratives already published in a book it was deemed unnecessary to file applications for approval of the study from the Ethical Committee or the Data Protection Agency.

Data analysis and constant comparison

A secondary analysis of six published narratives of nurse researchers' experiences of working in clinical practice settings was performed. Secondary analysis was described by Glaser (1962) as re-analyzing data that already exists and is the use of pre-existing data to investigate new questions (Andrews, Higgins, Andrews, & Lalor, 2012). It is not a method of analysis and can therefore be applied to grounded theory (Andrews et al., 2012). When applying knowledge discovered elsewhere Glaser (1962) recommended the researcher to acknowledge important questions of comparability. In relation to Glaser's descriptions of secondary analysis (Glaser, 1962), the population was compatible for the aim of this study as were the past findings compatibility to the present hypothesis and aim of this study: to generate a classic grounded theory on the general pattern of behavior of nurse researchers employed in clinical hospital research positions.

The constant comparative method of classic grounded theory is as an iterative research process involving substantive and theoretical coding, and a constant comparison of concepts and incidents discovered during the data analysis (Glaser, 2001, 2011). The theory is eventually written up by sorting theoretical memos based on concepts of the emerging theory (Glaser, 1978, 1998).

The six narratives from the anthology were printed and these served as data. Data analysis began with line-by-line open coding, which is the first step in substantive coding (Glaser, 1978), to answer the questions of "What is going on?", "Which concepts are represented in this data?" and, most importantly, "What is the main concern of the nurse researchers in clinical hospital research positions and how do they try to resolve it?"

After initial open coding of the first narrative, 113 line-by-line codes appeared and were condensed into five concepts. These were used as further focus in the analysis of the second narrative. Because a secondary analysis was used it was not possible to follow the methodological dictum of theoretical sampling (Glaser, 1998) or to include new participants, settings or other sources of data to saturate the concepts of the theory (Andrews et al., 2012). However, the generated codes were kept in mind for constant comparison. During the open

coding of the second narrative, four new concepts emerged from the 74 line-by-line codes during the analysis, caused by the different behaviors between the first and second nurse researcher. Constant comparisons of incidents and empirical indicators were performed and compared. During open coding and analysis of the third narrative, the differences in behavior of the first two nurse researchers, as well as the nine concepts, were kept in mind. The third nurse researcher's behavior and actions were both similar to and different from the first two nurse researchers, by being close to practice as well as following a concrete career path. The last three narratives were coded and analyzed, in the same way as the first three, by using open line-by-line coding, condensing concepts and following the dictum of theoretical sampling. After all six narratives had undergone open coding, the narratives were scrutinized again, focusing on the 43 condensed concepts, and the core category of Positioning was discovered. The six narratives were read again, focusing on the core category and selective coding for any data, concepts, and incidents concerning Positioning.

Theoretical memos were hand-written from the beginning of the analysis and until the core category was discovered (Glaser, 2011). Memos are ideas and thoughts about the theoretical codes and their relationships as they emerge during coding, collecting, and analyzing data (Glaser, 1998). As a core stage in the process of generating classic grounded theory, the theoretical memos were eventually sorted and written up to theory (Glaser, 1998).

Theoretical coding was used to organize the connections between the core category of Positioning and the related concepts (Glaser, 2005). The theoretical codes of Identify-Self emerged during the analysis of nurse researchers' pattern of behavior of Positioning. The Identity-self explains different types of self-image, self-worth, identity, self-realization, and transformations of self (Glaser, 1978), which are all a part of the theory of Positioning and the nurse researchers' general pattern of behavior.

The theory of Positioning

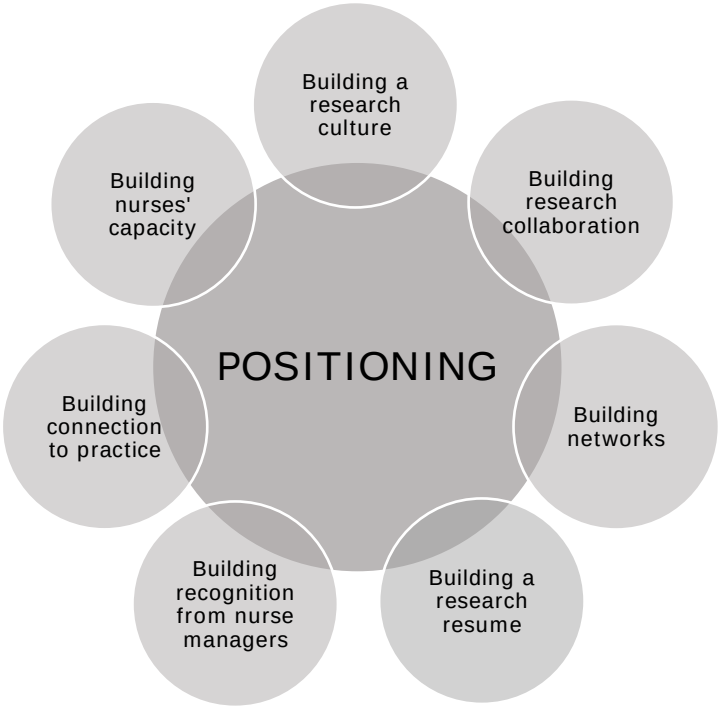
Positioning emerged in the analysis as nurse researchers' general pattern of behavior through which they resolved their main concern of establishing their position and finding their identity as nurse researchers in clinical hospital research positions. Nurse researchers followed and connected two career paths to resolve their main concern. One path was directed towards working in a postdoctoral job in a clinical hospital position and the other path was directed towards a career in research.

Positioning was discovered to be guided by nurse researchers' personal indications, such as intentions, beliefs, ambitions, experiences, and perceptions of nursing and nursing values, which determine their general career pathway. However, Positioning was not perceived to be an egotistical or manipulative behavior but a way to establish their identity as nurse researchers in a clinical hospital setting through personal indications. Nurse researchers were the first of their kind in their respective hospital departments. The specific tasks associated with their positions were not well described by the departments and they therefore had to lay the foundations as they went along.

The theory of Positioning involved seven interconnected actions of building an identity and transformation of self, which varied in intensity and range of performance between nurse researchers, depending on their personal indications and main choice of path. The seven actions were characterized as building a research résumé, building networks, building research

collaboration, building a research culture, building nurses' capacity, building a connection to practice, and building recognition from nurse managers (Figure 1).

Figure 1: The nurse researchers' seven interconnected actions of Positioning



Building a research résumé

Building a research résumé characterized nurse researchers' direct actions to promote their career in research. Their actions in building a résumé were directed towards concrete research tasks, such as developing own research projects, conducting different kinds of research, collecting and analyzing data, and writing papers. Tasks concerning quality improvement and developmental studies were often passed on to other staff members so they could concentrate on the research topics which supported their path towards a researcher identity. However, some nurse researchers, who mostly worked toward a career in the clinic, enjoyed working with development and small-scale projects using non-research methods as their priority. Building a research résumé also involved representing the department in national and international conferences, where nurse researchers presented their research and built new networks, to support their position as researchers.

Some nurse researchers work full time as postdoctoral researchers in the hospital while others work in dual positions between the university and their clinical hospital research position in order to build a research résumé and to promote their career movement. Holding a university position as a postdoctoral researcher might allow them to pursue a position as an associate professor or reader in nursing in their future career. However, the dual position was mostly undefined and their tasks in their hospital position were unclear, leaving the nurse researchers to determine their tasks themselves. Having control over their own time provided

nurse researchers with opportunities to build their research résumé and to plan their workdays as they wished. This makes no difference to how they engage in Positioning.

Building networks

Building networks characterized nurse researchers' actions to become acquainted with colleagues at other levels in the department and hospital, and to meet new research collaborators in regional, national, and international settings. One of the ways in which nurse researchers built their network was by attending numerous monodisciplinary and interdisciplinary meetings inside and outside the hospital. During these meetings, nurse researchers planned mutual projects for new research with the management, the medical doctors, and their peers. Even though there were many meetings and nurse researchers had to prioritize some meetings over others, their attendance was important for building networks and an important step to position themselves. Network building was of great importance to nurse researchers, since most of them were pioneers in their department. The theme of Pioneering was discovered through the analysis of data from nurse researchers who described how she was the first nurses with a PhD in their department. Nursing research and evidence-based nursing was a new concept showing how nurse researchers were hired to build an evidence-based practice along with their multi-disciplinary colleagues. Building networks for collaboration was therefore necessary for the nurse researchers in order to conduct research and develop evidence for practice to strengthen their position as researchers in clinical practice.

Building research collaboration

Building research collaboration characterized the nurse researchers' actions to brainstorm, plan, discuss, and conduct research with academic peers. Collaboration with academic peers ranked high on nurse researchers' list in Positioning because it could lead to a more comprehensive aim for the research in the department as well as provide a boost in their academic careers. Building research collaboration was explained as looking for academic peers, such as mono- and interdisciplinary researchers, in various research environments in hospitals or universities. Nurse researcher collaborated in a monodisciplinary manner with other nurse researchers in the hospital, the University, and abroad, and in an interdisciplinary manner with medical doctors, physiotherapists, and nutritionists. Collectively the researchers had patient care and treatment as focal points. Nurse researchers used their nursing research collaborators, with whom they felt professionally connected to for reflections of ideas for projects, sparring in project development and supervision when the nurse researchers entered new and unfamiliar research areas. Through building research collaboration, nurse researchers grew with new knowledge and former nursing research supervisors becomes allied and confidential equals to the nurse researchers, strengthening them with knowledge during Positioning. Interdisciplinary research collaborators, especially medical doctors, were important to the nurse researchers for assorted competencies, recognition, and acceptance. Nurse researchers viewed this collaboration as a journey to new research areas and agreed that having different research perspectives was a strength in improving patient care and treatment, and in building an evidence-based practice. In order to establish themselves as researchers it was important for them to have research collaborations on many levels.

Building a research culture

Building a research culture characterized nurse researchers' actions to combine the paths of working in postdoctoral jobs in a clinical hospital setting and their constant movement towards a career in research. The nurse researchers aimed to contribute with research knowledge to clinical practice in the hope of strengthening the knowledge of their nurse colleagues and improving patient care. Through this endeavor, nurse researchers made their position as researchers clearer to their nursing colleagues which empowered their Positioning. Nurse researchers were aware of the need and importance of the research and development projects to be close to practice, with a strong focus on nursing values and patients' perspectives, to get the nurses involved. The goal was to establish nursing research and development culture in the department to create a mutual consolidation of research-related practice improvement. This strategy was often successful if the research was closely related to practice. Nurse researchers were very aware of the importance of nurses' participation to create a nursing research culture and to build evidence-based practice. They believed that a close collaboration, reflection, and dialogue with nurses in clinical practice was an important key to build a research culture and to Position themselves in the departments. The growing collaboration was based upon nurses' curiosity about patient-related issues in clinical practice, on nurse researchers' ability to accept diversity among nurses, and their familiarity with the context and culture of the department. Building a research culture was acknowledged by nurse researchers to be challenging and to require time and patience; however, it was necessary for their Positioning. The challenges were related to nurses' barriers to research, including lack of time and engagement; however, as nurses realized the practice-relevance of the projects the interest for research grew stronger.

Building nurses' capacity

Building nurses' capacity characterized the nurse researchers' actions to educate and supervise nurses and nurse managers in research-related knowledge. Nurse researchers aimed to develop nurses' and managers' academic competencies through teaching sessions, which were planned to fit the staff's daily schedule and expectations as well as the local context of the department. Building nurses' capacity explained nurse researchers' actions to establish their position in research through the benefits of working with strong and knowledgeable staff members who could join and collaborate on nurse researchers' research and development projects. This was seen as a successful strategy to Positioning. Nurse researchers facilitated the teaching sessions about research methods and supervised nurses and nurse managers during their participation in projects in the department. As the interest and capacity of nurses' academic knowledge increased in the department, so would research engagement; evidence-based practice would also be developed. Nurse researchers were aware of how their close connection with nurses improved their engagement in research and development and nurse researchers therefore tried to establish a stronger connection to the practice setting of the department.

Building a connection to practice

Building a connection to practice characterized the nurse researchers' actions to work closely with nurses and nurse managers and within the clinical hospital setting. Being close to practice was experienced as necessary by the nurse researchers in order to build a bridge between research and practice. They were aware of the importance of staff being involved and interested in research prior to initiating a project. Research projects were aligned with the hospital department strategy and overall visions of nursing and were developed in close

collaboration with the department nurses and management. The nurse researchers adapted to the busy daily schedules of the staff and concentrated on never forcing a research process if the department was not ready. Every step in the nurse researchers' scholarship within clinical practice depended on creating a synergy with the nurses and nurse managers through establishing ownership, adjusting to the department context, and being in "eye-contact" with the staff. In order to create a synergy with the nurses and nurse managers in the clinical hospital setting the nurse researchers focused on their visibility in practice. Being visible to the staff every day constituted being available and interested in patient care and nursing practice– the most important elements in nursing. The nurse researchers would strive to gain visibility by having their office placed in the department, communicating with the nurses about current patient situations, and having their lunch in the department.

Building recognition from nurse managers

Building recognition from nurse managers characterized nurse researchers' actions to gain access, support and engagement from nurse managers in their department. The strategy was important for nurse researchers to establish their identity as researchers in the clinical hospital settings. Nurse researchers signified the importance of nurse managers' collaboration and participation, and everything that they did was communicated to nurse managers. The *in vivo* code of "Gatekeepers" emerged several times in data describing the nurse managers' important roles in nurse researchers' aims to develop a research culture and Positioning. Nurse researchers experienced how nurse managers were gatekeepers of their inclusion in clinical practice, their concrete job tasks, which research to conduct, and of promoting the necessity of research in the department. Ward managers, who had the closest relation to nurse researchers, were true gatekeepers of the nurse researchers' access to clinical practice in general, because the ward managers had the final decisions about nurses' participation, time used for research, and financial resources. Nurse researchers often felt challenged by this collaboration because of the ward managers' focus on operational issues and because of their lack of interest in nurses' participation in research-related tasks. Some nurse researchers concluded that a lack of academic education was the reason for the ward managers' lack of interest in research. Other nurse researchers established an allegiance with the head nurse of the department as a way to gain access to research in clinical practice.

Discussion

The theory of Positioning characterized nurse researchers' actions of following and connecting two paths, resolving their main concern of establishing their position and finding their identity as nurse researchers in clinical hospital research positions. One path was directed towards working in a postdoctoral position in a clinical hospital setting. The other path was guided by nurse researchers' constant movement towards a career in research. Nurse researchers combined the paths and followed them through their individual personal indications, which determined their actions in their clinical hospital research positions.

In an earlier published collective case study (Hølge-Hazelton,Kjerholt, Berthelsen, & Thomsen, 2016), three postdoctoral nurse researchers' actions in clinical practice were described as very different from each other, although they were employed in the same position, at the same formal level, and with the same education and overall responsibility. The postdoctoral nurses in the case study had, similar to nurses in the Positioning theory, different approaches to establishing their position in clinical practice and to engaging the department

nurses and managers. They either focused on practice-based evidence as in “building connections to practice’ and ‘building nursing capacity,” or evidence-based practice and career path as in “building a resume,” “building a network,” and “building research collaboration.” The findings of both studies indicated how inexperienced nurse researchers build their research identity, driven by personal indications, intentions, beliefs, ambitions, experiences and perceptions of nursing and nursing values.

Comparisons to existing literature

Classic grounded theory methodology encourages researchers to conduct the literature review after the core category and theory have been developed, in order to avoid contamination of the theory with preconceived knowledge (Glaser, 1998). The post-theory review of this grounded theory study was guided by a comprehensive example of literature reviews in classic grounded theory studies (Berthelsen & Frederiksen, 2018a) to support further theoretical saturation of the theory of Positioning.

The literature search of Positioning

The databases PubMed, CINAHL, SCOPUS and PsycINFO were searched for literature on Positioning. The search terms were the core category of “Positioning” combined with “grounded theory” and “qualitative” (due to occasional comparisons of grounded theory with qualitative methodology). Studies were included if they used either grounded theory or qualitative methodology with the main findings of Positioning as a core category, concept, category or theme. 168 studies were identified after the first search and 61 studies (PubMed N=10; CINAHL N=16; SCOPUS N=19; PsycINFO N=16) were included by title and abstract. A total of 36 studies remained after duplicates were removed, and these were scrutinized full-text for Positioning as a central finding. 15 studies were finally included.

Research literature. The concept of Positioning was found as either a main category or theme in 15 studies using grounded theory (N=10) or qualitative (N=4) methods and methodologies. One study was performed using mixed methods (Thornberg, 2010), where grounded theory and statistics were combined. An analysis was conducted to develop overall concepts of Positioning in the included studies (Berthelsen & Frederiksen, 2018a). The findings of the included studies were summarized into smaller groups of similarities and were conceptualized as: Positioning of self (N=8) or Positioning in relation to others (N=3) (Table 2).

Table 2: The summary and conceptualization of the Positioning research literature

Categories, concepts and themes	Substantive areas	Overall concepts	References
Professional-, personal-, and social positioning, self-positioning, and positioning oneself as a researcher, as a nursing student and	Health care, midwifery, research and the school system	Positioning of self (Definition: The actions of an individual to position	Anderson & Whitfield, 2013; Bartholemew & Brown, 2019; Calvert, Smythe, & McKenzie-Green, 2017; Hjälmhult, 2009; Samson-

as a teacher		themselves in a specific setting, circumstance or position to achieve personal gains.	Mojares, 2017; Thornberg, 2010; Wiese & Oster, 2010; Yoon, 2008
Contextual and dual positioning, as well as positioning infants to play	Family care	Positioning in relation to others (Definition: The actions of an individual to position themselves in relation to others through interactions in a caring and collaborative perspective	Colquhoun, Moses, & Offord, 2019; Peled, Gueta, & Sander-Almoznino, 2016; Pierce, 2000.

Four studies were found on diverse definitions and findings on the concept of Positioning and were not included in the two overall concepts. These covered positioning a leg in rehabilitation after a hip fracture (Leland et al., 2018), positioning electronic musical technologies in clinical music therapy (Magee & Burland, 2008), positioning the breast to get the best image during mammography (Lopez et al., 2012), and strategic positioning in mothers choice of food for their preschool children (Walsh, Meagher-Stewart, & Macdonald, 2015).

The concept of Positioning of self was extracted from eight of the included studies. In three of the eight studies Positioning of self was related to how healthcare providers navigated their practical settings. This topic was specific to midwives' work to maintain their practice competencies (Calvert et al., 2017), how to be accepted as a legitimate healthcare provider when practicing alternative medicine (Wiese & Oster, 2010), and self-positioning as a factor to trigger the existence and fueling the persistence of incivility in nursing (Samson-Mojares, 2017). In three studies Positioning of self was discovered as being related to positioning oneself in the roles of being an English teacher (Yoon, 2008), a researcher navigating between ethnography and psychological research (Bartholemew & Brown, 2019), and a nursing student positioning themselves as a learning strategy (Hjälmhult, 2009). Two studies described social positioning as a way for stroke patients' to regain a position in society (Anderson & Whitfield, 2013) and as a result of bullying among schoolchildren (Thornberg, 2010).

The concept of Positioning in relation to others was extracted from three of the included studies. Positioning in relation to others was related to how couples position themselves in relation to their stage of life and support systems when their spouse has dementia (Colquhoun et al., 2019), how mothers' experience dual-positioning as forgotten victims of their daughters' intimate partners' violence and as caregivers for their daughters (Peled et al., 2016), and

maternal management of the home as a developmental play space for infants and toddlers (Pierce, 2000).

Research literature related to Positioning The theory of Positioning explained the general pattern of behavior for nurse researchers when resolving their main concern of establishing their position and their identity as researchers in clinical hospital research positions. Positioning characterized nurse researchers' interconnected actions of building an identity and the transformation of self, to establish identity as nurse researchers. This aspect was related to the overall concept of Positioning of self, which emerged through summarizing and conceptualizing the finding in the included studies. In a grounded theory study of Australian midwives' maintenance of their practice competencies, Calvert and colleagues (2017) found the process of their professional positioning to be contextual, diverse and influenced by the conditions in the setting and resources. This idea could be related to the actions of Building a connection to practice and Building recognition from nurse managers in the theory of Positioning, where nurse researchers strive for a connection to practice and to their nursing colleagues and managers. Another grounded theory by Samson-Mojares (2017) found the core category of Self-positioning. A related concept to this theory was finding oneself, which constituted the process of reflecting on experiences, interactions with others, and acknowledging one's strengths and limitations (Samson-Mojares, 2017). Nurse researchers' actions and behavior in the theory of Positioning bear a similar relation to the concept of finding oneself, through the actions of building networks, building a research culture, building nurses' capacity, and building a connection to practice, due to the resemblance with the nurse researchers' actions.

Theoretical literature Through a search in the literature, Positioning theory was found. Positioning theory takes its point of departure in Hollway's discoursive theory on gender differences and positioning (McCrohon & Tran, 2019). Holloway (1984) demonstrated how people take up and negotiate their gender-related places in conversations and her understanding of positions is grounded in a recognition that an individual takes a position, in relation to other people, through a social episode of discourse and that such a position relies on a power relationship. This is done through respect in the mutual meeting and in communication. Holloway's Positioning theory and its discursive perspective was further modified by social psychologists during the late 1990s through a social-constructionistic approach of how communication shapes identity (Hárre & van Langenhove, 1999; McCrohon & Tran, 2019). Hárre and van Langenhove (1999) stated that a cluster of short-term disputable rights, obligations and duties is called a position and that Positioning theory is about how people use discourse of all types to locate themselves and others.

Theoretical literature related to Positioning The grounded theory of Positioning characterized nurse researchers' actions of following two paths, guided by establishing their position and finding their identity as nurse researchers in a clinical hospital setting. Nurse researchers' personal indications of intentions, beliefs, ambitions, experiences and perceptions of nursing and nursing values determined their actions in their clinical hospital research positions to resolve their main concern. Similarities between the grounded theory of Positioning and the Positioning theory by Holloway (1984) and Hárre and van Langenhove (1999) were found according to nurse researchers' paths of working in a postdoctoral position and in a dual position with the university. On this path the relations and interactions were important for the nurse researchers to establish their position in clinical hospital research positions. This was seen especially in six of the seven interconnected actions of building a

network, building research collaboration, building evidence-based practice, building nurses' capacity, building a connection to practice, and building recognition from nurse managers. Connections to the overall concept of Positioning in relation to others from the literature, defined as the actions of an individual to position themselves in relation to others through interactions in a caring and collaborative perspective, were also found. However, differences between the grounded theory of Positioning and the Positioning theory were also found in relation to the nurse researchers' path of constant movement towards a career in research. On this path, no interactions were immediately necessary for the nurse researchers, as seen in the interconnected action of Building a research resume, where their actions were directed towards concrete research tasks, such as developing research projects, conducting different kinds of research, collecting and analyzing data, and writing papers.

Other authors about nurse researchers' positioning in clinical practice research positions have found results closely related to the theory of Positioning in this study (van Oostveen et al., 2017; Orton et al., 2019). In a qualitative study van Oostveen and colleagues (2017) interviewed 24 academic nurses about how they succeeded in combining clinical practice with academic work in hospitals. Opposite to the nurse researchers in the theory of Positioning, the academic nurses had difficulties finding career opportunities due to limitations in positions at the hospital (van Oostveen et al., 2017). However, they still tried to implement research knowledge in practice to improve patient care (van Oostveen et al., 2017), which is related to the nurse researchers actions of Building a research culture. In another qualitative study by Orton and colleagues, (2019) implementation of research knowledge and developing practice was also important for the 14 academic nurses with a PhD who were interviewed. The authors (Orton et al., 2019) showed how the academic nurses had a strong motivation to improve practice, which is related to the interconnected action of Building nurses' capacity and Building a connection to practice.

Limitations

Doing classic grounded theory is a vibrant and energetic way to discover the general pattern of behavior of participants within a substantive area and context (Glaser, 1978). In grounded theory, data collection is usually moved by theoretical sampling, which is the concurrent guide by emergent new concepts discovered in data as to how, where, and what data to collect next (Glaser, 1998). Because a secondary analysis was performed on six existing narratives, it was not possible to follow the methodological dictum of theoretical sampling (Glaser, 1998) or to include new participants, settings, or other sources of data to saturate the concepts of the theory (Andrews et al., 2012). . However, the concepts that emerged during data analysis and coding were kept in mind for constant comparison and to strengthen the deductive focus of the theory development.

In classic grounded theory theoretical saturation is reached when no new data can point out new aspects or knowledge to densify the concepts and core category of the emergent theory (Glaser, 1978). The present grounded theory study was limited by having six narratives for data. However, in this secondary analysis, it was not possible to be certain that no new knowledge could be identified due to the restrictions of available data (Andrews et al., 2012) due to data limitation in the six narratives.

Conclusion

The grounded theory of Positioning showed how nurse researchers tried to establish their position and find their identity as researchers in clinical hospital research positions by following and connecting two paths of working as a postdoctoral researcher in clinical practice and moving towards a career in research. The nurse researchers' choice of path was guided by their personal indications such as their intentions, beliefs, ambitions, experiences and perceptions of nursing and nursing values. The nurse researchers' general pattern of behavior was discovered as seven interconnected behavioral actions of building an identity and transformation of self. The seven actions varied in intensity and range of performance between the nurse researchers and were characterized as Building a research resume, building networks, building research collaboration, building a research culture, building nurses' capacity, building a connection to practice, and building recognition from nurse managers.

The theory of Positioning provides a conceptual framework for nurse researchers academic work in clinical hospital research positions. The theory shows the diversity in nurse researchers' actions, tasks, and practical and academic ambitions, and the nurse leaders in hospital departments can use the theory to match characteristics and create profiles for the specific needs in their departments.

The quality of the grounded theory of Positioning was evaluated by fit, work, relevance, and modifiability, following Glaser's (1978) methodology. The theory had to fit the data from which it was collected, work in the sense it explained nurse researchers' behavior in clinical hospital research positions, be relevant for nurse researchers, and be modifiable in the future. The grounded theory of Positioning already meets the criteria of fit, by consisting of data from narratives provided by nurse researchers in clinical practice, and it works by explaining nurse researchers' actions in the substantive area of hospital settings. Further research is needed to discover the theory's relevance to nurse researchers in clinical hospital research positions and be modified by collecting new data to explore further variations in the theory.

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Teresa Carmichael, BSc(Hons), MM(HR), PhD. University of the Witwatersrand, Johannesburg, South Africa. Professor Carmichael was born in Zimbabwe and undertook her tertiary education in South Africa. Her first degree was in microbiology and biochemistry, which lead to her initial career choice in agricultural microbiology. Subsequently she moved into the pharmaceutical industry, doing marketing and staff training, before taking a post as faculty member at the Wits Business School in Johannesburg. Her research interests lie in management education, diversity, entrepreneurship and the discipline of qualitative research methodology; she has several publications in these areas. In addition, she is very involved in teaching and research supervision of Master's and PhD students. Email: terri.carmichael@wits.ac.za

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Ruth Tiffany Naylor, BA (Wells College), MSc (Tufts University, MBA Hons (Boston University), AA Hons (Montgomery College), DipAT (British Autogenic Society), DipCBH (UK College of Hypnosis and Hypnotherapy), PhD (Canterbury Christ Church University, 2013) is currently practicing as a psychotherapist and autogenic therapist in Hastings, England. She is a Trustee of the British Autogenic Society, the society's representative to the British Psychological Society, and a tutor on society courses. Email: ruth@ruthnaylor.com

Mogamat Reederwan Craayenstein, BSc, BA(Hons), MBA, PhD. University of the Witwatersrand, Johannesburg, South Africa. Born and educated in South Africa, Dr Craayenstein's main concern is about people operating and interacting in their everyday lives, and how they identify with and address the contextually-relevant issues they must

deal with. In this vein, his MBA research sought to identify the reasons why affirmative action was perceived to be failing in post-apartheid South Africa. His research is cross-disciplinary, but always deals with issues of humanity; he has been involved in social movements in various countries trying to make the world a better place. His interest in classic grounded theory is well-suited to his field of study. He has also been a long-time Director of various companies and a part-time faculty member at the Wits Business School.

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