THE LIVED EXPERIENCE OF EMOTIONAL WELLNESS IN ACUTE CARE

REGISTERED NURSES

by

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Rachel Eron Clements

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ABSTRACT

Emotional wellness is not defined in the nursing literature. Instead, a great deal of effort is placed on defining stress, burnout, and compassion fatigue from a quantitative perspective. This study uses Nola Pender's Health Promotion Model (HPM) as a guide for defining emotional wellness, and applies Streubert-Speziale's ten-step method of analysis of qualitative data to define emotional wellness from the interviews of five acute care registered nurses (RN). Results indicate that four factors, Boundaries, Balance, Self-Awareness, and Support, define emotional wellness. Future research is suggested to further define emotional wellness, and its principles should be explored further in nursing research, education, and leadership and management to determine its long-term relevance and applicability to the nursing profession. Ultimately, the definition of emotional wellness is intended to benefit all nurses regardless of professional role or setting by reflecting the common emotional needs of all within the profession.

CHAPTER 1

STATEMENT OF THE PROBLEM/RESEARCH QUESTIONS

The constructs of burnout, compassion fatigue, and stress are well-known within the nursing profession. These are often lamentable facts of life for each nurse (Aiken, Clarke, Sloane, & Sochalski, 2001; Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty, & Shamian, 2001; Berliner & Ginzberg, 2002; Gunther & Thomas, 2006; MacKusick & Minick, 2010).

Entering the words "burnout", "compassion fatigue" and "stress" along with "nursing", individually or in combination, in any search engine yields hundreds of thousands of documents (Google, retrieved 10 September 2011; NurseTogether.com, retrieved 10 September 2011). Listed among these are characteristics and tips for the management of these problems. Seminars, courses, and professionals also provide information to facilitate nurses' coping with burnout, compassion fatigue, and stress (Kravits, McAllister-Black, Grant, & Kirk, 2010; Stevens-Guille, 2003). Both scholarly research and articles, written within the nursing community, address these ideas.

A great deal of research has been done on these constructs within the last ten years, both nationally and internationally (Aiken, et al., 2001a; Aiken, et al, 2001b; Berliner & Ginzberg, 2002; Gunther & Thomas, 2006; MacKusick & Minick, 2010). Collectively the work points toward an upswing in burnout, compassion fatigue, and stress due to an aging nursing workforce, downsizing, budget cuts, and caring for highly acute patients (Garrosa, Moreno-Jimenez, Liang, & Gonzalez, 2008; Jenkins & Elliott,

2004; Lang, Pfister, & Siemens, 2010). Essentially, nurses are expected to do more with less, and to please all they interact with on the job, specifically patients, family members, physicians, supervisors, and co-workers. Sometimes, these expectations result in a great deal of sacrifice on the part of the nurse, from postponing meal breaks and/or bathroom breaks, to tolerating verbal, physical, and emotional abuse from those they are trying to help (Aiken, et al., 2001a; Spence-Laschinger, Lieter, Day, & Gilin, 2009).

With such negativity occurring within a nurse's shift, it is no wonder that they often seek comfort from not-so-healthy sources. Nurses are known for suffering from eating disorders (King, Vidourek, & Schwiebert, 2009) and substance abuse (Monroe & Kenaga, 2010), and, even on a lesser scale, for simply not caring for their bodies as a result of maintaining sedentary lifestyles and taking in less than optimal nourishment (i.e. junk food) (Garrosa et al, 2008; Kravitz et al, 2010). It is also understandable that some choose to leave nursing altogether (Aiken, et al, 2001a & 2001b).

Despite these negative factors and some maladaptive coping skills, nursing continues to survive as a profession. It is doubtful that anyone would remain in the profession, some for many years, if there was not something keeping nurses motivated to come to work and provide excellent patient care (Humpel & Caputi, 2001; LeVasseur, Wang, Matthews, & Boland, 2009). Essentially, nurses must be doing something right in terms of self-preservation to sustain themselves, or they would have been replaced by another profession long ago (Allen & Mellor, 2002; Button, 2008; Downey, 2007; Etowa, Sethi, & Thompson-Isherwood, 2009; Garrosa, et al., 2008; Hallin & Danielson, 2007;

Kirschling, Colgan, & Andrews, 2011; Kravits, McAllister-Black, Grant, & Kirk, 2010;

Larrabee, Wu, Persily, Simoni, Johnston, Marcischak, Mott, & Gladden, 2010).

Purpose

The purpose of this paper is to define the construct of emotional wellness in acute

care staff registered nurses (RNs) by exploring how RNs define it through their lived

experiences and implement the construct, and to develop a formal definition of emotional

wellness. Thus, the research question for this paper is "What is emotional wellness for

hospital RNs, and how do they perpetuate/foster this within themselves?"

Background and Significance of the Problem

While the literature addresses the physical ways of combating stress, through

physical wellness strategies (Kravits et al, 2010; McElligott et al, 2009), there is

surprisingly little, if any, research on emotional wellness strategies for combating

emotional stress. Emotional wellness and emotional self-care has not been defined for

anyone, let alone health care professionals in general or nurses in particular.

Logically, to practice wellness, one must incorporate the emotional with the

physical. Spiritualism is also part of holism, but it is outside the scope of this writer's

expertise to address, whereas emotional wellness falls under mental health and within this

writer's purview. Further, to accurately define emotional wellness, it is necessary to have

some idea in mind other than the fact that it is an absence or decrease in burnout,

compassion fatigue, and stress. Defining a concept by its absence is inadequate, not only

for research purposes but for interventions as well (Polit & Beck, 2008). It is not like negative space in art, in which the shape of an object is implied and defined through its absence. Art is tangible, whereas concepts and constructs are not.

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published the white paper "Healthcare at the crossroads: Strategies for addressing the evolving nursing crisis" from their newly-formed Public Policy Initiative to address nursing retention, staffing, and recruitment. With this, JCAHO sought to gather information, formulate solutions, and assign accountability for implementing solutions, all part of their mission "to improve the safety and quality of care provided to the public"(2001, p. 6). Follow up to this mission, while stated to be ongoing, has not been addressed in JCAHO's publications, on web sites (JCAHO, 6 November 2011), or related web sites, particularly the Joint Commission Center for Transforming Healthcare (JCCTH, 6 November 2011).

However, since the white paper's inception there has been a great deal of research done on nursing retention, staffing, and recruitment, particularly in academia. JCAHO's white paper (2001) merged with other studies and commentary, some international in scope, all addressing nursing retention, shortage, staffing, work environment, and treatment of nursing staff (Aiken et al, 2001a; Aiken et al, 2001b; Allen & Mellor, 2002; Humpel & Caputi; and Piko, 1999). While certainly not the first crisis concerning the nursing workforce, as the first occurred in the 1950s and was a shortage, the current issues are more complex (Berliner & Ginzberg, 2002; Burtson & Stichler, 2010). There are fewer nurses entering the work force, fewer nurses remaining in hospitals, and more

nurses retiring or leaving the profession. In turn, nurses are also pursuing different specialties such as education or utilization review rather than staff nursing (Berliner & Ginzberg, 2002; Burtson & Stichler, 2010).

Likewise, the physical demands have increased, and aging nurses experience more difficulty meeting these (Berliner & Ginzberg, 2002). Other factors driving individuals away from nursing include the need for a college degree, the presence of more career options, particularly for women, and nurse dissatisfaction, all of which deter entrance into the nursing field (Berliner & Ginzberg, 2002). While nursing wages are reported to be adequate to keep pace with the rising cost of living, they are not enough to retain nurses, particularly if they must be expected to deal with understaffing, floating between units, mandatory overtime, and disrespect in their work environments (Berliner & Ginzberg, 2002). Further, there is little perceived incentive for nurses to remain in staff nurse positions past their late 50s if they are part of a two-income household, their children are grown, and the physical demands of the job co-exist with lack of financial incentives to remain to mentor new nurses (Berliner & Ginzberg, 2002).

In order to emphasize further the impact of burnout, compassion fatigue, and stress on nursing, as well as the roles of nursing retention, staffing, and recruitment, it is essential to look at the impact of these in terms of monetary and nonmonetary costs. These can be examined from the perspectives of hospital and healthcare systems; patients, society, and consumers; and nurses professionally and personally.

Monetary Costs

Hospital expenses regarding nurse turnover are documented in the literature as an international concern. In one study, (O'Brien-Pallas, Griffin, Shamian, Buchan, Duffield, Hughes, Spence-Laschinger, North, & Stone, 2006), nurse turnover was estimated to cost hospitals $10,000 to $60,000 per specialty per nurse. They also cited one study that noted that $42,000 was lost per each medical-surgical nurse resignation and approximately $60,000 per each critical care nurse (O'Brien-Pallas et al, 2006). Further, the cost to replace a nurse and the resultant decreased productivity was estimated at $5,200 to $16,000. O'Brien-Pallas et al. (2006) further observed that loss of productivity makes the cost of turnover four to five times higher than hospitals have estimated.

With the cost of turnover and loss of productivity, there are also direct and indirect hiring costs (O'Brien-Pallas, et al., 2006). Direct, or visible costs, are 21 percent, while indirect, or hidden costs, are 79 percent to hospitals. Hidden costs include a four percent loss of hospital income during nurse pre departure, fifteen percent loss during vacancy, and an eighty-one percent loss while a newly-hired nurse achieves a productive level (O'Brien-Pallas, et al, 2006). As turnover in a hospital reaches 50 percent, the net effect on productivity is negative. Yet, by reducing turnover from thirteen percent to ten percent, a 500-bed hospital can save approximately $800,000 annually (O'Brien-Pallas, et al, 2006).

The financial impact on patients, society, and consumers is influenced by nurse turnover as well. Health care organizations with high turnover rates (greater than or

equal to 21 percent) have a 36 percent higher cost per discharge rate than hospitals with low nurse turnover rates (less than or equal to 12 percent) (JCAHO, 2002).

Finally, there are monetary costs incurred by nurses because of nurse attrition. Between absenteeism and overtime there exists a strong direct correlation, and, likewise, a strong correlation between hours of overtime worked and nurse attrition (Aiken et al, 2001a and 2001b; O'Brien-Pallas et al., 2006). However, these are not listed as dollar amounts or estimates in the literature. Because nurses are losing hours, they are likewise losing income.

When nurses make the decision to leave the hospital to work elsewhere or not at all, the effects ripple outward financially. If large numbers of nurses choose to leave, the effect is like a tidal wave (Aiken et al, 2001a and 2001 b; O'Brien-Pallas et al., 2006).

Nonmonetary Costs

Losing nurses causes other effects besides financial ones. When nursing attrition is significant, hospital productivity is decreased (O'Brien-Pallas et al, 2006). This is due to the presence of a new employee who must learn the routine of the unit as well as hospital policy and procedure, thus, through no fault of their own, reducing productivity and efficiency. There is also a decrease in staff morale due to the loss of a colleague, and an overall decrease in group productivity as nurses cope with their loss and strive to bring the new nurse on board (O'Brien-Pallas et al, 2006). Further, patients seem to pick up on nurse dissatisfaction, and it negatively impacts their own satisfaction (O'Brien-Pallas et al., 2006). Being short one nurse can leave patient care needs unmet. Such a shortage can also impact patient safety if there are fewer nurses on the floor (JCAHO, 2002

O'Brien et al, 2006). Nurses themselves report that they love their jobs, but hate their

work (Aiken et al., 2001a). Indeed, this is the case not only nationally but internationally,

with estimates running from 30 to 40 percent in nations such as the United States,

Canada, England, and Scotland (Aiken et al, 2001a & 2001b).

All of these factors combined not only result from nursing attrition, they also

perpetuate it, thus creating a global system of dissatisfaction impacting nurses, patients,

and hospitals. Over time, dissatisfaction in nurses translates into stress, burnout, and

compassion fatigue, with resulting deleterious effects on their emotional wellness

(Garrosa et al, 2008; Kravits et al, 2010).

<div align="center">Conceptual/Theoretical Framework</div>

Pender's Health Promotion Model

The results of the above studies are disheartening. Nevertheless, this investigator

is determined to find the proverbial silver lining by discovering that individuals who

choose to remain in nursing have qualities that help them weather the storms and

maintain their emotional wellness. This investigator anticipated that these qualities exist

in an active space rather than as a negative, passive space, generating a balance in the

lives of nurses alongside stress, burnout, and compassion fatigue. Such a positive

approach to health and wellness is shared with Nola Pender, and her Health Promotion

Model (HPM) serves as the conceptual framework for this study. (Please refer to

Appendix A for Nola Pender's Health Promotion Model.)

According to Pender, health is a positive dynamic state, not merely the absence of disease (Health Promotion Model [HPM], 15 April 2011). Health promotion is directed at increasing health, which individuals actively seek. An individual's interaction with her or his environment in the pursuit of well-being is crucial to change, with the end result either increasing or decreasing health (Nursing theories HPM, 2011). Cognitions, affect, and the interpersonal and physical environment create incentives as well as disincentives for health actions (Sitzman & Eichelberger, 2004).

Individuals bring their multidimensional selves with them, including past experiences, constituting both successes and failures, based on their interactions with the environment (Nursing theories HPM, 2011; Sitzman & Eichelberger, 2004). If experiences have been successful, positive emotions from these perpetuate proactive commitment to positive change, with health promoting behaviors as the end result (Nursing theories HPM, 2011). Thus, "improved health, enhanced functional ability, and better quality of life at all stages of development" is achieved (Nursing theories HPM, 2011, para. 1). Likewise, if one has been successful in the past, one will also anticipate and perceive fewer barriers to overcome as one continues to strive for health. If an individual anticipates benefits from her or his interaction with the environment, she or he will in turn participate in behaviors that are perceived to benefit health (McElligott, et al, 2009). In turn, interpersonal relationships likewise reinforce participation in these health-seeking behaviors, especially with modeling, assistance, and support (Nursing theories HPM, 2011).

As an individual interacts with the environment, however, she or he will encounter competing demands and preferences that can "derail an intended health promotion action(s)" (Nursing theories HPM, 2011, para. 1). These are perceived barriers. More attractive options may also derail commitment. Interpersonal relationships may likewise reinforce participation in these competing demands by modeling, and lack of support might discourage participation in health promoting behaviors (Nursing theories HPM, 2011). Thus, one may struggle or fail to achieve this optimal and positive dynamic state unless the individual or the environment can overcome these through positive cognitions, affect, and a highly-supportive interpersonal and physical environment (Sitzman & Eichelberger, 2004).

Pender's definition of health is positive and proactive, aligning with this writer's definition of health and her personal observations, and supported by the literature (McElligott, Leask-Capitulo, Morris, & Click, 2010; McElligott, Siemers, Thomas, & Kohn, 2009). Individuals wish to do more than survive. They wish to thrive and be happy. Such is the case with nurses, not only in their work lives but also in their personal lives (McElligott, et al, 2009 & 2010). Nursing is not just about passing medications, charting, and other miscellaneous tasks, it is about connecting with human beings and guiding them toward wellness. Nurses do not exist solely to care for others, and deserve to consider their own health, health promotion, wellness, and holism for their own lives (McElligott, et al, 2009 & 2010).

Thus, in addition to these, consideration of nurses' individual characteristics and experiences is key, as well as their interpersonal and situational experiences at work and

in their personal lives (McElligott, et al, 2009 & 2010). Understanding these, combined with the competing demands nurses face and commitment to their plan of action as they strive for emotional wellness, was the focus of this study.

Definitions

For the purposes of this study, a nurse is defined as an associate, diploma, or bachelor's prepared registered nurse, licensed to practice in one rural Northwestern state, who provided bedside patient care in an acute care setting. Further, an acute care setting "is a hospital that provides twenty-four hour per day inpatient nursing care" (Anderson, March 2010, p.7). Finally, a hospital is "an institution for the treatment, care, and cure of the sick and wounded, for the study of disease, and for the training of physicians, nurses, and allied health care personnel" (MedLexicon, n.d.).

Assumptions

There are a number of assumptions that can be made based on Pender's Health Promotion Model. First, nurses can identify when they are not stressed but are emotionally well, yet distinct from being unstressed. In essence, they can recognize that emotional health is not merely the absence of stress (Nursing theories HPM, 2011). Further, nurses engage in activities that build and strengthen emotional wellness within themselves. This is in keeping with the idea that nurses will continue to engage in positive behaviors that give them positive outcomes, thus reinforcing future performance of the behavior (Nursing theories HPM, 2011).

When nurses confront stressful situations in their work lives, their emotional wellness practices will sustain them through these situations. There may be attractive options and lack of interpersonal support that serves as barriers to their practices, but, based on positive past experiences, nurses are more likely to overcome these barriers (Nursing theories HPM, 2011).

Additionally, emotional wellness activities are not potentially harmful in the long run (i.e., substance use). This would run completely counter to the concepts of health promotion and emotional wellness (Nursing Theories HPM, 2011).

Finally, emotional wellness practices incorporate a wide variety of activities that may fall into physical and spiritual wellness domains (Richards, Oman, Hedberg, Thoresen, Bowden, 2006). Nevertheless, these activities reinforce emotional health and wellness, as they reinforce "improved health, enhanced functional ability, and better quality of life at all stages of development" (Nursing theories HPM, 2011, para. 1).

Limitations

Creating a survey questionnaire regarding emotional wellness, based on the quantification of the construct of emotional wellness, would be ideal, particularly for this novice investigator. However, emotional wellness as a construct is not well-defined, thus limiting its quantitative measurability at this time. Instead, this investigator must rely on qualitative approaches which she is not well practiced at. As with other constructs such as self- esteem, a psychological phenomenon, one cannot currently directly measure emotional wellness (Polit & Beck, 2008). Further required for an instrument would be a

pilot study to obtain preliminary data regarding reliability and validity, making necessary advanced statistical analysis in order to determine if there are factors which identify key components of the construct being measured (Polit & Beck, 2008). Then, once the instrument had been adjusted, a large sample size that is representative of acute care registered nurses would be necessary to further validate the instrument. While well-tried, such an approach is time and labor intensive for a graduate thesis. Analysis of the data would also be necessary to determine if emotional wellness as a construct matches that defined through inferential statistics and the literature (Polit & Beck, 2008). Such a process in its entirety requires a great deal of time, money, and education on the part of investigators to see the definition of such a construct through to its conclusion. This necessitates that one begin defining the construct of emotional wellness on a smaller scale, based on smaller samples of participants, less defined dimensions of the construct, and without the use of powerful statistical tests (Polit & Beck, 2008).

With the use of a smaller scale approach to defining emotional wellness, it is necessary to begin by looking at the nursing literature. This in itself proved problematic, as there were a multitude of terms used to describe what could be completely different constructs (Polit & Beck, 2008). These terms may be incorporated into the construct of emotional wellness completely, partially, or not at all. From this it was necessary to determine if a pattern existed that defined emotional wellness, and not just as an absence of burnout, stress, or compassion fatigue. Additional refinement, by going to acute care nurses themselves, may yield very different information from what the literature defines as emotional wellness, even if participants are completely candid, not to mention

available, in sharing their perspective and the investigator is completely objective. People are "fallible tools" for providing and gathering information (Polit & Beck, 2008, p. 17). While this may be the case, it must be remembered that no study can definitively answer a question. Science advances by correcting for the limitations imposed upon it (Polit & Beck, 2008).

<u>Summary</u>

Nurses are familiar with the concepts of burnout, compassion fatigue, and stress, not only within their work lives but also through nursing commentary online and in research literature. Trends nationally and internationally indicate that these negative aspects to nursing work are increasing, with some nurses succumbing to inadequate self-care or electing to leave the profession as a result (Aiken, et al., 2001a; Aiken, et al, 2001b; Berliner & Ginzberg, 2002; Gunther & Thomas, 2006; MacKusick & Minick, 2010).

Despite working in such a difficult environment, nursing manages to remain as a profession providing care to its patients. The purpose of this paper is to determine how nurses defined emotional wellness. Little research existed that defined emotional wellness and emotional self-care. Instead, the construct was defined by its absence. Further emphasizing the scope of the problem of a difficult work environment, national and international efforts are directed at examining retention, staffing, and recruitment. Nursing is not unfamiliar with shortages, but the factors are different and incentives to remain are perceived as few and far between for up to 40 percent of nurses participating

in studies examining retention. Further, the costs in terms of money, productivity, patient satisfaction, and nursing morale are global and likewise feed into and feed off of the declining emotional health of nurses (Aiken, et al., 2001a; Aiken, et al, 2001b; Berliner & Ginzberg, 2002; Gunther & Thomas, 2006; MacKusick & Minick, 2010).

This study will be applying Pender's Health Promotion Model (HPM) to the examination of emotional wellness in nurses. A middle range theory, HPM has been implemented widely throughout the nursing literature, addressing patient care and wellness-promotion as well as nursing self-care (Downey, 2006; McElligott et. al., 2010; Polit & Beck, 2008). With HPM, it is intended that activities will be directed toward developing resources that maintain or enhance a person's well-being; it can also be applied toward developing and testing interventions, and likewise understanding health behaviors (Polit & Beck, 2008)

The Health Promotion Model was proposed initially to be a "complementary counterpart to models of health protection" (Nursing theories HPM, 2011, Introduction); Pender's work has addressed exercise, behavior change, and relaxation training (Sitzman & Eichelberger, 2004). With this, examples of health-promoting behaviors include healthy diet, regular exercise, managing stress, gaining adequate rest, enhancing spiritual growth, and building positive relations (Sitzman & Eichelberger, 2004). HPM is holistic, incorporating physical, emotional, and spiritual wellness. Further, it emphasizes that health is more than the absence of illness, and that health promotion is a proactive approach to achieving well-being (Nursing theories HPM, 2011). As do their patients, so do nurses in turn demonstrate these same needs to maintain health and well-being.

CHAPTER 2

LITERATURE REVIEW

Emotional Wellness

Using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), three articles were located addressing "emotional wellness" when literature searches were conducted in October 2010 and 2011. When the search phrase included "nurses" as a search term with "emotional wellness", zero articles were found. "Emotional wellness and nursing", used as search terms, yielded four articles, with nurses providing interventions or witnessing emotional wellness rather than experiencing it. The search phrase "emotional wellness" combined with "nursing professionals" yielded zero articles; "emotional wellness of nurses" yielded one article, again focusing on the delivery of care to patients.

The phrases "emotional support" and "nurses" yielded 471 articles, 30 of which applied to nurses. "Emotional support of nurses" yielded ten articles. "Nursing wellness" yielded 43 articles, with 5 applicable to nurses. "Wellness of nurses" yielded 62 articles, with 15 applicable to nurses and included in this study. Using the Web of Knowledge, the phrase "emotional wellness" yielded 169 articles, with 29 articles addressing "emotional wellness" and "nursing". Of these, four are applicable to the emotional wellness of nurses.

Using CINAHL to determine if "Pender's Health Promotion Model" "emotional wellness", and "nurses" had ever been studied together yielded zero articles. When

searching for articles on the "Health Promotion Model", "nurses", and "stress", only two

articles were found. Both dealt directly with patient care. Based on the above results,

one can conclude that the emotional wellness of nurses has not been a significant focus of

nursing research. Rather, it appears that resources have been devoted to studying patient

care issues, particularly fostering the promotion of emotional wellness in patients, and,

based on this paucity of findings, the time is right to begin examining emotional wellness

in nurses. Please refer Table 1 for a summary of findings.

Table 1. Summary of Search Terms and Results Using CINAHL and the Web of
Knowledge.

Search Term(s)	Number of Results	Relevance to RN's Emotional Wellness
"emotional wellness"	0	N/A
"emotional wellness and nursing"	4	0
"emotional wellness" and "nursing professionals"	0	N/A
"emotional wellness of nurses"	1	0
"emotional support" and nurses	471	30
"emotional support of nurses"	10	0
"nursing wellness"	43	5
"wellness of nurses"	62	15
"Pender's Health Promotion model" and "emotional wellness" and "nurses"	0	N/A
"Health Promotion Model" and "nurses" and "stress"	2	0
"emotional wellness" (Web of Knowledge)	169 29 articles—"emotional wellness and nursing"	4

This investigator reviewed a portion of the literature addressing the emotional work life of nurses in hopes of better understanding issues effecting emotional wellness. As it turns out, much of the research focused on the constructs of "burnout", "stress", and "compassion fatigue". Each construct is unique, despite their frequent appearances in the literature together, and bears some mention in this study despite its focus on the construct of emotional wellness in order to provide a clearer understanding of all of these constructs in relation to each other.

Burnout

Burnout is defined as "a syndrome that consists of emotional exhaustion, depersonalization, and reduced physical accomplishment" (Lang, et al., 2010, p. 435). It was examined in nurses in 8 studies (Allen & Mallor, 2001; Attan, 2002; Burtson & Stichler, 2010; Chen & McMurray, 2001; Garrosa et al., 2008; Jenkins & Elliott, 2004; Jourdain and Chenevert, 2010; Lang, Pfister, & Siemens, 2010; Spence-Laschinger, Leitter, Day, & Gillin, 2009).

Stress

Stress was defined as "stimuli that when exposed to the human body cause a physiologic response characterized by sympathetic nervous system activity and the release of hypothalamic, pituitary, and adrenal hormones" (McCance, Huether, Brashers, & Rote, 2010, p. 1774). It is the most frequently addressed of the constructs reviewed, with 18 studies addressing this construct in the lives of nurses (Boztor, 2003; Garrosa, Moreno-Jimenez, & Monteiro, 2008; Garrosa, Rainho, Moreno-Jiminez, & Monteiro,

2010; Gelsema, Van der Doef, Maes, Janssen, Akerboom, & Verhoven, 2006; Gordon, Ulrich, Feeley, & Pollack, 1993; Hayne, Gerhardt, & Davis, 2009; Humpel & Capali, 2001; Jenkins & Elliott, 2004; King, Vidourek, & Schwiebert, 2009; Kravits, McAllister-Black, Grant, & Kirk, 2010; Larrabee, Wu, Persily, Simoni, Johnston, Marcischak, Mott, & Gladden, 2010; Lavoie-Tremblay, Wright, Desforges, Gelinas, Marchionni, & Drevniok, 2008; Mackenzie, Poulin, & Siedman-Carlson, 2006; Mrayyan,2009; Piko', 1999; Richards, Oman, Hedberg, Thoresen, & Bowden, 2008; Severinson, 2003; and Walker, 2008).

Compassion Fatigue

Compassion fatigue "is a social, physical, spiritual, and emotional exhaustion that results in an inability to care for others" (Lange et al., 2010, p. 435).

Emerging Themes of Emotional Wellness

Providing rich detail, a number of mixed method and qualitative studies examined a range of topics with stronger ties to the construct of emotional wellness, with findings giving more depth than many quantitative studies could provide that proved useful in examining emotional wellness in nurses. Several qualitative studies examined the balance between stress and stimulation experienced by nurses in their daily work, and themes of a stressful work situation (with subthemes of meeting all demands, of being insufficient, of being unsure of oneself, and of too little contact with patients) and also a stimulating work situation (subthemes encountering patients and health care staff is enriching, having the situation under control, and having the skills necessary to be

independent) emerged (Hallin & Danielson, 2007). Thematic analysis of stress (time pressures, nature of nursing work, multiple roles), uplifts (feeling good), and ways of coping (taking time out, seeking emotional support, belief systems) in the personal and professional lives of 21 Singaporean nurses (Lim, Hepworth, and Bogossian, 2011) revealed and illuminated the ambiguity experienced by nurses in their work lives, and likewise revealed emerging themes relevant to defining emotional wellness.

Nursing Self Care and Self-Management

Other studies explore nursing self- care and self-management, including application of complementary and alternative medicine (CAM), implementation of individual wellness plans, spiritually-based interventions such as meditation, and the HeartTouch technique (Downey, 2007; Kravits, McAllister-Black, Grant, & Kirk, 2010; Richards, Oman, Hedberg, Thoresen, & Bowden, 2006; Walker, 2008). In her mixed methods study, Downey (2007) observed that introduction of the concepts of self-care with holistic approaches to health generated value and belief shifts in nursing students' personal and professional health practices, with use and positive effectiveness reported one to seven years after completing the nursing course. Kravits et al. (2010), also using mixed methods, observed an increased number of low Personal Effectiveness scores, as well as decreased Emotional Exhaustion and Depersonalizations scores on the Maslach Burnout Inventory (MBI) after providing a six hour class based on Lazarus and Folkman's Cognitive Model of Stress and Coping and the Transtheoretical Model of Change, using discussion, interaction, and participant-tailored outcomes to facilitate learning. Relaxation, guided imagery training, art exploration of proactive coping

strategies, and creation of a personalized wellness plan were also implemented in a

program involving 248 hospital nurses (Kravits et al., 2010). Richards et al. (2006) found

that when participants used an eight-point, spiritually-based self-management tool,

incorporating a non-sectarian spiritually-based stress reduction program, meditation and

self-management, and Watson's Theory of Caring, meditation was reported as effective

when used (The Eight Point Plan). Participants used mantram, slowing down, one-

pointed attention, and putting others first most frequently (Richards et al., 2006). Walker

(2008), in turn, implemented the HeartTouch Technique with 48 nurses and observed that

most had a positive experience, thus impacting themselves and others. Further,

participants identified that the technique was relatively easy to use, although at times

practicing and remembering the steps of the technique proved challenging (Walker,

2008). Nevertheless, it changed the nurses' feelings about work and their patients, and

likewise influenced interactions with others and the technique's impact on themselves

(Walker, 2008).

Activities Fostering Factors
of Emotional Wellness

When nurses are encouraged to participate in activities that asked them to recall

when they last felt like a nurse, this action encouraged them to focus on the very core of

nursing on an individual level (Spence & Smythe, 2008). With use of CAM in their lives

and in their practice, nurses considered what their lived experience was in its use in

addition to how frequently and which techniques they favored (Downey, 2007). They

identified forms of stress and distinguished differences between these as well as between

compassion fatigue, burnout, and vicarious traumatization (Sabo, 2008). Further, they also discovered moderating factors within themselves such as resilience and compassion satisfaction (Sabo, 2008). Additional moderating factors included spirituality and social support as methods of coping (LaSalle, 2000). All of these factors are worth considering in terms of developing emotional wellness as a construct.

Systematic Approaches to Fostering
and Measuring Self-Care

There is a need for regular, systematic efforts to support positive nursing self-care behavior and resolve organizational challenges based on the volumes of literature regarding stress, burnout, and compassion fatigue, and the paucity of literature regarding emotional wellness (Kravits, et al., 2010). Recovery is not addressed from burnout and relapse prevention perspectives, but may be measured repeatedly from the Personal Achievement Factor of the MBI or a related measure focusing on the nursing population (Kravits, et al., 2010). Likewise, further examination of the Eight Point Plan and longitudinal study may track changes in nursing staff regarding stress, empathy, focused attention, and self-care, with follow up meetings and discussion (Richards, et al., 2006).

Nursing Specialty and Emotional Wellness

While studies have examined globally the negative factors related to, as well as theories pertaining to the work lives of nurses, the nursing specialty must also be considered in relation to emotional wellness. Figuring prominently in studies of acute care nurses were oncology, intensive care/critical care, and psychiatric/mental health specialties. Other specialty areas, less prominent but no less important, were pediatrics,

military, and rural nursing (Chen & McMurray, 2001; Gunther & Thomas, 2006; Humpel & Caputi, 2001; Jenkins & Elliott, 2004; Lang, Pfister, Siemens, 2010; LaSalle, 2000; Mrayyan, 2009; Sabo, 2008).

Oncology, critical care, and mental health nursing face unique patient populations as well as health concerns, which contribute to complex and stressful situations that are likewise unique to their specialty. Pediatric, military, and rural nurses face similarly complex issues. While these nurse specialties will not be studied individually in this research, the uniqueness of these nurses' experiences are certainly worthy of consideration as part of the exploration of the construct of emotional wellness (Chen & McMurray, 2001; Gunther & Thomas, 2006; Humpel & Caputi, 2001; Jenkins & Elliott, 2004; Lang, Pfister, Siemens, 2010; LaSalle, 2000; Mrayyan, 2009; Sabo, 2008).

HPM Research

Holistic wellness is addressed with HPM research, but not in its separate parts. However, as one sets a goal to improve any aspect of their health, HPM factors can and do influence behaviors (Downey, 2006; McElligott et al., 2010). Nurses have an advantage over their patients in that they are knowledgeable about biological processes of health, by virtue of their education. What makes them no different from their patients is the influence of past behavior and personal influences, due to their genetic make up, on their behavior (McElligott, Siemens, Thomas, & Kohn, 2009; Sitzman & Eichelberger, 2004). As explained above, nurses suffer from the stresses and strains of their work life, which may prove deleterious to their health, just as their patients must deal with stresses and strains in their own work lives. Indeed, the nursing population mirrors the general

population nationally, particularly in regards to age distribution (McElligott et., al, 2009)

Likewise, in the nurse's mind he or she must confront a plus or minus system which

reinforces and nurtures his or her health-seeking behaviors or, conversely, detracts from

and limits it (Sitzman & Eichelberger, 2004). A nurse may perceive that what he or she

is doing is beneficial, that he or she can achieve the change they desire, and that he or she

is happy participating actively in the change. Nurses may even have the support of

family, friends, co-workers, their health care provider, or even the media. All the doors

may be open to them from a situational standpoint, thus paving the way for success in

achieving and maintaining their health-seeking goals and behaviors. Rarely is this the

case, as there is always the allowance for barriers to action which may hold their progress

in check (Sitzman & Eichelberger, 2004). Nevertheless, if nurses, like their patients, can

overcome these limitations, they will reinforce their own efforts toward achieving health

and well-being. On occasion they may have to confront competing demands and their

own preferences, but in general they can achieve their goals, thus reinforcing and guiding

them in future health promotion endeavors (Sitzman & Eichelberger, 2004).

Pender's Health Promotion Model is strongly based in behavioral health

approaches in addition to nursing (Sitzman & Eichelberger, 2004). While this may seem

to be an ideal fit when considering and promoting, emotional wellness, it does not appear

to make a difference. Individuals will be able to report changes and demonstrate

emotional health in their interactions with others in their environment (Sitzman &

Eichelberger, 2004). It is somewhat fitting, however, that this model is viewed as a

salient approach by nurses to take charge of health promotion leadership. It demonstrates

that nurses can become leaders in promoting and improving their own health (Maben & Macleod-Clark, 2006).

As a middle range theory, one must bear in mind that, by its nature, such a theory is limited in its explanation of behaviors. In this case, such a behavior is health promotion (Polit & Beck, 2008), and cannot go beyond this to explain a wider range of behaviors. Further, most research application of this theory has been to nurses' patients, rather than to nurses themselves. While nurses do not differ greatly from their patients in terms of health and wellness, they do have a unique perspective in that they work in a high-stress environment that is physically, spiritually, and emotionally taxing (McElligott, et al., 2010; McElligott, et al, 2009). Literature on HPM has not examined factors of holistic wellness in isolation, specifically emotional wellness (Polit & Beck, 2008; Sitzman & Eichelberger, 2004), to determine its fit with the overall theory as well as for any unique characteristics of this factor. Finally, HPM has been applied to quantitative and mixed studies (Downey, 2006; McElligott et al., 2010; McElligott et al, 2009), particularly in nursing self-care, but not in strictly qualitative research. It remains to be seen how this will apply, in that qualitative findings are not quantified and instead originate directly from the participants themselves (Polit & Beck, 2008).

<u>Summary</u>

Review of the literature indicates that emotional wellness is essentially absent in nursing research. Instead, concepts such as stress, burnout, and compassion fatigue are explored. There are a number of studies that addressed health and holism in nursing, as

well as approaches to these, however, and they provided fertile ground for the

development of emotional wellness as a construct (Downey, 2006 & 2007; Kravits,

McAllister-Black, Grant, & Kirk, 2010; Richards, Oman, Hedberg, Thoresen, & Bowden,

2006; McElligott et al., 2010; McElligott, Siemens, Thomas, & Kohn, 2009; Walker,

2008).

CHAPTER 3

METHODS

Prior chapters introduced the concept of emotional wellness, particularly its absence from the literature. The current chapter addresses the methodology for defining the construct of emotional wellness through scientific methods.

Population and Sample

Participants in this study were RNs currently employed in acute care hospital settings in a small city and its outlying neighboring communities in the Northwestern United States. Because the majority of RNs within the United States are employed in hospital settings (60%), this investigator sought to gain the perspectives of individuals who are not only the focus of the majority of nursing studies, but who are likewise the most abundant in the nursing population (United States Department of Labor, 2010-2011). Registered nurses were diploma, associates, or bachelors-prepared. The participants in this study's sample had at least one year of work experience as a RN, with this demonstrating some familiarity with the patterns of work and stress flow on a hospital unit (Gelsema, et al., 2006) and were currently working as staff nurses within any acute care specialty such as medical-surgical, critical care, emergency, pediatric, oncology, or psychiatric nursing.

Size and Sampling Procedures

Because the nature of this research is to determine what emotional wellness is as lived by the RNs working in acute care settings, and such a concept was lacking development in nursing research, qualitative research methods were most amenable to this end (Polit & Beck, 2008). With this, qualitative research made use of a small sample size to get the most data-rich findings that can, in turn, contribute to research as a whole by defining a concept (Streubert Speziale & Carpenter, 2007). In this instance, a sample size of five participants was used, although the goal was ten in order to obtain richer, more saturable data. This investigator was unable to obtain ten participants, however, possibly due to the fact that recruitment and data collection took place in the summer and participants were not readily available due to vacations.

Because this investigator has no current ties via employment with administration or nursing research departments of any of the acute care hospitals in the region, registered nurses (RNs) from previous work, school, and social experiences were used as initial contacts to determine if they or nurses they worked with might be interested in participating in at least one interview up to an hour long, asking them how they defined emotional wellness in their lives (Streubert Speziale & Carpenter, 2007). Participants who lived in or around the small city in the Northwestern United States where this investigator resided were contacted via a private message through Facebook to those RNs who were acquaintances of this investigator and worked in acute-care hospital settings to determine if they would like to participate in the study. E-mail and/or phone contacts were used to make initial appointments in which this investigator explained the purpose

of the research as well as the time commitment required, anticipated to be up to an hour,

and that comments made by the participant would be recorded with the use of an audio

cassette recorder and transcribed later for review (Streubert Speziale & Carpenter, 2007).

In turn, the participants were asked to speak with at least one other acute care RN who

might be interested in being part of the study. This latter approach is known as the

snowball technique, where one participant recommends at least one additional contact for

the investigator to make, with the process continuing until the research has fulfilled the

number of participants deemed necessary for adequate data analysis and interpretation,

achieved when the investigator obtains the same information on repeated inquiries

(saturation) (Streubert Speziale & Carpenter, 2007).

Participant Recruitment: Rationale

This investigator considered both recruitment from hospitals as well as from a

pool of friends, past co-workers, and/or acquaintances, and reached the conclusion that

while both presented challenges and advantages for the study, because the emphasis is on

gaining the perspective of nurses regarding their emotional wellness, it would be more

appropriate to approach them free of a hospital affiliation or approval (Streubert Speziale

& Carpenter, 2007). This investigator felt that it would reinforce the participants'

comfort in sharing their thoughts if they knew that their views would not be sought after

by nursing administrators who gave the study approval (Streubert Speziale & Carpenter,

2007). Further, this investigator considered that because participants and investigators

alike are RNs and, therefore colleagues, the potential for bias is ever-present. RNs form

opinions about each other all the time, and not even the most objective nurse researcher

will refrain from making judgments about another nurse (McConnell-Henry, James, Chapman, & Francis, 2009; Polit & Beck, 2008)

Discussion of Rights of Human
Subjects and Consent Process

Prior to contacting any participants or beginning the interview process, approval for the study was sought and obtained from the Institutional Review Board (IRB) at Montana State University. The nature of this research involved disclosing personal views as well as potentially emotionally-sensitive information via one-on-one semi-structured interview. Therefore, it was important to assure participants that they were in no way obligated to participate or continue with an activity that made them feel emotionally uncomfortable. If participants did elect to continue, it was likewise important to secure their informed consent in writing, to record the data shared as accurately and privately as possible, and to safeguard this data in a manner that protected their identity and their views. After the forms were signed, they were stored in a locked file cabinet (Parslow, 2008; Streubert Speziale & Carpenter, 2007). Participants were assigned a code for information quoted directly from the participant. Likewise, for accuracy and to prevent misinterpretation, participants were asked to review and approve (or reject) a copy of their interview transcript. Once data was collected and recorded, it was secured in a locked file cabinet, with code books, transcripts, and audio recordings to be destroyed three years later in accordance with The Federal Wide Assurance Code of Federal Regulations (2005). A copy of the consent form is included in Appendix B.

Design

The qualitative nature of this research utilized interviews of participants, with the goal of defining the construct in question, namely emotional wellness. It lacked the formal structure and precise data analysis of a quantitative study, but nevertheless has a guiding methodology, specifically that of descriptive phenomenology, permitting the investigator to gain an understanding of the essence of the phenomenon of emotional wellness (Polit & Beck, 2008; Streubert Speziale & Carpenter, 2007).

Phenomenology

The focus of phenomenology in research concerns the lived experiences of humans. It attempts to determine what the essence of a phenomenon is, based on experience. Essence is "an essential invariant structure that can be understood" (Polit & Beck, 2008, p. 227). Polit and Beck (2008) offered further insight regarding the role of phenomenology in research, by identifying that investigators investigate the "subjective phenomenon in the belief that critical truths about reality are grounded in people's lived experiences" (p. 227). Such an approach is particularly helpful with a phenomenon that lacks adequate definition, such as emotional wellness, because these critical truths are revealed for each individual and explored for both differences and commonalities on a basic level. In order to gather data for phenomenological research, investigators incorporate in-depth conversations with informants, typically ten or fewer, and possibly through two or more interviews. The process of inquiry focused on helping the

informants describe lived experiences, with the goal of the investigator experiencing the phenomenon in much the same way (Polit & Beck, 2008, p.227).

Descriptive Phenomenology

In order to understand the essence, or meaning of phenomena, scientists must learn how people perceive this from their subjective lived experience (Streubert Speziale & Carpenter, 2007). Using Streubert Speziale's ten step process, derived from the work of various scientists and philosophers oriented to descriptive phenomenology (Parslow, 2008), this investigator was able to follow a rigorous guide to conduct research. Incorporated within this ten step process were four other processes: intuiting, bracketing, analyzing and describing (Streubert Speziale & Carpenter, 2007). With intuiting, the investigator must immerse herself in the phenomena of emotional wellness, free from personal evaluation, biases, and assumptions as the interviewees describe it (Streubert Speziale & Carpenter, 2007). Bracketing, in turn, requires identifying prior knowledge and biases about a phenomenon to the point of neutrality (Streubert Speziale & Carpenter, 2007). It is revisited prior to the beginning of the study and repeated through data collection and analysis (Streubert Speziale & Carpenter, 2007). Analysis likewise requires identifying the essence of the phenomenon based on the data collected and search for commonalities (Streubert Speziale & Carpenter, 2007). Finally, description is integral to intuiting and analyzing, and occurs simultaneously (Parslow, 2008; Streubert Speziale & Carpenter, 2007). Once common elements, essences, and patterns of repetitive descriptions of the phenomenon are identified and described, written and verbal descriptions can, in turn, become distinct (Parslow, 2008).

Streubert Speziale's 10 Step
<u>Method of Qualitative Analysis</u>

Streubert Speziale's 10 Step process (Parslow, 2008; Streubert Speziale &

Carpenter, 2007) consists of the following:

1. *Explicating a personal description of the phenomenon of interest:* This

   investigator chose to focus on the phenomenon of emotional wellness

   because of its absence in the literature as well as an overall lack of

   measuring emotional health in nurses. A great deal of emphasis is placed on

   the absence of emotional wellness, particularly stress, burnout, and

   compassion fatigue, and this investigator felt that it was important to explore

   emotional health in nurses from a positive perspective. Specifically, this

   investigator wanted to address what nurses were doing right to sustain

   themselves emotionally in their profession.

2. *Suspending presuppositions:* Such an approach requires that investigators

   suspend his or her own beliefs or disbeliefs regarding the experience of

   emotional wellness, also known as bracketing (Parslow, 2008). This

   investigator spent some time reflecting upon her own conceptualization of

   emotional wellness, particularly at the beginning of the research, and

   approached data collection with an eagerness for participants to share their

   views and an open mind to hear what participants had to say. Audio

   recording commenced with the written and verbal permission of the

   participants (informed consent), with the investigator asking questions to

   clarify comments made by the participant and to keep the participants' train

of thought going in order to gain understanding of their views and lived

experience (Parslow, 2008; Streubert Speziale & Carpenter, 2007). Each

interview consisted of approximately ten minutes of building or re-

establishing rapport with the RN, and began with an open-ended question of

"As a Registered Nurse, how do you define emotional wellness?" Ten

interview questions addressing the participants' impressions of the phrase

"emotional wellness", the definition of emotional wellness in their lives, the

role, practice, goals, support, hindrances, and components of emotional

wellness were also queried. Included in the interview were demographic

questions asking what age group each RN belonged to, the number of years

they have been in practice, and their primary specialty (Parslow, 2008; Polit

& Beck, 2008; Streubert Speziale & Carpenter, 2007). (Please refer to

Appendix C for a list of the interview questions.)

Throughout the interviews, the investigator made notes regarding body language

in the form of posture, hand gestures, eye contact, and facial expression, as well as any

other information deemed relevant to the participants' description of emotional wellness

(Parslow, 2008; Streubert Speziale & Carpenter, 2007).

3. *Interviewing participants in a place unfamiliar to the investigator:* Once the

participant agreed, a meeting time was scheduled that was mutually

convenient to both parties and likewise free of interruption (Parslow, 2008;

Streubert Speziale & Carpenter, 2007). RNs were interviewed one-on-one

by this investigator in a variety of settings deemed convenient and private

by the participant (Parslow, 2008; Streubert Speziale & Carpenter, 2007).

This included meeting in coffee shops, restaurants, in the participant's

home, or, if scheduling conflicts were too cumbersome, via phone or Skype.

This investigator felt it was necessary to be able to at least view the

participant's face while completing the interview to obtain information from

nonverbal communications that could often underscore what participants

were attempting to communicate, but took into consideration that not all

participants had access to this means of communication (Parslow, 2008;

Streubert Speziale & Carpenter, 2007).

This investigator anticipated that interviews could be completed in up to two

weeks, with responses transcribed immediately following interviews and returned for

review in up to three weeks. Thus, data collection was anticipated to take up to three

weeks, with one week for participants to review the transcripts of their interviews and

offer feedback.

Once responses were recorded, this investigator reviewed each participant's

comments and then forwarded CD recordings to a transcriptionist who typed the

interviews into a Microsoft Word document. Each transcript was coded for each

participant to preserve anonymity (Parslow, 2008; Streubert Speziale & Carpenter, 2007).

4.   *Reading transcripts to obtain a general sense of the experience:* This

investigator reviewed notes, audio recordings, and transcripts as close to the

conclusion of each interview as possible. Following Streubert Speziale's

recommendations (Parslow, 2008), this investigator read transcripts as a

whole before coding data in order to get a general sense of the essences, and

also listened to audio recordings of the interviews. Such an approach is

known as dwelling, or immersion, in the data (Parslow, 2008; Streubert

Speziale & Carpenter, 2007). As soon as interviews were completed, the

audio recordings were transferred to writable CDs and forwarded to a

transcriptionist. There were a total of 10 pages of written notes and 48

pages of transcribed interviews. Once transcripts were completed, the

investigator reviewed these documents for accuracy, comparing the audio

recording with the hard-copy transcript of each interview. Out of the five

participants interviewed, only one required contact by this investigator to

elaborate further regarding the interview responses and answered

accordingly. Other interview responses did not require additional

clarification.

All participants were forwarded copies of their interviews. Of the five, three

responded back via e-mail that the transcripts provided were accurate representations of

their views and felt that there was nothing more to add. The remaining two participants

did not respond back via e-mail, and it was concluded by this investigator that the

transcripts of these participants were accurate and representative of the participants'

views.

5. *Reviewing the transcripts to uncover essences:* This investigator re-read

transcripts several times, with each reading used to find statements that were

significant regarding the participants' lived experiences of emotional

wellness. Statements that uncovered the essence of emotional wellness were considered to be comprehensive, leaving little doubt for this investigator as to what their experiences were. Parslow (2008, p. 53) noted that "essences compose the basic units of common understanding of phenomenon and are described as 'elements related to the ideal or true meaning of something…'".

6. *Apprehending essential relationships:* The process of re-reading transcripts offered clarity and discovery of themes. As this writer read each line, repeated expressions or words were underlined. Notes were also placed in the margins to identify recurring themes or patterns. As these recurring themes or patterns emerged, they were placed on separate sheets of paper with a general statement describing the expressions or words in common at the top of the page.

7. *Developing a formalized description of the phenomenon:* This involves a translation of the participants' themes into nursing language. It forms the essence of phenomenological method and provides readers with knowledge of the lived experience of emotional wellness in acute care RNs. As Parslow (2008) stated, such a step involves developing a rich, formal description of the lived experience of emotional wellness in acute care RNs. This required that the investigator draw from her own experience as an acute care RN and a student of nursing, as well as the experiences of the research

participants, and to integrate these into a description of the construct of emotional wellness.

Reviewing transcripts frequently helped clarify and highlight emergent themes, particularly when examining each line of the transcripts and underlining repeated expressions or words to identify patterns or themes. Distinct patterns or phrases were sorted further, and the evident patterns or essences served to organize the data into themes. "Essences compose the basic units of common understanding of any phenomenon and are described as 'elements related to the ideal or true meaning of something'" (Parslow, 2008, p. 53). Themes were then restated into a common language. As Parslow states: "This is the essence of phenomenological method and will provide knowledge of the lived experience…this step involves developing a rich and exhaustive formal description" (2008, p. 53), in this case nurses living emotionally well.

Following steps 4 through 7 of Streubert's 10-step research protocol for data collection and analysis separately for each participant (Parslow, 2008; Streubert-Speziale & Carpenter, 2007), this investigator completed and read transcripts as close to the conclusion of each interview as possible to preserve accuracy. Notes were likewise reviewed as a whole, along with the transcripts, and the audio recording in play, in a process called "dwelling in the data" (Parslow, 2008, p. 53). As part of this process, the investigator re-read transcripts multiple times, intending to extract participants' lived experiences of emotional wellness.

8. *Reviewing analysis with participants to establish trustworthiness:*

Transcripts of the interviews were forwarded to participants for their review

for validation and accuracy purposes. Feedback from participants validated the descriptions of the data when this occurred.

9. *Reviewing the relevant literature:* Because of the paucity of literature available regarding emotional wellness, the literature review was essentially complete. As time progressed, this investigator occasionally revisited the literature in hopes of finding more work on the topic as well as emotional health, stress management, nursing retention, and other related literature.

10. *Distributing the findings:* The findings of this study will be shared with the nursing community through a videoconference presentation of this thesis, as well as through Electronic Theses and Dissertation storage through Montana State University.

Incorporating Streubert Speziale's 10 step process (Streubert Speziale & Carpenter, 2007) provided a degree of rigor to this qualitative study, important not only to clarifying the construct of emotional wellness but also to guiding this novice researcher as she explored the construct of emotional wellness. Further, because the process was developed by a nurse researcher, it has aided the approach to understanding phenomena that are unique to nurses by sharing the same language and perspective of nurses (Streubert Speziale & Carpenter, 2007; Parslow, 2008).

<u>Summary</u>

Five registered nurses across acute care specialties were contacted via Facebook, and participated in semi-structured interviews exploring the essence of the phenomenon

of emotional wellness. Participants were advised that they could withdraw at any time, and that their emotional comfort was considered a priority in this study. Using Streubert Speziale's 10-step research process for descriptive phenomenology applied to nursing research, as well as the four processes of intuiting, bracketing, analyzing and describing (Streubert Speziale & Carpenter, 2007), this investigator was able to derive the meaning of living emotionally well in registered nurses across acute care specialties using a process developed by a nurse.

Despite a small sample size, results of the study do indicate the essence of emotional wellness. The following chapter explores this, as well as factors included in the definition of emotional wellness.

CHAPTER 4

RESULTS

The research question for this paper is "What is emotional wellness for hospital RNs, and how do they perpetuate/foster this within themselves?" To answer this question, this investigator sought the input of nurses from a number of institutions within the region. This intuitively lead to a greater variety of perspectives, but also made recruitment more challenging, particularly if the investigator was not affiliated with any of the local health care facilities from which participants may be recruited (Polit & Beck, 2008). Such a process limited the proverbial red tape associated with conducting research within a health care institution. However, if an investigator relied upon friends, acquaintances, and colleagues as participants, this in turn limits the replicability and applicability of findings because participants were not randomly selected (McConnell-Henry, et al., 2009; Polit & Beck, 2008). Not only this, but concerns about validity can arise because participants may be either too candid with an investigator who happens to be a friend, or too reluctant to share their thoughts because they are concerned about being judged by their friend (McConnell-Henry, et al., 2009).

Participant Selection

Figure 1 provides a summary of the selection process. Out of 75 nurses, including licensed practical nurses (LPNs), advanced practice RNs (APRNs), and RNs from outside the small city in the Northwestern United States in which this investigator resided, a total

of 55 RNs who were friends, past co-workers and/ or acquaintances living in or around this locale were contacted via e-mail message through Facebook in efforts to recruit ten participants for this study. Out of these, only five RNs expressed an interest in completing an interview and agreed to meet with this investigator. Despite three attempts to recruit and interview five more participants for this study, including reminders to the five participants to contact at least one other RN who they felt might be interested in participating, as part of the snowball sampling technique, these efforts were unsuccessful. Thus, data analysis was completed using responses from the five participants interviewed.
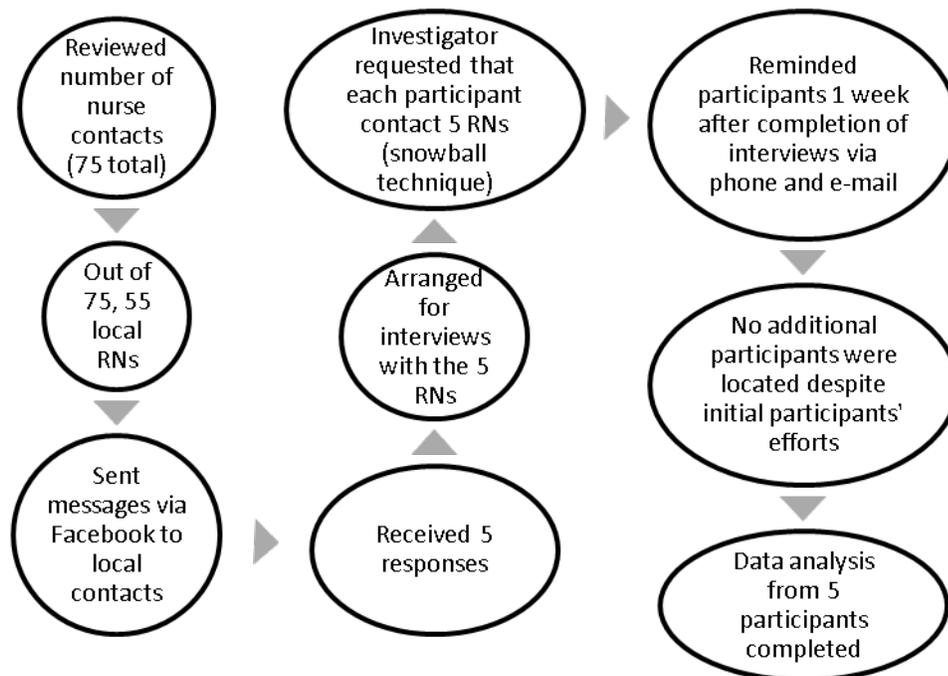
Figure 1. Participant Recruitment Process.

All participants met the inclusion criteria for the study, having an associate's level or bachelor's level nursing degree, and were registered nurses with more than one year of

experience in an acute care hospital setting. The nurses had from 4 to 51 years of nursing experience. Those interviewed also came from a variety of nursing specialties (medical oncology, neuroscience, neonatal intensive care unit (NICU), psychiatric/mental health, and emergency). The majority of participants (n=3; 60%) were in their thirties, with one in her forties and another in her early 70's. According to the Health Resources and Services Administration (HRSA), the median age of RNs from 2004-2008 was 46, but the number of RNs under age 30 has increased since then for the first time in thirty years (HRSA, September 2010). There were no participants in their 20s. All participants were female, despite frequent attempts by this writer to recruit male nurses. From HRSA (September 2010), the number of male RNs in the United States is 9.6%.

Table 2. Participant Demographics.

Age	20s	30s	40s	50s	60s	70s
	0	3 (60%)	1 (20%)	0	0	1 (20%)
Gender		Males			Females	
		0			5 (100%)	
Specialties Represented	Med-Onc	P/MH	Neuro	NICU	ED	
Number of Years as Practicing RN	<5	6-10	11-20	21-30	31-40	41-50	51+
	1 (20%)	2 (40%)	1 (20%)	0	0	0	1 (20%)

Other characteristics worth noting, discovered from the interviews, were that all participants could be considered nontraditional nurses to some extent. Three nurses (60%) have their first degree in another area (i.e., psychology, biology, and health education), and all chose nursing as another career option. Also, of the five interviewed,

four (80%) participate in major leadership roles on their units (charge nurses—[3], one helps to provide training for the hospital's electronic medical record [EMR] program).

Despite the small number of participants, this investigator was able to identify themes in the data that helped to define the concept of emotional wellness by following Streubert-Speziale's process for qualitative analysis (Streubert Speziale & Carpenter, 2007). The analysis of this data revealed the major factors of emotional wellness to include boundaries, balance, support, and self-awareness.

<u>Boundaries</u>

Based on the results from the interviews, boundaries can be described as limits placed on individuals, situations, and emotions. They are also defined by their permeability, be they personal or professional boundaries. This idea of permeability is much like that of a living cell. In order to survive, a cell must have an intact membrane that creates a barrier against harmful substances in the environment (McCance, Huether, Brashers, & Rote, 2010). However, this membrane must also permit nutrients to enter the cell in measured amounts. If too many nutrients enter a cell, it is at risk for dying (McCance, et al, 2010). Thus, personal and professional boundaries are a complex, delicate balance that can diminish or maximize the RNs emotional wellness.

In regards to individuals, participants shared that limits involved not accepting responsibility for the feelings or actions of others. As one participant explained, it was "okay for others to be mad" if they were unhappy with a situation or a person, including the participant. As for situations, be they personal or professional, this called for

participants putting their stressors "on a shelf", addressing situations and then proceeding forward despite the intensity of their stressor. In some cases this involved creating a work-home boundary whereby participants talked about stress occurring in both aspects of their life, but separating these out depending on whether participants were at work or at home. As Participant 1described, her husband had been unemployed for a number of years, thus making her the sole breadwinner of the family. In addition, she had to address her role as charge nurse on a busy medical oncology unit in which she was responsible for a number of staff, and in some cases, her own patient load. She described this as taking each as "one stress ball at a time" and keeping the two separate.

Inevitably, discussion of the permeability of personal and professional boundaries did occur. As above, participants felt that they had to develop clearer boundaries regarding their relationships with co-workers. Participant 1 stated that she did not feel that she could be friends with the nurses she supervised as she did not want to be put in a position where she had to correct her friends, with the result being hurt feelings and resentment that she had observed with other charge nurses. She was, however, close friends with another charge nurse on the Unit who worked another shift. Participant 3 discussed that despite separating out work from home, and even her feelings from those of her coworkers, at times she felt vulnerable to the effects of a negative coworker or situation. As she put it "…negativity can be infectious".

At times nurses identified that the boundaries they set with their families were not as clear cut as with co-workers or at home. Participant 4 shared that she often felt more effected by the reactions of her family than of her coworkers when she was at work and

speculated that this was based on the type of relationship she had with her family, particularly knowing what buttons they could push with her and the fact that they lived together and were related.

Despite the stress of their work and their personal lives, participants shared that they derived great emotional fulfillment from their satisfaction with their job. If they were pleased with their work, they were pleased with themselves.

Balance

Essentially, participants described balance as "making it work". It is having stability and consistency in both the home and work environments. Or, put another way, balance and emotional wellness is having stability in one's personal and professional lives. Participant 1 stated that having stability in her home life was essential to achieving stability at work as it provided her with reassurance that she could find comfort and rest in her own space and in her own way, while at work she is a professional and expected to fulfill that role.

Participants tended to point out that, in regards to balance and its part in emotional wellness, it was not an absence of stress that was key but being able to do what one could with what one had. Participant 5 stated that

> "…it's not just a matter of being happy or unhappy, it's everything. Your happiness, your relationships, your ability to communicate with others, your spiritual and everything, it's just rolled up into one. Ability to love, ability to hate, everything has to be balanced."

Thus, balance as a part of emotional wellness included the total human experience, with emotions, individuals, skills, and beliefs in one's life not dominating each other.

Support

      Support, as a factor of emotional wellness, came through very clearly during the interview process. All participants in this study are married, and each identified their spouses as a source of emotional support. In all cases, spouses were part of the participants' "alone time", giving them the opportunity to share their frustrations and to simply "reboot and recharge". Participant 2 identified that her husband served as a sounding board to talk through concerns she has from work. In addition, participants identified that they had what they felt were healthy relationships with their spouses. In some cases, they were strong helpmates. As Participant 1 stated, "My husband is not the typical male. He helps with taking care of the house, and helps with the kids". Participant 1 also identified that she was able to share her feelings openly with her spouse, sometimes prefaced with "I'm not angry with you. I just need to talk about how I am feeling right now about our [money] situation" before verbalizing her frustrations and concerns.

      Based on this, this investigator proposes that participants have at least one strong source of support, particularly from their marriage, that keeps their personal life intact and supports emotional wellness.

      As for family support, in some instances, this investigator found that the support offered by the family varied. Of the five interviewed, four (80%) identified that they had experienced highly stressful situations in relation to their family. One participant (20%)

had witnessed the emotional abuse of her mother by her stepfather while growing up. This served as the impetus for her to achieve her own independence through a career in nursing, but it also made her leery of confiding in her family regarding her needs.

Another participant described taking on the parental role for her parents, one who is chronically mentally ill and another who has residual effects from a brain tumor. Rather than relying on her family of origin, she looks to her in-laws, particularly her mother in law, for help.

While in some instances, participants did not rely on specific family members for emotional support, the participants' relationships with them were still draining. Participant 4 shared that "for the last ten years her relationship with her daughter has been very strained and emotionally trying". Participant 5 shared that "she likewise has a difficult relationship with her stepdaughter". In both situations, participants expressed that their emotional reserves and, as a result, their emotional wellness was nearly depleted at times.

Participants identified the importance of support from colleagues, and each related an instance where they received positive feedback from a coworker that made them feel good about themselves. In some instances, colleagues provide a listening ear for discussing difficult situations or coworkers. Participant 5 identified that in her new role as a charge nurse in the emergency department, she is still learning what her responsibilities as a supervisor are, and the extra reassurance offered by her supervisor makes a difference. Not only does she feel good, she feels that she is on the right track.

Even if she makes mistakes, she receives guidance regarding how to proceed the next time she confronts a similar situation.

As a matter of course, the lack of support is also necessary to discuss. Participants shared that, at times, they felt that their emotional wellness suffered because of negativity from peers and staff. This made their jobs less enjoyable and affected their moods. This is also the case with nurses in supervisory positions as they had to confront negative attitudes, and in some instances, insubordination.

Likewise, the lack of opportunity to grow can be draining. Participant 3 stated that she "was concerned that she would not be able to pursue her ultimate goal of transferring from the neuroscience unit to the NICU, and she felt that this, in turn, would limit her potential for growth as a nurse".

Support from the individuals in the participants' lives plays an important role in their emotional wellness. Consistently, participants identified their spouses as a major source of emotional support. Not only this, they maintained healthy relationships with them. In some instances, however, family relations were very strained and were, in turn, draining for the participants. As for colleagues, support is more or less mixed. With this, participants could identify consistent sources of support as well as of conflict. In one instance, one participant identified "the need for a supportive work environment as being important to her emotional wellness, particularly one affording the opportunity to grow as a person and a nurse".

From this, it appears that emotional wellness is derived from positive

relationships and the environment, be they personal or professional. Likewise, the

situations participants found themselves in impacted emotional wellness.

Self-Awareness

The self-awareness factor of emotional wellness also appears to be comprised of

additional parts, including: self-care habits, awareness of the mind-body-spirit

connection, the need for release, the importance of self-control and perception of a

greater need for self-care.

Self-care Habits: These habits included exercise, sleep and rest, vacations, and

scheduled breaks. In addition, participants also identified routine checkups with their

primary care providers and specialists, such as mental health, as key to their emotional

wellness. Participants also identified self-education regarding areas of interest,

particularly other cultures, positive thinking, and thought cycling. Participant 2 identified

"thought cycling", "alternately as 'processing' as 'talking with friends or my husband and

processing and rehashing a problem until I've worked it through and it isn't a problem

anymore'. Other participants (n=3, 60%) were also able to identify a similar process to

some extent as well, and stated that it helped them to put problems into perspective and,

eventually, to move on. From this, self-care habits are simple, well-studied, and

frequently identified by the participants (Downey, 2006, 2007; Hallin & Danielson, 2007;

Kravits, McAllister-Black, Grant, & Kirk, 2010; Larrabee, Wy, Persily, Simoni,

Johnston, Marcischak, Mott, & Gladden, 2010; Lavoie-Tremblay, Wright, Desforges,

Gelinas, Marchionni, & Drevniok, 2008; Mackenzie, et al., 2006; McElligott , et al., 2009; McElligott, et al., 2010; and Walker, 2008) .

Mind-body-spirit Connection: Participants also addressed the importance of the mind-body-spirit connection. Participant 3 explained that emotional wellness permeated physical and emotional wellness and was essential for life. Along with her counterparts (n=5, 100%), she pointed out that if you do not feel good emotionally, you will feel less motivated to complete your work and to help others. "If you do not feel well physically, you may feel disappointed in yourself because you cannot accomplish the tasks you would like to."

Two members (40%) further discussed the importance of spiritual connection for their total wellbeing. Participant 3 stated that "although she was raised a specific religion, she does not attend church. However, she feels a spiritual connection to others by volunteering at a local charity". Participant 4, who identified herself as a Christian, felt that her strong faith has helped her throughout her life, during both good and bad times. It has been instilled in her since she was a young child. Participant 4 discussed the importance of a philosophical approach as a guide to one's life, regardless of religious faith. In addition to seeing her life through the Christian perspective, she frequently re-reads a book that particularly inspires her. Participant 4 uses the metaphor of "the dance between living things" to help her cope with a difficult shift at work and to enjoy the unfolding of life before her when she is at home. With this approach, she was able to find and maintain peace within herself.

<u>The Need for Emotional Release</u>

The need for emotional release is also a key component identified by these participants as emotional wellness. All participants mentioned the desire to scream, shout, and cry in private as healthy and necessary. Participant 4 stated, "I'm being emotional, but to me that's not unhealthy either. It's just emotions, you know". One participant offered that she was curious what it would be like for her to "just lose it…go in a corner and suck my thumb" as a way of releasing her emotions, but instead opts for crying or screaming as well as other less intense methods of release, as mentioned below.

All participants shared that they enjoyed reading, particularly romances or science fiction. Others mentioned exercise, gardening, watching movies, playing games with their children or friends, and Internet surfing. Participant 2 stated that she enjoyed activities that provided distraction such as Internet surfing because "…those kinds of things…don't really stress you a lot emotionally or you have to think too much about. Sometimes it's a nice way to disconnect".

<u>Sense of Self Control</u>: A sense of self control was also described as key to self-awareness of emotional wellness. With this, participants described self-control as having "intact emotions", of knowing their healthy self. It also entailed choosing to respond versus react to difficult situations and the need to grow, particularly in assertiveness. Participant 2 stated that it was important for her to know who she is and how she deals with things: "It may not always be the most constructive thing in the world, but it works for me".

Self-Care Recognition

Other participants (n=4; 80%) recognized that they too could practice healthier habits, whether it was better diet, more exercise, or simply saying no to extra shifts and responsibilities. Often, this need for healthier habits was learned by trial and error. In Participant 4's case, she learned many years ago following an eight month long episode of illness that she needed to care for her body and for her spirit better. As part of her emotional wellness, she not only exercises regularly, but she also likes to spend time reading and praying.

As with self-control, awareness of the greater need for self-care is apparent. Participants (n=2, 40%) are aware of the need to better manage their anger, particularly with their children. Professionally, this awareness apparently has already been achieved. Participants are also aware of their unhealthy habits such as overeating. However, other forms of maladaptive coping, such as alcohol or drug use, were not mentioned. It is certainly possible that these forms of coping may be used, but were not explored by this writer at this time. Communication skills, which Participant 5 described as "saying the right thing in a difficult situation", may not directly appear to reflect an awareness of greater need for self-care. However, Participant 5 related a story in which she had to respond to a negative coworker who had bullied her and at one time threw a radio at her. Participant 5, in turn, sent this woman home. As Participant 5 described it, she had been bothered by this coworker's behavior for some time and did not know how to effectively confront her. Participant 5 cited this as the worst situation she has had to confront, and, even though she has found confrontation to be easier in similar situations, she does not

feel she knows how to do it gracefully. In her case, she finds that, while dealing with confrontations professionally has become easier, within her personal life this is still quite difficult. She jokes "If only my family could see that I'm right, I wouldn't have to tell them."

Self-awareness is a necessary component of emotional wellness, in that all participants report it involved self-care habits that are physical and emotional: a perception of the mind-body-spirit connection, the need for emotional release, the need for emotional self-control, and an awareness of a greater need for self-care. Participants were able to identify ways that they have achieved this awareness of self, and likewise ways in which they feel they need to grow.

Emotional wellness as described by these five participants can be divided into four major factors: Boundaries, Balance, Support, and Self Awareness. With Boundaries, participants further elaborated on the importance of setting limits, letting go, recognizing that they are influenced and can influence others positively and negatively, and the separation between personal and professional life. As for Balance, participants pointed to the need for: stability and consistency, a separate personal and professional life, recognition that balance does not entail an absence of stress or of being happy versus unhappy, and the importance of doing the best one can as one can. Support was detailed by participants as coming from spouses and families and from colleagues, and that sometimes support is absent. In this research, spousal support was present for all participants. Finally, self-awareness was further defined by participants as recognizing

their self-care habits, the mind-body-spirit connection, emotional release, self-control, and of the awareness of the greater need for self-care.

Summary

Five registered nurses from a variety of specialties and ages were interviewed to answer the research question "What is emotional wellness for hospital RNs, and how do they perpetuate/foster this within themselves?" From this, four factors emerged: Boundaries, Balance, Support, and Self-Care. In regards to Boundaries, participants established that these are essential for functioning in their personal and professional roles. However, the roles are meshed together in terms of personal satisfaction. As for Balance, participants shared as a group that this was essential to functioning optimally in their personal and professional roles. However, the absence of stress was not central to this aspect of emotional wellness. When addressing the Support factor, most evident from these results was the role the supportive spouse played in the life of each participant. In turn, the involvement of the family and that of colleagues can prove draining, and yet, superiors and peers can be supportive in some cases. Self-awareness, in turn, is exemplified by self-care habits, awareness of the mind-body-spirit connection, emotional release, and a sense of self-control.

CHAPTER 5

DISCUSSION

Emotional wellness as a construct has not been well-defined in the nursing

literature, particularly when applied to nursing itself. Through interviews of a small

sample of RNs from the Northwestern United States, this investigator was able to derive

four factors that comprise emotional wellness. Despite the small sample size and

exclusivity of the locale, these results are intriguing in and of themselves and suggest that

emotional wellness has some generalizability across nursing specialties, age of nurses,

and years of experience as nurses. It is hoped that the findings of this study will prove

useful in future nursing research addressing emotional wellness as it has provided a basic

working definition of the construct.

The previous chapter, Results, presented the findings from 5 RN participants in

answer to the research question: "What is emotional wellness for hospital RNs, and how

do they perpetuate/foster this within themselves?"   A ten question semi-structured

interview gauging the lived experience of emotional wellness in acute care RNs was

based on Nola Pender's Health Promotion Model (HPM), and used to answer the research

question (Sitzman & Eichelberger, 2004). Streubert-Speziale's 10-step process was used

for analysis of the data collected from participants (Streubert Speziale & Carpenter,

2007). Pender's HPM served as the foundation for this study because this investigator

shared the perception with Dr. Pender that health is more than the absence of illness

(Sitzman & Eichelberger, 2004). Health promotion, in turn, is directed at increasing a

client's level of wellbeing, and is a positive dynamic state, not merely the absence of disease (Sitzman & Eichelberger, 2004). Emotional wellness fits with health promotion because it too is a positive, multidimensional dynamic state. Likewise, it accounts for disease, but is not subsumed by it. While the HPM itself is also multi-dimensional, in this study emotional wellness was the focus of further exploration within a sample of the RN population (Nursing theories HPM, 2011).

Following data analysis, the presence of four components of emotional wellness emerged. These factors are: Boundaries, Balance, Support, and Self- Awareness. Each factor is interconnected with the other, with none figuring more prominently than the others. This observation is based directly on the discussion with interview participants, both of the content of the interviews and patterns of verbal communication (Streubert Speziale & Carpenter, 2007). Each factor contributes equally to the emotional wellness of this group of RNs.

<div align="center">Evaluation of Results</div>

Boundaries

Each of the four components of emotional wellness was further defined by a number of characteristics. Regarding Boundaries, participants set limits on individuals, situations, and emotions. Boundaries themselves were described as either personal or professional, with some permeability occurring between the two.

Balance

      As for Balance, interviewees discussed the idea of "making it work" personally or professionally, specifically creating stability within whichever environment they were and regardless of whatever was occurring in their lives. Participants also shared that Balance was not an absence of stress.

Support

      Support consisted of the individuals emotionally available to the participants. In these interviews, such individuals were spouses and nurse colleagues to whom they confided and with whom they processed their frustrations. Nurse colleagues were individuals, such as co-workers, who were either not subordinate to these nurses, or were supervisors in a mentoring position. Participants noted that, in some instances, although they experienced tiring interactions with step-children, children, or aging parents, these individuals were not a regular source of support for them. Spouses and nurse colleagues provided this support instead.

Self-Awareness

      Self-Awareness was characterized as: self-care habits practiced by participants, an awareness of the mind-body-spirit connection, the need for release, the importance of self-control, and a perception of a greater need for self-care. Delving deeper, self-care habits practiced by these participants consisted of exercise, vacations, taking breaks during work, receiving adequate rest, and healthy eating. Awareness of the mind-body-spirit connection was most noteworthy when participants discussed times they did not

perform as well as they would have liked at work because of negative emotions or feeling

physically worn down. One participant shared her choice to maintain good health

following a prolonged illness that affected her physically, spiritually, and emotionally.

The need for release was described by participants as spending time reading, particularly

science fiction or romance novels, as well as Internet surfing, playing computer games, or

simply playing with their children. By using these activities, they were able to disconnect

from stress occurring in their personal and professional lives. As for self-control, this

was related to maintaining professional decorum in the face of crises, whether the source

of the crises was from home or occurring on the clinical unit where they worked. Finally,

the perception of a greater need for self-care was a consensus expressed by participants in

that they were aware of the potential for growth in developing healthy habits, or, for that

matter, healthier habits.

<div align="center">Fit with HPM Theory</div>

The HPM focused on three areas: individual characteristics and experiences,

behavior-specific cognitions and affect, and behavioral outcomes (Nursing theories HPM,

2011; Sitzman & Eichelberger, 2004).

Individual Characteristics

Individual characteristics and experiences includes the observation "that each

person has unique personal characteristics and experiences that affect subsequent actions"

(Nursing theories HPM, 2011, para. 1). Indeed, each participant was a unique individual

with her own experiences within nursing and from life, from their area of specialization

to their views and opinions. While they may have shared the same behaviors,
participants spoke from different life experiences, as evidenced by the recorded dialogue
with this investigator.

Behavior-specific Cognitions and Affect

Behavior-specific cognitions and affect have motivational significance, and can
likewise be modified (Nursing theories HPM, 2011). Participants discussed the
emotional interplay which occurred between themselves, coworkers, and family
members. They also discussed the awareness of their emotional needs, and the desire to
meet these through various actions (behaviors).

Behavioral Outcomes

Behavioral outcomes are at the desired end point in HPM, and result in "improved
health, enhanced functional ability and a better quality of life at all stages of
development" (Nursing theories HPM, 2011, para. 1). Such outcomes can likewise be
"influenced by the immediate competing demand and preferences, which can derail an
intended health promoting action" (Nursing theories HPM, 2011, para. 1). Each
participant was able to articulate hurdles as well as enhancers for achieving these,
particularly when asked what prevented them and helped them to meet these needs.
Please refer to Appendix A for a visual representation of the HPM.

Four Assumptions of the HPM

There are four assumptions of the HPM (Nursing theories HPM, 2011; Sitzman &
Eichelberger, 2004).

1. *Individuals actively self -regulate their behavior.* During interviews, participants discussed regulating their professional behaviors as they worked on their units, and setting limits between their personal and professional lives so that they could fulfill their professional duties. They also discussed their choices to participate in self-care activities such as exercise, talking with significant others, and taking breaks and vacations for their own physical and emotional benefits.

2. *Individuals interact with, transform, and are likewise transformed by their environment.* Participants further discussed their interaction with, transformation of, and transformation by their environment as they shared with this investigator the influence of negativity on their very moods when they were at work, suggesting the permeability of boundaries. Participants also shared that, while peers could have a positive or negative influence on their work day, sometimes their feelings from home could influence their work or even those around them. The opposite could also occur in which they took negativity from work home with them. Further, participants observed that their mood impacted their co-workers or even patients, thus creating a negative environment that "hung like a cloud", as one participant shared.

3. *To change behavior, the person-environment interactive patterns must likewise change*: From this, behavior change was dependent on the interaction of the person and the environment. In some instances, this required that the participant realize that their current behaviors were unhealthy or were

stagnating their personal growth. Some participants began practicing self-care

such as exercise, and, with this, either changing their outlook on life to a more

positive, self-loving one or breaking free from past unhealthy behavior

patterns they observed in their families.

4. *Health professionals are part of the interpersonal environment, which exerts*

   influence on persons throughout their life span. As for health professionals

   being part of the interpersonal environment, only one participant mentioned

   that she maintains contact with a specialist to manage a chronic health

   condition. In this case the participant sees a specialist to facilitate her

   management of a long-term condition. The above suggests that assumptions

   of the HPM fit with the factors and characteristics of emotional wellness, and

   that, with more depth, the degree to which HPM and emotional fit can be

   better determined.

<div align="center">Theoretical Propositions of the HPM</div>

Theoretical propositions of the HPM "provide a basis for investigative work on

health behaviors" (Nursing theories HPM, 2011, Theoretical Propositions of the Health

Promotion Model). Such propositions were found to support this research without being

specifically used to guide it. When each proposition is addressed, the following was

discovered:

Proposition One: Prior behavior and inherited and acquired characteristics influence beliefs, affect, and enactment of health-promoting behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Participants who shared that they were raised in loving homes with strong values had a positive outlook that, in turn, promoted emotional wellness. One participant shared that she had been raised in a Christian home by parents who valued prayer and positive thinking. This participant shared that seeking out healthy relationships and positive interactions has, in turn, helped her to remain positive and to grow as a human being. Having this solid, healthy foundation in place, participants can establish lifelong patterns of emotional wellness.

Proposition Two: Persons commit to engaging in behaviors from which they anticipate deriving personally valued benefits (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

All participants shared that they maintained routine habits of exercise, scheduling regular vacations, and/or reading as these provided them with a "break" from the stress accompanying their professional lives. It permitted them to likewise function optimally in their personal and professional lives. They continue to engage in these behaviors because of the enjoyment they derive from them, whether it is for entertainment or escape.

Proposition Three: Perceived barriers can constrain commitment to action, a mediator of behavior as well as actual behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Participant 1 shared that a perceived barrier that constrained commitment to action was finances, as her family was experiencing financial hardship at the time and joining a gym was not a financial priority. "…I'm the sole provider pretty much for my family and in August his [husband] unemployment is done so what happens if my wages get cut?" It is clear that despite the participant's awareness of the need to engage in physical activity, this concern was superseded by the family's greater financial need, thus limiting the participant's commitment to action and mediating her behavior of going to the gym for exercise.

Proposition Five: Greater perceived self-efficacy results in fewer perceived barriers to a specific health behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Overeating was a specific health behavior mentioned by two of the participants, thus indicated as one barrier to overcome for these participants to feel that they had achieved self-efficacy. With this, participants indicated that they felt that emotional wellness also consisted of additional health behaviors such as exercise. While the factors of emotional wellness were the same across participants, the behaviors they practiced were slightly varied. As participants engaged in health behaviors that yielded positive results, their sense of accomplishment regarding these helped them to realize that emotional wellness was achievable.

Proposition Six: Positive affect toward a behavior results in greater perceived self-efficacy, which can in turn, result in increased positive affect (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Individual participants mentioned a number of behaviors that were in some cases unique to them which increased their sense of self-efficacy and, in turn, positive affect. For example, two of the participants talked about watching their children play sports. Another discussed hobbies such as stamping, and still others talked about gardening and sewing. One commonality among all participants, however, was the habit of reading. All participants engaged in this. The very nature of emotional wellness is positive, as it is more than just the absence of disease. It seems reasonable to propose that, by feeling good about a behavior, a participant may feel capable of performing it as well as pleased with the results (Sitzman & Eichelberger, 2004). Cumulatively, this could result in promoting emotional wellness within the individual.

Proposition Eight: Persons are more likely to commit to and engage in health-promoting behaviors when significant others model the behavior, expect the behavior to occur, and provide assistance and support to enable the behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Participants did not share whether they had role models for behaviors such as exercise. However, Participant 5 did discuss that assertiveness was role modeled, encouraged, and reinforced by her supervisor:

> "I'm new in the supervisor position so I'm still often times unsure of myself. A lot of the times I make decisions on scheduling, assignments, staffing, conflicts, etc. and use my gut instinct and hope I'm doing the right thing. Then later my boss will say 'good job' and it's a load off…I need the positive feedback…I do a better job when somebody says 'oh you did a good job'…I need somebody to say 'oh, you were right when you did that, or that was the way you should have dealt with that'…how my supervisor handles things, or handled things, is the approach that I try to use".

Participant 1 discussed her mentor, "…I love [former supervisor] and I bawled when I knew she was going to leave…she's kind of like the type of mom I never had, so I'm always trying to do good by her, or for her and for the floor and for the patients' safety". In the work setting, participants mentioned that there were supportive individuals such as supervisors who also held the expectation that assertive behavior, as a form of self- care, would occur and they were given support and assistance in carrying this out.

Proposition Nine: Families, peers and health care providers are important sources of interpersonal influence that can increase or decrease commitment to and engagement in health-promoting behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Families, with the exception of spouses, were not mentioned as sources of interpersonal influence that increased or decreased commitment to and engagement in health-promoting behaviors. Certain family members (i.e., stepchildren, dependent parents, adult children, and step-parents) were mentioned as a source of stress by 80% (n=4) participants and, thus, prompted participants to use their coping behaviors. However, a health care provider was important in helping one participant exercise self-care, particularly by providing assistance with medication management. Peers helped participants achieve emotional wellness by supporting their self-care efforts. Thus, these individuals either helped increase commitment to and engagement in health-promoting behaviors, or hindered it for the participants.

Proposition Ten: Situational influences in the external environment can increase or decrease commitment to or participation in health-promoting behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Participant 5 talked about her desire to be "more like I am at work" in resolving family conflicts, in particular exercising emotional objectivity and assertiveness, but that she has yet to learn how to do this effectively. She states

> "…I know probably at work I'm more emotionally well than I am at home, because I've got the step-kids and all those issues going on and I don't want to deal with them so it's just easier to just, you know, walk away or be mad. But at work I'm probably a lot better because I deal with it then I'm done with it. Home's harder."

Proposition Eleven: The greater the commitments to a specific plan of action, the more likely health-promoting behaviors are to be maintained over time (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Participants 3 and 4 talked about learning early on the importance of maintaining physical and emotional health. Participant 4 in particular shared that at one point in her life she had driven herself to the point of exhaustion from overwork, becoming very ill for a number of months. Following this, the participant became committed to maintaining her physical and emotional health by exercising, reading, and taking time to observe life. Participant 4 cited a book that she has read and re-read over the years as sort of a philosophical guide for being observant of life, allowing it to unfold for her. The commitment to emotional wellness is established over a long period of time.

Proposition Twelve: Commitment to a plan of action is less likely to result in the desired behavior when competing demands over which persons have little control require immediate attention (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

Participant 1 talked specifically about putting breaks from work on hold to resolve issues on the clinical unit.

> "…we have… a certain number of nursing hours that the floor can bill for and we ran so tight so they're now going to say, 'oh you did really well, you don't need 10.75 hours, you're going to only get 10 hours of nursing per blah blah blah'…and if you don't stay in a certain budget then you could lose some employees and we are already stretched for safe staffing."

She did not elaborate on competing demands occurring outside of work in her personal life. However, Participant 1 indeed has competing demands at work when it comes to safe staffing and remaining on the unit despite wanting and needing a break.

Proposition Thirteen: Commitment to a plan of action is less likely to result in the desired behavior when other actions are more attractive and thus preferred over the target behavior (Nursing theories HPM, 2011, Theoretical Propositions of the HPM).

One participant shared that she tends to overeat, resulting in weight gain on her part. While she "knows better", the appeal of food outweighs her desire to exercise or abstain from eating. "…like I said before, practicing being able to leave each stressor in their area and not combining them to…potentiate, making it worse for myself …unfortunately I've taken into eating a little bit too much". Certainly temptation in the form of treats will be succumbed to rather than abstaining, especially if one has to deprive themselves of something.

A number of theoretical propositions of the HPM were found to support this study without being specifically used to guide it. Such findings not only give support to the HPM theory, it also strengthens the construct of emotional wellness (Polit & Beck, 2008).

Study Limitations

There are some unique characteristics of this study that limited its applicability. While qualitative- phenomenological studies typically use small sample sizes, this study had only five participants (Polit & Beck, 2008; Streubert Speziale & Carpenter, 2007). Perhaps, this limitation was due to the fact that data collection took place in the summer, and potential participants were out of town and, therefore, unavailable (Polit & Beck, 2008). To ameliorate this in the future, it might be helpful to either broaden the time frame for data collection across several months or to move data collection to the fall, when most nurses, particularly those with families or who are enrolling in fall classes, might be more readily available (Polit & Beck, 2008).

Another limitation was the use of Facebook to recruit participants, as sampling was limited to those nurses this investigator was acquainted with. In future research, participant recruitment may take place within hospital settings, in schools of nursing, or other venues that will draw from a larger sample of nurses, and with this including both genders (McConnell-Henry, et al, 2009; Polit & Beck, 2008). Despite the small sample size, however, results reached saturability based on Streubert-Speziale's standard: the same information was being obtained from repeated inquiries of different participants (Streubert Speziale & Carpenter, 2007).

Another limitation of this study was the lack of male input, as all the participants were female. Again, this investigator had hoped to proportionately match the United States demographics of male RNs, but recruitment efforts were unsuccessful. The added male perspective, unique on its own, may have further enriched the data, possibly producing more variation between or within the factors defining emotional wellness (Polit & Beck, 2008). In future research, it may be helpful for investigators to emphasize the importance of this contribution to nursing research so that all nurses may benefit (Polit & Beck, 2008).

This investigator knew all of the participants to some degree. Those who participated were able to read this investigator's posts on Facebook and maintain some form of contact, even though this investigator had not made face-to-face contact with participants for at least a year. While such a relationship might accelerate rapport building and facilitate participation for some, for others mistrust may occur based on possible fear of reprisal, based on information being disclosed (McConnell-Henry, et al, 2009). This situation required role clarification, confidentiality, and anonymity, and also presented a role conflict as the acquaintance was now an investigator and must respond accordingly during the interview (Hallett, 1995; McConnell-Henry, et al., 2009). Knowing this, participants willingly agreed to be interviewed, as evidenced by their signature on their informed consent form. In future research, an investigator who is unknown to his or her participants is suggested to avoid complications that may arise from a role conflict (Hallett, 1995; McConnell-Henry, et al., 2009).

As this investigator completed data collection, she was also providing individual and group therapy as part of her clinical education in a graduate nursing program. When reviewing the audio recordings and dictations from the participant interviews, this investigator noted that her interview style changed from being rigid and brief to a warmer, more flexible style. The tone of voice and amount of delving by the investigator elicited more information from the participants as time progressed. It is also possible that this investigator became more comfortable with the process of interviewing, independent of the experience of leading counseling sessions (McConnell-Henry et al, 2009; Streubert Speziale & Carpenter, 2007). McConnell-Henry et al. (2009) address this concern in their paper regarding interviewing individuals known to the investigator, and ponder whether nurses can, in fact, be effective investigators if they assume a therapeutic relationship as this can blur boundaries and, in turn, reinforce role conflicts. Further, if this boundary was blurred, the investigator wonders if the participants see such interviews as data collection or therapy. Prior to data collection, however, this investigator considered the same issues and had a list of resources available for participants should they feel they needed additional help dealing with emotional issues that the interviews may have exacerbated, and this concern was discussed with participants (McConnell-Henry et al, 2009). Further, this investigator explained very clearly during rapport building and while obtaining informed consent that her role was that of an investigator, not as a therapist. However, participants did not express any emotional distress, instead stating that they enjoyed the thought-provoking experience and were interested in the results of the study.

Phenomenological research presents its own limitations that, in turn, may have influenced the results of this study. Qualitative research in general is difficult to conduct, as there is often no standard analytic procedure. The investigator did follow the ten step process developed by Streubert Speziale for analysis of qualitative data, but such a process was developed based on the work of descriptive phenomenology (Streubert Speziale & Carpenter, 2007). While such a process was adapted for use by nurses, it is still highly subjective and can be vulnerable to investigator bias (Polit & Beck, 2008; Streubert Speziale & Carpenter, 2007). In addition, the category scheme and data coding is often "vague, incomplete, and nonlinear" (Polit & Beck, 2008, pp. 509). It is also "labor intensive", and there is a risk that "data quality suffers in order to simplify it for reporting purposes" (Polit & Beck, 2008, p. 507). For future research, perhaps a panel of investigators examining the data may be used, thus developing a standard procedure with more descriptive coding, dividing the labor, and maintaining data quality (Polit & Beck, 2008).

Because phenomenological research involves the use of interview data, the interviews were transcribed for review by the investigator. This presented a risk for errors due to alterations of the data, which can be "deliberate, accidental, or unavoidable" (Polit & Beck, 2008, p.509). Once data analysis commenced, the search for themes, often not universal, must be revisited frequently for accuracy, and this process can be "tedious and cumbersome" (Polit & Beck, 2008, p. 515). Further, investigators using the phenomenological perspective frequently employ metaphors to explain the essence of their construct, and these may often be criticized as overused and uncreative. Likewise,

the validity of the themes must be explored, and this involves the perspective of at least

one other investigator reviewing the data. In this study, this investigator attempted to

solicit the aid of the participants in informant feedback, reviewing their responses for

clarity, but this did not occur consistently (Streubert- Speziale & Carpenter, 2007). Only

3 of the 5 participants confirmed that their interviews were accurate representations of

their views. For the 2 participants who did not respond, this investigator took the

perspective that, in their case, a lack of response indicated agreement and proceeded with

data analysis. There is software available that can transcribe recordings (S. Tavernier,

personal communication). However, such software is expensive. Even if this limitation

is overcome, the issue of thematic validity remains. In this instance, the use of a panel of

investigators may enhance such validity (Polit & Beck, 2008).

Other concerns center on the theory being used. This writer was drawn to the

work of Streubert-Speziale (2007), a nurse investigator, who derived a ten-step process

for descriptive phenomenology based on an amalgam of the work of various philosophers

and scientists oriented this approach. To this novice investigator, Streubert-Speziale's

approach offered structure and a method that incorporated multiple perspectives

contributing to descriptive phenomenology, and it was a documented approach that was

relatively easy to follow. Yet, Polit and Beck (2008) caution that using multiple

perspectives to guide research methodology can result in a lack of focus and consistency

in research. This may certainly be the case as future investigators attempt to replicate the

current findings, and strict adherence to the work of Giorgi or Colaizzi might yield results

that truly explain the essence of emotional wellness because they are focused and

consistent (Polit & Beck, 2008).

Implications

Nursing Investigators

In order to build and improve upon the concept of emotional wellness in RNs,

nurse investigators need to investigate the essence of emotional wellness qualitatively,

using a larger sample including males as well as more sophisticated sampling techniques

for more generalizable findings (Streubert- Speziale & Carpenter, 2007; Polit & Beck,

2008). Also, there were three theoretical propositions of the HPM which could not be

linked to this study's findings, but should be considered in future research. These

propositions were:

1. "Perceived competence or self-efficacy to execute a given behavior increases

   the likelihood of commitment to action and actual performance of behavior";

2. "When positive emotions or affect are associated with a behavior, the

   probability of commitment and action is increased", and

3. "Persons can modify cognitions, affect, and the interpersonal and physical

   environment to create incentives for health actions" (Nursing theories HPM,

   2011, Theoretical Propositions of the Health Promotion Model, 13).

While the focus of this research is on acute care RNs, the focus should widen to include

RNs working in non-acute care settings, especially stand-alone specialty hospitals, long

term care facilities, home health and hospice, and public health, as these settings employ

RNs and there may be differences between each of these groups (Polit & Beck, 2008).

Further, licensed practical nurses (LPNs) and unlicensed assistive personnel (UAPs) need

to be tapped for their lived experiences of emotional wellness (Mackenzie, et al., 2006;

Polit & Beck, 2008). This is to determine if there are unique differences existing

between RNs, LPNs, and UAPs (Polit & Beck, 2008). Nurse investigators can also

explore whether emotional wellness is better explained by other nurse theories, other

qualitative approaches, or by quantitative methodologies.

For the purposes of quantitatively defining emotional wellness (i.e., survey or

test), nurse investigators should create measures based on the four factors of emotional

wellness (Balance, Boundaries, Self-Awareness, and Support) using factor analysis, a

large diverse sample size, and examining the reliability and validity of the instrument and

subscales in depth (Polit & Beck, 2008). With the construct of emotional wellness

defined in the nursing literature and a reliable and valid instrument available, there would

now be a standard to upon which to build (Streubert- Speziale & Carpenter, 2007; Polit &

Beck, 2008).

Nursing Educators

Nursing educators are prominent consumers of nursing research, and, in turn,

share this information with their students (Downey, 2006; Parslow, 2008). Introducing

the concept of emotional wellness can prompt students to consider their own emotional

wellness, encouraging them to develop a plan to further improve in this area (Downey,

2007). The development of emotional wellness could be part of instruction in theory and

clinical courses (Downey, 2007), or even recommended by advisors to students as they

progress through the rigors of nursing school. Instructors, in turn, could foster and model the promotion of emotional wellness in order to provide their students with positive, healthy guidance regarding the factors of Boundaries, Balance, Self Awareness, and Support (Nursing theories HPM, 2011).

Faculty could also encourage students to challenge this phenomenon, particularly the research base supporting, it in order to further nursing research as a whole and emotional wellness in particular (Pereira, 2012; Pratt, 2012). Perhaps nurse educators can begin their own research of the phenomenon, exploring it within their students or at clinical sites as they provide instruction (Pratt, 2012).

Nursing educators are not limited to the academic sector, and play a key role in training within health care organizations (Hayne et al., 2009). Emotional wellness might be explored with new hires, whether new graduate nurses or seasoned RNs, as a way to improve nursing retention or health promotion (Lavoie-Tremblay, et al, 2008). How this is explored may vary. Nurse residency programs are one venue. In addition, supervisors and nurse educators may direct nurses to potential wellness programs and related resources which emphasize the four factors of emotional wellness, namely balance, boundaries, self awareness, and support. Administrators and support services could also advise the nurse or staff person toward such health services as the hospital employee assistance program (EAP), focusing on what nurses already do and could do to foster emotional wellness (Lavoie-Tremblay, et al., 2008). This includes teaching courses in emotional self-care and assertiveness training (McElligot et al, 2010; Walker, 2008).

Nursing Leadership and Administration

Nursing administrators accept the responsibility for managing and leading

employees (Codier et al., 2011). Nurse leaders must also consider recruitment, retention,

productivity, and health promotion of RNs and other staff (Codier et al., 2011).

Therefore, introducing the concept of emotional wellness has important implications for

this group as well. Nurse leaders and managers may wish to explore the relationship

between these issues and emotional wellness to determine how they may benefit each

other (Codier et al., 2011). They are in a unique position to discover from a bird's-eye

view if emotional wellness is a sound concept as applied to nursing staff, and may expand

on this within their own units or hospitals if emotional wellness is determined to be

beneficial to the staff (Codier et al., 2011).

Administrators may also further evaluate the findings of this study and determine

if making changes based on emotional wellness requires a drastic overhaul of the unit or

are simple to implement (Codier et al., 2011). In this instance, a needs assessment could

be helpful as this could be a forerunner to a quantitative measure for emotional wellness,

thus providing data that is easy to analyze and derive interventions (Polit & Beck, 2008).

With this assessment, administrators can also explore the organizational climate, as well

as the attitude toward nursing at their facility, in order to make positive changes within

the health care organization (Codier et al., 2011). For simplicity, however, administrators

could begin taking an inventory of what is already in place that is positive and helpful in

fostering emotional wellness so that they do not have to re-invent programs (Codier et al.,

2011). It might be a matter of informing programs already in existence (i.e., EAP and

other employee support programs) that emotional wellness of RNs is a new priority at the health care organization, and that they would like their assistance in meeting the needs of balance, support, boundaries, and self-awareness of RNs (Codier et al., 2011). Or, as part of the performance evaluation process, emotional wellness might be built in to each employee self evaluation, with individual feedback given to nurse managers regarding how nurses hope to achieve this (Codier et al., 2011)

Even if nursing administrators cannot implement a program immediately, in the interim they can explore the phenomenon of emotional wellness within their own lives and model it for their employees (Codier et al., 2011). Nurse managers are under intense pressure from their supervisors and their employees (Codier et al., 2011). Navigating such difficult waters with a sense of calm and inner peace will encourage employees to do the same (Murphy, 2005).

Nursing Practice

This investigator has discussed the implications for three distinct groups within nursing practice (investigators, educators, and administrators). All of this was in the hopes of, ultimately, benefiting emotional wellness within staff nurses. Staff nurses are the largest proportion of nurses within the U.S. workforce, and these nurses bear the brunt of change in health care on multiple levels (United States Department of Labor, 2010-2011). Weathering these changes is crucial for nurses to survive and thrive within the field, based on the number of nurses choosing to leave the field (14%) (AACN, 6 August 2012). Therefore, teaching nurses to care for themselves emotionally will help them to weather the changes so that they can continue to do what they do with love.

Summary

An evaluation of the results of this study revealed that four factors, (Boundaries, Balance, Support, and Self-Awareness) emerged when five acute-care RN participants were interviewed regarding their lived experiences of emotional wellness. Each factor consisted of a number of characteristics that further defined it.

The interview questions were based on Pender's Health Promotion Model (Sitzman & Eichelberger, 2004), and results were compared with this model. It appeared that there were similarities between the assumptions and propositions of this theory and the participants' responses. In some instances, further exploration of some of the propositions should occur in order to offer clarification regarding the role of HPM in explaining emotional wellness.

Implications for the research were examined from nursing research, education, and administration perspectives. Perhaps, investigators will examine emotional wellness from different theoretical perspectives in nursing, or find more factors relevant to emotional wellness. They may even begin quantitative work exploring emotional wellness. Nurse educators may explore the idea of emotional wellness with the students or as part of their research. Nurse educators outside of academia may alert the systems within the health care organizations of the importance of studying and recognizing emotional wellness. Nursing administrators, in turn, may examine emotional wellness within their own staff, and if they choose, conduct further research into this. At the very least, they may explore the benefits of simply modeling emotional wellness for their employees.

One of the goals for examining the phenomenon of emotional wellness was determining how its definition could contribute to the functioning of the nurse on the acute care unit. It is hoped that all nurses consider the implications of this study for their own lives, and make the choice to practice emotional wellness for both personal and professional practice. This investigator believes that she has made a contribution to nursing knowledge by defining the phenomenon, and hopes that future nursing research will examine further how to better the profession one nurse at a time.

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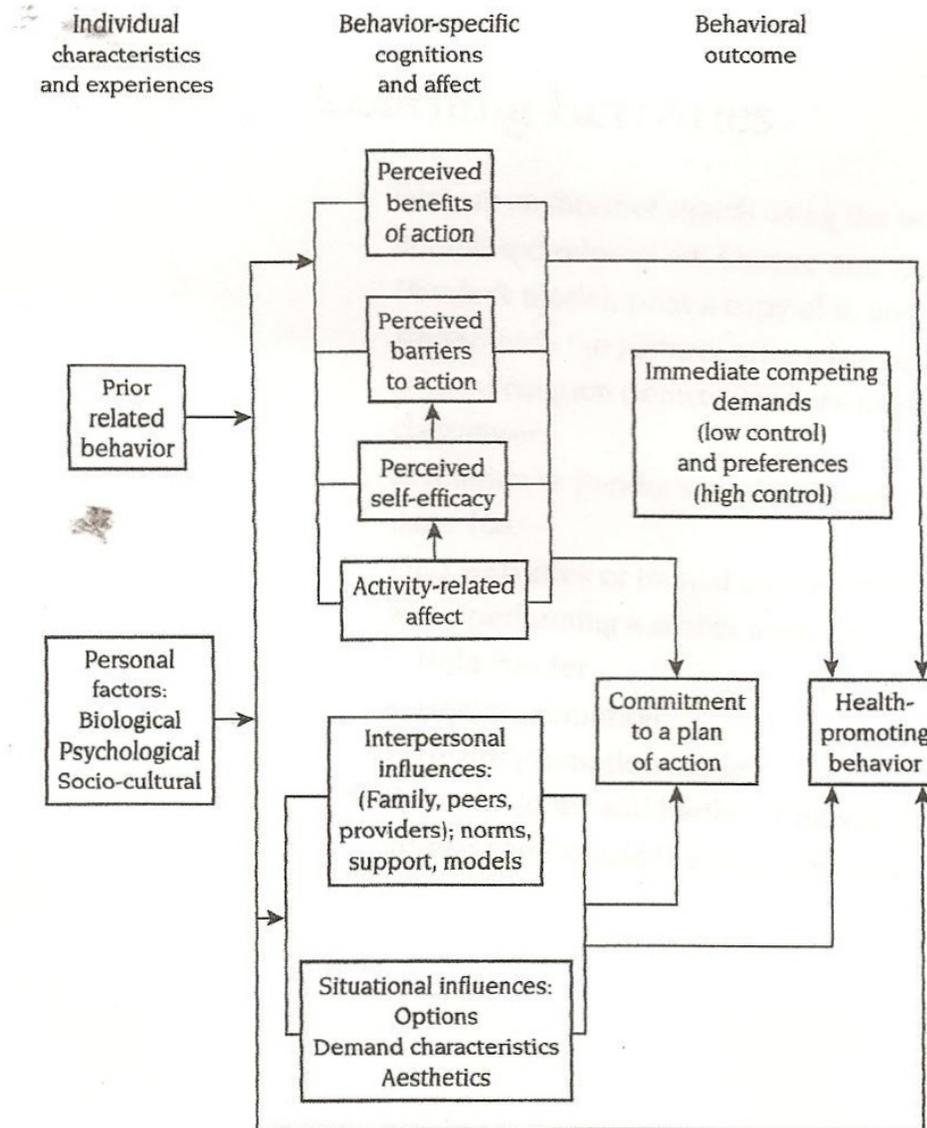
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APPENDICES

<u>APPENDIX A</u>

NOLA PENDER'S HEALTH PROMOTION

Nola Pender's Health Promotion Model

Individual characteristics and experiences	Behavior-specific cognitions and affect	Behavioral outcome

Perceived benefits of action

Perceived barriers to action

Immediate competing demands (low control) and preferences (high control)

Prior related behavior

Perceived self-efficacy

Activity-related affect

Personal factors: Biological Psychological Socio-cultural

Interpersonal influences: (Family, peers, providers); norms, support, models

Commitment to a plan of action

Health-promoting behavior

Situational influences: Options Demand characteristics Aesthetics

Figure 19.1 Pender's Health Promotion Model. Pender, N. (2001). *Health Promotion in Nursing Practice* (4th ed.). Upper Saddle River, NJ: Prentice Hall.

APPENDIX B

SUBJECT CONSENT FORM

SUBJECT CONSENT FORM
FOR
PARTICIPATION IN HUMAN RESEARCH AT
MONTANA STATE UNIVERSITY

Project Title: The Lived Experience of Emotional Wellness in Acute-Care Registered Nurses

You are being asked to participate in a research study of emotional wellness. The emotional wellness of nurses has not been explored in nursing literature. Because nursing is an emotionally demanding profession, this research is being conducted to determine how nurses live well emotionally. As a result, this study may help the profession gain a better understanding of how to foster emotional wellness within the nursing profession as well as within individual nurses.

You were identified by one of your nurse colleagues as a potential participant because you are a Diploma, Associates, or Bachelor's-prepared Registered Nurse who works in an acute-care hospital setting.

Participation is voluntary and you can choose not to answer any questions you do not want to answer. You can also stop at any time. If you agree to participate you will be asked to complete a semi-structured interview of up to one hour in which you will be asked questions about emotional wellness. Responses will be recorded using an audio tape and transcribed into a hard copy format for your review after the interview is completed.

Because the topic of the interviews is emotional wellness, it is possible that during the interview you may become tearful or emotional. If you do not feel comfortable with continuing, the interview will be terminated immediately at your request. If you feel it is necessary, I will provide you with a list of free and/or low cost counseling services available in the _____ area for you to receive additional help in coping with whatever emotional stressors you may be experiencing.

Benefits of participating in this study include furthering nursing research, particularly through increased understanding of emotional wellness in nurses. Your interview responses will help nurses grasp the concept of emotional wellness, harness it, and nurture it within themselves.

Your responses will be coded to protect your privacy. Transcripts, notes, and audiotapes of this interview will be secured in a locked file cabinet. Three years following completion of this study, they will be destroyed.

If you have any questions about the research, you can contact Rachel Clements at 284-2173 or by e-mail at clementsre@gmail.com. If you have additional questions about the

rights of human subjects you can contact the Chair of the Institutional Review Board, Mark Quinn, at (406) 994-4704 or mquinn@montana.edu.

AUTHORIZATION: I have read the above and understand the discomforts, inconvenience and risk of this study. I, _____ (*name of subject)*, agree to participate in this research. I understand that I may later refuse to participate, and that I may withdraw from the study at any time. I have received a copy of this consent form for my own records.
Signed: _____
Witness: _____
(optional)
Investigator: _____
Date: _____

APPENDIX C

INTERVIEW QUESTIONS

1. Tell me what you think of when you hear the phrase "emotional wellness".

2. How do you define emotional wellness in your own life?

3. How important is it for you to be emotionally well, as you define it?

4. Based on how you have defined emotional wellness, how do you practice this?

5. What goals do you have to achieve emotional wellness? How do you know when you are emotionally well?

6. What helps you achieve emotional wellness?

7. Who or what in your life helps you achieve emotional wellness?

8. What, or even who, might hinder your ability to achieve emotional wellness?

9. What are your thoughts on how you have worked toward emotional wellness?

10. When you think of emotional wellness, is it one thing or several? If several, how would you define them?

General Demographic Questions

1. What age group are you included in, per decade? 20's? 30's? 40's? 50's? 60's?

2. How long have you been practicing as an RN?

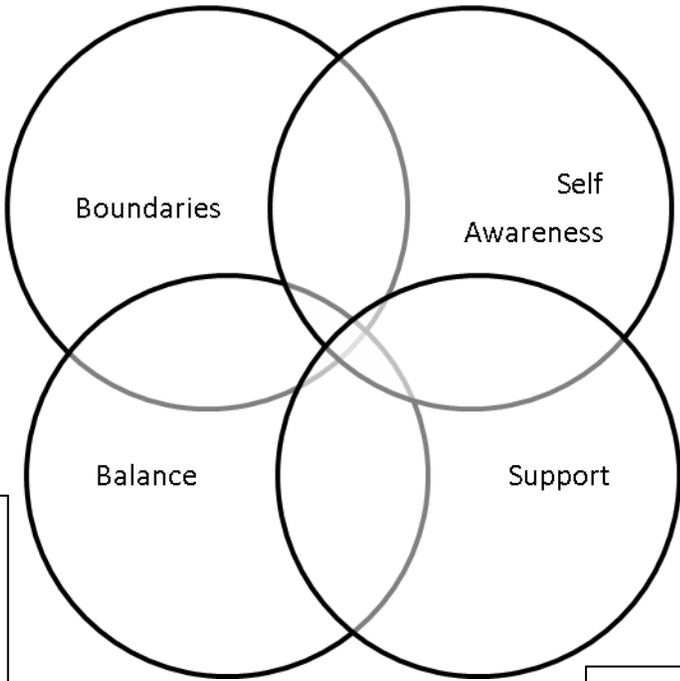3. What is your primary nursing specialty?

4. Gender

APPENDIX D

FACTORS OF EMOTIONAL WELLNESS

Boundaries
- limits on individuals, situations, emotions
- permeable
- personal and professional

Self Awareness
- self care habits
- awareness of the mind-body-spirit connection
- the need for release
- the importance of self control
- perception of a greater need for self care

Boundaries

Self Awareness

Balance

Support

Balance
- "making it work" at home and on the unit
- personal and professional life stability
- not an absence of stress

Support
- Individuals available for participants
- spouses and colleagues
- lack of this is draining