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FOSTERING INDIVIDUAL WELL-BEING IN NAVY NURSE CORPS OFFICERS:  
A GROUNDED THEORY

by

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Dissertation submitted to the Faculty of the  
Daniel K. Inouye Graduate School of Nursing Graduate Program  
Uniformed Services University of the Health Sciences  
In partial fulfillment of the requirements for the degree of  
Doctor of Philosophy 2021

[Dissertation approval form inserted here]

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## **DEDICATION**

I would like to dedicate this Ph.D. Scholarly Project to my family. To my mom and dad, Marty and Angie. Thank you for being the cheerleaders in my life, instilling your love for God, family, and pursuing my educational dreams. To my daughters, Krystal, Stephenie, and Karli, thank you for your patience and understanding when I had to focus on schoolwork and for giving me the strength and encouragement to persevere and succeed. Thank you for your patience and all the sacrifices that you made to help me pursue my dreams. Your support and encouragement mean so much to me. Without the love and support from each of you, I would never have been able to reach this accomplishment.

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Shawna G. Grover

January 19, 2021

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## **ABSTRACT**

Fostering Individual Well-Being in Navy Nurse Corps Officers: A Grounded Theory

Shawna G. Grover, Ph.D., 2021

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The mission of healthcare organizations is centered on the care of ill and injured individuals. The health and well-being of nursing staff, the largest single group of healthcare professionals, is of critical importance in accomplishing that mission. Despite the importance of nurse well-being, there is a lack of empirical evidence conceptualizing an operational definition of well-being within nurses or how nurses foster their well-being. Of particular note is the lack of evidence describing military nurses' experiences with providing care to patients with a life-threatening illness or injury and how they foster their well-being.

Therefore, the purpose of this research study is to gain an in-depth understanding of the process that military nurses who provide care to patients with a life-threatening illness or injury use to foster their own well-being. This was achieved through an exploration of the ways in which they experience, assess, and respond to the daily tasks and challenges in their workplace setting and life as a Navy Nurse Corps officer.

Constructivist grounded theory methodology was used to illustrate the phenomena under examination and construct a substantive theory. Semi-structured interviews were

conducted with 25 participants from a purposefully selected group of Navy Nurse Corps officers stationed at Walter Reed National Medical Center (WRNMMC) who had provided care to an individual with a life-threatening illness or injury in the in-patient setting within the past 12 months.

A definition of how Navy Nurse Corps officers define well-being and the substantive theory *Fostering Individual Well-being* was constructed. *Fostering Individual Well-Being* encompassed three main categories: (1) *Customizing Individual Practices*, (2) *Enacting Assuaging Practices*, and (3) *Enacting Restorative Practices*. These categories define and describe actions taken by Navy Nurse Corps officers to foster their well-being. Navy Nurse Corps officers also identified several facilitators and barriers to fostering their well-being.

It is anticipated that the constructed definition and *Fostering Individual Well-being* theory will inform Navy Nurse Corps officers and leadership on how to effectively enhance Navy Nurse Corps officers' well-being. In addition, the identified facilitators and barriers offer empirical evidence for organizational strategies and changes that are designed to promote the fostering of individual well-being in Navy Nurse Corps officers.

Keywords: constructivist grounded theory, well-being, military, nurse

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## **CHAPTER 1: Introduction**

### **INTRODUCTION**

The phenomena of how Navy Nurse Corps officers foster their well-being was the intent and exploration of this research study. The focus of the research was on the definition, description, and facilitator and barriers that Navy Nurse Corps officers encounter while enacting practices to foster their well-being. In addition, the knowledge generated from this inquiry would provide new insight about well-being of Navy Nurse Corps officers and inform the practice of Navy Nurse Corps officers, Navy leadership, and organizational policy. A constructivist grounded theory methodology was employed to illustrate the phenomena under examination and construct a substantive theory.

### **BACKGROUND OF THE PROBLEM**

The care of ill and injured individuals is largely carried out by nurses, the largest single group of healthcare professionals. Unfortunately, our largest single group of healthcare professionals are experiencing threats to their own well-being as evidenced by high rates of suicide (32), burnout (90), compassion fatigue (133), post-traumatic stress syndrome (PTSS) (63), and moral distress (168) – which have all been linked to impaired clinical decision making, a negative impact on quality of care provided and increased medical errors (11; 25; 114). Medical errors are now the third leading cause of death in America (103). These threats to nurses' well-being and to the individuals for whom they provide care seem to be compounded in work environments where care is frequently provided to individuals with life-threatening illness or injury (33; 45; 64; 67; 136; 137;

143; 167). Therefore, nurses' well-being is a cause for concern with professional, organizational and personal consequences.

Currently, there is a heightened awareness and focus on the importance of clinician well-being due to the COVID-19 pandemic (2; 66; 161). The pandemic has driven clinician well-being into the spotlight, capturing global attention. However, prior to the pandemic, clinician well-being was already recognized as a high priority due to alarming increased rates of burnouts, depression, and suicide within healthcare professionals (32; 40; 41; 152). In an effort to better understand and alleviate clinician burnout, the National Academy of Medicine (NAM) launched a consensus study, The Action Collaborative on Clinician Well-being and Resilience, in 2017 (122; 162). Recommendations from this consensus study, *Taking Action Against Clinician Burnout: A Systems Approach to professional Well-Being* (123), called for system-wide approaches to addressing clinician burnout and enhancing well-being. Furthermore, the American Nurses Association (ANA) deemed well-being important enough to be included in 1 of 9 provisions in the Code of Ethics for Nurses. Provision 5.2 Promotion of Person Health, Safety, and Well-Being specifies that it is a nurse's duty to promote personal well-being (5). The first step toward addressing the recommendation of enhancing and promoting well-being within a population from a personal and organizational level requires a consensus of how the term well-being is operationalized and measured.

## **WELL-BEING**

The determination of what well-being is, how it is defined, and how it is measured is somewhat difficult because currently, there is no one accepted definition or

measurement for the term “well-being”(37). Well-being has been conceptualized, defined, measured, and applied in many different ways. The American Psychological Association defines well-being as "a state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook or good quality of life”(7). Well-being has been described by the Centers for Disease Control and Prevention (CDC) as fulfillment, positive functioning, satisfaction with life, the presence of positive emotions, and the absence of negative emotions (18). Pollard and Lee (135) (p.11) identified well-being as a “complex, multifaceted construct that has continued to elude researchers’ attempts to define and measure.”

Historically well-being has been conceptualized in two distinct approaches, emotionally and cognitively. A body of research on well-being has been derived from two general approaches: the hedonic approach and the eudaimonic approach (147). The first approach emphasizes an individual's evaluation of his or her own life from both the emotional and cognitive standpoint. This approach referred to as the hedonic approach, or subjective well-being, refers to emotional aspects including happiness, satisfaction, and interest with life and defines well-being in terms of pleasure attainment and pain avoidance (35; 80).

The second approach includes several concepts that together have been referred to as eudaimonic well-being. The eudaimonic approach views well-being as having particular needs or qualities that are essential for an individual's psychological growth and development, and the fulfillment of these needs enables an individual to reach his or her potential (147). The concept of psychological well-being (148) is an example of eudaimonic well-being. The hedonic and eudaimonic well-being measures are highly

correlated, suggesting that positive feelings and functioning go hand in hand. However, numerous studies demonstrate that the measures are distinguishable from one another (26; 83; 99). The most recent studies support the integration of these two approaches to studying well-being (81; 166).

Throughout the past several decades, well-being has been studied in several different disciplines creating a broad range of definitions in the published literature. Numerous scholars have addressed the question of “what is well-being?” in different ways, resulting in a range of well-being concepts, models, and theories. Models of well-being explored in the literature all contain several components, each of which can be measured and contributes to, rather than wholly defines, well-being (154). Well-being may also be defined differently between different cultural groups, level of ability and disability, gender, country of origin, age, and trauma experience. Therefore, defining and measuring this broad and encompassing construct has been a consistent challenge within disciplines and interdisciplinary, resulting in several definitions, theories, and measurements. Recently, Linton, Dieppe, and Medina-Lara (100) identified 99 well-being measures and determined that there are numerous approaches for how to define and measure well-being. In addition, nearly 200 dimensions were identified within the realm of well-being (100).

### **Nurse Well-Being**

The lack of consensus on how well-being is conceptualized, defined, and measured is also noted within the literature exploring the well-being of healthcare professionals, including nurses (58; 122; 123) The body of research on well-being

appears to simply and predominantly describe nurses' experiences with burnout (12; 106), compassion fatigue (64; 67), moral distress (22; 131), and stress (34; 48; 60; 61). Recently there has been a shift towards single positive indicators of well-being in nurses such as resilience (170), work engagement (76) and satisfaction with work, family, and life (1). There has also been an increase in more comprehensive measurements of well-being (95; 101). Although, these measurements vary among studies, there is no one accepted conceptualization, measurement, or definition of well-being within nursing.

### **Military Nurse Well-Being**

There are no studies that attempt to define military nurse well-being or explore overall well-being of military nurses. However, there are studies that explore the concept of resilience, a single positive indicator of well-being. These studies showed that military nurses with higher rates of resilience had lower rates of burnout and compassion fatigue (96; 167). In addition, studies that explored negative psychological effects in military nurses, such as burnout (89; 151; 163), depression (8; 74; 85; 163), compassion fatigue (29; 167), and PTSD (74; 85) were identified in the literature. Key findings from this literature indicated that military nurses providing care for ill and injured fellow service members experience higher rates of burnout than civilian nurses working in the same facility (89). Within the same study, additional military responsibilities were also found to be at risk for higher rates of burnout in military nurses (89).

### **PROBLEM STATEMENT**

There is a paucity of literature focused on an informative exploration that encompasses all major components of well-being to enhance, sustain, and foster well-being. Of particular note is the lack of evidence describing military nurses' experiences with providing care to patients with life-threatening illness or injury and how they manage their well-being. To support, maintain, and enhance military nurses' well-being caring for this population, it was paramount to discover what well-being means to them, how they describe well-being, and what factors facilitate and detract from their well-being. This information is instrumental in continually supporting and enhancing the well-being of military nurses caring for fellow service members with life-threatening illness or injury.

#### **STATEMENT OF PURPOSE AND RESEARCH QUESTIONS**

This study's primary focus was on the social process of military nurses fostering their own well-being while providing care to individuals with a life-threatening illness or injury. Employing constructivist grounded theory methods, this study answered the following **research questions**:

1. How do military nurses describe and define well-being related to providing care for patients with a life-threatening illness or injury?
2. What is the process for military nurses fostering their well-being while providing care for patients with a life-threatening illness or injury?
3. What factors serve as facilitators or barriers to military nurses' achievement of overall well-being or specific aspects of well-being?

The **specific aims** of the proposed study are to:

1. Explore the perceptions of military nurses who provide care for individuals with life-threatening illness or injury about their well-being, such as how they define and describe it.
2. Explore the barriers and facilitators that arise in attempts of military nurses to foster their well-being.

## **RESEARCH APPROACH**

Because little is known about military nurse well-being, the constructivist grounded theory approach was appropriate for this study to explore how Navy Nurse Corps officers describe and define well-being and actions taken to foster their well-being. Qualitative methods are optimal for addressing such experiences because qualitative research provides unique strategies for exploring "what lies behind, or underpins, a decision, attitude, behavior or other phenomena" (140) (p.28). A grounded theory design allowed for an exploration of the process by which military nurses foster well-being across the trajectory of caring for individuals with a life-threatening illness or injury. Several variations of grounded theory have emerged since its introduction by Strauss and Glaser in 1967 (56).

### **Grounded Theory Approaches**

The three main approaches of grounded theory are classical grounded theory by Glaser and Strauss (56) and Glaser (54), systematic grounded theory by Strauss and Corbin (28), and constructivist grounded theory by Charmaz (19; 21). The approaches to grounded theory have more similarities than differences. All of the approaches use coding, constant comparison, theoretical sampling, and memoing during the research

process. In addition, all the approaches follow a similar process of gathering, coding, comparing, categorizing, and thematizing data.

The main difference between grounded theory approaches lies in the philosophical paradigm, including views about research objectivity, use of literature and the literature review, and rigidity versus flexibility in the analysis process of grounded theory. The style of grounded theory selected is dependent on the researcher's relationship with the participants and is a congruent research paradigm with the researcher's beliefs about the nature of reality (19; 21).

This study used the grounded theory research design guided by the constructivist approach (19; 21). This approach is a contemporary revision that adopts strategies from earlier versions of grounded theory; however, it differs from the previous versions. Constructivist grounded theory assumes a relativist epistemology, acknowledging the multiple standpoints, roles, and realities of the researcher and participants; adopts a reflexive stance toward the researcher's background, values, actions, situations, relationships with participants, and representations of them; and it situates the research in the historical, social, and situational conditions of its production (19; 21).

### **Philosophical Underpinnings**

The philosophical underpinnings of grounded theory are symbolic interactionism and pragmatism. Symbolic interactionism is a sociological concept developed by George Mead in 1934 and further illustrated by his student Herbert Blumer in 1969. Blumer (1969) identified three assumptions of symbolic interactionism: 1) people act towards things based on meanings they have for them, 2) meanings stem from interaction with

others, and 3) people's meanings are modified through an interpretive process used to make sense of and manage their social worlds.

The concept of symbolic interactionism provides the "philosophical foundations for grounded theory and guides the research questions, interview questions, data collection strategies, and methods of data analysis" (19; 56). Symbolic interactionism further "assumes that people can and do think about their actions rather than respond mechanically to stimuli" (20) (p. 7). Further, meaning is constructed by action and interaction that are inherently dynamic and interpretive, and subsequent action is influenced by that interpretation (20).

Pragmatist philosophy informs symbolic interactionism, in which "meanings emerge through practical actions to solve problems and through actions people come to know the world" (20) (p.188). Within the pragmatist philosophy, reality is fluid and open to multiple and individual interpretations. Facts and values are related, and truth is relative. The Chicago School tradition, with its pragmatist underpinnings, encourages grounded theorists to "construct an interpretive rendering of the worlds we study rather than an external reporting of events and statements" (20)(p. 184). With regard to the present study, Navy Nurse Corps officers experience and interpret the world in many different ways, and their interpretations inform their actions. The experience of caring for individuals with a life-threatening illness or injury draws from and forms further interpretations of reality.

### **Constructivist Grounded Theory**

As previously stated, Charmaz's (21) constructivist grounded theory approach was used to guide data collection and the analytical processes in this study. Charmaz situated her approach within the constructivist paradigm where, from an ontological perspective, reality is constructed, interpreted by the researcher, and more than one reality at a time may exist. From an epistemological perspective, a relationship exists between the knower and the known in constructivism, and the researcher closely impacts the process of knowledge development (98). The researcher considered these various perspectives given their relationship to the phenomena, their prospective connection to the participants, and the way in which they would collect and analyze the data as this would have an impact on the integrity of the research process and how the results may be regarded (97). Given that the researcher was intimately involved in all aspects of the research process in this study, the grounded theory approach articulated by Charmaz was ontologically, epistemologically, and methodologically compatible with the researcher's world view, the phenomenon of interest, the research questions, and the study aims.

#### **ASSUMPTIONS**

The Constructivist approach applied to this study required the researcher to make five assumptions. These assumptions are:

1. Navy Nurse Corps officers will be able to provide an in-depth description and definition of well-being.
2. Caring for individuals with a life-threatening illness or injury can have a negative impact on the well-being of Navy Nurse Corps officers.

3. The negative impact on well-being would be intensified when Navy Nurse Corps officers are faced with multiple competing priorities associated with being a nurse and an officer in the United States Navy.
4. Regardless of the negative impact on Navy Nurse Corps officers' well-being, they will describe their role of providing care to individuals with a life-threatening illness and injury to be very rewarding, especially when that care leads to the successful recovery of the ill or injured individual.
5. Navy Nurse Corps officers would describe facilitators and barriers that could be identified in nursing in general and identify facilitators and barriers that would be unique to the Navy Nurse Corps context.

#### **THE RESEARCHER**

Based on the researcher's experience as a Navy Nurse Corps officer, an Adult Oncology and Medical-Surgical Clinical Nurse Specialist (CNS), a Division Officer (DO)/Nurse Manager of an Adult in-patient Hematology/Oncology unit, and a Ph.D. candidate, the researcher made several assumptions regarding this study. At the time of conducting this study, the researcher had been on active duty for approximately 14 years and held several roles as a Naval Nurse Corps officer such as a staff nurse, charge nurse, Adult Oncology Clinical Nurse Specialist and Division Officer (nurse manager) all on an Adult in-patient Oncology unit. In addition, the researcher had held multiple collateral (additional) duties in conjunction with those roles. Thus, the researcher brought to the inquiry process an array of practical experiences as a Navy Nurse Corps officer who has

provided nursing care to numerous individuals with a life-threatening illness or injury and had both knowledge and understanding of the context.

The researcher spent 4 years as a staff and charge nurse on an in-patient Hematology-Oncology unit providing care to individuals with a life-threatening illness and injury to include multiple cases where that care progressed to end-of-life comfort care. The researcher also held multiple high-profile collateral (additional) duties, and she worked to set herself apart from peers to secure future promotions and a full military career. The researcher also maintained a family life as the mother of three daughters and a wife. This experience helped the researcher gain insight and understanding of the emotional toll yet rewarding aspect of the care provided to those with a life-threatening illness and injury and the complexity of balancing the dual professional career as a nurse (clinical) and Navy Officer (leader).

The researcher understands that the same experiences that are so valuable in providing insight could serve as a liability, biasing the researcher's judgment regarding the research design and the interpretation of the findings. The researcher also has a positive outlook and optimistic view of the world. This characteristic may influence the lens that the researcher uses when collecting and analyzing data. In addition to the researcher's assumptions and theoretical orientation being made explicit at the onset of the study, the researcher remained committed to engaging in on-going critical self-reflection by journaling and dialogue with professional colleagues, advisors, and mentors. Moreover, to address the researcher's subjectivity and strengthen the credibility of the research, various procedural safeguards were taken, such as triangulation of data sources and

interrater reliability checks with University faculty with qualitative methodology expertise.

### **SIGNIFICANCE OF THE STUDY**

This study aimed to fill the gaps in the literature on military nurse well-being; how they define well-being, and actions they take to foster their well-being. The findings generated from this proposed study provided critical evidence towards the construction of theory. Such theory is needed to guide policies that govern military nurses who provide care for individuals with a life-threatening illness or injury.

### **DEFINITIONS OF KEY TERMINOLOGY USED IN THIS STUDY**

For the purpose of this study, the following terms were defined as:

*Adversity* is defined as any negative, stressful, traumatic, or difficult situation or episode of hardship that is encountered in the workplace setting.

*Burnout* is defined as a psychological syndrome that occurs in response to chronic, overwhelming work stress (110) and includes three dimensions: emotional exhaustion, cynicism or depersonalization, and reduced perceived personal accomplishment (110).

*Compassion Fatigue* is defined as a state of tension and preoccupation with the individual or cumulative traumas of clients and described as a natural consequence of working with individuals who experienced distressing events and being vicariously exposed and responding empathetically to the event (45).

*Moral Distress* is the emotional state that arises from a situation when a nurse feels that the ethically correct action to take is different from what he or she is tasked with doing.

*Moral Resilience* is the ability to preserve or restore integrity in response to moral adversity (62; 171).

*Negative psychological effects* are identified as burnout, compassion fatigue, Post-Traumatic Stress Syndrome, Post Traumatic Stress Disorder, and moral distress.

*Post-Traumatic Stress Disorder (PTSD)* is a complex chronic disorder associated with traumatic events, characterized by the following symptoms: recurrent, intrusive, and distressing recollections of the trauma; heightened autonomic reactivity; sleep disturbances; concentration and memory problems; anhedonia (inability to experience joy); and impaired occupational and social functioning (8).

*Resilience* is the process of coping with or overcoming exposure to adversity as it relates to psychological well-being (115).

*Well-being* is a multidimensional concept, and the dimensions of well-being are not mutually exclusive but are rather inter-related components of a holistic whole (36; 147; 148).

## **CHAPTER 2: Review of Literature**

### **PURPOSE**

The purpose of this constructivist grounded theory study is to explore military nurses' perceptions of well-being, the process for how they foster their well-being, and perceived barriers or facilitators to fostering their overall well-being or aspects of their well-being. Specifically, the research investigation sought to explore the experiences of these individuals and actions they take for fostering well-being. This was done to develop a substantive theory for the process of fostering well-being in military nurses who provide care to individuals with a life-threatening illness or injury. A critical review of the literature was conducted, and it will be presented first by considering the role that the literature review has in grounded theory.

### **THE ROLE OF THE LITERATURE REVIEW**

The literature review in grounded theory has been debated by its originators, Glaser and Strauss (56), as well as other grounded theorists. It is widely recognized that the extent and timing of the literature in grounded theory is one of the most contentious and misunderstood aspects of this research methodology (14; 19; 21). This contention has primarily focused on the use of literature in the initial stages of inquiry. Glaser and Strouse (56) and Glaser's later work (54) argue that a formal review of the literature is delayed in grounded theory research to prevent contamination of the data to be collected and to "prevent the imposing existing theories or knowledge on the study process and outcomes (14). However, to justify the need for the study, a critique of existing literature is presented to delineate gaps in the knowledge regarding military nurses' well-being and

to strengthen the argument that the proposed study will help to fill a gap in understanding the conceptualization and definition of well-being in military nurses.

In keeping with the grounded theory method, this preliminary literature review involves consideration of relevant areas surrounding the phenomenon of interest of the study and the process of fostering individual well-being of military nurses. The review will first consist of a historical overview of the concept of well-being and related theories followed by a well-organized review of well-being in military nurses. Consistent with grounded theory, the literature will also be cited and discussed in the data collection and analysis sections (14; 19; 21) and will be expanded in the discussion in chapter five.

#### **ORGANIZATION OF THE REVIEW**

For the historical literature review of well-being section, multiple information sources, including books, internet resources, professional journals, and periodicals were used. These resources were accessed through PubMed, American Psychological Association (APA) PsycINFO, and the Clinical Index for Nursing Allied Health Literature (CINAHL). For the primary literature review of the research on military nurse wellbeing, a research librarian at the University Library was consulted to establish the most appropriate search strategy for each database.

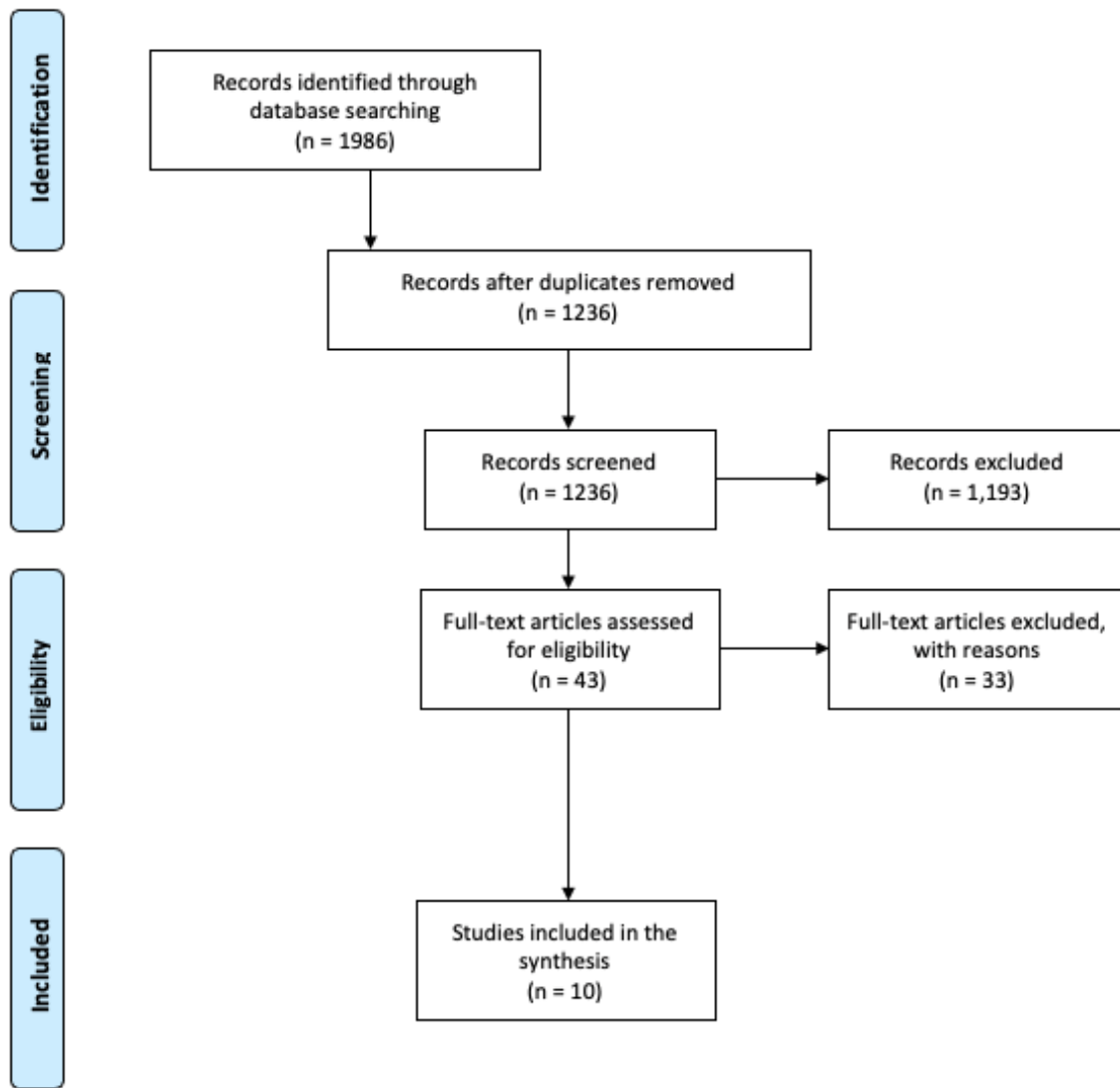
The three databases were searched to identify studies related to well-being of military nurses followed by a hand-search of reference lists of included studies. An electronic literature search was performed using key terms and concepts related to the topic of this review. A search with key terms included well-being, resilience, army, navy, air force, military, and nurses and was conducted in the medical and

nursing literature without year restriction. The complete list of search terms and limiters is available in Table 1. To provide a historical and current view of the literature, date restrictions were not applied to the search. The review was limited to English language. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) served as a framework for reviewing the articles (120). The PRISMA diagram for this literature review is available in Figure 1.

Table 1. Search Terms for Well-Being in Military Nurses

Database	Search Terms	Results
Pubmed	(Well-being OR “Well being” OR Wellbeing OR Competence OR Engagement OR Meaning OR Purpose OR Optimism OR Accomplishment OR Relationships OR Resilience OR Purpose OR Self-Esteem) AND (nursing OR nurse OR nurses) AND (military OR army OR navy OR "Air force") AND English [lang]	599
CINAHL	(MH "Wellbeing" OR Well-being OR “Well being” OR Wellbeing OR Competence OR Engagement OR Meaning OR Purpose OR Optimism OR Accomplishment OR Relationships OR Resilience OR Purpose OR Self-Esteem) AND (nursing OR nurse OR nurses) AND (MH "Military Personnel+" OR MH "Military Nursing" OR MH "Military Dentistry" OR MH "Military Medicine" OR military OR army OR navy OR Air force)	728
PsycINFO	(MH "Wellbeing" OR Well-being OR “Well being” OR Wellbeing OR Competence OR Engagement OR Meaning OR Purpose OR Optimism OR Accomplishment OR Relationships OR Resilience OR Purpose OR Self-Esteem) AND (nursing OR nurse OR nurses) AND (MH "Military Personnel+" OR MH "Military Nursing" OR MH "Military Dentistry" OR MH "Military Medicine" OR military OR army OR navy OR Air force)	659

Figure 1. PRISMA Flow diagram



A total of 1,986 articles were identified, reviewed, and included if they specifically addressed well-being in military nurses or if they addressed a single positive or negative indicator of well-being such as resilience, burnout, or compassion fatigue. After removing duplicates, a total of 1,236 articles remained and were screened and ten articles were selected as relevant for this review.

## **HISTORICAL OVERVIEW OF WELL-BEING THEORIES**

In this section, a brief historical overview of the prevailing theoretical and empirical models of well-being (Table 2.) will be provided.

Well-being is a complex multidimensional construct that cannot be reduced to any single indicator or aspect of behavior. Throughout the history of scholarship on well-being, the notion of well-being has been conceived and described in many forms. Well-being is a positive human functioning concept. The study of positive human functioning has a long-lasting tradition in Psychology and Social Science (4; 111). However, the scientific investigation of the positive aspects of quality of life started to gain more recognition nearing the 1950s and 1960s. One prime example of this paradigm shift is Marie Jahoda's seminal work, "Current Concepts of Positive Mental Health" (75).

Positive mental health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life (9).

In 1958, Jahoda developed the theory of *Ideal Mental health*, a theory that stems from the analysis of researchers' thoughts regarding positive mental health (75). This focus on positive mental health indicated that mental health was more than the absence of mental illness (75). Jahoda theorized that six criteria encompass well-being: (1) a positive attitude towards the self, (2) personal growth, development, and self-actualization, (3) integration or synthesis of psychological function that helps resist stress, (4) autonomy, (5) an accurate perception of reality, and (6) environmental mastery (75). Although this theory was never officially empirically tested, it sparked the

investigation of well-being by researchers in psychology, resulting in several subsequent models and theories.

In 1988, Ishizuka developed the model known as the *Lifetrack Model of Positive Mental Health*, which includes three broad criteria of well-being: (1) the search for self, (2) the need for intimacy, and (3) the quest for achievement. Ishizuka refers to self as the ability and willingness to be "in touch", "at peace", and "in control" of one's thoughts, feelings, and actions (71). To accomplish this, an individual must recognize and accept both the positive and negative elements in life, integrating them into an overall balanced perspective (71). The model defines intimacy as three dimensions of a couple's relationships, including (intellectual/social, emotional, and physical/sexual), as well as an individual's relationship with parents, children, friends, God, or the universe. The last criterion, achievement, is defined as the capacity to move beyond the self to productive, constructive, and creative expressions of one's capabilities.

Around the same time, Dr. Carol Ryff completed a systematic review of optimal psychological function theories, identifying several points of convergence in prior theories (148) and developed a scale to assess well-being. In addition, the review identified and operationalized six broad criteria of well-being: (1) self-acceptance, (2) positive relationships with others, (3) autonomy, (4) environmental mastery or competence, (5) purpose in life, and (6) a sense of personal growth (148). Ryff's Scale of Psychological Well-being model expanded the empirical measurement of well-being and is currently the most widely used measure of positive psychological functioning (68; 148).

In 2002, Seligman, a founder of positive psychology, developed his theory of *Authentic Happiness*. He later revised the theory in 2011 to develop a theory of human flourishing, which he refers to as the well-being theory (154). Seligman identified components for his theory by subjecting them to the three following criteria: it contributes to well-being, individuals pursue it for its own sake, and it is defined and measured independent of other components (154). The human flourishing theory includes measurements for (1) positive emotion, (2) engagement, (3) positive relationships, (4) meaning, and (5) accomplishment.

Positive emotion included subjective variables like pleasure, ecstasy, comfort, and warmth, which refer to feeling good (154). Engagement refers to what Csikszentmihalyi (31) refers to as the flow state, which is defined as a deep immersion in life activities. Meaning is similar to Jahoda's (75) integration element and Ishizuka's (71) intimacy with God or the universe domain and refers to belonging to and serving something beyond the self. Seligman (154) discusses that accomplishment was included as a component because positive psychology is descriptive, and each component reflects what brings well-being to individuals and not what one feels should bring well-being. The final component, positive relationships, are a critical component of positive psychology because other people and how we connect with them matter to our well-being (154).

One of the more recent models, a 10-item construct of optimal well-being, was developed by defining the opposites of the internationally agreed-upon symptoms of depression and anxiety (69). The model includes the following domains: (1) competence, (2) emotional stability, (3) engagement, (4) meaning, (5) optimism, (6) positive emotion, (7) positive relationships, (8) resilience, (9) self-esteem, and (10) vitality. It was noted

during the development that different country profiles resulted from the psychometric analysis, which indicates that cultural differences in well-being exist (69). This model differs from the previously discussed models, especially with the introduction of vitality. Also, it diverges from Ryff's model by separating optimism, resilience, and emotional stability from positive emotion. Similar to Seligman's model, the model adds engagement yet uses self-esteem in the place of acceptance, autonomy, and personal growth.

Table 2. Theoretical Models of Well-being

<i>Ideal Mental Health</i> Jahoda, 1958	<i>Lifetrack Model of Positive Mental Health</i> Ishizuka, 1988	<i>Scale of Psychological Well-being</i> Ryff, 1989	<i>Human Flourishing Theory</i> Seligman, 2011	<i>European Social Survey</i> Huppert & So, 2013
1. Positive attitude towards self 2. Personal growth, development, and self-actualization 3. Integration or synthesis of psychological function that helps resist stress 4. Autonomy 5. Accurate perception of reality 6. Environmental mastery	1. The search for self 2. The need for intimacy 3. The quest for achievement	1. Self-acceptance 2. Positive relationships with others 3. Autonomy 4. Environmental mastery or competence 5. Purpose in life 6. A sense of personal growth	1. Positive emotion 2. Engagement 3. Positive Relationships 4. Meaning 5. Accomplishment	1. Competence 2. Emotional stability 3. Engagement 4. Meaning 5. Optimism 6. Positive Emotion 7. Positive Relationships 8. Resilience 9. Self-esteem 10. Vitality

This historical review of the literature substantiates that well-being extends beyond the mere absence of disease or illness. Well-being includes but is not limited to the presence of positive psychological strengths including optimism, future-mindedness, perseverance, resilience, and achieving success in various aspects of personal and professional life (155; 157). These factors both buffer against and prevent psychological

disorders such as depression and burnout and promote a state that is distinct from the absence of disease known as, flourishing (83; 154).

Dr. Martin Seligman dedicated his American Psychological Association (APA) presidential address in 1998 toward leading an era of psychology that “seeks to understand and nurture those human strengths that can prevent the tragedy of mental illness” (153; 155). The decades that have followed his address to the APA are notable for the field of positive psychology proliferating with several thousand researchers all over the world studying the pathways to optimal human flourishing (154). Despite the promising research and practice in the realm of positive psychology, the notion of positive well-being or human flourishing has not been adequately investigated in the nursing profession, especially military nursing.

This is alarming, especially given that investing in one’s own well-being is a moral mandate of the nursing profession (5). Therefore, there is a critical need of understanding the concept of well-being in military nurses and factors that influence military nurses’ well-being.

#### **WELL-BEING IN MILITARY NURSING LITERATURE REVIEW**

The body of knowledge that currently exists on military nurse well-being needs to be evaluated and critiqued. Therefore, the purpose of this section of the review is to provide a review of literature associated with the concept of well-being in the military nursing context. The aims of this review are to explore: (1) how military nurses’ well-being is conceptualized and defined, (2) how military nurses’ well-being is measured, and (3) potential factors influencing military nurses’ well-being.

Ten research articles were identified and included in the final syntheses. No research studies were identified that directly explored the overall well-being of military nurses. Therefore, the studies that will be presented in this review include two articles that explored the concepts of resilience and compassion fatigue. Resilience was identified by Huppert & So (69) as a construct of well-being. The addition of these two studies will provide the perspective of well-being in military nurses from a single positive indicator of well-being, resilience and the absence of compassion fatigue. In addition, the review includes eight studies that explored negative psychological effects (e.g., burnout, compassion fatigue, and PTSD) that have been shown to negatively impact well-being in nurses. These studies will provide the perspective of well-being in military nurses based on the absence of burnout, compassion fatigue, or PTSD.

### **Resilience and Compassion Fatigue**

Resilience has been defined in multiple ways by different authors. Resilience has its origins in the disciplines of science and mathematics, with an often-quoted example of resilience being the process of a metal bending under stress, and then bouncing back without breaking (91). There is a long history in the behavioral sciences with the term resilience used to describe contributors of human survival (92; 112). The conceptual definition of resilience as it relates to well-being has been defined as the process of adaptation in the response to exposure to adversity (115).

Resilience has been found to protect against work-related stress and identified as a crucial component for nurses to maintain well-being in the face of adversity (16; 170). All nurses face an abundant amount of adversity within their practice, including but not

limited to schedule pressures, workload, multiple roles, physical constraints, disruptive behaviors in the workplace, and ethical challenges. This abundant and frequent workplace adversity can have an impact on individual aspects of or the overall well-being of nurses.

Previous research has outlined healthcare professionals' resilience as a concept associated with mitigating the effects of factors that cause burnout, which is linked to workplace adversity (44). With regard to personal resilience, healthcare professionals' resilience appears to involve positive adaptation and developing personal resources, not just avoiding burnout (72). Therefore, personal resilience is further defined as a dynamic process that can positively adjust to adversity and moderate potential damages (72), and is a concept used to explore and understand healthcare professionals who survive and thrive in their workplaces (113). This aligns well with the concept of moral resilience, the ability to preserve or restore integrity in response to moral adversity (62; 171).

Research has also indicated that resilience, well-being, and health are linked. Empirical literature has shown that resilience can minimize and buffer adverse, stress-related outcomes, such as burnout syndrome (39). Additionally, the evidence demonstrates that resilience is related to better physical and mental health and earlier recovery from disease (27). Included in this review are two studies that explored resilience and compassion fatigue in military nurses.

Compassion fatigue has been defined in various ways in the literature. The concept was first coined in 1992, by an emergency department nurse, Joinson while studying burnout (78). Joinson proposed that empathetic nurses, caring individuals, may absorb the traumatic stress of those they help. She described compassion fatigue as a

form of burnout that is seen in individuals in the caregiving professions (78). Charles Figley later defined compassion fatigue as a state of tension and preoccupation with the individual or cumulative traumas of clients and described it as a natural consequence of working with individuals who experienced distressing events; and being vicariously exposed and responding empathetically to the event (45). As it is currently conceptualized, compassion fatigue consists of three concepts: increased burnout, increase secondary traumatic stress (STS) and low compassion satisfaction (158).

STS is a form of posttraumatic stress disorder that health care workers develop in response to caring for patients who have experienced trauma. The nurse does not need to have witnessed the traumatic event to develop STS (67). STS can cause a variety of negative cognitive, emotional, and physical symptoms, such as irritability, anger, lack of concentration, and sleep disturbances (67). Conversely, compassion satisfaction is the positive feelings associated with caring for others and the connections made with patients (67). Compassion satisfaction happens when nurses feel that they are contributing to the workplace and that they are making a difference in their patient's lives (30).

The military context of compassion fatigue has been defined as “an occupational hazard in military healthcare teams marked by empathy, sense of helplessness, fear, loss of purpose, and the inability to recognize one's own needs that causes psychological distress” (133) (p.9). Regardless of the variations in the definition, the literature is consistent that compassion fatigue can have a profoundly negative effect on the nurse, the patient population, and the organization.

In the first study, an exploration of the resilience and compassion fatigue among military healthcare professionals using a cross-sectional survey design was conducted

(96). The sample consisted of active duty or active reserve bachelor's degree prepared nurses, advanced practice nurses and physicians who attended the convention of the American Military Surgeons of the United States (AMSUS) in San Antonio Texas. The participants were mostly female, held the rank of commander (05), and had a history of deployment. The 25-item Resilience Scale (RS) developed by Wagnild (1964) was used to measure resilience and the 30-item Professional Quality of Life Scale (ProQOL) was used to measure compassion fatigue (Appendix A).

A significant positive relationship was found between resilience and compassion satisfaction ( $r = .45, p < 0.001$ ); and a significant negative relationship was observed between resilience and burnout ( $r = -.37, p < 0.001$ ) and secondary traumatic stress ( $r = -.29, p < 0.001$ ). Furthermore, those who had not deployed had a higher resilience score ( $p = 0.05$ ), higher compassion satisfaction scores ( $p < 0.01$ ), lower burnout scores ( $p < 0.01$ ) and secondary traumatic stress ( $p < 0.001$ ) than those who had deployed. With further analysis, it was demonstrated that participants who had been deployed to Iraq had lower compassion satisfaction ( $p < 0.05$ ), higher burnout ( $p < 0.01$ ) and higher secondary traumatic stress ( $p < 0.01$ ) than those who had not deployed and those who had deployed to other locations. Participants who deployed to other locations did not differ from those who had not deployed.

This was the first study to explore resilience and compassion fatigue among military healthcare professionals. These findings support the potential benefit of the implementation of resilience building programs in the effort to decrease compassion fatigue in military healthcare professionals. Future studies exploring resilience pre-deployment and post-deployment are warranted given the findings that resilience scores

were higher in those participants who had not deployed. Another future area of investigation would be replication of the study in a population with a more diverse rank structure. In particular, the inclusion of more junior nurse corps officers is warranted.

In another second study, a cohort pilot study examining the impact of the Army's Care Provider Support Program (CPSP) on resilience, coping, and compassion fatigue in military healthcare professionals was conducted (167). The study was conducted at an Army MTF and included a convenience sample of 93 military and civilian RNs, LPNs, and medics. They completed the initial questionnaires, however, only 30% of the participants completed the 30-day follow-up questionnaires. Investigators used three well-known validated instruments. To measure resilience the Connor-Davidson Resilience Scale (CD-RISC) was used. Coping was measured using the Ways of Coping Questionnaire (WQC) and compassion fatigue was measured using the ProQOL.

There was no statistical difference in the measurement of CD-RISC scores ( $p=0.970$ ), total WQC scores ( $p=0.240$ ), the sub-scale secondary traumatic stress ( $p=0.200$ ) and the subscale compassion satisfaction ( $p=0.618$ ) prior to the program and 30 days post-program attendance. The results did indicate a significant decrease in the level of the burnout ( $p<0.001$ ) and the individual WQC coping factor of Positive Reappraisal ( $p=0.025$ ), prior to the program and 30 days post-program attendance. Limitations of the study included the small sample size, the sample consisted of mostly senior leadership (71.4 %) which is not a representation of active-duty force (37%), and a single site study. Areas of future research include larger samples across multiple sites to determine the true effectiveness of resilience training and a higher representation of junior officers for a better representation of the active-duty force.

In totality, these studies indicate that there is a relationship between resilience, the subscales of the ProQOL and deployment. Further studies are needed to address the limitations of cross-sectional design, sample size, recruitment of participants of lower ranks and the finding that resilience is higher and compassion fatigue is lower for individuals who have not deployed. An additional study was included in the review that assessed well-being of military nurses from the perspective of absence of compassion fatigue without the exploration of resilience.

In this study, investigators used a cross-sectional survey design to establish the impact of combat deployment on compassion fatigue among military healthcare professionals working in the Department of Emergency Medicine at San Antonio Military Medical Center (29). The Professional Quality of Life Scale (ProQOL) version 5 survey was used to measure compassion fatigue. The sample consisted of a convenience sample of current and former active-duty emergency care providers in direct patient care: 30 technicians, 42 nurses, and 33 physicians. The study's overall response rate was low at 28%, potentially affecting the reported findings.

The results indicated that there was not a significant correlation found between deployment history and the ProQOL 5 sub-scores. The mean raw score for the burnout subscale was 21.8 (never deployed) and 22.3 (history of deployment) ( $p=0.976$ ), the secondary traumatic stress subscale 18.9 (never deployed) and 20.7 (history of deployment) ( $p=0.134$ ), or compassion satisfaction subscale 39.0 (never deployed) and 37.2 (history of deployment) ( $p=0.919$ ). The data trended towards higher compassion fatigue of those included with deployment history, indicating a potential inadequate sample size. Additionally, quarterly resilience training in the department could have

decreased the rate of compassion fatigue. Future studies that examine the correlation between resilience training and compassion fatigue are warranted.

As discussed in these three studies using the ProQOL, instrument, a subscale of the measurement is STS. Secondary traumatic stress refers to a set of psychological symptoms that mimic PTSD but is acquired through exposure to persons suffering the effects of trauma. There were three studies included in the review that explored PTSD in military nurses. They will be discussed in the next section.

### **Posttraumatic Stress Disorder**

PTSD is a disabling psychiatric condition that is triggered by a traumatic event that is either experienced or witnessed (8) and is common among military and veterans, creating a significant public health challenge (10). The diagnosis of PTSD, defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), requires either directly experiencing threat to oneself or witnessing a threat to others with feelings of intense fear, helplessness, and horror (8). Three studies exploring PTSD in military healthcare professionals who had deployed were identified that met inclusion criteria for this review on the basis that they explore well-being from the perspective of the absence of PTSD.

In the first study, the risk factors for PTSD, depression, and mental health care use among military healthcare professionals who previously deployed to combat settings were examined utilizing a cross-sectional survey design administered at Navy Medical Center San Diego (85). A clearly specified or defined population was not provided for this study. The demographics for participants included: physicians (n=25), nurses (n=5),

enlisted medical technicians (n=59), and other (n=13). Participants were predominantly male, Caucasian, and married.

The questionnaires used in the study included the PTSD checklist (PCL) to assess PTSD and the PHQ-9 to assess depression. The questionnaires were described with references provided and the validity and reliability of instruments used (Appendix A). The results of this study revealed 9% of the participants met the criteria for PTSD, and 5% met the criteria for depression. The only demographic characteristic found to have a significant association with increased risk of probable PTSD ( $p = 0.018$ ) and depression ( $p = 0.048$ ) was being non-Caucasian. Given these important findings, further research in non-Caucasian military healthcare professionals is warranted. When controlling for demographic variables, respondents that reported frequent personal engagement in direct combat or being fired upon by opposition forces were 17 times more likely to meet the criteria for probable PTSD ( $p=0.012$ ). Furthermore, respondents who reported a frequent concern regarding being in danger were at 8.87 times greater risk of meeting the criteria for probable PTSD ( $p=0.037$ ).

In another study, investigators compared the rates of PTSD among Navy healthcare personnel with non-health care personnel following single and repeated combat deployments using secondary data analysis (102). The study used records maintained by the Defense Manpower Data Center (DMDC). The sample consisted of 8,064 Navy personnel. Personnel records were included if they reported one (n=6,109), two (n=1,660), or three (n=295) deployments to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) between September 2001 and November 2008 and completed a post-deployment health assessment within 30 days. Due to the small sample

size of female participants, they were excluded from the study. The results of the analysis indicated that healthcare professionals had significantly higher rates of PTSD compared to non-healthcare personnel after one ( $p<0.001$ ), two ( $p<0.001$ ) and three ( $p<0.001$ ) deployments. Additionally, a Chi-square test for trend indicated a significant linear trend in PTSD diagnosis rate among healthcare personnel ( $p<0.001$ ) but not non-healthcare personnel ( $p=0.18$ ).

In the last study investigating PTSD, the purpose was to address the lack of prospective longitudinal studies that evaluated the mental health of military healthcare professionals with a history of deployment using the Millennium Cohort Study and applied longitudinal analysis techniques (74). The Millennium Cohort Study is an ongoing large, prospective cohort aimed at evaluating the effects of military service on short and long-term health outcomes. Participants were surveyed every three years after initial enrollment. The study contained questionnaires including the PTSD Checklist-Civilian Version (PCL-C), a 17-item screening tool for PTSD, and the PHQ-9 screening tool to assess depression.

The results demonstrated that rates of new positive screens for PTSD or depression were similar for those in health care occupations compared with those in other occupations for the first and second follow-up (74). Among military personnel deployed with combat experience, health care professionals did not have increased odds for new-onset PTSD or depression over time. However, among deployed health care professionals, combat experience significantly increased the odds for new-onset PTSD or depression ( $p<0.001$ ). These results suggest that combat experience, not features specific

to being a health care professional, was the key exposure explaining the development of these outcomes.

## **Burnout**

Burnout is another measurement that focuses on the absence of aspects of well-being. Although the absence of burnout does not indicate well-being, higher levels of burnout have been shown to be related to lower levels of well-being in healthcare staff (58). The phenomenon of burnout has been studied for many decades, with one of the first articles published in 1974 (51). The burnout field of research has since proliferated. Burnout is defined as a psychological syndrome that occurs in response to chronic, overwhelming work stress (110), and includes three dimensions: emotional exhaustion, cynicism or depersonalization and reduced perceived personal accomplishment (107; 110). The dimension of emotional exhaustion refers to feelings of being depleted, overextended, and fatigued. Depersonalization (also called cynicism) refers to negative and cynical attitudes toward one's consumers or work in general. A reduced sense of personal accomplishment (or efficacy) involves negative self-evaluation of one's work with consumers or overall job effectiveness (110).

Four of the studies identified in the review measured the rates of burnout in military healthcare professionals as the primary measurement. All four studies used the Maslach Burnout Inventory (MBI) scale as the measurement for burnout. The MBI is one of the most widely used instruments for the measurement of burnout in a wide variety of occupations and settings (110). The MBI was specifically designed to assess the three dimensions of the burnout experience, which had emerged from the earlier qualitative

research. It has been considered the standard tool for research in this field and has been translated and validated in many languages (109).

Two of the studies that measured burnout included both military and civilian groups for comparison. In the first study, a cross-sectional study to determine if there were differences in the rate of burnout in active-duty Army nursing personnel compared to civilian nursing personnel was conducted (90). Recruitment literature was distributed to 600 nursing personnel meeting inclusion criteria with a response rate of 60% (n=364). Participants included: RNs; licensed practical nurses (LPNs); certified nursing assistants; and Army medics who worked full-time in direct patient contact for six months or more. The majority of the participants were Nurse Corps Officers and civilian RNs, who worked in the inpatient setting, and routinely cared for Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) patients. There were notable differences in the civilian nursing personnel demographics, such as their work patterns with: (1) primarily day shift, (2) less than 12-hour shifts, (3) less overtime, and their educational background with less than a bachelor's degree in nursing.

Burnout was measured with the 22-item Maslach Burnout Inventory for Human Services Survey (MBI-HSS). Active-duty personnel were found to experience higher rates of burnout than civilian nursing personnel working at the same facility ( $p < 0.001$ ). Lower rates of emotional exhaustion were associated with working day shift ( $p = 0.03$ ) and not routinely providing care to soldiers who were injured in Iraq and Afghanistan ( $p = 0.045$ ). Lower rates of depersonalization were associated with working eight-hour shifts ( $p = 0.039$ ). Due to the finding potentially being unique to the organization,

researchers should continue to explore burnout in military healthcare professionals working in different environments.

Another study was conducted at a large Navy Military Treatment Facility (MTF) and utilized a cross-sectional survey design as part of a command internal review to identify the prevalence of burnout and identify potential associated factors (151). Although the demographics provide some insight into the participant population, the population was not defined and inclusion and exclusion criteria were not discussed, making it difficult to fully understand the targeted population. A response rate of 52.3% that consisted of mostly active-duty physicians who had deployed one or more times was reported.

In contrast to Lang, Pfister & Siemens (90), the burnout rates were similar between active duty and civilian healthcare professionals. This difference may be related to response bias due to the purpose of the data collection being a command initiative. Significantly higher scores of emotional exhaustion were associated with (1) time on-call ( $p=0.024$ ), (2) time spent on collateral duties ( $p=0.013$ ), and (3) working in the medical and mental health directorates ( $p=0.003$ ). In addition, the depersonalization subscale scores were higher for respondents under 50 ( $p < 0.001$ ). There was not a correlation between deployment and burnout. Further research of military healthcare professional burnout monitoring is recommended to determine the trend and influencing factors of burnout.

Another study examined the nursing practice environment and burnout between two Army combat support hospitals and Army nursing personnel assigned to an Army hospital located in the United States using a non-experimental cross-sectional design

(89). Differences were compared in deployed and non-deployed Army nursing personnel (89). This study expanded from the previous study conducted by Lang, Pfister & Siemens (90). Data was obtained from 152 Army nursing personnel from the 2010 study at a large Army hospital in the United States and compared to the rates of burnout with 105 Army nursing personnel who deployed to two different combat support hospitals in Iraq. A total of 257 nursing personnel were included in the study. Nursing personnel consisted of Army LPNs, medics and RNs.

The findings suggest that United States hospital based, and deployed nursing personnel experienced burnout as described by Maslach et al.'s (108) conceptualization of burnout. However, there were noted differences between the two groups. For deployed nursing personnel, emotional exhaustion was related to a perceived lack of support from management, foundations for quality of care, collegial relationships, and extended work schedules. The United States based Army hospital group scored significantly higher in emotional exhaustion ( $p < 0.001$ ), but it was related to the additional responsibilities associated with being an Army nurse, working extended schedules, and working with combat casualties for extended periods of time. In addition, the United States based group perceived more personal accomplishment ( $p < 0.001$ ) from the work they did.

There are several limitations to the study. The use of a convenience sample may not represent the population and has the potential to introduce bias. In addition, the instrument was administered to RNs, LPNs, and medics whose scope of practice, education and socialization were potentially different. This may influence the validity and reliability of the responses. Another limitation of was related to the lack of pre-deployment or post-deployment comparison data. This would have allowed the

investigator to determine if burnout is a new onset in the deployed setting and if it resolves with returning from deployment. Future studies are needed to validate the findings and explore factors that remain unexplained. In addition, a mixed methods approach, which would allow for the perception of the nursing personnel to be captured, is recommended.

The final study explored the prevalence of burnout in military healthcare professionals. Unlike the three prior studies, a civilian or another group comparison was not included. Rather, U. S. Air Force family medicine providers were studied to assess burnout and depression (163). A cross-sectional study was conducted using the Maslach Burnout Inventory – General Survey (MBI–GS) to measure burnout and the Patient Health Questionnaire 9 (PHQ-9) to measure depression. The MBI-GS version of the MBI was designed for use with occupational groups other than human services and education (109). Therefore, it is unknown how utilizing the MBI-GS in this population affects the results given the validity of this instrument has not been demonstrated in this or a comparable population.

The survey was sent to 726 active-duty U.S. Air Force family medicine practitioners across the globe and there was a 21% response rate. The respondents consisted of family medicine physicians, physician assistants, and nurse practitioners. More consistent with Lang, Pfister & Siemens (90), the findings indicated that 59% (n=89) reported a medium or higher level of emotional exhaustion, and 34% (n=51) reported medium or higher depersonalization; however, the majority (95%, n=143) reported medium or higher levels of personal accomplishment. With an analysis of the PHQ9 data, the majority of the participants (84%, n=126) scored positive for some

degree of depression symptoms. Consistent with the findings of Sargent et al. (151), a significant relationship between age and burnout was observed. Respondents over the age of 44 reported lower emotional exhaustion and depersonalization, and higher personal accomplishment.

The limitations of the study included a cross-sectional study design and a low response rate from participants. Another potential limitation was the use of the MBI-GS version of the burnout scale versus the MBI-HS version. Future studies were recommended that include more specialties other than family medicine, include other branches of service, and use prospective and longitudinal designs that allow for cause, consequences and risk factors of burnout and depression to be identified.

Collectively, these studies indicate that burnout is a valid concern for military nurses, with one study indicating that military nurses are at higher risk than civilian nurses. Additionally, military nurses who provide care for injured service members over an extended period of time in MTFs are at higher risk for burnout. Both longitudinal and qualitative design research are needed as a future direction to determine the trend, influencing factors, and experience of burnout in military nurses.

## **Discussion**

There is growing awareness of the public health importance of well-being both in the general population and in specific groups. The well-being of military nurses is likely to influence the quality of care they deliver, impact patient health, and potentially negatively impact the organization. This review was carried out to examine the literature related to the well-being of military nurses and to explore how well-being has been

conceptualized and defined in the military nursing population, how it has been measured, and the factors that influence well-being in military nurses.

Without knowledge about well-being from the perspective of the military nurse, the ability to create programs and environments that support, enhance, or improve their well-being is impaired. Well-being cannot be defined or described by researchers. When researchers define well-being for individuals or groups, they frequently miss central concepts (84; 88). If this concept is not well understood and incongruence exists, then supporting the well-being of military nurses may be an elusive goal. Military nurses and leaders need to be clear about what well-being is in the context of military nursing, before they can effectively enable efforts to support and enhance well-being.

### ***Conceptualization and definition of military nurse well-being***

The present review intended to extract and compare definitions of well-being. However, there were no studies identified that directly discussed the concept of well-being in military nursing. The limited literature identified for inclusion in the review predominately focused on negative psychological effects related to nursing care: burnout (89; 90; 151; 163), compassion fatigue (29; 167), and PTSD (74; 85; 102). Three articles focused more in the direction of well-being with a focus on the measurement of military healthcare professional resilience (29; 96; 167); however, they included measurement of burnout and compassion fatigue and placed the majority of the focus there.

In summary, the overview and synthesis of the studies highlighted four very disparate concepts (e.g., resilience, compassion fatigue, PTSD and Burnout) in terms of study focus, definitions, and measures. In addition, this disproportionate focus on

negative psychological effects brings to attention an identified gap of imbalance between well-being and negative psychological effects related to military nurses in the literature.

### ***The measurement of military nurse's well-being***

The present review also intended to identify measures of well-being used in military nurses. There were no studies identified that measured well-being in military nurses. As discussed above, the identified studies presented data and outcomes primarily in terms of the presence or absence of a single positive indicator of well-being, resilience and the presence or absence of negative psychological effects that have been shown to impact well-being.

Focusing on the measurements that were identified in the review established that military nurses suffer from burnout, compassion fatigue, and PTSD. Reports are conflicting about whether rates of burnout are higher in military compared to civilian nurses and the association of deployment history and burnout, compassion fatigue and PTSD. For example, higher rates of burnout in military nurses were reported in a group of Army nursing personnel (90), compared to a diverse group of disciplines in a Navy population where rates were found to be comparable, if not lower than civilian burnout rates (151).

Several factors could have contributed to these conflicting findings, such as the potential environmental or service-specific differences between the two study groups. Further work utilizing methodologically sound approaches are needed to better understand these and other questions/gaps identified in this review.

### ***Potential factors influencing military nurse's well-being***

The present review highlights potential associated factors that detract from or contribute to the psychological well-being of military nurses. In summary, some of the identified factors in the review included correlation in higher rates of burnout with working a shift other than day shift, working greater than 8-hour shifts, routinely providing care for injured soldiers (90), more time on call, more time spent on collateral duties, working in the medical or mental health directorate (151), and more leave days accrued (165). In addition, it was suggested that combat experience, not features specific to being a health care professional, was associated with higher rates of PTSD (74).

With the majority of the studies using a cross-sectional design, the development of an experimental or longitudinal design to identify causation of the identified factors associated with military nurse's well-being would add to the body of knowledge and move the science forward. However, based on the results of this review, the next step should be the development of a clear, conceptual definition of military nurse's well-being, utilizing a qualitative study to help define the phenomenon of military nurse's well-being.

A potential sub-population that would lend itself to rich data would be military nurses who provide care for injured or ill patients over an extended time period. This sub-population of military nurses was identified as having higher rates of burnout (89; 90) in this review. Investigating the phenomena of well-being in military nurses by engaging thriving individuals and individuals experiencing burnout in this sub-population will benefit the efforts to conceptualize and define well-being in military nurses.

## **SUMMARY**

Despite the importance of military nurse's well-being, little research has been conducted to explore military nurse's well-being. Relatively few well-designed, empirical studies have examined the psychological consequences of the military nurse role and fewer have examined the positive psychological effects on well-being. Many prior studies have methodological weaknesses, including small samples, samples of convenience, high attrition rates, cross-sectional rather than longitudinal designs, and some lack clearly described statistical analysis. Despite these frequent methodological limitations, it is clear that burnout, compassion fatigue and PTSD are significant problems in military nurses, both in prevalence and association with a wide range of other problems for individual staff persons, for the organizations that employ them, and likely for the people whom they serve.

There is a pressing need for additional, research related to the psychological consequences of the military nurse role but an even greater need for research addressing a comprehensive exploration of military nurse's well-being. In particular, our ability to understand psychological consequences will improve as researchers use representative samples and multivariate and longitudinal designs in future studies. Thresholds for burnout, compassion fatigue and PTSD should also be defined and validated to determine whether interventions can reduce these identified issues to sub-threshold levels.

Important and under-studied topics include the consequences of military nurse burnout, compassion fatigue, and PTSD on those they provide care for, the role of organizational and other environmental factors in causing burnout, compassion fatigue and PTSD and models and theories for military nurse's well-being. Further, additional attention should

focus on the positive aspects of working, such as the process by which military nurses experience compassion, joy, meaning, and fulfillment in their jobs.

Overall, many questions remain unanswered, related to concepts and factors that influence or detract from well-being in military nurses. One of the most pressing questions noted in this review was, “How is military nurse well-being conceptualized?” This review has identified military nurses’ well-being as both an understudied and undefined concept. The complexity and pressures of the military nurse’s dual roles provides a unique opportunity to balance existing research focused largely on psychological consequences with an equivalent emphasis on well-being. The future research agenda should engage key stakeholders and military nurses, to explore their conception of well-being, improve understanding of the correlates of well-being in military nurses, and to develop and test interventions directed at improving well-being.

## **CHAPTER 3: Method**

### **INTRODUCTION**

This study was designed based on the gaps in the literature on military nurse well-being. The purpose of this constructivist grounded theory study was to gain an in-depth understanding of the process of fostering well-being of military nurses who provide care to patients with life-threatening illness or injury. This was achieved by exploring how they experience, assess, and respond to the daily tasks and challenges in their workplace setting and life as a Navy Nurse Corps officer.

The purpose of this chapter is to provide the research design, strategies, and methods used in this study and a guide to assist the reader in the assessment of the study's integrity. This chapter describes the study's research methodology. It includes discussion around the following areas: (a) rationale for research approach, (b) description of the research setting, (c) description of the research sample, (d) overview of research design, (e) methods for data collection, (f) methods for data analysis, and (g) protection of human subjects, and (h) trustworthiness of the study. The chapter culminates with a brief concluding summary.

### **RATIONALE FOR QUALITATIVE RESEARCH DESIGN**

As demonstrated in chapter two, most of the research about well-being of Navy Nurse Corps officers is fragmented, focusing more on proxy measurements of well-being and the absence of aspects of well-being (e.g., burnout, compassion fatigue, and depression). None of the research focuses on a holistic construct of well-being that encompasses all the dimensions and an actual measurement of well-being itself. In

addition, theories specific to fostering and sustaining military nurses' well-being were not found in the literature review. Another missing aspect was input from the military nurse's point of view about their perspective on well-being.

As Kiefer (84) explained, learning groups or individuals' perspective is the initial step towards improving well-being in the group or individual. Therefore, a qualitative research methodology that elicits military nurses' viewpoints as a means of understanding their experiences, how they define well-being, and actions they take to manage their well-being was utilized.

#### **RATIONALE FOR CONSTRUCTIVIST GROUNDED THEORY METHODOLOGY**

Within the framework of qualitative approach, the study was most aligned with the Constructivist Grounded Theory study design. Although grounded theory originated in sociology, it is a popular qualitative research design across various disciplines, including nursing (14; 19; 21). Grounded theory research aims to explore a social phenomenon of interest based on human interaction and systematically generate comprehensive explanations of these patterns leading to a substantive theory grounded in the data being investigated (14; 19; 21; 56). Furthermore, grounded theory aims to generate a substantive theory that accounts for the basic social process, representing patterns of actions and behaviors relevant to those involved (55). The basic social process is labeled as a gerund, explaining what is happening in the data (19; 21). Given that its philosophical underpinnings stem from sociology, grounded theory research is rooted in the theoretical perspective of symbolic interactionism (14; 19; 21; 54; 56). It offers a systematic approach to exploring the shared understanding of what is happening in

relation to the social phenomenon under investigation from the perspective of the participants in the study (14; 19; 21).

### **THE RESEARCH SETTING**

In the original study design, participants were planned to be recruited from two large MTFs in the United States, Walter Reed National Military Medical Center (WRNMMC) and Naval Medical Center Portsmouth (NMCP). However, due to the limitations posed by the COVID-19 pandemic, such as mass deployment of Navy nurses from NMCP, COVID-19 travel restrictions for military members, and social distancing guidelines, it was not possible to recruit from the two sites. Therefore, the study population included a sample of active-duty Navy nurses who cared for individuals with a life-threatening illness or injury from at a large MTF in the United States, WRNMMC.

Recruitment took place on 11 units where military nurses routinely cared for patients with life-threatening illnesses or injury at WRNMMC. WRNMMC is the Nation's largest joint military medical center employing roughly 7,000 staff members and serves military beneficiaries in the Washington, D.C. area. WRNMMC is a tertiary care center that provides services in over 100 clinics and specialties and routinely cares for ill and injured service members. WRNMMC was selected due to feasibility, large size (allowing for adequate sample size), and geographical location.

The nursing population consists of Navy Nurse Corps officers, Army Nurse Corps officers, Air Force Nurse Corps officers, and non-active duty (General Schedule (GS) and contract) nursing staff. Even though this sample was enrolled from a single MTF site, this sample represents a sample across multiple different in-patient settings. Also, given

that the Navy Nurse Corps is a transient population, several participants brought the experiences of working in multiple other settings. Some of the Navy Nurse Corps officers in the study had previously been stationed overseas, at smaller MTFs, and in non-joint environments. In addition, some of the Navy Nurse Corps officers discussed their experiences in the deployed setting, such as the middle east, humanitarian missions, shipboard deployments, and stateside deployment in response to the COVID-19 pandemic.

### **THE RESEARCH SAMPLE**

This study's target population included active-duty Navy Nurse Corps officers who cared for seriously ill or injured individuals and may be at high risk for dying. Seriously ill or injured individuals include but are not limited to oncology patients, service members wounded during deployment, those with mental health disorders requiring extensive hospitalization and treatment, as well as those with complex/severe pulmonary, cardiac, hepatic, and other diseases or disorders.

Participants for the study were recruited using the grounded theory sampling structure, which evolved throughout the data collection process. Purposeful, snowball, and theoretical sampling allowed for sampling across various in-patient units at WRNMMC and provided diversity in the sample demographics. The final research sample included 25 Navy Nurse Corps officers from 11 different units.

### **Initial and Snowball Sampling**

Charmaz (19; 21) proposed initial sampling as the first step in constructivist grounded theory that proceeds theoretical sampling since the identification of data

sources is required before theoretical sampling. Initial sampling was conducted using purposeful sampling of participants who have been identified as having the knowledge and experience to provide initial data for the area of inquiry. Snowball sampling was employed after the first participant was interviewed, whereby participants were asked to refer any of their colleagues who were active-duty Navy Nurse Corps officers. An IRB approved flyer that described information about the study was provided to those interested in participating.

It is essential to maintain control over the sample's composition to ensure it meets the criteria of appropriateness, represents a good mix, and is adequate (121). To ensure the sample met the criteria, the inclusion criteria were reviewed with each potential participant at the time of recruitment. In addition, a demographic sampling grid was used to detail the diversity and size of the sample. The sampling grid allowed for additional recruiting efforts for groups (e.g., gender, rank, specialty, and time in service) that may not be represented in the study as it develops. With this said, to stay true to the grounded theory methodology, the driving force of the sample's construction and size was directed by theoretical sampling and not the demographic profile of the participants.

### **Theoretical Sampling**

As the iterative process of data collection and data analysis took place and preliminary categories were constructed, theoretical sampling was added as a strategy. Theoretical sampling is a strategy that focuses on the preliminary categories and their properties, enabling the collection of data to elaborate and refine categories in the emerging theory (19; 21). Theoretical sampling is not limited to sampling participants

but may also include sampling the literature and other documents (e.g., policies and or organizational documents) relevant to the phenomenon. Theoretical sampling strategies entail revisiting existing data, conducting interviews with new participants, and re-interviewing previous participants using a few focused questions directed at refining categories, studying documents, and conducting observations (19; 21). Theoretical sampling was undertaken as data collection and analysis occurred simultaneously, the results of which provided a guide to the areas of further inquiry.

### **Inclusion Criteria**

The criteria for selecting participants were as follows: (a) active-duty Navy Nurse Corps officers, (b) duty station at WRNMMC at the time data collection took place, (c) experience as a Navy Nurse Corps officer for six months or greater (d) care provided to an individual with life-threatening illness or injury within the last 12 months.

### **Exclusion Criteria**

Exclusion criteria included non-active-duty nurse and active-duty nurses caring for maternal-child populations.

### **OVERVIEW OF RESEARCH DESIGN**

The following list summarizes the steps used to carry out this research. Following this list is a more in-depth description of each step.

1. Preceding the actual data collection, a selected review of the literature was conducted to identify other researchers' contributions in the broad areas of well-being, well-being in nursing, and well-being in Navy Nurse Corps officers.

2. Letters of support from the proposed research sites' commanding officers and directorate and department leadership were obtained.
3. The study protocol was submitted to the Uniformed Services University of the Health Sciences Institutional Review Board (IRB), and approval was obtained to proceed with the research (Appendix B). A survey control number (SCN) was obtained per the Defense Health Agency-Administrative Instruction (DHA-AI). The IRB approval process involved outlining all procedures and processes needed to ensure adherence to standards put forth for the study of human subjects, including participants' confidentiality and informed consent (Appendix C).
4. To obtain experience in patient interviewing techniques, mock interviews were carried out with nursing doctoral students and the assistance of a University faculty member experienced in qualitative interviewing.
5. Prior to recruiting participants, the Service Chief (nurse managers) of each target unit was contacted to provide information on the study's details and discuss recruitment strategies that would be used to recruit potential participants from each unit.
6. IRB approved flyers about the study were posted in the break room and on the units of the identified units by the Service Chiefs. In-person recruitment was initiated, targeting one unit at a time. This approach allowed for ensuring the iterative process of data collection and data analysis known to Grounded Theory.
7. Once initial contact was made with potential participants, and they agreed to participate, the interview's time and location were arranged with input from the participant.

8. After approximately four weeks of in-person recruitment and the recruitment of six participants, recruiting was disrupted due to guidelines and restrictions implemented in response to the COVID 19 pandemic.
9. In an effort to enhance recruitment with the new public health guidelines, IRB approved social media flyers were posted to private Navy Nurse Corps officer groups, and Service Chiefs were asked to ensure that IRB approved flyers were posted on the units.
10. Participants 1-6 were interviewed prior to the implementation of COVID 19 guidelines and restrictions. Participants 7-25 were interviewed following the restrictions to maintain social distancing (six feet) and wear a facial mask covering.
11. Each potential participant reviewed the consent, and any lingering questions were answered. It was emphasized that study participation was voluntary. To reduce the influence of military rank, the researcher wore civilian attire for all interviews. All participants were interviewed in person at a mutually agreed upon location.
12. Before the semi-structured interviews took place, participants 1-6 were provided a paper copy of a survey to complete capturing participant demographics. To follow the COVID 19 guidelines, participants 7-25 completed the exact survey items electronically via a provided laptop that was appropriately sanitized before and after each use.
13. Verbal consent from the participants to record their interview was obtained once the digitally audio recorder was turned on.

14. Semi-structured interviews lasting approximately 25 - 60 minutes were conducted with 25 Navy Nurse Corps officers.
15. Interviews 1-3 were conducted with a University faculty qualitative methodology expert experienced with interviewing.
16. All interviews were conducted using an interview guide and appropriate questioning probes or follow-on questions as indicated by the flow of the discussion. The initial probes during the first interviews were used to primarily direct the respondent to expand on some of the answers provided as appropriate for the flow of the interview. Time was given at the end of the interview for participants to clarify any information shared in the preceding discussion.
17. Memoing began after the first interview to track methods and the analytical process. Immediately following each interview, memos were written to reflect descriptions of the impressions and ideas. All post-interview memos were initially handwritten and then electronically transcribed. These memos and memos written during the analysis and coding were used throughout the study to define and describe categories, define characteristics, and identify gaps to allow for theoretical sampling.
18. Interviews were transcribed using QSR International NVivo transcription software (130) and verified for accurate transcription. All data were transcribed verbatim and maintained on media storage. Next, after verification of transcription accuracy, each transcript was uploaded into QSR International NVivo 12 software (129) for data management that allowed for coding and

analysis oversight from University faculty with expertise in qualitative research methodology.

19. Potential bias was controlled through the information validation process. Initial recruiting efforts focused on maximum variation and sample diversity, and thick description containing actual quotes to illustrate each major theme and issue. Objectivity of the interview data was protected through on-going review of the interviews to ensure neutral non-directional probes, consistent question administration, and naturalistic comfortable tone and style.
20. Data collection and data analysis occurred simultaneously in a cyclical manner to refine and add probes to address constructed codes and categories using the constant comparative method. Data collection continued until no new findings were constructed from the data, theoretical saturation.
21. As the interviews continued, validation probes were added, reflecting on codes and categories identified in the previous interviews. This step was added to further enhance credibility of the data, verifying the constructed codes or categories are not an isolated occurrence or experience. The verification is added after the other sections to decrease the potential of prematurely introducing closure of other constructed categories, codes, or issues. Constructed categories or basic social processes, were identified which served to organize the constructed substantive theory.
22. Once the analysis of interviews 1-18 were completed, the following preliminary findings were reviewed to identify gaps and direct further theoretical sampling:  
(1) the definition of well-being as defined by Navy Nurse Corps officers; (2)

major categories; and (3) facilitators and barriers to fostering well-being. Based on the review, theoretical sampling of Navy Nurse Corps officers with greater than four years of experience were recruited. This theoretical sampling strategy was used to refine the properties of the major categories and learn more about the theory's basic process; as the career of a Navy Nurse Corps officer progressed, they gained experience and transitioned into leadership roles.

23. During the interviews for participants 19-25, member checking was conducted.

The preliminary results for the constructed definition of how Navy Nurse Corps officers define well-being and identified barriers and facilitators were presented to the participants. The participants were then asked if they agreed with the findings and if they had anything additional to add. The remaining interview questions about how they managed their well-being were asked without presenting the research findings. Once the participants responded to questions about how they managed their well-being, follow-up questions were asked to refine and define major categories and fill in gaps in the developing theory.

24. All research participants were given the option of being informed about the study's general outcome and results upon its completion.

## **DATA COLLECTION**

The process of data collection in constructivist grounded theory is inherently nonlinear and evolves throughout the research in response to data analysis (21). Multiple forms of data are appropriate for use in a grounded theory study. Glaser (54) considers that "all is data." A demographic questionnaire, face-to-face semi-structured interviews,

field notes, literature, and memos were used in this study. Semi-structured interviews formed the main body of data collection, while field notes, literature, and memos supported the interview data analysis. In addition, an analysis of basic demographic data were also undertaken to define the study sample.

## **Recruitment**

After receiving approval from the IRB and the two proposed research site leadership, recruitment efforts to capture a diverse sample were initiated through multiple recruitments methods. Department level and unit level Service Chiefs were provided an overview of the study. Each unit Service Chief approved in-person recruitment strategies and agreed to post IRB approved study flyers in unit breakrooms. The flyers contained the study's purpose and procedures and contact information for potential participants interested in participating in the study.

Initial contact was made with Navy Nurse Corps officers on their unit after organizing dates and times with the unit Service Chiefs. Brief informational sessions were presented to nurses working on eligible units. During informational sessions, the study's purpose, inclusion and exclusion criteria, and the data collection methods were presented to prospective participants. Once participants agreed to participate in the study, a time, date, and location was organized based on the prospective participant's availability and preferences.

After approximately four weeks of recruitment efforts, six participants were recruited and interviewed from WRNMMC. Shortly after the sixth interview, in-person data collection was interrupted due to COVID-19 restrictions implemented at the

proposed research sites, WRNMMC and NMCP. Additionally, multiple Navy Nurse Corps officers were deployed to support COVID-19 efforts for patient care in areas of greatest impact in the United States.

Additional recruitment efforts included posting the IRB approved flyers on social media sites targeting Navy Nurse Corps officer's recruitment. However, these efforts were not successful in obtaining additional participants for the study. Due to military travel restrictions and unsuccessful social media recruitment, a single site, WRNMMC, was selected for recruitment. In-person recruitment at WRNMMC was reinitiated following the facility's COVID-19 restrictions and social distancing.

## **Sources of Data**

### ***Demographic Questionnaire***

A demographic questionnaire collected participants' personal and professional characteristics (Appendix D). This questionnaire took approximately 5-10 minutes to complete. The questionnaire was reviewed at the time of data collection to ensure that no questioned were missed or left blank by the participant.

### ***Semi-structured Interviews***

Once the demographic questionnaire was completed, individual face-to-face semi-structured interviews were conducted. Twenty-five individual interviews with Navy Nurse Corps officers were conducted between February 2020 and October 2020. Interviews lasted approximately 25-60 minutes and allowed the participants the opportunity to reflect on their thoughts, feelings, and struggles related to their own

experiences. Interviews were conducted using a semi-structured interview guide (see Appendix E for original/initial interview guide).

The semi-structured interview method is most fitting with constructivist grounded theory because it facilitates the exploration of assumptions, interpretations, meaning, and stories of the participants in detail (19; 21). The interview guide served as a beginning topical outline for the initial interviews; however, it was refined and modified as themes and categories were constructed from the data. Preliminary questions were structured as broad, open-ended inquiries coupled with possible probes to elicit a detailed description of the experience. As the interviews progressed, theoretical sampling and constant comparison, hallmarks of the grounded theory approach, were directed toward filling constructed categories and defining and describing the basic core process that is constructed from the data (19; 21).

### **Theoretical Sampling**

Data collection proceeded based on theoretical sampling. As previously discussed, theoretical sampling means sampling based on constructed concepts and categories from the data. Theoretical sampling for this study aimed to develop and saturate theoretically relevant categories in terms of their properties (characteristics) and dimensions (range), uncover variations, and identifying relationships between concepts (19; 21). Data collection and analysis proceeded simultaneously in an iterative, cyclical process. Thus, data collection was analysis-driven and based on the sampling of concepts and categories. Data collection and analysis was systematic and sequential, beginning with data collection, followed by analysis, followed by more data collection until

categories reached saturation (19; 21). Theoretical sampling involved reviewing existing transcript data, reviewing relevant literature, and collecting new data on concepts and categories with subsequent interviews.

### **Field Notes**

Field notes were documented before and after the interviews. Depending on the interview, notes were written about the processes occurring in the setting, the participant's verbal and nonverbal expressions, the physical environment, and the researcher's response to them. Field notes provided reminders of what was happening during the interview, such as (1) actions; (2) impressions; and (3) feelings. Field notes were reviewed with the transcripts to help inspire insight about the congruence and incongruence between words, body language, and emotion (19; 21).

### **Literature**

A further source of data for this study was literature relevant to the field of study and categories constructed during interview data analysis. The use of literature in grounded theory has been a contested issue, as previously mentioned in Chapter two. In traditional grounded theory, the literature review is initially avoided to prevent contamination, which could stifle or limit the researcher's analysis of codes emergent from the data and potentially force the data into pre-existing codes (56). As other approaches to grounded theory developed, so did the interpretation of the use of the literature review. Strauss and Corbin (28) believe that a review of the literature can provide a vital role as examples of similar processes and stimulate thinking about the properties or dimensions used to examine the data. Charmaz (19; 21) argues for the

researcher to take a more critical stance towards using literature and earlier theories to where concepts are required to earn their way into the study being undertaken and the resulting theory.

In this study, the literature was used to clarify categories constructed from interviews as part of the constant comparative analysis. Literature also informed on-going question development. For example, in the initial interviews, participants reflected on their personal experience with bullying. A return to the literature to clarify an understanding of bullying allowed for a comparison of what was known and participants' experience. In addition, the literature informed future question structure targeted to elicit data to refine and define the preliminary category, bullying. Therefore, the literature was used to clarify ideas, make comparisons, further theoretical discussion, and help identify how and where this work fits or extends relevant literature (19; 21).

## **DATA ANALYSIS**

This section details the research methods used in the analysis of the data. Grounded theory is not a linear process. Rather, the approach is concurrent, iterative, and integrative with simultaneous data collection, analysis, and conceptual theorizing from the beginning of the research process. Therefore, data analysis began immediately after the first interviews were collected, transcribed, and checked for accuracy. This process continued throughout until the theory was constructed.

### **Concurrent Data Collection and Analysis**

The iterative process of concurrent data collection and analysis is one of the essential methods that differentiates grounded theory from other qualitative research

designs (14). This study applied concurrent data collection and analysis, collecting interviews in five rounds (21). Round one interviews (1-3) were collected in the first week of data collection with the presence of a University faculty member with qualitative research expertise. Adhering to the iterative process of grounded theory interviews 1-3 were transcribed verbatim and analyzed. The analysis consisted of: (1) informal analysis and memoing in the form of field notes during and after the interview and during the transcription stage; (2) initial line-by-line coding; and (3) design of theoretical sampling for the next round of data collection.

Round two, interviews 4-6, were collected and analyzed in the same fashion with the addition of utilizing both initial and focused codes as themes were noted and tentative categories were constructed. Round three consisted of a single interview, interview 7, due to the need to renegotiate recruitment strategies in response to the COVID-19 pandemic. Once recruitment strategies were renegotiated, round four was conducted. Round four consisted of interviews 8-18. When the analysis of the fourth round of data collection was completed, a definition of how Navy Nurse Corps officers define well-being was constructed, and several tentative categories. This allowed for member checking to be conducted during the final round of data collection (round five) consisted of interviews 19-25.

### **Member Checking**

Member checking refers to taking information back to the participants to confirm interpretations and gather information to further develop and refine your categories (21). Given that a well-constructed preliminary definition of well-being and several main

categories had been constructed, the interviews shifted to providing participants with the definition and asking them if they agreed with the definition or had anything to add. The interview guide pertaining to the main categories and facilitators and barriers were asked in a manner for participants to provide an organic response allowing for the illumination of any new concepts. The participants were then provided with aggregated and analyzed data in the form of categories as a form of member checking and to generate data to refine and define the categories.

### **Demographic Survey Data**

The demographic survey data were exported from google forms into Microsoft Excel version 16.45 (Redmond, WA) (118). Once the data was exported into Microsoft Excel, the spreadsheet was then uploaded into SPSS version 25.0 (Armonk, NY) (70). For the purposes of this study, the demographics were summarized and presented using frequencies and descriptive statistics.

### **Interview Data**

Interview data analysis began with the first interview and continued throughout and beyond the data collection period. The first step in the analysis of the digital audio recordings was transcription.

### ***Interview Transcription***

Digital audio recordings of the interviews were transcribed verbatim by the researcher using NVivo transcription (Burlington, MA) (130). The transcription of the digital audio recording allowed for deep immersion within the data, and the interview's lived content, attuned to the contextual meanings of the Navy Nurse Corps officers'

words. When the words were re-read later, the Navy Nurse Corps officers' inflections, emphases, or emotions remained. This was a way of coming as close to the data as possible during the analysis and coding process. The process of transcribing also required a degree of sensitivity to transforming oral language to written text representation. Final transcripts were minimally edited to remove repeated words that didn't contribute to the overall meaning of the statement. For example, if a participant repeatedly used the word "like" in a sentence when searching for their words, the researcher removed excessive use of the word. Once the digital audio recordings were transcribed and checked for accuracy, they were exported from NVivo transcription and imported into NVivo 12.

### ***Computer-Aided Qualitative Data Management***

The computer-aided qualitative data management software, NVivo version 12 (Burlington, MA)(129), was used for data management and analysis. The software enabled coding of the interview data with labels, the ability to create relationships between codes, the ability to place codes and concepts into categories, and the capability to write memos about categories. The software also offers the capability to easily navigate among documents. The NVivo 12 software was used throughout the entire coding and analysis process in conjunction with Microsoft Word version 16.45 (Redmond, WA) (117).

Microsoft Word was used to pull sections of the data out of NVivo 12 after tentative categories were constructed to help better maneuver through the constant comparative method of grounded theory. The mechanical operations involved in using the software did not compare to the nuanced interpretive analysis described (14). It was

determined that a greater familiarity with the data was achieved by handling the data in a word document. Through reading and re-reading of the pages, it was possible to elicit the data's true meaning.

The Microsoft Word document also serves as a more easily shared audit trail of the coding and analysis process. Codes and categories were sorted, and resorted, moved and revised, and analytical memos were written to capture the researcher's thoughts within the Microsoft Word document and NVivo 12 when working through the coding and analysis process. After each analysis session of the data in Microsoft Word, updates to any categories or sorting of the data were then captured in NVivo 12.

### **Constant Comparative Analysis**

Constant comparison is an analytical process that is a hallmark of grounded theory and integral to constructivist grounded theory (19; 21). Constant comparison is the fundamental analytic strategy for comparing units of data with each other early in analysis and then for comparing categories, properties, and dimensions as theoretical components are constructed (19; 21; 56). Constant comparison of an incident with an incident within the initial interviews of this current study led to the generation of initial codes. As data collection progressed, codes were compared with codes within and across interviews, and groups of codes were collapsed into categories. When preliminary categories were established, categories were compared to categories. The constant comparison of data at different conceptual levels drove theoretical sampling and the continued data collection. Ultimately it was this iterative analytic method that resulted in

high-level conceptually abstract categories, rich in meaning and possessive of defining properties (14).

The constant comparative method was utilized to establish analytic distinctions and determine if the data supported and continued to support the categories constructed from the data (19; 21; 54; 56). The constant comparative method required that the researcher continually return to the data, and the words of the Navy Nurse Corps officers, using previous data and analysis to influence future data collection and analysis. Constant comparison involved comparing incidents to another incident to establish uniformities and varying conditions that could be identified. It also involved comparing constructed concepts to more incidents for theoretical elaboration, saturation, and densification of the concepts and the comparison of constructed concepts and categories with each other (19; 21). Associated with this process was memo writing.

### **Coding in Constructivist Grounded Theory**

The analytic process for grounded theory starts with coding. Charmaz (19; 21) describes the coding process of Constructivist Grounded Theory as having three levels: (a) initial coding that names each word, line, and segment, (b) focused coding that is more selective and aims to synthesize and integrate larger segments of data, and (c) theoretical coding which is a more sophisticated level of coding and assists the researcher in telling the analytic story of the data. The process for how these three-coding levels were undertaken will be described in this section using a small sample of the data from the study findings.

### ***Initial Coding***

The first of the three levels of coding, initial coding, resulted in establishing codes that were deemed pertinent to the data representation. As the initial coding level progressed, the same codes were applied to the responses of new interviewees. An early course of action in studying and analyzing the data in the initial coding level involved coding the data line-by-line. This form of coding fragmented the data by closely examining words, lines, segments, and incidents and applying a code that sticks close to the data. It required examination of each transcript from the participants' interviews and their stories, line-by-line, continuing the interaction that was shared with the participants while collecting the data, and brought the researcher into an interactive analytical space with the data (19; 21). This initial line-by-line coding assisted in analysis of the data from the ground up, based on the participant's actions and statements, and reduced the likelihood of superimposing preconceived notions on the data (19; 21).

Initial coding used gerunds, words ending in *ing*. Gerunds reflect process rather than topic. This approach conveys a sense of action and imagery and stays close to the data, capturing the meaning that the Navy Nurse Corps officers were conveying (19; 21). Starting with the Navy Nurse Corps officers' words or actions helped preserve the fluidity and provided a way of looking at their experience from their perspective. Table 3. provides an example of initial coding using gerunds.

Table 3. Example of initial coding using gerunds

Raw data	Initial coding using gerunds
I also like rely a lot on my coworkers here. They've all been very helpful.	Relying on coworkers
because I have a team, a collective team of individuals, professionals that are willing to help and, you know, likewise to do the same.	Having a collective team

And then I think just knowing that people have my back here has taken a lot of stress off of things.	People having your back.
--	--------------------------

After the initial coding of interviews (1-3), approximately 1200 codes were listed. In subsequent interviews, coding was shifted to initial coding and focused coding to allow the data to be condensed during the iterative process of data collection and analysis.

***Focused Coding***

Focused coding was the next major level in the coding process. Focused coding synthesized larger segments of data and identified the most significant or frequent codes. When undertaking focused coding, Navy Nurse Corps officers' experiences, actions, and interpretations of what was happening were compared through constant comparison of initial codes within and across interviews. For example, constant comparison of initial codes identified related concepts such as: relying on coworkers, having a collective team, and people having your back. The comparative analysis of the data resulted in the construction of the focused code, “having a collective team.” This focused code was later elevated to a provisional category (Table 4.).

Table 4 Example of focused coding

Raw Data	Initial Codes Using Gerunds	Focused Codes
I also like rely a lot on my coworkers here. They've all been very helpful.	Relying on coworkers	Having unit teamwork
because I have a team, a collective team of individuals, professionals that are willing to help and, you know, likewise to do the same.	Having a collective team	
And then I think just knowing that people have my back here has taken a lot of stress off of things.	People having your back.	

A category is an aggregation of similar themes (codes) into significant parsimonious units of analysis (119). It is interpreted in the context of the situation, other interviews, and the constructed theory. Categories explicate ideas, events, or processes in the data (19; 21). In keeping with grounded theory methods, the early categories were considered provisional to remain open to analytic possibilities. On-going comparative analysis and conceptualization resulted in some changes in the initial and focused codes, subcategories, and categories. Focused coding facilitated the organization of the codes and concepts established during the initial coding stage into higher-level categories.

Through the constant comparative method used during focused coding, similarities, themes, and categories were constructed. The construction of themes and categories allowed for the reduction in codes within NVivo 12 as the initial codes were collapsed into focused codes. The initial codes were not removed from NVivo 12. Instead, the initial codes were collapsed under the focused code as a child node. This allowed for the initial codes to be analyzed on an on-going basis as the analysis progressed. The total number of codes were reduced from approximately 1200 codes to 250 parent codes in NVivo 12 after the transcription and coding of interview rounds two and three, consisting of interviews 4-7. After the analysis and coding of the fourth and fifth round of interviews (interviews 8-25), the number of codes was reduced to 34 parent codes in NVivo 12. The last stage of coding, theoretical coding, enabled the saturation of the core categories identified during focused coding and a further reduction in codes.

### ***Theoretical Coding***

Theoretical coding is the third and final level of coding in Constructivist Grounded Theory. Theoretical coding clarifies the relationship between categories constructed during focused coding (19; 21). The use of theoretical codes lends form to the focused codes and helps the researcher to report the results coherently as an analytical story (19; 21). For example, during this study's theoretical coding level, the researcher continued to refine the code "Having unit teamwork" using multiple iterations of the constant comparative method and analytical memoing. This complex and on-going process led to the development of the category "Relying on unit teamwork and cohesiveness." With continued constant comparison and analytic memoing, the category "Relying on unit teamwork and cohesiveness" was later established as a property of the higher-level category "Building and Maintaining Social Connections." As theoretical coding continued, the main category "Enacting Restorative Practices" was constructed, and the category "Building and Maintaining Social Connections" was established as a subcategory. Theoretical coding continued in the efforts to refine developed concepts and expand conceptual categories into a theoretical structure, eventually leading to the construction of the substantive theory *Fostering Individual Well-being*. A full description of the constructed substantive theory *Fostering Individual Well-being* is presented in Chapter four. The complexity of this iterative process is difficult to visually display. However, a simplistic example displaying final codes constructed with theoretical coding can be seen in Table 5.

Table 5. Example of Theoretical coding

Raw Data	Initial Codes Using Gerunds	Focused Codes	Subcategory or Property	Subcategory	Main Category	Core Category
I also like rely a lot on my coworkers here. They've all been very helpful.	Relying on coworkers	Having unit teamwork	Relying on unit teamwork and cohesiveness	Building and Maintaining Social Connections	Enacting Restorative Practices	Fostering Individual Well-Being
because I have a team, a collective team of individuals, professionals that are willing to help and, you know, likewise to do the same.	Having a collective team					
And then I think just knowing that people have my back here has taken a lot of stress off of things.	People having your back.					

### Memo Writing

Through memo writing, initial thoughts about the similarities and the differences within the data were captured and explored. Memo writing is a pivotal step in grounded theory between data collection and writing (19; 21). Potential categories are established, and the codes that the categories subsumed were recorded through the activity of memo writing. The process of writing memos while conducting constant comparative analysis of the constructed codes helped in the generation of the theoretical outline or conceptual framework for the construction of the theory. This process assisted in looking for similarities, connections, and differences within the data, where to locate codes and

categories, and in the resultant theoretical higher-order conceptualization (19; 21). During memo writing, ideas and insight were developed because it forced the researcher to pause and engage different categories, forming a place of exploration and discovery around the ideas about the meaning of what had been seen, heard, transcribed, read, and coded.

The memos contained reflections on the concepts and categories, and constant comparison between focused codes were instrumental for theoretical coding. Memos served as an analytic tool, facilitating reflection on the data collection procedure and the data that is collected (19; 21). In order to be able to allow the construction of concepts and identify the core categories, a memo writing technique of constructivist grounded theory was adopted, starting from the early stages of the research endeavor. These memos helped the researcher think aloud, explore participants' responses, relate and compare various responses, and discover conceptual themes. Memos served as enabling tools, allowing the researcher to reflect on the whole research process, including during data collection, analysis, and write-up. In addition, memoing helped in maintaining rigor.

(Table 6.)

Table 6. Examples of memo writing

<p><b><u>Analytic Memo 09 SEP 2020:</u></b>          This code here made me re-think how I coded the subcategory. This category has changed through the constant comparative method of data, and I have gone back and forth with what the data is saying and what captures the meaning. Currently, I have coded it as "Having teamwork and cohesiveness on the unit." However, as I am revisiting the data, the section here "<b><u>rely a lot on like my coworkers here</u></b>" resonated more with an action or strategy that can be taken by the participant rather than just being in the setting itself. As I reexamined the data, "Relying on unit teamwork and cohesiveness" is a better subcategory and explanation of what the data is saying.</p>
<p><b><u>Analytic Memo 10 SEP 2020:</u></b>          This section of data speaks to how "relying on unit teamwork and cohesiveness" helps manage well-being. This participant moved units due to health reasons with COVID. Her old unit was an environment where she experienced bullying. Here on here new unit, she speaks to how she does not dread coming to work because of the teamwork and cheesiness felt on the new unit.</p>
<p><b><u>Analytic Memo 15 SEP 2020:</u></b>  <i>As I continue to analyze the data related to the codes identified as strategies or actions that individuals take, I am beginning to see this data as Subcategories under a larger category of "Enacting Restorative Practices."</i></p>

**Analytic Memo 18 SEP 2020:**

I have identified three subcategories that fit under the theme of “Enacting Restorative Practices” 1) Choosing Self, 2) Maintaining and Building Social Connectedness, and 3) Engaging in Religious or Spiritual Practices.

The similarities noted in these three categories establish that they are related to each other due to each of these categories describing ACTION OR STRATEGY taken by Navy Nurse Corps officers that focus on fueling or restoring the “self” been impacted by intervening factors in the work setting.

**PROTECTION OF HUMAN SUBJECTS**

Respect for privacy is a crucial element associated with recruitment; at times, the simple act of being invited into a study may involve privacy concerns. Although there were public marketing efforts, individual enrollment did not occur in a public area. Information on how to participate in the study was distributed to the targeted group as a whole to ensure fair participant selection, and enrollment was conducted in a location of the participant's choice to ensure confidentiality and privacy.

To ensure fair participant selection and sampling variation, study participants were recruited: (1) men and women, (2) fall units that provide care to service members with life-threatening illness or injury, and (3) all shifts were recruited. All military service members who were stationed at WRNMMC and met study criteria were provided equal access to participate in the study. Recruitment numbers were determined by the theoretical sampling process in line with grounded theory methodology to avoid excessive enrollment and increased burden imposed upon additional participants unnecessarily.

As previously mentioned in the design overview to ensure participant protection, the research study protocol was reviewed and approved by the Uniformed Services University of the Health Sciences IRB. The IRB determined that the use of written informed consents was not necessary because the study met the criteria for waivers of

informed consent 45 CFR 46.117 C (42): (i) the informed consent document would be the only record linking the subject to the research, and (ii) the research presents no more than minimal risk of harm to the subject. Therefore, informed verbal consent was obtained from all 25 Navy Nurse Corps officers who agreed to participate.

After providing verbal consent, the demographic survey was completed in one of two ways: (1) paper and pen, which was stored in a locked cabinet and later manually transcribed into an electronic repository accessible only to the researcher and University faculty methodology expert, or (2) participants were provided an electronic link to complete the demographic survey on a provided computer. Once the electronic survey was submitted, it was automatically deposited into the secure repository that was password and id protected. At the start of the survey, participants were asked to create a unique identifier consisting of the first two letters of their mother's name, the numeric day of their birth, and the last two digits of their cell phone number. This unique identifier was placed on the survey. Names were never collected from any of the 25 Navy Nurse Corps officers during data collection as a measure to ensure anonymity.

During the initiation of the recording for the semi-structured interviews, participants were asked to state the unique identifier they created. This unique identifier created by the participant would allow their interview data to be linked to their survey response. Once the interview was concluded, the digital audio recordings were downloaded to an electronic repository (password protected), and all audio recordings were deleted from the digital recording device. As previously mentioned, participants provided verbal consent after review of the consent process with the principal investigator. Therefore, there were not any paper or electronic consent copies containing

participant identifiable information. The completion of surveys and interviews were conducted in a private, mutually agreed upon location that afforded privacy to the Navy Nurse Corps officers as they told their stories.

The risk associated with participation in this study was considered minimal; however, when data collection occurs primarily through interactive dialogue, it is not possible to predict with certainty what direction the interview might take (17). These include (1) potential for sensitive topics raised and (2) memories associated with events that may be unpleasant for the participant. Participants were advised of their right to refuse to answer any question posed by the researcher, request the digital audio recording device to be turned off, end the interview at any time, or withdraw consent and end their participation in the study at any time without penalty. In addition, an information sheet providing services and mental health resources within the MTF was provided to each participant following the interview process (Appendix F).

There were no direct benefits to individual participants associated with involvement in this study. However, there may be indirect benefits for participants associated with the discovery of substantive theory related to Navy Nurse Corps officers' well-being. Theory development may: (1) further the understanding of the process of fostering well-being; (2) improve efforts for individuals and organizations in implementing strategies to facilitate fostering well-being and mitigate barriers to fostering well-being; and (3) contribute to the development of policy directed at enhancing Navy Nurse Corps officer well-being. In addition, some Navy Nurse Corps officers reported that the interviews were very therapeutic for them.

## SUMMARY

Data analysis began when the first round of interviews were completed. The interviews were transcribed verbatim and subjected to initial line-by-line coding. The constant comparative method of grounded theory was applied during the analysis of the first interview and continued throughout the data collection/analysis process within and among all interviews. Focused coding was applied for coding reduction and construction of themes, concepts, and categories. Provisional categories were formed during the focused coding process. During the final phase of coding, theoretical coding, the categories were refined and defined, leading to the construction of the theory, *Fostering Individual Well-Being*. *Fostering Individual Well-Being* is the resulting substantive theory of this original Constructivist Grounded Theory. A full description of the theory and the main categories is outlined in Chapter Four.

## CHAPTER 4: Presentation of Findings

### PURPOSE

In this chapter, the key findings obtained from 25 semi-structured interviews from participants in the study are presented. The participant demographics are presented to provide insight into the purposive sample. Following this, research question one of Aim one will be addressed by providing an in-depth description of how Navy Nurse Corps officers define and describe well-being accompanied by a constructed definition and model of well-being as perceived by the participants. Then research question two Aim one will be addressed with an overview of the theory, *Fostering Individual Well-being*, and the categories and subcategories that informed the theory. The results that answer research question one of Aim two will also be addressed by providing an in-depth description of facilitators and barriers to Navy Nurse Corps officers *Fostering Individual Well-Being*.

Excerpts from participant interviews are also provided. Participants excerpts are identified by their study participant id (e.g., P01= participant one) to protect individual confidentiality. The focus on participant excerpts will assist credibility of the findings and demonstrate the degree to which the study ensures accurate representation of the participants' views and experience. All of the findings discussed in this chapter are presented through the lens and words of the participants of the study. The approach used deliberately privileges participants' views and constructs a theory that is useful, meaningful, and relevant. The findings of the study are clearly grounded in the data and in this part of the work, the Navy Nurse Corps officers' words are privileged, while

recognizing that all forms of data sources were important. The chapter will conclude with a summary of the key findings.

## **SAMPLE**

### **Demographic Questionnaire**

Descriptive quantitative data were analyzed using SPSS version 25.0. The demographic characteristics for the participants are presented in Table 7. The participants in the study included 25 Navy Nurse Corps officers with ages ranging 22-50 stationed at a large MTF. The participants were primarily female (76%), Caucasian (68%), married (44%), held the rank of ensign (40 %), and worked on an in-patient Adult Medical-Surgical unit (56%).

Table 7. Demographic Details of Participants

<b>Variable</b>	<b>Group</b>	<b>n=25</b>	<b>Percentage</b>
Sex	Female	19	76
	Male	6	24
Racial identity	Caucasian	17	68
	Latino or Hispanic	3	12
	Asian	2	8
	Black/African American	2	8
	Prefer not to say	1	4
Relationship status	Single	5	20
	Committed	9	36
	Married	11	44
Spouse current or former military	No	16	64
	Current	6	24
	former	3	12
Children in home	yes	8	32
	no	17	68
Type of unit	Adult Med-Surg	14	56
	Neonatal ICU	2	8
	Adult Critical Care	4	16
	Adult Oncology	5	20
Education	Bachelor	20	80
	Master	4	16
	Doctorate	1	4
overtime	yes	18	72
	no	7	28
Prior Enlisted	yes	3	12
	no	22	88
Rank	ENS	10	40
	LTJG	6	24
	LT	5	20
	LCDR	4	16
Number of Deployments	0	21	84
In current role	1	3	12
	3	1	4
Formal Resilience Training	Yes	11	44
	No	14	56
Formal Palliative Care Training	yes	10	40
	No	15	60
Unit Selection	Selected	10	40
	Organization needs	15	60
Intent to Separate	yes	10	40
	no	15	60
Change in intent	yes		
	No		
<b>Variable</b>		<b>Mean (SD)</b>	<b>Range</b>
Age		29.68 (6.75)	22-50
Hours worked		51.12 (15.99)	40-88
Years in Military		5.62 (6.57)	.92-24
Years in Specialty		2.66 (2.67)	.00-11

## DESCRIPTION OF FINDINGS

### Aim 1 Research Question 1 Results

How do military nurses describe and define well-being related to providing care for patients with life-threatening illness or injury? In addressing this research question, seven categories were constructed that are grounded in the data: (1) fluid, (2) individualized, (3) holistic, (4) whole person, (5) interconnected, (6) overall health, and (7) multidimensional. In addition, eight sub-categories were constructed to further refine and define the meaning of the multidimensional category. Each of these categories are discussed in further detail in the following section.

#### *Category 1: Fluid*

A *Fluid* state in regard to well-being as defined by Navy Nurse Corps officers is the tendency to change in response to internal or external influences. A visual representation of the coding and analytical process of the raw data is shown in Table 8. Participants expressed that how they defined or described well-being had changed over-time as they were exposed to individuals with life-threatening illness and injury:

P10: I mean, I think it's changed over time after seeing so many people with long term illnesses.

Participants also described well-being as being sensitive, identifying that one's health impacts well-being, as well as life events. In addition, each dimension of well-being can fluctuate.

P12: I would say low well-being, I mean, either high or low...could be very sensitive.

Table 8. Fluid Category

Raw Data	Gerunds	Focused	Category	
Things can change because a degree of health in all those categories can change.	Changing in relation to health	Being susceptible to change	<b>Fluid</b>	Well-Being Defined
I mean, obviously, there's you know some big things that can change that. Like you said, it's a fluid state.	Changing with big things Being Fluid			
I mean, I think it's changed over time after seeing so many people with long term illnesses.	Changing over time			
I would say low well-being I mean, either high or low could have could be very sensitive.	Being very sensitive, level of well-being			

### **Category 2: Individualized**

*Individualized* in regard to well-being as defined by Navy Nurse Corps officers is adapting to the specific circumstances, desires and needs of an individual. The raw data related to the category *Individualized* and related constructed codes is presented in Table

9. Participants describe this category in the following excerpts:

P21: It is individualized.

P1: Whatever that means for you as an individual

P5: But I think it looks different for everybody because that's really what there would be. The type of things that they want to be involved in, right. But they're actually able to be involved and be present and feel like they're like functioning and achieving in the various realms that they desire.

Table 9. Individualized Category

Raw Data	Gerunds	Focused	Category	
It is individualized.	Being Individualized	Being Individualized	<b>Individualized</b>	Well-Being Defined
Whatever that means for you as an individual				
I think it's really up to the individual.	Being Individual			
But I think it's I think it's individually dependent				
But I think it looks different for everybody because that's really what there would be. The type of things that they want to be involved in, right, but they're actually able to be involved and be present and feel like they're like functioning and achieving in the various realms that they desire.	Looking different for everyone			
I think it's very personal.	Being very personal			

Again, I think it's a relative term because we can all say based on our own levels of what well-being is.	Seeing well-being as a relative term			
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**Category 3: Holistic**

*Holistic* integration in the constructed definition of well-being represents the formation of the whole or complete person. Participants describe this category in the following excerpts:

P14: I guess Well-being is just like... your holistic state. It kind of just takes everything in your situation, or anybody's situation. Your well-being is how everything is affecting you and how you're turning out your emotions to everything.

P18: Probably holistic is the first just kind of meaning, not just... your body, like you know that...is certainly something that's shown me here not to take for granted.

P18: Oh, God, that's another adult thing I started to encounter. It's holistic is well-being to me.

A visual representation of the coding and analytical process of the raw data is shown in Table 10.

Table 10. Holistic Category

Raw Data	Gerunds	Focused	Category	
Well-Being is holistic. Set of characteristic traits almost, like being in touch with yourself, your spirit, your body and mind. Feeling good about life.	Being in touch with yourself holistically	Being Holistic	<b>Holistic</b>	Well-Being Defined
I guess detail of someone's well-being, like their overall like mental health, physical health, emotional health, spiritual wellness, kind of like everything like holistically combined.	Combining Holistically			
I guess Well-being is just like your holistic state, like it kind of just takes everything in your situation or anybody situation. And that's just like your well-being is how everything is affecting you and how you're turning out your emotions to everything.	Being a holistic state  Taking everything into consideration			
I would say just a holistic or,	Being Holistic			
I think it's just a really good combination of like everything like your physical health and well-being,	Combining everything			

and then also just like your mental well-being and fortitude,				
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Through continued analysis and the use of the constant comparative method, the data initially associated with the code *Holistic*, a related but separate code, *Whole Person*, was constructed. This association between the two categories provided the linking concept of integration between the two constructed concepts in the resulting definition. This realization led to the construction of “*holistic integration of the whole person*” as part of the definition. The following section addresses further the *Whole Person* category.

**Category 4: Whole person**

The *Whole Person* in the constructed definition of well-being as defined by Navy Nurse Corps officers represents the entirety of a person to include the mind, body and spirit and the things that they go through. Participants describe this category in the following excerpts:

P21: I feel like well-being is basically a state of mind as well. And it encompasses the whole person and whatever they’re going through. And yes, that basically describes everything that I would define as well-being.

P6: You know, I think the whole body, the whole person

The codes constructed from the raw data associated with the category *Whole Person* are shown in Table 11.

Table 11. Whole Person Category

Raw Data	Gerunds	Focused	Category	
I agree with all of the above, and I feel like well-being is basically a state of mind as well. And it encompasses the whole person and whatever they’re going through. And yes, that basically describes everything that I would define as well-being.	Encompassing the whole person	Encompassing the whole person	<b>Whole Person</b>	Well-Being Defined
You know, I think the whole body, the whole person	Involving the whole person			

**Category 5: Interconnected**

*Interconnected* in the constructed definition of well-being as defined by Navy Nurse Corps officers represents the connection between the multiple dimensions of well-being that were identified by the participants. Participants describe this category in the following excerpt:

P16: Well-being taken care of yourself mentally and physically. You know, sometimes they go hand-in-hand.

P3: Emotional health, I think, is a big one, too, just making sure I have support, calling my family, seeing how they're doing. Just kind of touch bases with friends too. Just kind of keeping that...social network close by. Along with eating healthy and exercise. That kind of helps my emotional health, too.

P6: To me, I think that physical health is a very important aspect of that. But I also think that your spiritual health [and] your emotional health are just as important. And, you know, really you cannot separate the two.

It was noted that all the codes were representing the connection between the different dimensions of well-being and the code *Interconnected* was constructed and later identified as a property of how Navy Nurse Corps officers define well-being. A visual representation of the coding and analytical process is shown in Table 12.

Table 12. Interconnected Category

Raw Data	Gerunds	Focused	Category	
Well-being taken care of yourself mentally and physically. You know, sometimes I go hand-in-hand.	Going hand in hand, mental and physical	Being connected, dimensions of well-being	<b>Interconnected</b>	Well-Being Defined
Emotional health, I think, is a big one, too, just making sure I have support, calling my family, seeing how they're doing Just kind of touch bases with friends too. Just kind of keeping that social, social network close by.	Taking care of emotional health Having support			
Along with eating healthy and exercise. That kind of helps my emotional health, too	Eating right and exercising Helping emotional health			
to me, I think that physical health is very important aspect of that. But I also think that your spiritual health	Not being able to separate, dimensions of well-being			

and your emotional health are just as important. And, you know, really you cannot separate the two.				
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**Category 6: Overall Health**

*Overall health* in the constructed definition of well-being as defined by Navy Nurse Corps officers further represents the view of “the whole” being taken into account. This concept focusses on “the whole” as it relates to the individuals state of health. Therefore, *overall health* represents complete health across the eight dimensions of well-being identified by Navy Nurse Corps officers. Participants describe this category in the following excerpt:

P11: I think like overall someone’s health, like the big picture.

P17: I think of just overall... a well-rounded, healthy individual. Just healthy. I say just healthy. Well-being is just being, you know, overall healthy.

*Overall Health* was later elevated to a category of how Navy Nurse Corps officers define well-being. Table 13. provides a visual of the coding and analytical process.

Table 13. Overall Health Category

Raw Data	Gerunds	Focused	Category	
And I think about health I think about.	Thinking about health	Being Healthy overall	<b>Overall Health</b>	Well-Being Defined
I think like overall someone’s health, like the big picture.	Being overall Health			
I think of just overall... a well-rounded, healthy individual. You know...just healthy. I say just healthy. Well-being is just being... overall healthy.	Being overall Healthy			
Health in general... Not just like sickness, disease, but function. How well do I move? How well am I able to do the things that I want to do every day?	Being health in general			
A state of optimum health.	Being a state of optimum health			

**Category 7: Multidimensional**

Multidimensional in the constructed definition of well-being as defined by Navy Nurse Corps officers, represents the multiple (eight) dimensions, that were identified by the participants. Participants describe this category in the following excerpt:

P19: That would be physical, financial, spiritual, emotional, mental and relational.

P11: Like mental health... physical health, emotional health, spiritual wellness.

P12 Emotionally, physically, spiritually, mentally.

P14: And then like aspects of well-being, like your emotional well-being, your physical well-being, spiritual well-being.

The focused codes of emotional, physical, mental, financial, occupational, social, nutritional and spiritual were elevated to a subcategory and the category of Multidimensional was constructed as a concept of how Navy Nurse Corps officers define well-being. Table 14. provides a visual illustration of the coding and analytical process of the raw data.

Table 14. Multidimensional Category

Raw Data	Gerunds	Focused	Category	
Yeah. I'd say physical and emotional state to where they can perform daily activities in a well, in a good manner.	Being physical well-being Being emotional well-being Performing activities well	Physical Emotional	<b>Multidimensional</b>	Well-Being Defined
And then like aspects of well-being, like your emotional well-being, your physical well-being, spiritual well-being.	Being emotional well-being Being physical well-being Being spiritual well-being	Emotional Physical Spiritual		
I just say I like having the mental, physical and like even like spiritual.	Being mental well-being Being physical well-being Being Spiritual well-being	Mental Physical Spiritual		

When I think of well-being, I think of more so the mentality as far as like a mental well-being	Being mental well-being	Mental		
I think of a physical well-being.	Being physical well-being	Physical		
I think of nutritional standpoints.	Being Nutritional	Nurtritional		
But I would say not really, because I feel like I have a good grip on finances, like I have a lot of stuff planned out as far as one of my bills or do all that stuff	Being financial well-being	Financial		
and even the relations and relationships that you have with others, that's kind of how I view well-being.	Being social well-being	Social		

### *Subcategories of Multidimensional*

The participants identified multiple dimensions of well-being. There were a total of eight dimensions identified by the participants. These eight subcategories were used to further describe how Navy Nurse Corps officers defined well-being. The eight subcategories were emotional, financial, mental, nutritional, occupational, physical, social, and spiritual and are represented in the above section, Category 7: multidimensional. A diagram outlining the analysis process for how Navy Nurse Corps officers define well-being is shown in figure 2. This demonstrates a link between the raw data and constructed definition.

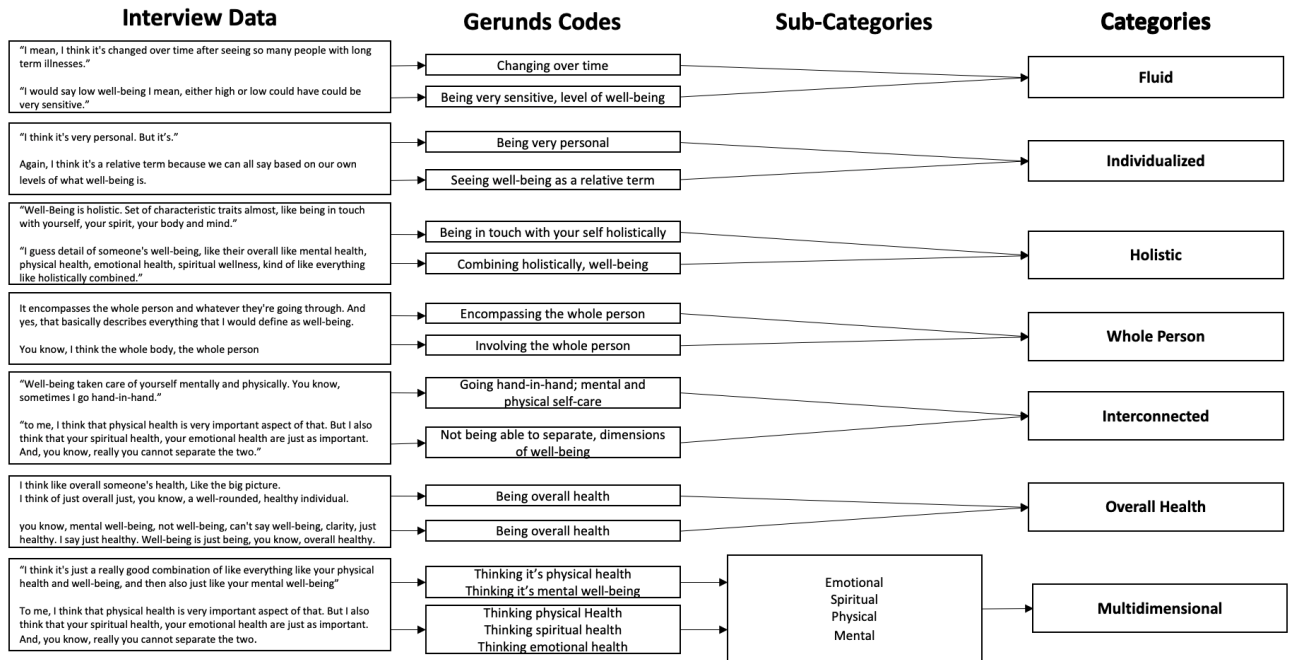


Figure 2. Analysis Process for How Well-Being is Defined

### ***Summary of Well-Being Defined***

Together these seven categories and eight subcategories of the category *Multidimensional* demonstrate how Navy Nurse Corps officers define and describe well-being. Navy Nurse Corps officers define well-being as a *fluid* state that is *individualized* with a *holistic* integration of the *whole person* that encompasses diverse and *interconnected* dimensions. They further describe well-being as a state of *overall health* that is *multidimensional* to include *emotional, financial, mental, nutritional, occupational, physical, social, and spiritual* aspects of well-being (Figure 3). If the visual representation of how Navy Nurse Corps officers define well-being could be seen three-dimensionally, it would show that each of the dimensions intersect and partially overlap not only with its neighbor but with all other dimensions, such that all are inextricably linked together.

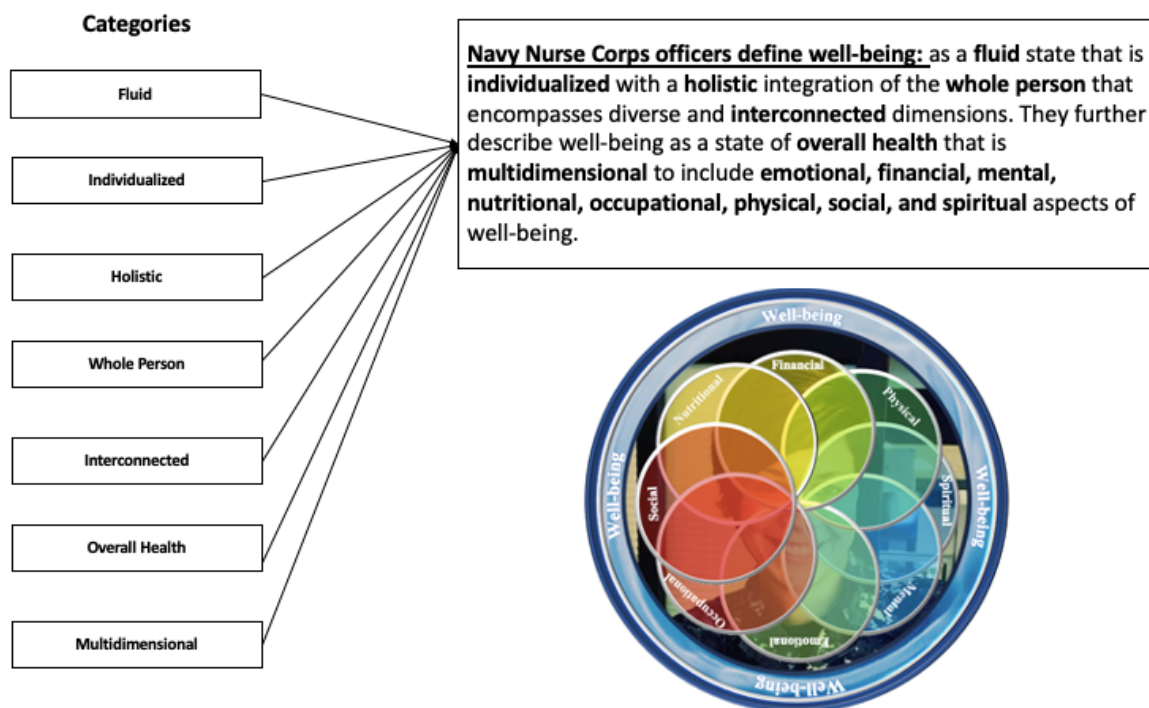


Figure 3. Well-Being Defined

### *Characteristics of High and Low Well-Being*

In addition to describing and defining well-being, participants provided characteristics of what they perceived as high and low well-being. This data was left in the descriptive form to provide descriptive properties of high and low well-being. Characteristics that Navy Nurse Corps officers distinguished as high well-being included but were not limited to the following descriptors: approachable, objective, confident, organized, calm demeanor, physically fit and optimistic. In total, there were 44 high well-being characteristics identified by the participants. Characteristics that Navy Nurse Corps officers distinguished as low well-being included but were not limited to the following descriptors: burnout, disinterested, not approachable, constantly stressed, poor nutrition, poor sleep hygiene and suffering mentally and physically. In total, 36 low well-being

characteristics were identified by participants. A comprehensive list of high and low well-being characteristics is shown in Figure 4.

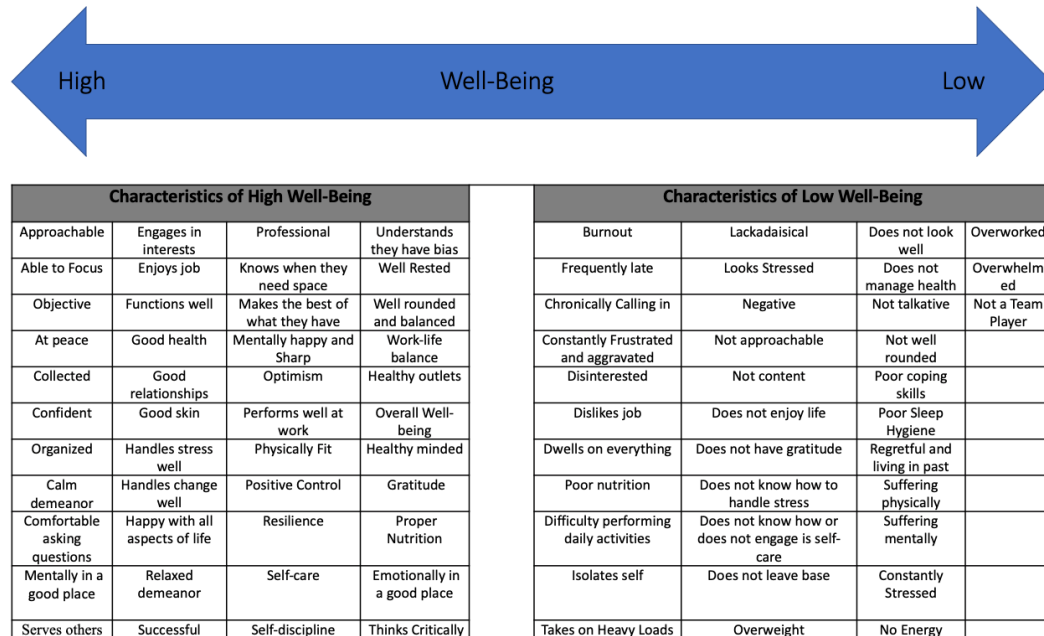


Figure 4. High and Low Characteristics of Well-Being

### Aim 1 Research Question 2 Results

This study's core aim was to understand the process for managing well-being. However, during the final analysis of the data, the exploration of managing, supporting, and fostering was compared to the interview data. It was identified that the process reflected in the interview data indicated the terminology that best fit the data was fostering (encourage or promote the development of). Additionally, the participants described an in-depth perspective of how well-being is defined that encompasses multiple dimensions that cannot be separated and therefore are interconnected. The participants in this study demonstrate that the dimensions of well-being do not occur in isolation, but in concert with each other. While the participants in this study emphasized the importance of multiple interconnected dimensions, they also described well-being as individualized.

Therefore, what was important to and described by participants was the process for *Fostering Individual Well-Being* and this became the core category of the substantive theory constructed for this study.

### ***The Substantive Theory***

*Fostering Individual Well-Being* was constructed from the data as the basic social process of how Navy Nurse Corps officers integrate their dual role (nurse and Navy officers) and self in an environment where they routinely provide care to individuals with life threatening-illness and injury. The Navy Nurse Corps officers interact within their social environment: the workplace. Navy Nurse Corps officers communicate constantly with peers, co-workers, leadership, patients and patient family members. Social interaction, then, is common and the work environment is created based upon those interactions. The behaviors and actions of Navy Nurse Corps officers were based on the interactions they had with their peers, co-workers, leadership, patients and patient family members.

The empirical data from the 25 semi-structured interviews provided information necessary for the construction of the substantive theory grounded in the interpreted meaning of the Navy Nurse Corps officers' experiences and perceptions. Those experiences and the related substantive grounded theory are presented in the following sections, which encompass the core category, the three main categories and several subcategories or properties that provide defining characteristics to the main categories of *Fostering Individual Well-Being*.

### ***Core Category: Fostering Individual Well-being***

According to Birk and Mills (14), a core category emerges when the researcher can trace connections between frequently occurring categories and subcategories. Furthermore, the core category must be central to the data and must relate to most of all the other categories (19; 21). In this study, the core category, which explains the basic social process is *Fostering Individual Well-Being*. The phrase *Fostering Individual Well-Being* is an abstraction of the data that encompasses the core or central concept of all interviews conducted with the sample of Navy Nurse Corps officers (19; 21). *Fostering Individual Well-Being* in a multifaceted and complex interchange of numerous behaviors and activities that in turn contribute to varied experiences and level of well-being for Navy Nurse Corps officers at any given time. As such, the core category *Fostering Individual Well-Being* is linked to three main categories: (1) *Customizing Individual Practices*, (2) *Enacting Assuaging Practices*, and (3) *Enacting Restorative Practices*.

It is important to note that the main categories that inform the substantive theory of *Fostering Individual Well-Being*, are not mutually exclusive. Even though these categories are presented in the form of what might appear to be discreet entities, often times the interchange between the different subcategories of such categories means there is going to be overlap. The process of *Fostering Individual Well-Being* is dynamic and fluid with the Navy Nurse Corps officer moving through components of the three main categories over the course of their career or even day as they interact with peers, co-workers, leadership, patients and patient family members. There is a constant movement in the model, where the Navy Nurse Corps officer engages in different aspects of the

three main categories on a daily and at times, a moment-by-moment basis as their situation and circumstance changes.

The discussion that follows provides a brief overview of the three main categories of the substantive theory, *Fostering Individual Well-Being*, followed by a more in-depth explanation of each of the three main categories and their associated subcategories.

1. *Customizing Individual Practices*. Customize is defined as “to build, fit, or alter according to individual specifications.” The category *Customizing Individual Practices* are behaviors and actions that individuals take to identify, implement and adapt practices that work for them. This main category consists of three subcategories: (1) *Having Self-Knowledge*, (2) *Acting on Self-Knowledge*, and (3) *Adapting to Situation*.
2. *Enacting Assuaging Practices*. Assuaging is defined as “to make less severe or intense.” The category of *Enacting Assuaging Practices* are behaviors or actions described by the participants that lessened the severity or impact of workplace adversities that are inherent to the Navy Nurse Corps workplace setting. This category is the largest of the main categories consisting of nine subcategories: (1) *Navigating Balance*, (2) *Gaining Experience and Confidence*, (3) *Embracing Vulnerability*, (4) *Attaining Empowerment*, (5) *Having Flexibility and Agility*, (6) *Setting Goals and Feeling Accomplished*, (7) *Connecting with a Sense of Meaning and Purpose*, (8) *Embodying Positive Emotions*, and (9) *Letting Things Go, Forgiving and Forgetting*.
3. *Enacting Restorative Practices*. Restorative is defined as “having the ability to restore health, strength or a feeling of well-being.” The category, *Enacting*

*Restorative Practices* are behaviors or actions described by the participants as being beneficial for restoring their well-being after a particular stressful event or day at work or just a long day at work in general. This category consists of three subcategories: (1) *Choosing Self*, (2) *Building and Maintaining Social Connections*, and (3) *Engaging in Religious and Spiritual Practices*.

### ***Main Category 1: Customizing Individual Practices***

The main category *Customizing Individual Practices* is comprised of three subcategories: (1) *Having Self-Knowledge*, (2) *Acting on Self-Knowledge*, and (3) *Adapting to Situation*.

#### ***Subcategory 1: Having Self-Knowledge***

Having Self-Knowledge is defined as having an understanding of oneself and knowing actions and practices that work for fostering one's well-being. Having Self-Knowledge is linked to the individual nature of well-being that was constructed as a component of how Navy Nurse Corps officers define well-being. Given that well-being itself is individualized it is only natural that fostering well-being would have an individual aspect as well. Participants described this subcategory in the following excerpts:

P12: And so that's where you... have to know what helps decompress or what helps like either make the next time I go in an even better day or, or to have recovered from it.

16: Know good coping mechanisms that work for you that aren't going to impact you negatively.

*Having Self-Knowledge* was identified as a tentative category and was later elevated to a subcategory of *Customizing Individual Practices*. The raw data above

includes brief excerpts from the participants that allows the reader to understand the category as perceived by Navy Nurse Corps officers. Table 15 provides a diagram of example participant excerpts and final codes constructed during the analytical process.

Table 15. Having Self-Knowledge

Raw Data	Gerunds	Focused	Subcategory	Main Category	Core Category
Like finding things that help you relax. Like working out or reading a book. Yoga. Things like that.	Finding what works for you	Identifying what works	Having Self-Knowledge	Customizing Individual Practices	Fostering Individual Well-Being
You have to figure out what do you need in order to help you, do that. And so, what helps?	Figuring out what helps you				
And so that's where you like. I have to know what helps decompress or what helps like either make the next time I go in an even better day or, or to have recovered from it.	Knowing what helps me decompress	Knowing what works			
So, I can list all these things that maybe work for me.	Knowing what works for me				
Knowing what works for me	Being in tune with inner self				

*Subcategory 2: Acting on Self-Knowledge*

*Acting on Self-Knowledge* is defined as implementing practices that are known to work in an attempt to foster one's well-being and at times applying what has worked in the past to new situation(s). *Acting on Self-Knowledge* represents Navy Nurse Corps officers using individual actions and behaviors that they know work for fostering their well-being. Originally the raw data of Having Self-Knowledge and Acting on Self-Knowledge were in the same category. However, upon further analysis and constant comparison it was concluded that these sections of data differed, and two categories were constructed. Participants described this subcategory in the following excerpts:

P17: Do what you do, do what you love to do as long as it's within reason and enjoy it.

P17: You know, do they want to go to the bar. That's fine if that your cup of tea.

P16: You know, if people like to work out or do something, like that's their go to, to kind of relieve stress.

For this set of raw data, the focused codes were condensed to *Acting on Self-Knowledge*. This was later elevated to a subcategory of *Customizing Individual Practices* during theoretical coding. In Table 16 example excerpts of raw data and the final constructed categories are presented.

Table 16. Acting on Self-Knowledge

Raw Data	Gerunds	Focused	Subcategory	Main Category	Core Category
And that's like that would be the one thing that's important for you, whatever that is, if it's getting a massage or taking a bath, taking a nap or whatever it is. Make that your priority. If that's the one thing that you can keep consistent when everything else is chaotic.	Making what works for you priority  Keeping what works for you consistent	Consistently doing what works	<b>Acting on Self-Knowledge</b>	Customizing Individual Practices	Fostering Individual Well-Being
But I just think that like on days off, what's necessary are just certain things that like, you know, that works for you.	Doing what works for you	Doing what works			
You know, if people like to work out or do something, like that's their go to, to kind of relieve stress.	Working out if that relieves stress				

### *Subcategory 3: Adapting to Situation*

*Adapting to Situation* is defined as making small changes or adjustments in actions and behaviors depending on the situation to find the best actions or activities that work in the process of fostering one's well-being. *Adapting to Situation* refers to the unpredictable nature of the Navy Nurse Corp workplace setting and speaks to the flexibility required when engaging in actions or behaviors to foster individual well-being. Participants described this subcategory of *Customizing Individual Practices* in the following excerpts:

P14: Yeah, I think it's you need to manage it based on your situation

P03: So, it's very situational. What, what I do?

P12: Like I can, I can list like what I do and what works, but I just think it's been tough, and I haven't found one change that has like radically shifted how, because I just know when you're a nurse, like every day is unexpected

For this set of raw data, the focused codes were condensed to *Adapting to Situation* and later elevated to a subcategory of *Customizing Individual Practices* during theoretical coding. Table 17 provides additional participant excerpts and associated codes.

Table 17. Adapting to Situation

Raw Data	Gerunds	Focused	Subcategory	Main Category	Core Category
It is, just kind of depends	Depending	Being situational	<b>Adapting to Situation</b>	Customizing Individual Practices	Fostering Individual Well-Being
Yeah, I think it's, you need to manage it based on your situation	Basing it on your situation				
So, it's very situational, What, what I do.	Being situational				
Like I can, I can list like what I do and what works, but I just think it's been tough, and I haven't found one change that has like radically shifted how I, because I just I know when you're a nurse, like every day is unexpected And then like ready to take on whatever is happening throughout the day.	Being ready for the unexpected	Being Flexible			

**Summary: Customizing Individual Practices**

To summarize, there are three subcategories of the main category, *Customizing Individual Practices*: (1) *Having Self-Knowledge*, (2) *Acting on Self-Knowledge*, and (3) *Adapting to Situation*. These subcategories provide defining properties of the main category and are outlined in Table 18.

Table 18. Customizing Individual Practices

Subcategory	Main Category	Core Category
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Having Self-Knowledge	<b>Customizing Individual Practices</b>	Fostering Individual Well-Being
Acting on Self-Knowledge		
Adapting to Situation		

**Main Category 2: Enacting Assuaging Practices**

*Enacting Assuaging Practices* are behaviors or actions described by the participants that lessened the severity or impact of workplace adversities that are inherent to the Navy Nurse Corps workplace setting. This main category encompasses nine subcategories: (1) *Navigating Balance*, (2) *Gaining Experience, Competence and Confidence*, (3) *Embracing Vulnerability*, (4) *Attaining Empowerment*, (5) *Having Flexibility and Agility*, (6) *Setting Goals and Feeling Accomplished*, (7) *Connecting with a Sense of Meaning and Purpose*, (8) *Embodying Positive Emotions*, and (9) *Letting Things Go, Forgiving and Forgetting*.

*Subcategory 1: Navigating Balance*

Navy Nurse Corps officers have multiple roles they take on in and out of the workplace setting. Therefore, there is a need to effectively navigate all these roles and responsibilities. The subcategory, *Navigating Balance*, describes actions or behaviors taken by Navy Nurse Corps officers to find balance. This subcategory of *Enacting Assuaging Practices* encompasses three subcategories. These subcategories provide defining properties to *Navigating Balance*. The three subcategories are: (1) *Leaving Work at Work* (2) *Protecting Personal Time*, and (3) *Prioritizing Workload*.

*Leaving Work at Work*

*Leaving Work at Work* refers to consistently not taking work home and maintaining a work-life balance. Navy Nurse Corps officers identified that being able to

leave work at work and have a work-life balance was important and a beneficial aspect of *Fostering Individual Well-Being*. *Leaving Work at Work* is reflected in the following excerpts:

P21: I'll say basically going home, making sure that I have a work-life balance. Like I mentioned earlier and knowing when to shut it off. Don't look at emails. Leaving at an appropriate timeframe. And just making sure that I don't overwork myself. That, that helps me with my well-being.

P13: Keeping work and personal life separate and not letting your emotions come into the work area or go home with you.

P09: I think just being able to, it depends on the person, but if you have a good support system like at home and people are there for you and finding ways to just go home and not think about work and do things that you enjoy that helps... you relax and take your mind off stressful things. I think that helps. So typically, I'm able to leave it at work, but there are those shifts that stick with you. And I feel like I'll take it home with me and I'll like reflect on it for like as long as I need to. Typically, not like longer than an hour or so. I try to think about other things, and you know ease my mind, but typically I'm able to leave work at work unless it's a very stressful, emotional day.

In addition, *Leaving Work at Work* refers to Navy Nurse Corps officers succeeding in not thinking about work when they are away from the workplace setting in a way that is detrimental to them *Fostering Individual Well-Being*. Participants shared their experience with how much they think about work when they are away from the workplace setting, the things they think about and how that might affect them away from the workplace setting. Some attributed the difficulty of *Leaving Work at Work* to the "military in a larger sense being a lifestyle," and the extra responsibilities and roles that come with being a Navy Nurse Corps officer.

P12: I actually think about it all the time, but I think that's because it might be circumstantial, but I think it's because of the military in a larger sense is like a lifestyle. It's not a life, but it's like it is a bigger... commitment and job then something that might be 9 to 5, and you go home. I do think that as a nurse, you're not necessarily taking your work home, but you are taking home the

process of what went on throughout the day and that... you have a lot in the military and a lot of responsibilities, and you have a lot of roles. I think it can be a compounded stress.

Other participants reported that they thought about patients with whom they may have built a relationship. This aspect of *Leaving Work at Work* overlaps with and links to a subcategory of the main category *Enacting Restorative Practices, Building and Maintaining Relationships*. In the excerpt below this overlap and link is reflected. In the exemplar, the participant indicated that relationships that are formed with patients can have an impact on their ability to *Leave Work at Work*.

P13: I guess it would have to depend on, you know, like... what's been going on at work. You know, if there's a patient that I have formed a good relationship with and I'm thinking about how they're doing or just kind of situations like that or like just like wondering how the patients have been. I'd say it's a good amount. I do think about work on my days off. If I'm distracted well enough, then, you know, it's a little less frequent. But, yeah. I'd say if it's a negative situation, like if I'm thinking about something that I did or how a patient did during a procedure, chemo or something like that, it does make me a little stressed and anxious. Just the not knowing. Just thinking about dwelling on what could happen.

Participants also reported thinking about work because it is their home away from home and their passion. Again, there is some overlap with and link to the subcategory *Building and Maintaining Relationships*. In addition, they identify that emotions at work can have an effect on their emotions at home and a bad day can be more difficult to leave at work.

P14: A lot! But it's, because I think, it's not an unhealthy way, but it's a passion. So, but like friends here, this is like my home away from home. So, I think when I think about work, it's not usually anything bad, but I do think about it a lot. My patients. Just how they're doing. Just hoping that everything's good. Or if I have friends that are working, that I'm not working with, like I'll send them a message or just be like, I hope they're having a good shift. I mean, sometimes the thoughts are like, oh, crap, like I've training I forgot to do, or I forgot to sign off like somebody else, like verifying somebody else's med. I'm like, oh, my God. But most of the time it's just like average, like, everything's okay at work, like I hope everyone is Okay. I think it affects my mood a lot at home... if I had a good day, I'm pretty like, okay, like I can switch off after a good day and just be like, now,

this is my life outside of work. But if I had a bad day, I think it's kind of hard for me to, like, get out of that and just put a lot of emotion into my patients here just out of like, I guess passion for being a nurse. And I feel like that's not very uncommon. I feel like that's something that people do. But yeah, I just I think it does affect my emotions a lot. I mean, you're here for 12 hours a day, seven days out of a fortnight. So, it's like half your life.

Participants expressed how *Leaving Work at Work* became easier as they gained experience. This aspect of the subcategory *Leaving Work at Work* overlaps with and is linked to another subcategory of *Enacting Assuaging Practices, Gaining Experience, Competence, and Confidence*.

P07: I'm thinking about dreading going back. I've gotten better about not dwelling on things. More recently, I've gotten a lot better. But in the beginning when I was like brand new was a lot harder. But yeah, it's just over time, just realizing like there's no reason to be so stressed about this. Just go home and relax. Just come back for another day. So, yeah.

P06: Dreading going back to work as a new nurse and dwelling on things at home. Leaving work at work got easier overtime.

Participants also expressed that when mentoring new nurse corps officers on how to manage well-being they would tell them to make sure that they leave work at work.

P07: I would probably say the same thing, like work is work, like do your best while you're here, but don't take it with you. Because in the end, it doesn't do anything for you.

P12: Try not to take it home with you.

*Leaving Work at Work* was identified as a focus code and was later elevated to a higher-level subcategory of *Navigating Balance* during theoretical coding. Additional participant raw data and final codes of different levels is shown in Table 19.

Table 19. Leaving Work at Work

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
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Keeping work and personal life separate and not, not letting your emotions come into the work area or go home with you.	Keeping work and personal life separate	Keeping work and personal life separate	<b>Leaving Work at Work</b>	Navigating Balance	Enacting Assuaging Practices	Fostering Individual Well-Being
Outside of work, I'd say I do. I do try to keep my work and my personal life separate as best as I can. You know, there's something that you don't... leave at work and leave at home.	Keeping work and personal life separate					
I think I always let them know that, you know, this is work and leave work at work and not just think about work the whole time.	Letting them know to leave work at work	Leaving work at work				
Now that I've been nurse two years, maybe once or twice on my days off, just kind of thinking you know what I have to do.	Thinking about work less after two years	Overtime, thinking less about work				

### *Protecting Personal Time*

*Protecting Personal Time* refers to Navy Nurse Corps officers making sure that they protect their time outside of work hours. Not letting work related activities take over every aspect of their lives and ‘eat into’ personal time was reported as an important and beneficial aspect of *Fostering Individual Well-Being*. There is notable overlap in this subcategory with *Leaving Work at Work* as participants speak to balancing work and personal time; however, this concept is different in that it distinguishes the need to protect time.

P19: The Navy will get plenty of time out of you. So, make sure you get plenty of time away from the Navy, not away from the core values of the Navy. But away from the duty station, away from the work center. Try to keep the balance. I don't think it's been too extreme towards being... at the work center more. And I think there's been some payoffs at different times and seasons that was required to get to a certain objective and goal, but to not ever feel like you have to give more. And I think luckily someone told me that pretty early on. The Navy will get their time out of you.

P11: So, I definitely feel like days off are super important and like having time off and not being overwhelmed with work, responsibilities, things like that. Also talking about just kind of being like organized like, you know, setting aside time for yourself, making sure you have an adequate amount of days off time in between work so you can rest and recover things like that.

P12: And just not letting like those things carry over so much into your time off.

Participants reported that it is a personal responsibility to protect personal time, but they also reported that the organization is responsible for protecting individual’s personal time to facilitate well-being, as well.

P18: But yeah, we have to we have to value that. People need to get out of here to recover. And you personally, I experience when I don’t get out of here. The irritability goes up. Difficulty sleeping gets up. And that affects both here and home. And so. Absolutely. I don’t know if it’s but, in some ways, it’s a military way. SA2085 Like, you know, if it was required, I could be working seven days a week. You know, when I’m on a battlefield, battlefield and I wouldn’t and shouldn’t ask for it, it’s exactly what I signed up for I don’t know that it’s really difficult, but that is the problem is Keeping sacred people’s personal time through leadership way, organizing that when they’re at work, they’re working and when they’re at home they’re at home.

P24: I think protecting people’s time. Setting clear expectations for people’s time and protecting people’s time. I really, really believe. That that would do a lot in a non-deployed environment. To have that. That your hours you work, are your hours you work. But you can be an officer at your kid’s baseball games and not think, oh, my gosh, I might get called in, I’m like, I’m not saying you wouldn’t take call, but, you know, to really protect people’s time and to allow people to.

For this set of raw data, the focused code *Protecting Personal Time* was elevated to a high-level code and identified as a subcategory of *Navigating Balance* during theoretical coding. A visual depiction of the final codes by type is shown in Table 20.

Table 20. Protecting Personal Time

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
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The Navy will get plenty of time out of you. So, make sure you get plenty of time away from the Navy, not away from the core values of the Navy. But away from the duty station, away from the work center	Navy getting plenty of time  Getting plenty of time away	Protecting personal time	<b>Protecting Personal Time</b>	Navigating Balance	Enacting Assuaging Practices	Fostering Individual Well-Being
And just not letting like those things carry over so much into your time off.	Protecting time off					
but that is the problem is Keeping sacred people's personal time through leadership way, organizing that when they're at work, they're working and when they're at home they're at home.	Keeping sacred people's personal time					
Because it is kind of like hustle and bustle, but actually protect the Quality time	Protecting Quality Time					

### *Prioritizing Workload*

*Prioritizing Workload* refers to Navy Nurse Corps officers' actions and behaviors related to managing time and prioritizing their daily tasks. These actions and behaviors were described as being important to *Fostering Individual Well-Being* by Navy Nurse Corps officers.

P19: And then you make your plans and things come up and there's deadlines and you just have to re-evaluate what is your priorities and what needs to get done. But I think it becomes negative when you have to suffer.

P03: I try not to do anything that's going to stress me out on the days that I work. Time management is a huge one. Figuring out, especially while on the floor how to get everything done in a timely manner. Figuring out what's priority if you can't get everything done. What do you need to get done? I'd say that's the biggest thing.

For this set of raw data, the focused codes were condensed to *Prioritizing Workload* which was later elevated to a subcategory of *Navigating Balance* during theoretical coding. A visual representation providing a snapshot of the coding and analytical process of how this code was constructed is shown in Table 21.

Table 21. Prioritizing Workload

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
And then you make your plans and things come up and there's deadlines and you just have to re-evaluate what your priorities and what needs to get done. But I think it becomes negative when you have to suffer.	Re-evaluating your priorities					
Like there's nothing you can do about the amount of stress you have or the amount of things going on right now	Not in control of how much you have to do					
Just deal with them one at a time	Dealing with one thing at a time	Prioritizing tasks	<b>Prioritizing Workload</b>	Navigating Balance	Enacting Assuaging Practices	Fostering Individual Well-Being
It's like, OK, you're not doing anybody any favors if you're stressed and you can't think straight.	Being stressed doesn't help anyone					
So just pick one thing and do it like whatever that is.	Dealing with one thing					
Sometimes I'll be like, OK. No. Now I'm shutting my door and now I'm not going to deal with some other things because I have to get this done	Making it priority to get tasks done					

*Summary of Navigating Balance*

Together these three subcategories provide defining properties of *Navigating Balance*, a subcategory of *Enacting Assuaging Practices*. These three subcategories were constructed as tentative categories earlier in the analysis process. It was much later during the constant comparative method of these constructed categories that the similarity and differences were identified, and the overarching category of *Navigating Balance* was constructed. Table 22 outlines the subcategory *Navigating Balance*.

Table 22. Navigating Balance

Subcategory	Category	Main Category	Core Category
Leaving Work at Work	Navigating Balance	Enacting Assuaging Practices	Fostering Individual Well-Being
Protecting Personal Time			
Prioritizing Workload			

## *Subcategory 2: Gaining Experience, Competence and Confidence*

The subcategory, *Gaining Experience, Competence and Confidence* refers to the ability to gain experience, competence and confidence, over a period of time, with skills and situations in your workplace setting. Participants described *Gaining Experience, Competence and Confidence* activities and behaviors as part of fostering their well-being. Participants shared their experiences with being a new Navy Nurse Corps officer and expressed how stressful and overwhelming it can be.

P08: No, I don't know, I think in the Navy you're put in. That's part of being in the Navy. You're put in high stress situations... put in them early and often. And I think just like knowing ... it's gonna be okay that you're going to... learn from it and it's gonna be okay. But I mean, look, like that's what I would say to myself, you know, like you learn what you can, and you and you go on. You do the best that you can. Continue your education as you go. Yeah, it'll be OK. And you just... expect it like there are going to be high stress situations. And it's like I guess that's probably preparing you for the field too. I mean, like as a new nurse every day is stressful, I feel like every day.

P25: I'm a nurse on five west, so which is our oncology floor, we have a patient that was terminal, and we were titrating up morphine and it really seemed like, oh my gosh, we're just killing this patient. But really, after talking to palliative care. This was this patient's wishes, and we weren't. It's not euthanasia. We were making her comfortable based off her symptoms. So, I think that's challenging as a new nurse to understand why we're doing that.

P13: Yeah, it's... definitely a stressful, scary time. Starting out, you know, being brand new nurse, you know, you don't know everything.

Navy Nurse Corps officers expressed that over a period of time they were able to foster their well-being more effectively because they became experienced, competent and gained confidence in providing care in their workplace and in their role as a Navy officer.

P03: In the beginning, like I was saying, when you call an RRT I don't know what to do and that's stressful. I'm just standing there, and I'm supposed to be the one in charge telling people what to do and I don't even know what to do. So luckily, you know, I think that charge came in that day or whatever and took over it. But I was like, I don't know what to do. That was... really stressful. At first is more

like beating myself up. Like, I don't know what to do, and just the whole process of calling it, an RRT was like for whatever reason, it's like stressful. Now I feel like I've had enough experiences and called enough RRT here, that is my control. Does that make sense?

P23: So, yeah, your confidence as an officer for sure over time builds and so your well-being gets better. Absolutely. Because you don't feel like you're gonna mess up. You kind of you know, it's like more enate how to behave. So, you just. Yeah, for sure. I don't get nervous when I come to work because of my rank or anything, especially being a lieutenant. And just feel like once you put on lieutenant, it's like, you, it's just different.

The excerpt below reflects *Gaining Experience, Competence and Confidence* but it also indicates overlap with and a link to the category, *Having Self-Knowledge*. As participants gain experience in their workplace setting, they may also gain self-knowledge that will benefit them in their actions and behaviors for future situations and events.

P09: So, I think I've definitely gotten better. The one day that I was mentioning... about having two end of life care patients and that day... I had my first patient pass away. So, I feel like that was like three or four months ago. And since then, I've been able to cope better. And just knowing what to expect and seeing that happen, I think prepares you better and it makes you like finding out what you need to do to be able to cope with it. What works best for you? I think that's helped me improve.

To further expand on the category of *Gaining Experience, Competence and Confidence*, some participants expressed the need to gain experience, competence and confidence as the workplace setting changes or their role in the workplace setting changes.

P15: Um prime example, I was on a five center, now I'm in the ICU learning a completely different skill set. You know... I had a very strong grasp on med surge. That was my comfort zone and now COVID hit, now I'm in ICU and it's a completely different nursing world. You know, I'm learning all completely new skills. I'm adding on to the skills that I've already learned. But more... of them. And I think the beginning of the transition was a little overwhelming for me. But now that I've been here for about a month, month and a half now, I feel like I'm finally getting a grasp on things again.

The participant excerpt below reflects *Gaining Experience, Competence and Confidence* but also reveals an overlap with and link to the subcategory, *Connecting with a Sense of Meaning and Purpose*. The participant indicated that as an experienced nurse, having six years of experience, their purpose was clear. However, as they moved into the leadership role along with *Gaining Experience, Competence and Confidence*, they were working to solidify their new purpose.

P18: But that has been kind of challenging because I went from, I felt like after six years in nursing, I became very comfortable, an expert, even at like patient care and even teaching other people patient care, end of life care. And now I've moved into more of a management role, kind of looking at more practice issues and staffing issues. And that's certainly been a challenge. When my purpose was so clear, I was here to serve and like, you know, clean the people up, give them something to eat, get them their medication. And now it's. Are we doing? Are we doing everything to prevent a fall? Are we doing everything to prevent a central line infection? It's been a... little bit of a challenge, which will probably be question for later. I'd say it's more stressful.

Participant excerpts of raw data associated with the subcategory *Experience, Competence and Confidence* and final codes of all levels are presented in Table 23.

Table 23. Gaining Experience, Competence and Confidence

Raw Data	Gerunds	Focused	Category	Main Category	Core Category
I realized like I didn't even know who I was working with, like those first couple months. Like...like I couldn't even name a doctor because I was just so focused on what I was doing, That I didn't even absorb of the world around me. I feel like. Yeah, because you just want to be the best nurse you can be. You don't want to hurt anybody you know, you don't want to mess up	Not realize who you are working with  Focusing on what I was doing  Wanting to be the best nurse you can be  Not wanting to hurt anyone	Gaining confidence in embodying the Core Professional Nursing Values (CPNVs) as a new nurse	<b>Gaining Experience, Competence, and Confidence</b>	Enacting Assuaging Practices	Fostering Individual Well-Being
I know in the beginning it can be hard to manage your time and manage your assignment with everything that you have to do. And it could get overwhelming.	Getting overwhelmed, as a new nurse	Being overwhelming in the beginning			

So, I try to tell them [new nurses] to like, you know, just take a deep breath and you'll get to things eventually.	Reminding them (new nurses) they we get it eventually				
Possibly, as always, I think we can kind of get lost in the optimism of a treatment and so explaining like there's nothing we could've done for leptomeningeal cancer. You know? For me personally, <b>actually going through for the certification</b> and starting to see the actual prognosis numbers is a lot more like oh this isn't a failure.  This is an unfortunate consequence of the disease. Like most people don't survive this	Getting lost in the optimism  Explaining nothing can be done  Gaining Knowledge through certification  Identifying it is not a failure  Seeing it as an unfortunate consequence of the disease	Establishing scope of responsibility and acknowledging treatment limit			
I think just learning how to be a nurse period helped. Learning how to delegate things.	Learning how to be a nurse	Gaining experience			

### *Subcategory 3: Embracing Humility*

The subcategory, *Embracing Humility*, refers having a sense of self-acceptance and the ability to recognize the limits of one's capability and understanding. Participants reported that it was important to not be afraid to express the need for help and ask questions if assistance is needed to understand a situation.

P15: And don't be like afraid to ask for help from, like, other people and not be afraid to say, I don't know how to do it. Like everyone, they all started in that position. And it's okay like even if you're not done with your task to seek out a co-worker who is in a position to help you and... to ask, just tell them you need help. And get the help you need so you can take care of yourself, too.

P17: And more so collectively, you know, like if I don't know anything, I can ask this person or, you know, don't have to be afraid to ask for help or anything like that, because I have a team, a collective team of individuals, professionals that are willing to help and, you know, likewise, to do the same.

P03: One big thing I do is I ask for help, whoever, not the most senior person who can help me because I don't like to tire out the charge nurse or the Service Chief if I don't need to. But another nurse, a corpsman, a tech, you know, just having an

extra set of eyes or hands or ears. Sometimes it's hard to think straight or you just get, get a second opinion. Talk it out. You know, just find somebody who understands and that can help. This is what I'm dealing with. How would you deal with it or can you help me fix it? Or delegate, you know, maybe I get stressed out because I have too many things to do. And again, it's just a matter of asking for help or letting somebody know that you need help.

For this set of raw data, the focused codes were condensed to *Embracing*

*Humility*. *Embracing Humility* was elevated to a subcategory of *Enacting Assuaging*

*Practices* during theoretical coding. Table 24 provides participant experts and final codes and categories.

Table 24. Embracing Humility

Raw Data	Gerunds	Focused	Subcategory	Main Category	Core Category
And then, you know, asking for help would be like if I need to do it, but I need help with it. So, again, it's just like another set of hands.	Asking for help Having another set of hands	Asking for help	Embracing Humility	Enacting Assuaging Practices	Fostering Individual Well-Being
Even when it is like a lot to, to manage asking for help when you need it.	Asking for help				
And if it's like something is really important, it needs to be done and you're somewhere else. Like you have help with you.	Having help with you				

*Subcategory 4: Cultivating Self-Compassion*

Nursing is a complex, challenging, and continuously changing profession with the advancement of knowledge and technology. Self-compassion involves being open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness. Self-compassion also involves a non-judgmental understanding of one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience (124). *Cultivating Self-Compassion* refers to Navy Nurse Corps officers developing the understanding that at the

end of the day they are human, and they did their best. Participants reported that accepting you did your best at the end of the day was beneficial to fostering well-being.

P01: knowing that I did the best I can.

P13: You're not going to know everything. There's always resources to find the answers, whether it's a more experienced nurse or the doctors or the Internet. Even like there's always, always ways to find your answers.

P14: But it's dependent on the situation. I mean, on a normal day, I'm going home and I'm like, I did the best I could in twelve hours and that's all someone could ask of me. Like everyone's a human, you know. Just remember that.

In addition, *Cultivating Self-Compassion* refers to the understanding and acceptance that as humans we all have the potential to make mistakes. This is a very vulnerable position/stance to take; however, participants expressed that recognizing that they are human and have the potential to make mistakes helps them to foster their well-being.

P14: But just understand that mistakes will be made. Stuff happens

P07: Like you're going to make mistakes. I still make mistakes. Everyone still makes. You could be a veteran nurse and you'll make a mistake to not beat yourself up over it because nursing there is a huge learning curve. Like every day is something new.

A visual representation providing a snapshot of the coding and analytical process of how this code was constructed is presented in Table 25.

Table 25. Cultivating Self-Compassion

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
So, yeah, it's just learning hey, this is where you're at right now and you focus on being, you know, the best that I can be,	Knowing you did your best	Accepting you did your best	<b>Cultivating Self-compassion</b>	Embracing Vulnerability	Enacting Assuaging Practices	Fostering Individual Well-Being
So, I feel like I think I would just be like, you're gonna do it and it's OK. I, do the best you can.	Doing the best, you can					
Just don't be like so hard on yourself because, like, you don't know it all.	Not be hard on yourself					

Like you're going to make mistakes. I still make mistakes. Everyone still makes. You could be a veteran nurse and you'll make a mistake to not beat yourself up over it because nursing there is a huge learning curve. Like every day is something new.	Going to make mistake  Everyone makes mistakes  Learning something new everyday	Recognizing Mistakes Happen			
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*Subcategory 5: Gaining a Voice*

*Gaining a Voice* is a subcategory of *Enacting Assuaging Practices*. Navy Nurse Corps officers identified that achieving the confidence to advocate for themselves and others was beneficial to them *Fostering Individual Well-Being*. *Gaining a Voice* refers to Navy Nurse Corps officers succeeding in achieving the knowledge and confidence to take part in speaking up for and advocating for themselves as well as others. In *Gaining a Voice* Navy Nurse Corps officers are empowered to develop professionally as both a nurse and Navy officer increasing their self-confidence and allowing for more freedom of action within the workspace. This subcategory shares similarities and overlaps with the subcategory of *Gaining Experience, Competence and Confidence*. Participants shared their experience with addressing disruptive behaviors in the workplace setting through *Gaining A Voice* to speak-up and advocate for themselves:

P23: So, I just turned around and was like, Hey. And it's like, what's up? Just bring this. I'm right here. Just tell me what's going on. So, and she did. I stood up for myself. But yeah. So, when she said that, I was like, look we, what do you have to say? And I think like me asserting myself in that situation. Ever since then, it's been squashed.

In addition, Navy Nurse Corps officers shared their experience with speaking-up and advocating for themselves to empower junior nurses to speak up.

P24: And I will absolutely speak up and say I'm not OK. So that younger nurses can see that it's OK to say that out loud because it's OK not to be OK. Coming back from a war zone, seeing people blown up, it's OK. In fact, you shouldn't be OK. Coming home from that.

Another important aspect of *Gaining A Voice* is achieving the confidence to advocate for your patients care needs.

P04: I have taken care of a dying patient with liver cancer. So, the biggest issue for him is pain. So just because as a nurse, we can't prescribe medication. So that's the barrier to that, is the doctors have to prescribe it. The issue we ran into was they are, were hesitant to give him any pain medication. So constantly calling them every 30 minutes to an hour and like, hey, the patient is in pain. He is in tears. He wants something for pain. So, it's definitely taught me a good lesson of advocating for your patients, for sure.

Having an understanding that achieving confidence to advocate for themselves and others was beneficial to fostering well-being, Navy Nurse Corps officers also engaged in mentoring others in how to gain a voice.

P04: Because even though we're all doing the, the same mission, you know caring for the people. Certain people like to take advantage of that... care that they have to provide because they wanted to be a little bit easier and definitely never let anyone take away the hard work you put through. So that's what I try to instill to all the people I've taken under my wings.

For this set of raw data, the focused codes were condensed to *Gaining a Voice*.

Participant excerpts along with final codes associated with the subcategory *Gaining a Voice* are shown in Table 27.

Table 27. Gaining a Voice

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
But I also feel like I had to kind of step up and defend myself and, you know, be more of a stronger personality than I might even be used to	Stepping up to defend myself Being a stronger personality	Advocating for Self	<b>Gaining a Voice</b>	Navigating Balance	Enacting Assuaging Practices	Fostering Individual Well-Being
Self-advocacy as far as like patient load is concerned, and assignment load,	Self-advocating					

because I feel like that's a big contributing factor to, you know, resiliency and burnout and all that stuff because our floor sometimes can get a little hectic						
But still at the same time, you know, have a firm backbone, you know, not to be a doormat or a stepping mat, you know.	Having a firm backbone					
And a lot of nurses like the newer Navy nurses, like they don't feel comfortable telling them not to talk to them that way.	Not feeling comfortable advocating for self					
So, I feel comfortable being that person. That's like, no, I don't come into their station yelling at a nurse at shift change when you don't understand what's going on, this is a appropriate way to handle it. This is why it happens. How can I help you?	Advocating for others		Advocating for other			

*Subcategory 6: Having Flexibility and Agility*

The subcategory, *Having Flexibility and Agility* refers to actions or behaviors taken by Navy Nurse Corps officers to adapt their self-expectations and to adapt to the expectations of the organization. Participants described *Having Flexibility and Agility* activities and behaviors as part of fostering their well-being. This subcategory of *Enacting Assuaging Practices* encompasses three subcategories. These subcategories provide defining properties to *Having Flexibility and Agility*. The three subcategories are: (1) *Adapting Expectations of Self*, (2) *Adapting to Meet Organization Needs*, and (3) *Being Mentally Ready for Anything*. Each of these subcategories are further described in the following section.

*Adapting Expectations of Self*

*Adapting Expectations of Self* refers to Navy Nurse Corps officers continually assessing the expectations that they or others place on them to ensure their self-expectations are realistic given their current situation. In addition, it refers to not taking on so much responsibility.

P14: Like don't be so hard on yourself all the time. I'm really hard on myself a lot as a new nurse. Just. I have high expectations for my care. Every nurse has high expectations for their care. You would hope. Just like don't get so caught up on being perfect.

P06: I would tell the ensign me. To. To go slower. That's what I would tell the ensign me. And I definitely have not been as hard charging here at Walter Reed as I was at my last duty station. And I think that it has been healthier for me.

Participants also talked about their experience with mentoring new Navy Nurse Corps officers on their self-expectations.

P19: I might also ask them if their expectations are reasonable. Help them to think through what their expectations are, reasonable for themselves or for the people around them. And Maybe not expect that they're going to be at a certain level when they're brand new to their job or when other people have reasons that they can't serve as part of the team as fully. If that's one of their issues with low well-being.

For this set of raw data, the focused codes were condensed to the subcategory

*Adapting Expectations of Self*. A visual illustration of participant excerpts and the final codes constructed in the analytical process are presented in Table 28.

Table 28. Adapting Expectations of Self

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
I'm trying to do a better job. I like put a lot of responsibility on myself and especially... like as a new nurse, right. Because if you want to know, you want to be on top of it. Right. Because	Trying to do a better job  Putting a lot of responsibility on myself Overwhelming	Not putting so responsibility on yourself	<b>Adapting Expectations of Self</b>	Having Flexibility and Agility	Enacting Assuaging Practices	Fostering Individual Well-Being

you got, Oh, my gosh, it's so overwhelming.						
I might also ask them if their expectations are reasonable. Help them to think through what their expectations are, reasonable for themselves or for the people around them. And Maybe not expect that they're going to be at a certain level when they're brand new to their job	Assessing if expectations are reasonable  Helping assess expectations as a new nurse	Determining if self-expectations are reasonable				
Like don't be so hard on yourself all the time. I'm really hard on myself a lot as a new nurse. Just. I have high expectations for my care. Every nurse has high expectations for their care. You would hope. Just like don't get so caught up on being perfect.	Not being hard on yourself all the time  Having high expectations  Not being caught up on being perfect					

*Adapting to Meet Organizational Needs*

*Adapting to Meet Organizational Needs* refers to Navy Nurse Corps officers understanding that the needs of the organization have to be taken into consideration for the organization's mission to be met. Therefore, to manage well-being, at times Navy Nurse Corps officers must adapt their own personal expectations to align with the needs of the organization. Some participants identified that they have seen individual's well-being suffer because they were unable to adapt to the needs of the organization.

P01: Individuals who, you know, came to this job for the wrong reasons, and now is faced with like, you know, me, like somebody who join the military and then, you know, it's like it's like a four-year thing and a five-year thing. You know, they can't just quit. I've heard a lot of people come to me and say, this is not what I want. And so, it makes it difficult for them to come to work and enjoy. Like having, we have a lot of elderly people now. I think a lot of people don't expect that. They want to go to the E.R. or go to them or do something else.

Some participants indicated that they initially set themselves up for failure but were successful in adjusting their expectation to meet the needs of the organization to manage their well-being.

P04: At first because I thought I would be taking care of the soldiers. That’s what I was... signing up for. It was like that when I first got here. But then that changed. And then I noticed that the population changed. And it was kind of my fault, too because... I set myself up for failure thinking I was going to take care of particular population. But then, you know, in reality, it’s everyone who’s been attached to a military branch, so I did adjust my personal expectations that I definitely learned from that. Yes, definitely. Yeah. So, I’m not just setting myself up to failure.

*Adapting to Meet Organizational Needs* was constructed from focused codes and identified as a higher-level subcategory of *Having Flexibility and Agility* during theoretical coding. Table 29 provides participant excerpts and final codes constructed in the analytical process.

Table 29. Adapting to Meet Organizational Needs

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
Individuals who, you know, came to this job for the wrong reasons, and now is faced with like, you know, me, like somebody who join the military and then, you know, it’s like it’s like a four-year thing and a five-year thing. You know, they can’t just quit. I’ve heard a lot of people come to me and say, this is not what I want. And so, it makes it difficult for them to come to work and enjoy.	Coming for the wrong reason Having a four- or five-year contract Not being able to quit Making it difficult to enjoy work	Job not meeting expectations	<b>Adapting to Meet Organizational Needs</b>	Having Flexibility and Agility	Enacting Assuaging Practices	Fostering Individual Well-Being
At first because I thought I would be taking care of the soldiers. That’s what I was signing up for. It was like that when I first got here. But then that change. And then I noticed that	Expecting to take care of soldiers Population of patients changed	Adjusting Expectations				

the population change. And it was kind of my fault, too because I, I set myself up for failure thinking I was going to take care of particular population. But then, you know, in reality, it's everyone who's been attached to a military branch, so I did adjust my personal expectations that I definitely learned from that. Yes, definitely. Yeah. So, I'm not just setting myself up to failure.	Taking responsibility for setting self up for failure  Adjusting expectations					
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*Being Mentally Ready for Anything*

*Being Mentally Ready for Anything* refers to the unpredictable nature of nursing and military service. Participants described the need to mentally prepare themselves for anything that might happen in the workplace.

P12: I think maybe the big the biggest thing is like your mentality when you go into work and just kind of tell yourself, like, be ready for anything

P17: I mean, just be prepared. I would say for any military nurse to be prepared for everything.

Participant excerpts and the final codes for *Being Mentally Ready for Anything*, a subcategory of *Having Flexibility and Agility* are presented in Table 30.

Table 30. Being Mentally Ready for Anything

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
So, you don't know, like, you just have to. I think maybe the big the biggest thing is like your mentality when you go into work and just kind of tell yourself, like, be ready for anything	Not knowing  Mentally be ready for anything	Being Mentally ready	<b>Being Mentally Ready for Anything</b>	Having Flexibility and Agility	Enacting Assuaging Practices	Fostering Individual Well-Being
I mean, just be prepared. I would say for any military nurse to be prepared for everything.	Being prepared for anything	Being prepared				

*Summary of Having Flexibility and Agility*

Together these three subcategories provide defining properties of *Having Flexibility and Agility*, a subcategory of *Enacting Assuaging Practices*. These three subcategories were constructed as tentative categories earlier in the analytical process. As the constant comparative method continued, similarities of these categories were identified, and the subcategory *Having Flexibility and Agility* was constructed. An outline of the subcategory *Having Flexibility and Agility* is provided in Table 31.

Table 31 *Having Flexibility and Agility*.

Subcategory	Category	Main Category	Core Category
Adapting Expectations of Self	Having Flexibility and Agility	Enacting Assuaging Practices	Fostering Individual Well-Being
Adapting to Meet Organizational Needs			
Being Mentally Ready for Anything			

*Subcategory 7: Setting Goals and Feeling Accomplished*

*Setting Goals and Feeling Accomplished* refers to Navy Nurse Corps officers' perceptions that setting goals and gaining a sense of accomplishment assisted them in fostering their well-being. Participants described this category in the following excerpts.

P05: I like kind of achieving at work. I like getting projects done and accomplished, and that kind of helps me feel a sense of well-being.

P03: And it's like I did it, you know? It's kind of like a... little gold star for me

P06: So, yeah, I think just setting small goals honestly and focusing on those versus, you know, oh, my gosh, it's so much longer to go. It was really important

P13: I think we did mention this, but I think just the big thing is taking that time to yourself to figure out what you want to do with your career and what your next steps are. And just having a plan and working towards that plan,

*Setting Goals and Feeling Accomplished* was a focused code that was later elevated to a subcategory of *Enacting Assuaging Practices* during theoretical coding. A

visual representation providing raw interview data and final codes is provided in Table 32.

Table 32. Setting Goals and Feeling Accomplished

Raw Data	Gerunds	Focused	Category	Main Category	Core Category
I'd say try to get as many certifications as you can. Try to go to courses when you can think about your goals and how you can get there And it's not going to happen overnight. So just think, you know, the steps that it takes to get there and what you can do just to get to the next step.	Getting as many certifications as you can  Thinking about your goals and how to get there  Thinking about the step	Setting Goals and Making a Plan	<b>Setting Goals and Feeling Accomplished</b>	Enacting Assuaging Practices	Fostering Individual Well-Being
I think we did mention this, but I think just the big thing is taking that time to yourself to figure out what you want to do with your career and what your next steps are. And just having a plan and working towards that plan,	Taking time to figure out your career  Making a plan				
I mean, there's things that Like becoming certified, go to DUINS things that I like I always wanted to achieve.	Identifying things to achieve				

*Subcategory 8: Connecting with a Sense of Meaning and Purpose*

*Connecting with a Sense of Meaning and Purpose* was constructed as a subcategory of *Enacting Assuaging Practices*. Navy Nurse Corps officers identified that being able to find purpose and meaning in their role as a nurse and a Navy officer was beneficial to them *Fostering Individual Well-Being* by lessening the impact that the workplace setting may have on their well-being. Connecting with patients and family members was described as one of the ways for Navy Nurse Corps officers to find meaning and purpose in the workplace. Participants shared their experience with providing care to patients with life-threatening illness and injury and the emotional toll this can have on their well-being. However, they followed up those experiences with how

rewarding those experiences were and finding meaning and purpose in the work they do.

The following excerpts reflect *Connecting with a Sense of Meaning and Purpose*.

P18: And that's just a patient. Again, we're so unique in that once they get a neutropenic or really bad type of infection, let's say a fungal pneumonia, they're here like for months and had worked through that with a patient that was heading towards an end-of-life situation. Knew the family really well, because I saw them as much as my family. Every time you worked, you might come in and interact with them. And so just to go through that with them and to have those 1:00 a.m. kind of discussions. ...like I thrive in that intimate connection, that human connection... Awe it's just so fulfilling. I just love it. I hope that's part of my Navy future... you know, some sort of palliative care.

P23: I've also never been in a more rewarding environment because when you see a baby go home after like, you know, months of being there, starting from like not even being really alive and you know, they're alive, but they don't even look like a baby. Sometimes when they're born so preterm were growing their organs for them. And then you get to see them go home. And it's just like the most rewarding thing ever. So, I would say the positive, like the positives definitely outweigh the negatives for me.

P13: First off, I love working on oncology floor. I think, you know, this is the floor that I was meant to be on, and I have a purpose in what I do every day.

Participants also reflected on their experiences *Connecting with a Sense of Meaning and Purpose* from the perspective of their Navy Nurse Corps leadership role.

P19: I think I would have a hard time if I was working on the schedule and rosters and spreadsheets every single day. But when I get to take a break and go teach corpsman what the importance of mean arterial pressure is, low blood pressure versus high blood pressure, and hypertensive emergency it's so much more fulfilling. When I have a Navy nurse or an army nurse participate in teaching, when you're teaching them to teach, helping them coordinate. OK, well, you're going to teach the crash cart. So, let's see if we can coordinate with the quality representative. He has a training crash cart. You can meet at this time place. The corpsmen will be there. The medics will be there. And you get to open up the train crash cart and get through with them. So, I think having that balance is nice.

P25: Positive for my well-being, I feel like I make an impact with the nurses.

In addition, participants talked about the difficulty in transitioning from the more clinical role such as a bedside nurse, to administrative leadership roles such as a unit

manager. Participants indicated that their purpose was clear in the clinical role and as they transitioned into the administrative leadership role they discovered they would need to find the connection to their purpose again. These experiences further highlight the benefit of *Connecting with a Sense of Meaning and Purpose* in the process of *Fostering Individual Well-Being*. In addition, it highlights an overlap with the main category *Enacting Restorative Practices*, by introducing the idea that one can restore well-being by re-connecting with a sense of meaning and purpose.

P18: And then I guess the big change is that in February there was a vacancy and our assistant service chief for all and I'm a lieutenant. So, they didn't leave me long at all. I think they moved me before I made lieutenant into more of a management role. And I imagine there's some questions coming down the line, but that has been kind of challenging because I went from, I felt like after six years in nursing, I became very comfortable, an expert, even at like patient care and even teaching other people patient care, end of life care. And now I've moved into more of a management role, kind of looking at more practice issues and staffing issues. And that's certainly been a challenge. When my purpose was so clear, I was here to serve and like, you know, clean the people up, give them something to eat, get them their medication. And now it's. Are we doing? Are we doing everything to prevent a fall? Are we doing everything to prevent a central line infections? It's been a, it's been a little bit of a challenge, which will probably be question for later.

*Connecting with a Sense of Meaning and Purpose* was constructed as a preliminary category and later identified predominately as a subcategory of *Enacting Assuaging Practices*, based on how the majority of participants' raw data reflected the meaning of the category. However, a few segments of raw data reflected a connection to the category *Engaging Restorative Practices*, with the idea of establishing a subcategory *Recommencing with a Sense of Meaning and Purpose*. This overlap demonstrated a link between the two main categories and the potential for future investigation of reconnecting

to a sense of meaning and purpose. Table 33. depicts participant excerpts and final codes constructed throughout the analysis process.

Table 33. Connecting with a Sense of Meaning and Purpose

Raw Data	Gerunds	Focused	Category	Main Category	Core Category
But like I said before, it's I find it very rewarding, you know, even if that is the hardest thing that they've ever had and they're just not doing well. You can still be that that person there to hold their hand or just, you know, support them in whatever they need and help them and just be there for them.	Finding it rewarding  Even when things don't go well  Being there for them	Finding work rewarding	<b>Connecting with a Sense of Meaning and Purpose</b>	Enacting Assuaging Practices	Fostering Individual Well-Being
But yes, so I, and then from your previous question, I definitely if I have had a horrible day or something, I try to remind myself like "why did I become a nurse?"  So, it's definitely something I go back and I'm like, oh yeah, like that's why.  So, it kind of makes you or me feel better. I guess you'd say so	Remembering purpose  Going back to purpose  Feeling better	Reconnecting with purpose			
First off, I love working on oncology floor. I think, you know, this is the floor that I was meant to be on, and I have a purpose in what I do every day.	Loving working Oncology  Having a purpose everyday	Having a purpose everyday			
You make these connections with your patients and. You know, you're. There are still patients I remember from three years ago that I'll, I'll probably always remember and, you know, that kind of stuff just sticks with you. And as amazing as it is to see these patients continue through their treatment and get better and walk out of here ten times stronger than they did when they came in. You also have the other side of it where you see these patients that you form relationship within the beginning and then you see them not get better and, you know, potentially pass away, which can be hard when you when you do make those relationships with the family and the patient. And so, it can be it can be difficult for sure, especially on their on an oncology unit.	Making impactful Connections with patients  Witnessing patient success  Making connection with patients that pass away  Making it difficult, when you made connections	Making impactful Connections with patients			

**Summary: Enacting Assuaging Practices**

To summarize, there are eight subcategories of the main category, *Enacting Restorative Practices*: (1) *Navigating Balance*, (2) *Gaining Experience, Competence and Confidence*, (3) *Embracing Humility*, (4) *Cultivating Self-Compassion*, (5) *Gaining a Voice*, (6) *Having Flexibility and Agility*, (7) *Setting Goals and Feeling Accomplished*, and (8) *Connecting with a Sense of Meaning and Purpose*. These subcategories and their supporting concepts provide defining properties of the main category (See Table 34).

Table 34. Enacting Assuaging Practices

Subcategory	Subcategory	Main Category	Core Category
Leaving Work at Work	Navigating Balance	<b>Enacting Assuaging Practices</b>	Fostering Individual Well-Being
Protecting Personal Time			
Prioritizing Workload			
	Gaining Experience, Competence and Confidence		
	Embracing Humility		
	Cultivating Self-Compassion		
	Gaining a Voice		
Adapting Expectations of Self	Having Flexibility and Agility		
Adapting to Meet Organization Needs			
Being Mentally Ready for Anything			
	Setting Goals and Feeling accomplished		
	Connecting with a Sense of Meaning and Purpose		

**Main Category 3: Enacting Restorative Practices**

The main category *Enacting Restorative Practices* encompasses five subcategories: (1) *Choosing Self*, (2) *Building and Maintaining Connectedness*, (3) *Engaging in Religious and Spiritual Practices*, (4) *Embodying Positive Emotions*, and (5) *Letting Things Go, Forgiving and Forgetting*.

### *Subcategory 1: Choosing Self*

*Choosing Self* refers to an individual taking time from the day to engage in actions or behaviors for themselves to provide self-care. Self-care is any activity that an individual takes part in to provide care to themselves. Self-care was identified as a characteristic of high well-being by Navy Nurse Corps officers. They further highlighted the importance of self-care here when they describe actions, they took to foster their well-being or things that they mentored others on for fostering their well-being. Participants described *Choosing Self* activities and behaviors as part of fostering their well-being. However, the specific actions taken varied among the participants.

This subcategory of *Enacting Restorative Practices* encompasses eleven subcategories. These subcategories provide properties to further define *Choosing Self* by providing detailed self-care activities and behaviors that Navy Nurse Corps officers perceived as being critical elements of fostering their well-being. The eleven subcategories are: (1) *Taking Time for Self*, (2) *Employing Exercise*, (3) *Enlisting Relaxation Techniques*, (4) *Recharging with Sleep*, (5) *Disconnecting to Recharge*, (6) *Finding Solace in Pause*, (7) *Spending Time with Pets*, (8) *Enjoying Nature Outdoors*, (9) *Fueling with Proper Nutrition*, (10) *Having a Creative Outlet*, and (11) *Participating in Therapy*.

### *Taking Time for Self*

*Taking Time for Self* refers to making sure that you take time for yourself in order to be able to engage in self-care activities. Navy Nurse Corps officers indicated that their schedules can be very hectic and unpredictable.

P7: And then just trying to enjoy like every, you know having a nursing schedule is very strange. You have weekdays off, you work weekends, etc.

In addition, they described the work that they do as very emotionally and physically taxing.

P13: Because what we do is it's taxing emotionally and physically taxing, especially on oncology unit.

By understanding the unpredictable nature of a nurse's schedule and the toll that it can place on your well-being, Navy Nurse Corps officers expressed the need to make sure that time is taken for self-care activities.

P14: So, it's like having designated self-care activities or a time or whatever can make or break your well-being, good or bad

P14: Just take care of yourself.

They further explained that taking this time is not only for the well-being of them as a Navy Nurse Corps officers, but it also allows them to provide appropriate care to others.

P3: It's just like making sure you are taking care of yourself so that you can take care of other people.

P3: I'll just... state again, take care of you so that you can take care of others.

Participant excerpts and final codes for the subcategory *Taking Time for Self* are shown in Table 35.

Table 35. Taking Time for Self

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
You deserve to do what you need to do outside of work to decompress from that.	Deserving to do what you need to	Taking time for Self	<b>Taking time for Self</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
So, it's really important to take care of yourself outside of work	Being important to take care of self					
Just like taking personal self-care will be like when I leave here.	Taking personal self-care					
No, just take time for yourself	Taking time for self					

But really taking any time off and taking advantage of it, whether it's like meeting friends or anything.	Taking time off, taking advantage of it					
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*Employing Exercise*

*Employing Exercise* is a *Choosing Self* subcategory described by Navy Nurse Corps officers as physical activities that they engage in as part of self-care in the attempt to foster their well-being. Some Navy Nurse Corps officers described this category in a less descriptive way, just identifying the importance of exercise or working out as beneficial to improving their well-being.

P7: Definitely focus on exercise. That's like an easy outlet.

P3: Always for me, exercise is a coping mechanism. So, if I don't do it, I'll feel more stressed out. I feel like doing something isn't right. Get antsy.

P18: Ok, exercise is... almost essential now to like. Which I guess it was before, so I don't know if that's different. But it remains that like I've gotta go home and burn off a little bit of the stress. Exercise is really important to me. I can tell I can literally tell, especially during winter if I'm skipping days that my well-being is, is deteriorating.

Other Navy Nurse Corps officers were more specific about the types of exercise they enjoyed and engaged in to foster their well-being.

P25: Then after here, I have a Peloton, ride my Peloton. So, that is what I do to try to help with my well-being.

P10: Do a lot of kickboxing. Something about it helps. The idea of striking out against your issues, Helps.

P06: So, a big thing for me over the last couple years has been yoga. But, you know, I see a significant difference in myself versus the days that I do yoga versus the days that I don't do yoga and how I feel and just my energy, how I act like everything. So that's something that I definitely do to help with my well-being.

For this set of raw data, the focused codes were condensed to *Employing Exercise*, which was elevated to a subcategory of *Choosing Self* during theoretical

coding. A visual representation providing a snapshot of the coding and analytical process is provided in Table 36.

Table 36. Employing Exercise

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
getting up and getting active  I think physical exercise is really important.  Whether or not that's going to the gym and doing a really vigorous workout versus just going for a walk or some like that.	Getting up and active  Thinking physical exercise is really important	Thinking exercise is important	<b>Employing Exercise</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
exercising,  like I mentioned earlier. Exercise is important to me, so that usually helps with the stressful day.  And going for a walk or run	Exercising  Exercising being important  Going for a walk or run					
I like exercise.  And working out  It helps. And I think there's like yoga and exercise help.	Liking exercise  Working out  Doing yoga and exercise help	Getting exercise				
Definitely focus on exercise. That's like an easy outlet. It is definitely exercise.	Focusing on exercise as an outlet	Exercising as an outlet				

*Enlisting Relaxation Techniques*

*Enlisting Relaxation Techniques* is a *Choosing Self* subcategory described by Navy Nurse Corps officers as activities that help them to relax as part of self-care in the attempt to manage their well-being. Navy Nurse Corps officers perceive relaxation to be an important part of fostering their well-being. Participants described this subcategory of *Choosing Self* in the following excerpts:

P11: Like stress relief...giving them time to relax or cope with different stressors.

P14: When you go home, have those little moments of just having your time and

decompressing and relaxing.

P15: Just doing anything relaxing that doesn't add too much stress on.

Some Navy Nurse Corps officers reported specific activities that they engaged in that allowed them to relax.

P17: And a nice warm bath. It's the simple thing and a nice massage or whatever.

P15: I like to do relaxing things like reading.

P13: Reading. Sometimes all it takes is just watching TV, just like to distract my mind. Get it off of work and just kind of decompress after a shift.

*Enlisting Relaxation Techniques* raw data and final codes are presented in Table 37.

Table 37. Enlisting Relaxation Techniques

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
I know if I've had a long day, you know, I like to come home from work and just kind of hang out and chill out by myself.	Chilling out by myself	Taking time to relax	<b>Enlisting Relaxation Techniques</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
Especially if they're back-to-back to back days so that I just can come home, just decompress, relax,	Decompressing and relaxing					
I like to take a bath.	Taking a bath					
If it's like more physical, sometimes I go to the gym because the gym I belong to also has a massage chair and bed. So, I use that. That helps me to relax.	Getting a massage to relax					
reading a book.	Reading					

### *Recharging with Sleep*

*Recharging with Sleep* is another *Choosing Self* subcategory described by Navy Nurse Corps officers as a self-care activity that they utilize in the attempt to manage their well-being. The subcategory *Recharging with Sleep* is reflected in the following excerpts.

P16: To manage well-being like I said sleep, definitely. Sleep

P24: So, you have to wrap up your shift, go home, fall asleep.

P24: Typically, for me, a twelve hour, a difficult job, twelve-hour shift wipes me out, so I typically sleep.

Some of the participants highlighted that especially working nights was exhausting and sleep was the main source of self-care when they got home from their shift.

P09: Night shift. I typically go home, take a shower, go to bed because I'm exhausted.

P16: So, yeah, definitely being on nights. Go home, sleep, because I am tired.

Other participants discussed needing to catch up on sleep on their off days or if they had worked overtime.

P02: But after work is concerned, I'll probably, if I'm not working the next day, I'll tell myself I'll sleep in a little bit longer, catch up on some rest. Because I know I'm really tired.

P19: Getting enough sleep regularly or trying to catch up on sleep in shifts or other obligations, demand some shorter sleeping hours.

Raw data and the associated final codes for *Recharging with Sleep* are provided in Table 38.

Table 38. Recharging with Sleep

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
Good sleep As far as resting But after work is concerned, I'll probably, if I'm not working the next day, I'll tell myself I'll sleep in a little bit longer, catch up on some rest. Because I know I'm really tired.	Getting good sleep Getting rest Catching up on sleep Realizing I am tired	Recharging with sleep	<b>Recharging with Sleep</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
There's a couple of things I do depending on how mentally. So, if it's mentally exhausting day, I just go home and take a shower and I eat. I may have a glass of wine and then go to sleep to just sleep it off.	Just sleeping it off					
Sleep (long laughter)	Sleeping	Sleeping				

If I can get a good eight hours of sleep	Getting eight hours					
But sleep, I love to sleep.	Loving to sleep					
But other than that, sleeping.	Sleeping					
But by the end of my day, I just want to go home, see my dogs, pet them, eat and then I go to bed. And that's like all I do on the day that I work. You know I just eat and go to sleep	Getting Sleep					

*Disconnecting to Recharge*

*Disconnecting to Recharge* was constructed as a subcategory of *Choosing Self*.

Participants perceived that it is important to have time away from their dual role (clinician and Navy Officer) as a Navy Nurse Corps officers. They reported that when they took time to recharge, they were better prepared to be in the workplace setting. Navy Nurse Corps officers described this subcategory of *Choosing Self* in the following excerpts:

P13: But also having your... time away from work and military and nursing and all of that just to kind of decompress for yourself and your well-being.

P7: Just kind of escaping for the day so you can recharge and go back to work.

P2: But it's relatively at least just for me, so I've been doing it so long. It's just a place where I can go and kind of forget about the things that go on in the hospital and just kind of focus on doing something I enjoy.

For this set of raw data, the focused codes were condensed to *Disconnecting to Recharge* and elevated to a subcategory of *Choosing Self* during theoretical coding. Table 39 encompasses participant excerpts and final codes for *Disconnecting to Recharge*.

Table 39. Disconnection to Recharge

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
just trying to really disconnect from work to recharge  And then really, I'm a workaholic, but I really purposely try on the weekends to try to just to disconnect with work.	Disconnecting and recharging  Disconnecting from work	Disconnecting and recharging				
In this particular area here because it's so nice and it's near D.C. I try to tell you, you know, you should definitely explore that, you know, the city. Get your mind off of work because it's a very nice and there's a lot of things to do here. A lot of museums this year are the history. You can learn about the monuments or what not.  Definitely. Just try to get out and away from here when you can	Exploring the city  Getting your mind off work  Getting away from work	Getting away from work	<b>Disconnecting to recharge</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
Sometimes I just like to do home projects like chores, normal things go, walk, wash dishes, just normal things that remind me that life doesn't revolve around work.	Doing normal things  Reminding self that life doesn't revolve around work	Not revolving around work, life				
But find an outlet, you know, just to, non-nurse the outlet	Finding a non-nursing outlet	Finding a non-nursing outlet				

*Finding Solace in Pause*

Solace is defined as comfort or consolation in a time of distress or sadness.

*Finding Solace in Pause* is a *Choosing Self* subcategory described by Navy Nurse Corps officers which represents pausing in the moment to gain a sense of relief when they are feeling distressed or saddened. *Finding Solace in Pause* is reflected in the following excerpts.

P23: But I had, like I was just like lucky and had an office since I was only active duty. So, I could just go lock myself in there, if I needed to just kind of have a moment to regroup myself.

P17: I'll pause. Sometimes if I'm having too, too much of a difficult day, I'll take a breather. You know, I'll go back a little, even if it's just right in the bathroom or anything like that.

*Finding Solace in Pause* was elevated to a subcategory of *Choosing Self* during

theoretical coding. Participant raw data and associated codes are presented in Table 40.

Table 40. Finding Solace in Pause

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
And then I might just say, hey, go get a coffee. Go, go eat, go take a thirty-minute break or something and then come back and we'll, you know, we'll get back into it.	Encouraging breaks	Pausing the workday	<b>Finding Solace in Pause</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
or sometimes I just have to take a breather and sit down and think about it. Like what? What do I need to do? Obviously not if a person's coding or something like that, but sometimes I get burnt out with a patient, you know, and you're just like, that's stressful And I'm like, just take lunch. Tell me I'll be back in half an hour. It's fine.	Taking a breather Questioning what needs to be done Getting burnt out	Taking a breather				
And just taking the time to step aside and even telling someone, I need a minute	Taking time to step aside	Stepping away				

### *Spending Time with Pets*

*Spending Time with Pets* is a *Choosing Self* subcategory described by Navy Nurse Corps officers as activities they take part in to spend time with their pets as a form of doing something for themselves. Participants described this subcategory of *Choosing Self* in the following excerpts:

P23: I'd just like to do something for myself. So that's like a walk through in the neighborhood with my dog

P15: I have a puppy that I like to spend time with, dog therapy

Focused codes were condensed to construct a tentative category, *Spending Time with Pets*. It was later elevated to a subcategory of *Choosing Self* during theoretical coding.

Participant excerpts and final codes are shown in Table 41.

Table 41. Spending Time with Pets

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
Walking the dog	Walking the dog	Being with pets	<b>Spending Time with Pets</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
But by the end of my day, I just want to go home, see my dogs, pet them,	Seeing my dogs at the end of day					
And just spending time outside with my dog, just doing anything relaxing that doesn't add too much stress on.	Spending time outside with dog					

### *Enjoying Nature Outdoors*

*Enjoying Nature Outdoors* is a *Choosing Self* subcategory described by Navy Nurse Corps officers as activities that highlight the importance of being outside as part of enhancing their well-being. Participants described this subcategory of *Choosing Self* in the following excerpts:

P19: Enjoying nature. In the outdoors. Getting enough sunlight

P25: Try to go outside on the weekends

P13: And I guess I'm getting outside when the weather's nice

While engaging in the constant comparative method it was noted that there is some overlapping of other activities within the subcategories of *Choosing Self*. In particular, there is overlap with the subcategories *Employing Exercise* and *Spending Time with Pets*.

This overlap can be seen in the following participants’ descriptions of activities they take part in when fostering their well-being.

P15: And just spending time outside with my dog, just doing anything relaxing that doesn’t add too much stress on.

P09: Go outside and run and find new trails around the area, explore.

The participants speak to engaging in activities that have been coded to fit into other subcategories of *Choosing Self*. However, there is a noted separate distinction that they are engaging in these activities while spending time in the outdoors. The participant excerpts and final codes for the subcategory *Enjoying Nature Outdoors* are presented in Table 42.

Table 42. Enjoying Nature Outdoors

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
I’m like, I’m outdoorsy. I like to go snowboarding and long distance, running on trails.	Being Outdoorsy	Enjoying outdoors	<b>Enjoying Nature Outdoors</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
Trying to try and get outside and exercise.	Getting outside to exercise					
being outside And I guess I’m getting outside when the weather’s nice	Being outside Getting outside in nice weather					
Enjoying nature. In the outdoors. Getting enough sunlight	Enjoying nature Getting sunlight	Enjoying nature				

*Fueling with Proper Nutrition*

*Fueling with Proper Nutrition* is a *Choosing Self* subcategory described by Navy Nurse Corps officers as activities related to ensuring adequate and proper nutritional intake. *Fueling with Proper Nutrition* is reflected in the following participant excerpts.

P19: Eating enough, but not too much or too much of the same thing all the time. Drinking lots of water.

P15: I would tell them to always take a lunch. That’s going to be number one.

P03: I know it seems silly, but it’s like you need food, to not stressed out.

The focused codes were condensed to *Fueling with Proper Nutrition*, which was elevated to a subcategory of *Choosing Self* during theoretical coding. Participant excerpts and final codes are represented in Table 43.

Table 43. Fueling with Proper Nutrition

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
Eat right	Eating right	Eating right	<b>Fueling with Proper Nutrition</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
I cook all of my own meals  Sometimes I even just. I think it’s lack of food. Like maybe, I just need to go eat	Meal prepping  Lacking nutritional intake	Ensuring proper nutritional intake				
Eating enough, but not too much or too much of the same thing all the time. Drinking lots of water.  Or to drink lots of water or to make sure I eat vegetables.	Getting proper nutrition  Drinking lots of water  Making sure to eat vegetables					

### *Having a Creative Outlet*

*Having a Creative Outlet* is a *Choosing Self* subcategory described by Navy Nurse Corps officers as activities they engaged in that have a creative aspect to them.

Participants described this subcategory of *Choosing Self* in the following excerpts.

P13: Art kind of stuff. I’m into art. So just crafting or drawing or doodling, even paintings.

P14: Doing my drawing. Oh, it’s like a, it’s like my meditative activity. That’s like that’s my, my doodling is kind of just like my thing, I guess

The subcategory *Having a Creative Outlet* was constructed as focused codes were condensed using the constant comparative method. It was later elevated to a subcategory

of *Choosing Self* during theoretical coding. Table 44 provides participant excerpts and final code for *Having a Creative Outlet*.

Table 44. Having a Creative Outlet

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
Art kind of stuff. I'm into art. So just crafting or drawing or doodling, even paintings.	Being artistic	Being artistic	<b>Having a Creative Outlet</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
Doing my drawing. Oh, it's like a, it's like my meditative activity. That's like that's my, my doodling is kind of just like my thing, I guess	Drawing					
Like to do painting.	Painting					
Like to do writing, poetry	Writing poetry	Writing				
Yeah, I Journal Some, some, not consistently.	Journaling					

*Participating in Therapy*

*Participating in Therapy* is a *Choosing Self* subcategory described by some Navy Nurse Corps officers as an activity that helps them in fostering their well-being.

Participants described *Participating in Therapy* in the following excerpts:

P20: And I also go to therapy. You know, I have depression and anxiety. I take medication for that. And I go to therapy and I feel good.

P05: I sought out like behavioral health myself and then started seeing them for like some anxiety issues.

A visual representation of participant excerpts and final codes associated with the subcategory *Participating in Therapy* is provided in Table 45.

Table 45. Participating in Therapy

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
And then I just kind of go to, not, not like therapy. It's more like as needed, like talking sessions. But it's nice to know that I have that resource and a relationship established with someone so that if I do need to talk to	Attending talking sessions, as needed  Having a relationship established	Participating in therapy	<b>Participating in Therapy</b>	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being

<p>someone, I can. I've come a long way with I used to be very anxious and like how panic attacks, which kind of would, I don't know what I'm trying, what the right word is. They would it would kind of come out as like anger. So, I been, come a long way and I've been like working on how to catch it earlier and then also like come down quicker from the like really high, like panicky, angry state. So, I've come a long way with that. But that's just through talking to people</p>	<p>with behavioral health</p> <p>Coming a long way</p>					
<p>And I also go to therapy.</p> <p>You know, I have depression and anxiety. I take medication for that. And I go to therapy and I feel good.</p>	<p>Going to therapy</p> <p>Having depression and anxiety</p> <p>Going to therapy</p>					
<p>I sought out like behavioral health myself. And you started seeing them for like some anxiety issues.</p>	<p>Seeking Behavioral Health</p>					

*Summary: Choosing Self*

Together these eleven subcategories provide defining properties of *Choosing Self*, a subcategory of *Engaging in Restorative Practices*. These eleven subcategories were constructed as tentative categories earlier in the analysis process. It was much later during the constant comparative method of these constructed categories that their ‘self-care’ similarities were identified, and the overarching category of *Choosing Self* was constructed. When *Choosing Self*, Navy Nurse Corps officers set aside time for themselves by engaging in self-care activities that they enjoyed and have identified as beneficial to helping them foster their well-being. Table 46 lists each of the eleven subcategories.

Table 46. Choosing Self subcategories

Subcategory	Category	Main Category	Core Category
Taking time for Self	Choosing Self	Enacting Restorative Practices	Fostering Individual Well-Being
Employing Exercise			
Enlisting Relaxation			
Recharging with Sleep			
Disconnecting to Recharge			
Finding Solace in Pause			
Spending Time with Pets			
Enjoying Nature Outdoors			
Fueling with Proper Nutrition			
Having a Creative Outlet			
Participating in Therapy			

*Subcategory 2: Building and Maintaining Social Connections*

*Building and Maintaining Social Connections* is a subcategory of *Enacting Restorative Practices* that identifies the importance of connecting with others and the actions that Navy Nurse Corps officers take to build and maintain these connections. Participants described *Building and Maintaining Social Connections* with individuals inside the workplace setting (peers, co-workers, leadership, patients and patient family members) and outside the workplace setting (family and friends). Navy Nurse Corps officers perceived that social connections were a critical part of fostering their well-being.

This subcategory of *Enacting Restorative Practices* encompasses four subcategories. These subcategories provide defining properties of *Building and Maintaining Social Connections* by providing detailed activities and behaviors that Navy Nurse Corps officers explained as having restorative properties to their well-being. The four subcategories are: (1) *Relying on Teamwork and Cohesiveness on Unit*, (2) *Attaining Support and Understanding from Colleagues*, (3) *Engaging in Talk Therapy with Family and Friends*, and (4) *Being with Family and Friends*.

*Relying on Teamwork and Cohesiveness on Unit*

*Relying on Teamwork and Cohesiveness on Unit* was described by Navy Nurse Corps officers as activities and behaviors that helps them in improving their well-being.

*Relying on Teamwork and Cohesiveness* is reflected in the following excerpts.

P01: And knowing that I also have support, like the doctors, the charge nurse and other co-workers who can be there with me, helping me, looking out for my other patients or whatever so that you can destress.

P15: I also like, rely a lot on like my coworkers here. They've all been very helpful. Because someday there'll be someone else who needs help, and you can be that person for them.

Participant raw data and final codes associated with the constructed subcategory *Relying on Teamwork and Cohesiveness on Unit* are presented in Table 47.

Table 47. Relying on Teamwork and Cohesiveness on Unit

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
You know, if things are stressful and I see that as, you know, a preceptor I'll hundred percent step in and you know, let's say, what can I do to help you? I see, you know, I see that this is going on. You know, what can I do to kind of decompress this situation? Or even if you need to step away, go, you know, go get lunch, go take a break. I'll take over for a little bit. That's fine.	Stepping in to help during stress  Helping to decompress the situation  Taking over for a bit	Stepping in to help	<b>Relying in Teamwork and Cohesiveness on Unit</b>	Building and Maintaining Social Connection	Enacting Restorative Practices	Fostering Individual Well-Being
Because I have a team, a collective team of individuals, professionals that are willing to help and, you know, likewise, to do the same. This just try to just as collectively cohesiveness, bring people together.	Having a collective team  Having Collective cohesiveness	Experiencing Teamwork and cohesiveness				
We all. We're really good on our floor, going around, making sure	Making sure everyone has eating	Taking care of each other				

everybody's eaten.						
And then here they've been very supportive as well, you know.	Having a supportive team	Having a supportive team				

*Attaining Support and Understanding from Colleagues*

*Attaining Support and Understanding from Colleagues* was described as a strategy used to seek support and understanding from fellow healthcare professional by discussing incidences or challenges they faced in the workplace setting. Participants perceived that one of the benefits from talking with fellow healthcare professionals was a sense that you are not the only one experiencing a situation and that fellow healthcare professionals understand what you are talking about, “they get it.” *Attaining Support and Understanding from Colleagues* is reflected in the following excerpts.

P12: I think it helps to, to talk to like even though you kind of want to separate work and home sometimes it's nice to talk with somebody else who's medical. If there's something that's bothering or like something that you're thinking about just because they get it and I know like I have a lot of people who don't. They're not medical. So, it that can be both like nice to talk about something different. But then also they may not understand fully.

P02: Even though a bunch of them are nurses, we end up talk about work inevitably, but it's kind of nice hearing everybody else is experiencing the same thing and it makes the whole situation feel less crappy.

*Attaining Support and Understanding from Colleagues* was constructed as a subcategory of *Building and Maintaining Social Connections* during theoretical coding. Participant excerpts and final constructed codes are shown in Table 48.

Table 48. Attaining Support and Understanding from Colleagues

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
But other than, that I talk to the people here, and we basically commiserate together, if we have to.	Commiserating with co-workers	Commiserating	<b>Attaining Support and Understanding from Colleagues</b>	Building and Maintaining Social Connection	Enacting Restorative Practices	Fostering Individual Well-Being

Having people like the nursing staff of your team there for you, if you need to vent to them. I think that really helps.	Venting to fellow nurses	Venting				
My twin sister is also in nursing as well, so she can relate. Most of the time. So, I usually vent to her.	Venting to sister as a fellow nurse					
It's always fun talking and telling each other about our specific roles.	Having fun storytelling	Storytelling				
I... usually go home and talk about it with my roommate, my roommate is a nurse and she's been a nurse longer than I have. And she Yeah, she's pretty good to, like she had worked in Peds oncology. So, she... gets it. She's been in some tough situations. And I think talking it through with her is helpful because she can feel it, you know, too. Yeah. That's the big one. Really.	Talking with roommate as a fellow nurse  Fellow nurses getting it					

*Engaging in Talk Therapy with Family and Friends*

*Engaging in Talk Therapy with Family and Friends* is a subcategory of *Maintaining and Building Social Connections* described by some Navy Nurse Corps officers as activities and behaviors beneficial to their well-being. Participants reported talking with family members and friends differently than when they discussed *Attaining Support and Understanding from Colleagues*. Specifically, there was a different benefit

gained during these discussions, which many referred to as “talk therapy.” Additionally, they reported that they were able to gain a different perspective *Engaging in Talk Therapy with Family and Friends* and a sense of being cared for. Participants described this subcategory of *Building and Maintaining Social Connections* in the following excerpts:

P18: Good question. Yeah. Like it will definitely turn into like a therapy session with my spouse and like, you know, just saying like, this is what’s on my mind.

P06: And then going home and talking to my husband and everything I think is probably one of the biggest ways that I cope with this job. My husband is so gracious, and he is so loving, and he is such a great listener, and he provides great insight, and he can tell me that I’m burning out before I even notice it. And he actually does a very good job of grounding me. I feel like.

Participant raw data and the progressive level of final codes for the subcategory

*Engaging in Talk Therapy with Family and Friends* are shown in Table 49.

Table 49. Engaging in Talk Therapy with Family and Friends

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
And I have like an amazing like fiancé I can talk to.	Talking with Fiancé	Talk therapy with family	<b>Engaging in Talk Therapy with Family and Friends</b>	Building and Maintaining Social Connection	Enacting Restorative Practices	Fostering Individual Well-Being
I think like a lot of just I guess you almost say like informal talk therapy at home. Like I rely on him a lot.	Relying on informal talk therapy at home					
Talking to my family members,  you know, my husband being a sounding board, if you know something’s bothering me	Talking with family  Having a husband as a sounding board					

*Being with Family and Friends*

*Being with Family and Friends* was described as being beneficial to fostering well-being by Navy Nurse Corps officers. Although related to the subcategories *Attaining Support and Understanding from Colleagues* and *Engaging in Talk Therapy with Family*

*and Friends*, the actions described reflected time spent with family and friends rather than discussing their challenges experienced in the workplace setting. Participants described this subcategory in the following excerpts.

P13: Yeah. Seeing family for sure helps.

P02: Going to see some of my friends, as anybody would say would be, would be good.

P09: So, to manage my well-being, I like to. With my family they live in Pittsburgh, so about like a three-and-a-half-hour drive, so as much as I can I like to go home on weekends that I have off see them.

*Being with Family and Friends* was constructed as a subcategory of *Building and Maintaining Social Connections* during theoretical coding. Raw data excerpts and final codes are displayed in Table 50.

Table 50. Being with Family and Friends

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
And establish good relationships here. People that you're able to count on and hang out with them, spend time with them. I think the biggest thing for me is just like having a support system, like I would not be where I am today without my family and my close friends.	Establishing good relationships  Spending time with people  Having a support system  Needing family and friends	Spending time with family and friends	<b>Being with Family and Friends</b>	Building and Maintaining Social Connection	Enacting Restorative Practices	Fostering Individual Well-Being
Being able to spend time with my husband and kids. Like Quality time, which, you know, after work time, sometimes it's hard It's just like dinner, bath bed. It's not as but we like to read stories. So that's a time that we like to protect. Is. Because it is kind of like hustle and bustle, but	Spending time with husband and kids  Having Quality time with family  Protecting story time	Protecting quality time with family				

actually protect the Quality time And then I feel like I'm supportive when they come to me, if they're, you know, child sick or someone's having surgery or rearranging their schedule to go to a violent concert or different things.	Protecting Quality time  Being supportive of family time as a leader	Being supportive of family time as a leader				
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*Summary: Building and Maintaining Social Connections*

Together these four subcategories provide defining properties of *Building and Maintaining Social Connections*, a subcategory of *Engaging in Restorative Practices*.

These four subcategories and final constructed codes are shown in Table 51.

**Table 51. Building and Maintaining Social Connections subcategories**

Subcategory	Category	Main Category	Core Category
Relying on Teamwork and Cohesiveness on Unit	Building and Maintaining Social Connections	Enacting Restorative Practices	Fostering Individual Well-Being
Storytelling with Fellow Healthcare Professionals			
Engaging in Talk Therapy with Family and Friends			
Being with Family and Friends			

*Subcategory 3: Engaging in Religious and Spiritual Practices*

*Engaging in Religious and Spiritual Practices* is a subcategory of *Enacting Restorative Practices* that identifies the importance of religion and spirituality in enhancing well-being. Participants described activities and behaviors related to religious or spiritual practices as part of fostering their well-being. However, the specific actions taken varied among the participants. This subcategory encompasses four subcategories that provide properties to further define *Engaging in Religious and Spiritual Practices*. The four subcategories are: (1) *Attending Church*, (2) *Reaching Out in Prayer*, (3) *Having Faith*, and (4) *Being Spiritual*.

*Attending Worship*

*Attending Worship* is a subcategory of *Engaging in Religious and Spiritual*

*Practices* described by Navy Nurse Corps officers in the following excerpts:

P05: So, I do, I enjoy going to church and volunteering for church.

P08: Yeah, yeah. I'm a practicing Catholic, so I attend Mass weekly generally. But I think, yeah, I feel like in general just a better person when I've been going to church regularly.

P06: I am a Christian and we do have very good church community here that I do feel like I can lean on. Which is a contrast to my last duty station being overseas.  
We didn't have that community overseas and I definitely noticed a difference.

In addition to attending church as an activity for fostering their well-being some Navy Nurse Corps officers described encouraging and inviting co-workers to attend church with them.

P01: But also, maybe I encourage nurses to go to church and I have invited them to my church, things like that.

Raw data and final codes related to the subcategory *Attending Worship* are shown in

Table 52.

Table 52. Attending Worship

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
But also, maybe I encourage nurses to go to church and I have invited them to my church things like that.	Encouraging going to church Inviting others to church	Going to Church	<b>Attending Worship</b>	Engaging in Religious and Spiritual Practices	Enacting Restorative Practices	Fostering Individual Well-Being
Yeah, yeah. I'm a practicing Catholic, so I attend Mass weekly generally But I think, yeah, I feel like in general just a better person when I've been going to church regularly.	Practicing Catholic Attending Mass weekly Feeling better when I attend church					

So, before COVID, I would go to church. I'm Catholic, I would go to church, but during COVID, not so much, especially because I don't want my kids to get sick	Going to church before COVID  Being a Catholic					
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*Reaching Out in Prayer*

*Reaching Out in Prayer* is another subcategory of *Engaging in Religious and Spiritual Practices*. The following participants' excerpts reflect *Reaching Out in Prayer*.

P17: Now before I leave this base, I stay in my car for about 10-15 minutes and I'm really big on prayer. So, I pray before I come, I pray before I go. Just like really kind of I just leave it all in the garage or in the parking lot and just kind of clear my mind with spiritual music and by the time I get home because it's another hat that's coming, you know, the nurse hats going off and mommy, and wife is coming on.

P05: I do pray. So, I might take an opportunity to pray and sometimes even here in my office when maybe it's in the midst of a situation. If I can break away, sometimes I'll get down on my knees. Either, whether it's like I need to change... my attitude or be thankful, or you know, hope there's something is, can change with the patient or ready myself to pick up my own kids.

Table 53 depicts participant raw data and final codes reflecting the subcategory *Reaching Out in Prayer*.

Table 53. Reaching Out in Prayer

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
You know, I always pray. Make me a better nurse, please.	Always Praying  Praying to make me a better nurse	Reaching out in Prayer	<b>Reaching out in Prayer</b>	Engaging in Religious and Spiritual Practices	Enacting Restorative Practices	Fostering Individual Well-Being
But then I also prayed after because I'm Christian.  That's my way of decompressing.	Praying as a Christian  Praying to decompress					
I pray quite a bit. So, when, and I didn't mention it earlier, but when I just feel like man I can't do right here, like I'm just no matter what. Like, if I do this, I'd be wrong to do this I do wrong. In those situations, I'm just	Praying quite a bit  Reaching out in prayer for wisdom					

like I'm like, I don't I don't know what to do. Like I said, so just speak with me. Maybe wisdom, you know, to be a part of what's going on where I feel out of control.						
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*Having Faith*

*Having Faith* is a subcategory of *Engaging in Religious and Spiritual Practices*.

Participants described this subcategory *in* the following excerpts:

P01: I think for me, remembering that God is in control of everything. And just knowing that no matter whether it's time for the patient to go or not to go, that's not on me, that's on God.

P09: So, I'm Catholic and I believe in God and everything. But I think just like knowing that God is there and looking out for me and everything, I do think about that. And I would say it has a good part of my well-being. Yes.

*Having Faith* was constructed as a focused code and was elevated to a subcategory of *Engaging in Religious and Spiritual Practices* during theoretical coding. A visual representation of participant excerpts and final codes is provided in Table 54.

Table 54. Having Faith

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
But. I definitely think that I use my faith to cope with a lot of things.	Using faith to cope	Having Faith	<b>Having Faith</b>	Engaging in Religious and Spiritual Practices	Enacting Restorative Practices	Fostering Individual Well-Being
You know, and I think yes, I think I think God is important. And I think but it's nice to have someone there who can maybe help.	Thinking God is important Having someone who can help, God					
So, I'm Catholic and I believe in God and everything.	Being Catholic					
But I think just like knowing that God is there and looking out for me and everything, I do think about that. And I would say it has a good part of my well-being. Yes.	Believing in God Knowing God is there is everything					
So, like with my, my Christianity, that's like my core value,	Having Christianity as a Core Value					

*Being Spiritual*

*Being Spiritual* is a subcategory of *Engaging in Religious and Spiritual Practices* that describes spiritual activities that participants reported enhanced their well-being. The following excerpts reflect *Being Spiritual*.

P04: Yeah. Yeah, I am. Normally, I'm very, very spiritual because of my culture. Some people like to pray and what not. But my family, we don't you know, we don't believe in God for say, but we do believe in higher power.

P07: But I think, I don't, a lot of my I guess what drives me is spiritual or spiritual or what it is I want to do good to have so good things happen to me. I think it's kind of like karma.

The raw data and final codes for *Being Spiritual* are shown in Table 55.

Table 55. Being Spiritual

Raw Data	Gerunds	Focused	Subcategory	Category	Main Category	Core Category
Yeah. Yeah, I am. Normally, I'm very, very spiritual because of my culture. Some people like to pray and what not	Being very spiritual	Being Spiritual	<b>Being Spiritual</b>	Engaging in Religious and Spiritual Practices	Enacting Restorative Practices	Fostering Individual Well-Being
But my family, we don't you know, we don't believe in God for say, but we do believe in higher power.	Believing in a higher power					
But I think, I don't, a lot of my I guess what drives me is spiritual or spiritual or what it is I want to do good to have so good things happen to	Diving by spiritual					
I think it's kind of like karma.	Doing good to receive good					
	Being similar to Karma					

*Summary: Engaging in Religious and Spiritual Practices*

Together these four subcategories provide defining properties of *Engaging in Religious and Spiritual Practices*, a subcategory of *Enacting Restorative Practices*.

These four subcategories were constructed as tentative categories and were later identified as subcategories of the higher-level category, *Engaging in Religious and*

*Spiritual Practices*. When *Engaging in Religious and Spiritual Practices* Navy Nurse Corps officers engage in religious and spiritual activities that they have identified as beneficial to their well-being. Table 56 lists all four subcategories.

Table 56. Engaging in Religious and Spiritual Practices subcategories

Subcategory	Category	Main Category	Core Category
Attending Worship	Engaging in Religious and Spiritual Practices	Enacting Restorative Practices	Fostering Individual Well-Being
Reaching Out in Prayer			
Having Faith			
Being Spiritual			

*Subcategory 4: Embodying Positive Emotions*

*Embodying Positive Emotions* refers to Navy Nurse Corps officers’ perceptions that trying to find the positive in a situation and staying positive assisted them in improving their well-being. Participants described this category in the following excerpts.

P09: And then like I said before, just try to think of the positives.

P07: I’m like well you can’t do anything about it right not. So, you got to just think of something positive and just go in and do it.

P06: So, a coach that I always loved and looked up to like my whole life and was one of my mentors, always said to me that he firmly believes that life was absolutely 10 percent, you know, like what happens to you and 90 percent how you react to it.

Participant raw data and final codes for *Embodying Positive Emotions*, a subcategory of *Enacting Assuaging Practices* are presented in Table 57.

Table 57. Embodying Positive Emotions

Raw Data	Gerunds	Focused	Category	Main Category	Core Category
This is, I’ve tried I’ve tried to, like laser in on like I would describe myself as that. I’ve tried to be positive.	Trying to stay positive	Being positive	<b>Embodying Positive Emotions</b>	Enacting Assuaging Practices	Fostering Individual Well-Being
Just like your experience is what you make it. I was told that. So, I feel like I really benefited from that.	Feeling your experience is what you make it				
I’m like well you can’t do anything about it right not. So, you got to just think of something positive and just go in and do it.	Thinking of something positive				

*Subcategory 5: Letting Things Go, Forgiving and Forgetting*

*Letting Things Go, Forgiving and Forgetting* was described by Navy Nurse Corps officers as activities and behaviors that allowed them not to dwell on things. Participants reported that addressing things as they come and then letting them go, forgiving and forgetting to move on, was beneficial to fostering their well-being. The following participant excerpts reflect *Letting Things Go, Forgiving and Forgetting*.

P19: But at the end of the day, some things you can't 100 % control. Let it let it be. Just notify the right people and move on to the next thing and go home.

P01: Yeah, I think I used to take things personally like not patient or sometimes patient experiences too. Some patients can be rude to them. Patients or family members can be rude. And especially in my first years, nurse, don't take things personally. Let things go. Forgive, forget.

P07: I'm like your home. You need to let it go.

For this set of raw data, the focused codes were condensed to *Letting Things Go, Forgiving and Forgetting*. This category was later elevated to a subcategory of *Enacting Assuaging Practices* during theoretical coding. A visual representation providing a snapshot of the coding and analytical process of how this code was constructed is shown in Table 58.

Table 58. Letting Things Go, Forgiving and Forgetting

Raw Data	Gerunds	Focused	Category	Main Category	Core Category
But at the end of the day, some things you can't 100 % control. Let it let it be. Just notify the right people and move on to the next thing and go home.  Yeah, I think it's you need to manage it based on your situation and being very forgiving of yourself. Yes	You can't control 100% Letting it go  Going Home  Forgiving of yourself	Letting things go, Forgiving and forgetting	<b>Letting Things Go, Forgiving and Forgetting</b>	Enacting Assuaging Practices	Fostering Individual Well-Being
be forgiving.	Be forgiving				
Yeah, I think I used to take things personally like not patient or	Taking things personally				

sometimes patient experiences too. Some patients can be rude to them. Patients or family members can be rude. And especially in my first years, nurse, don't take things personally. Let things go. Forgive, forget.	Letting things go Forgiving Forget				
I'm like your home. You need to let it go.	Needing to let go				

**Summary: Enacting Restorative Practices**

To summarize, there are three subcategories of the main category, *Enacting Restorative Practices*: (1) *Choosing Self*, (2) *Building and Maintaining Social Connections*, and (3) *Engaging in Religious and Spiritual Practices*. These subcategories and their supporting concepts provide defining properties of the main category (See Table 59). A visual presentation of *Enacting Restorative Practices* is shown in Figure 7.

Table 59. Enacting Restorative Practices

Subcategory	Subcategory	Main Category	Core Category
Taking Time for Self	Choosing Self	<b>Enacting Restorative Practices</b>	Fostering Individual Well-Being
Enlisting Relaxation			
Employing Exercise			
Recharging with Sleep			
Disconnecting to Recharge			
Finding Solace in Pause			
Spending Time with Pets			
Enjoying Nature Outdoors			
Fueling with Proper Nutrition			
Having a Creative Outlet			
Participating in Therapy			
Relying on Teamwork and Cohesiveness on Unit	Building and Maintaining Social Connections		
Story telling with Fellow Healthcare Professionals			
Engaging in Talk Therapy with Family and Friends			
Being with Family and Friends			
Connecting with Patients			
Attending Worship	Engaging in Religious and Spiritual Practices		
Reaching Out in Prayer			
Having Faith			
Being Spiritual			
	Embodying Positive Emotions		

	Letting Things Go, Forgiving, and Forgetting		
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**Summary: The Substantive Theory, Fostering Individual Well-Being**

The core category *Fostering Individual Well-Being* encompasses three main categories: (1) *Customizing Individual Practices*, (2) *Enacting Assuaging Practices*, and (3) *Enacting Restorative Practices*. Each of these three main categories contains subcategories that provide defining properties for the main categories (See Table 60). A detailed description of the main categories was provided to allow the reader to see the development of the substantive theory, *Fostering Individual Well-Being*. A visual representation of the core category, *Fostering Individual Well-Being* is shown in Figure 8 with the associated three main categories: (1) *Customizing Individual Practices*, (2) *Enacting Assuaging Practices*, and (3) *Enacting Restorative Practice*.

Table 60. Fostering Individual Well-Being

Subcategory	Subcategory	Main Category	Core Category
	Having Self-Knowledge	Customizing Individual Practices	Fostering Individual Well-Being
	Acting on Self-Knowledge		
	Adapting to Situation		
Leaving Work at Work	Navigating Balance	Enacting Assuaging Practices	
Protecting Personal Time			
Prioritizing Workload			
	Gaining Experience, Competence and Confidence		
	Embracing Humility		
	Cultivating Self-Compassion		
	Gaining a Voice		
Adapting Expectations of Self	Having Flexibility and Agility		
Adapting to Meet Organization Needs			
Being Mentally Ready for Anything			
	Setting Goals and Feeling accomplished		
	Connecting with a Sense of Meaning and Purpose		
Taking Time for Self	Choosing Self		

Enlisting Relaxation		Enacting Restorative Practices	
Employing Exercise			
Recharging with Sleep			
Disconnecting to Recharge			
Finding Solace in Pause			
Spending Time with Pets			
Enjoying Nature Outdoors			
Fueling with Proper Nutrition			
Having a Creative Outlet			
Participating in Therapy			
Relying on Teamwork and Cohesiveness on Unit			
Story telling with Fellow Healthcare Professionals			
Engaging in Talk Therapy with Family and Friends			
Being with Family and Friends			
Connecting with Patients			
Attending Worship	Engaging in Religious and Spiritual Practices		
Reaching Out in Prayer			
Having Faith			
Being Spiritual			
	Embodying Positive Emotions		
	Letting Things Go, Forgiving, and Forgetting		

## **Aim 2 Research Question 1 Results**

The second Aim of this study was to explore the barriers and facilitators to military nurses fostering their well-being. To address Aim two the following research question was asked: what factors serve as facilitators or barriers to military nurses' achievement of overall well-being or specific aspects of well-being? This section of the results presents the most salient findings of Aim two in a descriptive format. Interwoven in the presentation of findings of the facilitators and barriers are de-identified excerpts from participant interviews.

### ***Facilitator of Fostering Individual Well-Being***

Navy Nurse Corps officers were asked to describe their experiences and perception with things they identified that facilitated them in fostering their well-being.

Participants reflected on their experiences with providing care to individuals with life-threatening illness and injury recounting *Aspects of Providing Care* that facilitated their well-being. Navy Nurse Corps officers indicated that *Serving Those who Serve*, *Witnessing Positive Outcomes of Efforts*, *Being Present and Caring* facilitated in *Fostering Individual Well-being*.

P07: [*Serving Those who Serve*] Like it's unfortunate what happened to them. But part of me is happy to know that I'm able to take care of someone like this who's been shot. I haven't been shot, but they have. [*Witnessing Positive Outcomes of Efforts*] We had a patient like that, and he was very injured, like paralyzed for months. And now he's running and walking around. It's just to know that we contributed to that, to an active service member is pretty cool.

P07: So, it's you know, for me, it's like when it's I take care of all the patients equally, [*Serving those who Serve*] but when it's an active duty who's been shot overseas, that's something I want people, especially newer nurses, to really hone in on. But yeah, I would just say take it day by day and learn as much as you can. Because you never know when you'll get called away, Yeah.

P23: [*Witnessing Positive Outcomes of Efforts*] But then I've also never been in a more rewarding environment because when you see a baby go home after... months of being there, starting from...not even being really alive... they're alive, but they don't even look like a baby. Sometimes when they're born so preterm were growing their organs for them. And then you get to see them go home. And it's just like the most rewarding thing ever. So, I would say the positives... definitely outweigh the negatives for me.

P13: [*Being Present and Caring*] But like I said before, it's I find it very rewarding, you know, even if that is the hardest thing that they've ever had and they're just not doing well. You can still be that that person there to hold their hand or just, you know, support them in whatever they need and help them and just be there for them.

P06: [*Serving Those Who Serve*] But it's been a good challenge. And I think that this has been a good experience, a good learning experience for me in my own like actually my own resilience as far as like just day to day life.

Navy Nurse Corps officers also described leadership as a facilitator to well-being.

Leadership was the most salient identified facilitator. In particular, they identified

different leadership qualities or characteristics that were beneficial in facilitating their efforts to foster their well-being. Navy Nurse Corps officers felt that it was important for the leadership (immediate and higher level): (1) to be supportive; (2) have a presence in the workplace; (3) take an interest and check in with their sailors; (4) be approachable; (5) model self-care; (6) show vulnerability; (7) be engaged with connecting members to the mission; (8) address disruptive behavior; and (9) try to minimize the impact of frequent leadership changes by pick up where the previous leader left off.

P06: [*Supportive of people's growth*] I think for the most part, the leadership that I've interacted with here is supportive to people's growth

P25: [*Having a presence on the unit: "Being part of the team"*] And they are visible on the floors so that the nurses, if there is going something, they have a pulse even before somebody is able to. Someone says something they can already tell.

P23: [*Taking an interest in people and showing that you care as a leader*] No, I think I think the only thing that I would add is so supportive Yes. But also showing that you care, and you don't have to know every single detail about someone's life. But even to just know, like how many kids they have, just like little things like that, you know, with all this stuff going on for leadership to not check in and be like, how is how is your transition been, you know, schooling your kids at home like those kinds of things? "If you're not checking in. You can't be support." I wouldn't ask for your support. It was a work-related issue because you don't even care about my well-being, which is affected by my home life. And all those things. So, I think, like, they need to take an interest in their people to a certain extent, even if it's just a little bit

P03: [*Being approachable as a leader*] Our service chief has an open-door policy. It's really easy. So, we don't have to be intimidated by coming to her with issues or concerns.

P24: [*Modelling Self-Care as a Leader*] I think that's, that's good. I think another thing that the leaders forget, and I'm very new in leadership, anything modelling those behaviors of self-care. That's so important. And you know, how many people do you see in leadership positions, so you need to do self-care. But then they're in the hospital 12 hours a day, five plus days a week. And that doesn't model that behavior. So, I think that is a huge thing. Modelling self-care.

P19: [*Showing Vulnerability as a leader*] Let them know. I might also tell them about some. Challenges that I have been through or observed.

P19: [*Leadership providing a sense of purpose and meaning*] The CEO's call from NMRTC because he was just there to answer questions. No, that's not a committee, but it's something command level. He was just there, to answer questions and talk about something. He is a leader who probably puts in long hours and also probably close to retiring. And he's right at the point in his career where he could provide guidance before he completely is out of out of this realm. But he has collected all this experience and then he's passing it on just in small ways. He's talking about when people submitted awards that he didn't want to let them sit on his desk because he thought it was important to "recognize accomplishments in a timely manner". My paraphrase, he said similarly, he wants to ensure he disciplines in a timely manner when people still remember what the grievance was. Oh wow, I've been in the Navy for how many years. And I don't think I've ever heard that. I think to hear some of the leaders talk, not in a way they're coming inspector spaces, but just talk an hour out of my year. You know, I guess he offers it twice a year. An hour out of two hours out of, of my year. It's just that he's in the open. And he shared some things that were from the enlisted perspective because he met with the junior sailors first. And then I guess some of the petty officers all the way through E6, I think had met with him. So, wow, you know, this is something that kind of brings us back to the mission. Because when we're disconnected from the mission and why we exist, it's hard to maintain well-being.

P10: [*Addressing disruptive behaviors on the unit*] Just having their backs and not tolerating. Like if there's one person everybody says they don't want to work with on a shift, instead of just moving that person around why not actually counsel them on why they're an issue for everyone, instead of always being like oh this poor person so angry and takes it out on people, it's just keep her away from the people that piss her off. No, like they're chronically being a problem. It's like figure out why you feel the need to be yelling at people all the time. Not avoiding conflict because it's uncomfortable. Like actually taking that conflict from your staff so that you're not feeling bullied by one person. I feel like that's one thing. And you always find in a nursing environment. There's always that one nurse that's just a dick and everybody just dances around the fact that they're that way

P09: [*Picking up where other leadership left off*] And then I feel like the leaders, the leaders that I have had here have really made the effort to get to know you and try to pick back up, pick back up where the others left off with, you know, meeting your goals and helping with that. So, I feel like on five west, they've done a pretty good job with doing that and making it easier.

Navy Nurse Corps officers also identified that *Giving Time* helped to facilitate their well-being.

P06: [*Giving Time*] I think as a manager or as a boss, in a way, you can only give the people that work for you two things. You can give them time, or you can give them money. We're in the Navy, so they can't give you money. But I think you can give people even in small chunks, you can't give people time. And I think that that makes a huge impact on well-being.

There were several areas that participants described in reference to giving time: (1) granting leave requests; (2) giving holiday owed time for holidays worked; (3) giving time off when census is low; (4) giving time as an award/recognition; and (5) having scheduled administrative days to work on collateral duties, training and other military responsibilities.

P03: [*Allowing Leave*] They do allow leave

P06: [*Giving holiday owed time for holidays worked*] But I think you can give people even in small chunks, you can't give people time. And I think that that makes a huge impact on well-being. For instance, when there's a holiday doing everything possible to give your team that holiday paid back, like within that month, you know.

P18: [*Giving Scheduled Administration days*] If again, it's just the frustrating part of the command and I'm new to this I'm not saying that it isn't an option for this, but I would love to somehow get so organized or prepared or staffed where you could instead of requiring someone to subtract from their personal life. You could give you can maximize your, your work. You could. I don't know. Organize that to where it didn't require someone to cut away something personal. Or you could give them an admin day scheduled.

P24: [*Giving time off on low census days*] And some messaging that I would like to see and implement see implemented. Is it the Navy's gonna get their time from you? So, on this day that we have low census, let's send. You, you know, you're, You're up on your training, you're up on this. Let's send you home.

P10: [*Time off as an award/recognition*] We get compensatory time. So, I got a lot of awards from patients and peers. And so, I got a day off. I got to cash in on that this Sunday. So, I have three days. I was going to work row and I only had two. That was nice. That's new. I think so. Yeah, I think so., I think I our Service

Chief is trying to think of new ways to get us to be excited about getting like Daisy nominations and these awards, which are like unit stuff. Yeah

In addition, Navy Nurse Corps officers identified that aspects of the work schedule and workload were facilitators to them fostering their well-being. Participants indicated that a fair work schedule and adequate days off were key factors. Some participants indicated the benefit of working on the units that were piloting self-scheduling and how that facilitated them fostering their well-being. Primarily because they had more control over their work schedule and could accommodate other commitments.

P13: [*Fair Scheduling*] I'd say fair scheduling, I'm just I think fairness is the biggest thing.

P06: [*Having Self Scheduling*] And it's like you schedule yourself basically and you just have a set standard. Hey, we need these many nurses on this shift, and you have to sign up for your set amount of shifts for the pay period and everything is not when you're working less. It's just. For instance, you know, my family, me and my husband like to attend the Bible study on Wednesday nights. So maybe I'm off three out of the four Wednesdays in the month vs. one to two, you know So that just makes life easier for families. So, if you are in school, right? So, they're trying to schedule where they're off on Monday nights because of class or whatever it may be. And so, I think people feel like their voices at least being heard a little bit.

In regard to workload, participants expressed their experiences of being able to foster their well-being better when assignments were well-balanced among the staff members on the unit.

P12: [*Well-balanced workload*] Something our floor has implemented recently is assigning not only trying to do equal patient loads per nurse, but making the acuity equal and so, we're looking at that now and that's where if it wasn't fair before, it's looking more fair now because we're not giving Nurses more than they can handle or trying not to. We wouldn't give two, we wouldn't give a nurse two acuity five patients and then one just like one acuity three.

Navy Nurse Corps officers also reported that *Promoting Teamwork and Cohesiveness* on the unit facilitated fostering their well-being. This is consistent with the subcategory of *Building and Maintaining Social Connections, Relying on Teamwork and Cohesiveness on Unit*.

P09: [*Promoting Teamwork and Cohesiveness*] So, they, they try, and I mean, it's really good about coming together. We do like potlucks pretty frequently, which I think is good for morale. This tomorrow, they're doing Cinco de Mayo celebration. Having catering brought it. Yeah.

P12: [*Promoting Teamwork and Cohesiveness*] The first thing that came to mind is actually just making sure there isn't too sharp of a divide between like the military and civilians. Just because at the end of the day you're all doing the same job when it comes to patient safety.

Additionally, participants reported that providing and receiving affirmation, going through the six-month residency program, finding good mentors and having debriefings after difficult patient situations helped them to facilitate their well-being.

P10: [*Providing and Receiving Affirmation*] Unfortunately for me, I would say I'm someone that requires a lot of positive reinforcement, like, OK, you're doing a good job. I like what you're seeing. Pats on the head. Kind of. I'm just really dependent on that. So, I would certainly for me personally define positive reinforcement or encouragement in that way.

P18: [*Providing and Receiving Affirmation*] I definitely, because I get frustrated and I try and take the brunt of crap for them. And then, I kinda tell them, you know, you did your best. You did a good job today. You should feel proud that you did this. So, I try and give them affirmation

P03: [*Six-Month Residency Program*] Just some of it's the preparation that they do for us. So, we have a lot of simulations and classes before and during our six months of training where we go over our situations and it's like you know.

P06: [*Six-Month Residency Program*] They do the CNTP [Clinical Nurse Transition Program] program here. So, I think they groom their ensigns in a very particular way. As a result of that, they very much ease, ease ensigns in to being a nurse and very much allow you to focus on yourself

P08: [*Finding Good Mentors*] Yeah, that's kind of tough too. I'd say, that, I had a really good preceptor coming in who is a JG and so and I can always count on her like I can send her my fitrep. Like anything I need. Like she's been there for me and it's been really good. And I feel like my assistant service chief is a civilian, but with prior military and has been good about like sharing her knowledge of the military and what I need to be doing or what I should be doing moving forward. And I came here with PCS, I came here from ODS at the same time my class officer at ODS PCS'ed and he's been helpful too. Anytime I need anything, I can ask him. He's a lieutenant.

P08: [*Debriefing*] And then but then every now and then you get one that's like a really tough ethical case. And like in those cases, they would debrief, which I felt was good, because that is being transparent about what happened and How it was dealt with and why. Why things were done the way they were.

P08: [*Debriefing*] Probably something that I don't do enough, I try to encourage them until, like again for new nurses and I can relate to this is like, did I mess up or is there something I should have caught and kind of say like, listen, like let's review what you could have done, how you did respond, if there was something. Let's be constructive about it. Let's learn from it. So just kind of debriefing for sure.

***Summary: Facilitators of Fostering Individual Well-Being***

In summary, Navy Nurse Corps officers emphasized several facilitators to fostering their well-being. Leadership was identified as being a key player by having a direct impact on facilitating well-being, and/or having the ability to ensure other identified facilitators are in place within the organization. A summary of all the facilitators identified by the participants are presented in Table 61.

Table 61. Facilitators of Fostering Individual Well-being

Category	Subcategory
Aspects of Providing Care	Serving Those who Serve Witnessing Positive Outcomes of Efforts Being Present and Caring
Leadership	Being Supportive Having a Presence in the Workplace Taking an Interest and Checking in Being Approachable Modeling Self-Care Showing Vulnerability

	Connecting Members to the Mission Addressing disruptive behaviors Minimizing Change on Arrival
Giving Time	Granting Leave Giving Holiday Owed Giving Compensation for Overtime Having Scheduled Administration Days Giving Time off as an Award/Recognition Giving Time When Census is Low
Scheduling	Having Fair Scheduling Having Self-Scheduling
Well-balanced workload	
Promoting Teamwork and Cohesiveness	
Providing and Receiving Affirmation	
Six-month Residence Program	
Finding good mentors	
Debriefing	

### ***Barriers of Fostering Individual Well-Being***

Navy Nurse Corps officers were asked to describe their experiences and perceptions with things they identified that were barriers to fostering their well-being. Nurses reported that even though there were aspects of patient care that served as facilitators, other aspects of patient care were considered barriers to fostering their well-being. When providing care to fellow service members, Navy Nurse Corps officers expressed mirroring their patient’s life and situation to their own. This mirroring exposed nurses to *Recognizing One’s Own Vulnerability and Mortality*.

P06: [*Recognizing One’s Own Vulnerability and Mortality*] You know that patient has been through a lot in the last six months of their life. And as a result, you know, I see a lot of myself in this person for none of the physical things they’ve been through. But having a lot of life change, you know, we haven’t. As long as this person has been here on our ward I’ve been here on this ward, you know. So, we’ve actually learned this ward together. But me as the nurse and that person is the patient. We also happen to be the same age. We also happen to have children the same age. We also happen to have spouses that are in different branches than us. And so, I’ve learned so much from caring for this person. But there were

definitely days in the beginning when this person was much, much sicker that you went home and you wondered, why is that happening to that person and not to your family, you know, and I think that definitely it was humbling...But it does wear on you. You know, when you go home, and you think about gosh like this could happen to your family any day. There's literally nothing that separates, you know, we're all one phone call from our knees. Right. You know, it's like there's literally nothing that separates this person's family and my family. They just happen to be the unlucky ones this particular moment in time, you know. And it's like across our lifespan, we're all going to find ourselves in similar situations, maybe not to the magnitude that this individual has. I hope not, because society would be crumbled, you know.

P24: [*Recognizing One's Own Vulnerability and Mortality*] I'm sure, you know, sometimes you see yourself or loved ones in the patients that you're taking care of or the dynamics of families that you're presented with.

Nurses also expressed that the care does not stop with the patient as the nurse interacts and engages with the family members and witnesses the strain that the patient's illness or injury places on the family as well.

P06: [*Caring for More Than the Patient*] And then you do see how it affects the family. You know, maybe they were expecting this. You know, if the spouse was deployed or the service members deployed, deployed, you know, and then all of a sudden, they get injured and they're back. But you're not at your home duty station more than likely. You know, and they have to pick up their lives that they were doing without you and come here and care for you while you're in the hospital. And you can definitely sense like financial strain, familial strain.

In addition, nurses expressed how providing care to this population can "boil over to the caregivers.

P06: [*Being a Jack of All Trades*] And then I think sometimes it does boil over to the caregivers, too, because their, we're the ones that are, you know, hearing it day in and day out. And, you know, as a nurse, right, you're the jack of all trades trying to manage the whole person and the whole thing. You know, sometimes it's like man, I think that we're all one moment away from just like crumbling.

Participants also reported that moral conflict with providing care was indicated as a barrier to fostering their well-being.

P24: [*Moral Conflict with Patient Care*] And sometimes there are you know as the initial survey, the ethical issues that come up be that whether, you know, care should be escalated or not or withdrawn. Or whenever, there are differences in opinions, of course, of course, of action from different consulting services. Or Yeah, that definitely can affect you. Yeah.

P10: [*Moral Conflict with Patient Care*] I just feel guilty, like if I leave work, I truly don't feel like I made a difference that day. KA0763 Like if I tried all day to make this patient that really didn't want to have a pic but they still get a pic, but I feel like I failed. That bothers me. I go home and I think about that because, you know, some people this is their last stop in their life. And if I could have done one thing and make a difference for a day, why couldn't I accomplish it? If it's ethically wrong, I'm sad that I couldn't fix it for them.

Another barrier that was identified as one of the most salient barriers to fostering well-being was experiencing disruptive behaviors in the workplace. The number one disruptive work behavior that participants reported was bullying. Some participants reported experiencing bullying themselves.

P24: [*Being Bullied in the ICU by GS ICU nurses*] As a new ICU nurse, there are, our unit was. There, you know, there were those GS ICU nurses. Well, and I will not knock their knowledge base. It was fantastic. But they were established. They would, they called it, quote unquote, pimping. They would pimp their nurses and their corpsman and kind of put you on the spot and quizzing on the nitty gritty of pathophysiology, pharmacology, etc. Which is fine and dandy in an academic setting. But at the bedside in front of patients and their families, in front of other staff members. And when it took a little while to kind of wise up to was, oh, you quote unquote, pimp everybody on the exact same information because this is your small little thing that you have memorized. And so, you know, as you kind of grew your teeth as an ICU nurse, you could turn that back around and fluster this other individual, which is not a healthy dynamic. But you mirrored the behaviors that you see. There was there was bullying. There was intentionally putting new nurses in rough situations to see how they handled it. Sometimes to the point of it being a patient safety issue

P23: [*Being Bullied by Civilian. The eat your young thing, is real.*] I just, it's just, I don't want my peers to see me flustered, or upset, or anything like that, especially in the environment that I'm currently in. They, the eat your young thing is real. So, I, they don't need to see me upset Yeah. Yeah. And I don't, I don't want it to sound like it's gonna sound. But I've worked with all civilians since I've been at Walter Reed. So, my first workspace, it was just me and there was one other

active duty. But she's she wasn't there. And then my current I'm the only one besides leadership like both my service chiefs are military. But when I first get to the NICU I got a lot of the why would you even bother teaching? You're gonna leave us in a year and those kind of things. There is definitely some strong personalities there. In my current workspace, before they, before they even got to know me, I had someone like purposefully retaliating were her words against me for something that I didn't do. She thought I did. And so, it was like a really, really rough the first two weeks. There, two or three weeks probably there. And then she was talking about me, but not saying my name in front of me to our leadership. So, I don't know. It's very interesting. But it's always been an older GS employee. Like every time that I've ever experienced that, even in my last command. Every time. Which I don't know. I don't know if it's. Civilian versus military conflict or what? But it's not always the case for me.

P07: [*Being Bullied by Civilians*] One of them just calling me a backstabber right behind me, literally right behind me, so I'm sitting there, just like whatever, I'm not to say anything. But there was a lot of backlash from that, which makes me never want to speak up because I'm like, well, if there's a problem, I guess I can't say anything because then I'll get tortured at work every day. So really nasty attitudes, like not willing to help me with anything. If they're in charge, that's even more of a nightmare sometimes because then they'll just, deliberately just ignore your existence and just makes your day really hard.

P24: [*Experiencing Bullying from Leadership*] I was once told I, when I was said to PCS. A few weeks before I was assigned to PCS, we had a horrible. We'd lost like 30 staff members to PCS and got maybe four in return, and all the hospices in the local area have closed and so suddenly all these people used to handle an outpatient or in a hospice setting. Were now intensive care unit patients that because they're in ICU, the family families do everything. It's a horrible work environment. And I was asked about four weeks before I was to PCS. Hey, would you be willing to extend here? We need you here? To watch my response. And I know I was working as a SAMFE at the time, as sexual assault examiner. I was, we were pulling extra shifts as working, probably five shifts a week. And I finally, for first time in my life said, no, I need to go. I'm in an unhealthy place. I'm drinking too much. I'm not sleeping. All of this is bad. And this person the position of leadership's response was. Don't worry, I won't tell anybody that you decided not to help us out. So. So, yeah, there's some pretty intensive bullying. I was in 0 2 at the time. It's my first duty station. There's some pretty intensive like bullying and manipulation that I have seen in the Navy Nurse Corps and it's Got to go.

Other participants reported witnessing or hearing about bullying taking place.

P21: [*Seeing Bullying on the Unit*] You know, so I've seen that a lot you know. And then some personalities on the floor, you know, some people are bullies, you know.

In addition, it was identified that a unit had reports of suicidal ideation resulting from multiple reports of bullying events taking place on the unit.

P25: [*Multiple reports of bullying resulting in suicidal ideation*] So that occurred, I took over as interim service for one of the floors and have resiliency come and there were multiple thoughts of suicide, suicidal ideation, on one of the floors, but that was not teased out until we actually brought an outside entity up to the floor and there had been multiple reports of bullying. So, I definitely think that plays into it.

Participants also reported lateral violence and being disrespected in the workplace.

P10: [*Lateral Violence, that's what it feels like*] And then that's when I was like, OK. I think that's what it is. People have told me that they don't want to talk to doctors. Doctors were being rude. I was like, well, that needs to change. Like, if, if they need a way and like an actual liaison, like either the nurses or the doctors to come to. And then I'm hearing the same complaints over and over. Then we can either make a unit wide change or we can actually talk to the attending who oversees the interns and possibly do like emotional behavioral change and hopefully the lateral violence. Oh, that's because that's what it seems like.

P19: [*Conflicts and disrespect on my unit*] I think that there have been some conflicts and some disrespect in my unit, and I have observed that.

P07: [*Disrespect for Military*] There's oftentimes a lot of disrespect for military, which is really strange at this hospital you'd think.

Similar to the facilitators section, leadership was a concept that was identified as a significant barrier to fostering well-being. Particularly, the frequency of leadership turnover at all levels of leadership was identified as a hindrance to fostering well-being. Participants expressed that when there is frequent leadership change it impacts well-being because expectations change with leadership and they become a 'moving target'. In addition, many projects or initiatives have to be redone to fit the new expectations.

P21: [*Experiencing Frequent Leadership turnover*] I 100 percent agree because we are experiencing the same situation in the past year. We've had possibly three DNSs and I feel like that greatly impacted our morale and well-being. And if we could just have some type of consistency and some stability, that will be great because we have to manage expectations based on who comes in one DNS might want, might expect this but another DNS might go in a completely different direction. So, it impacts well-being in my opinion and I completely agree them.

P25: [*Experiencing Frequent Leadership turnover*] No, I would certainly agree. We've had a great turnover of our DNSs. So, when that turnover between senior level leadership does not go very well, you can tell and I'm constantly, we're constantly redoing the same projects or the same presentation over and over again. Which is taxing.

P13: [*Experiencing Frequent Leadership turnover*] That's been awful, actually. Here on this floor? Yeah. It's something that I have noticed and that I that I did bring up here. So, for instance, I've only been here since November. But some of the other second lieutenants and ensigns that have been on the floor for like a year, they've already had four service chiefs. So, you do the math as a news new boss every three months. I think that definitely impacts well-being because people there's no consistency even with a schedule anywhere thing, right?

Frequent leadership turnover not only impacted the well-being of Navy Nurse Corps officers at the bedside it also impacted the well-being of Navy Nurse Corps officers serving in leadership roles. Participants who were serving in official leadership positions (e.g., Service Chief) indicated that frequent leadership turnover becomes a barrier to fostering their well-being due to the considerable amount of extra time it requires to learn their new role with each transition.

P19: [*Learning the role of a Service Chief*] Yes, it's a long process to learn this job. And. Especially early on in this job, I would routinely stay at work later because I had so much to do and accomplish to even catch up. And if fitness reports were due for some of this staff, I couldn't just neglect the deadline. But I was learning it.

P19: [*Learning the role of a Service Chief*] And with the army, I was learning officer evaluations and that system was used and so I couldn't keep up with the normal plus these extra schedules, but new tasks to me. And I will probably only be in this job for about 18 months total.

P19: So, I think the frequent turnover matters and I've seen it on sister units where the new person coming in is trying to a, if they're not interim in just doing it for a couple of weeks or having been there. And they're new to the command or new again to this command they're staying late to just try to catch up and get things accomplished.

Another barrier identified by Navy Nurse Corps officers was their multiple roles which leads to competing priorities. Navy Nurse Corps officers are clinicians ranging from novice to experts based on their experiences and competence just like their civilian counter parts. Navy Nurse Corps officers also take on other multiple roles as officers. Frequently Navy Nurse Corps officers are required to learn both roles simultaneously because they enter into this dual role as a new graduate nurse and a new Naval Officer.

P04: I think it's just because... I always tell myself...I felt cheated because I was a direct commission to the officer side. So, coming in, a brand-new nurse... but also, as a brand-new officer. I have to learn how to lead people. So, it's kind of like which one am I going to focus more on. And then, you know, so like a year into your job... you're expecting to lead, and you're expect expected to take collaterals [duties] and all this extra stuff. So that brings... a lot of stress. And on top of your 84 hours, I commit like an extra 30 to 40 hours every two weeks with collateral [duties].

As clinicians, Navy Nurse Corps officers take on multiple roles such as staff nurse, charge nurse, preceptor, patient and family educator, and phlebotomists similar to their civilian counter parts.

P10: You're their phlebotomist, you're their respiratory coordinator, you're giving meds, you're coordinating with pharmacy, discharge planning, social work.

P08: Immediately after I graduated CTNP [Clinical Nurse Transition Program, 6-month nurse residency program], I started taking LPN [Licensed Practical Nurses] students with me throughout the day and there's been a few shifts that I've precepted the nurses in the clinical nurse transition program.

P09: Yes, I am a preceptor. So, I've been precepting people for about a year now. So, I got to Walter Reed in October of 2018 and I went through a residency program and graduated last April. And they have me precepting people... pretty

fast, like the end of May. So, probably like almost a year, a little less than a year I've been precepting. But our residency program is six months long. And by the time you graduate it, you're pretty much able to be on your own and be able to educate nurses as well.

Unlike their typical civilian counter parts, they are required to take on the role and duties of the charge nurse as early as six months into the role as a Navy Nurse Corps officer. They will definitely serve in this role and capacity within a year of working as a new graduate nurse.

P02: Charge nurse was first. That was probably about ten months or eleven months after I'd been a Navy nurse, so there was a six-month orientation period for the new grad nurses that they bring in and then I'd say probably four months after that.

As a Naval officer, the participants mentioned the multiple collateral (administrative) duties that they were responsible for and most reported being engaged in multiple collateral duties within their first year as a Navy Nurse Corps officer.

P21: And right now, collateral wise, I am the Navy nurse, core competency program manager and also the Nurse Practices Council chair. And I also sit on several A3 projects. A 3 is basically a program similar... a black belt project. So, it's kind of integrated into...our program. And we basically get problems and see how to resolve problems with evidence.

P14: Now the collateral duties on top of that. So, I instruct, I teacher for the command's...preceptor course. I am also on the awards board... So, we review probably...20 awards, joint awards every month. And then I am on the nurse practice council as co-chair for the NPC. Think about it besides being a mentor, that is very time consuming. And right now, I think I have around seven junior officers that come to me. Either e-mail me or stop by or text or call and ask questions and get guidance. Along with that and my actual job as the CNTP [Clinical Nurse Transition Program] deputy.

Given the multiple roles of Navy Nurse Corps officers, it is not surprising that participants reported competing priorities as a barrier to fostering their well-being.

P05: *Having Competing Priorities*

But it's hard when you feel like you're not making headway, or you have all these competing priorities, and you can't focus on one thing or you can't do something

*P21: Having Competing Priorities*

I have competing priorities. My professional, clinical and personal priorities are all intertwined, and I feel like sometimes that is hard for me to manage them. And sometimes I feel like my professional career takes a backseat to everything else and that impacts my promotion and everything else in my well-being in the end. So, I definitely have experienced it.

*P19: Having Competing Priorities*

From a work standpoint, I think sometimes the challenge is keeping all these tasks that were just mentioned. Organized on your schedule, on your calendar, anticipating things and then also dealing with how things come up. So, you want to leave work at a certain time so that you can get to the next things, you can get your personal errands and chores accomplished and work out whatever it is. And then you realize, OK, well, I have to skip a couple of these things today or skip some sleep. I don't know. You have to make those decisions. And so a lot of times work necessary I can leave here but the time, time does bleed over what I would hope to work some days.

In line with competing priorities at work, participants also indicated that having a family contributed at times to being a barrier to fostering well-being.

*P15: Family as a Competing Priority*

I have my fiancé he has things like that he needs me for. So, like something was just balancing the family life, like I'm home. And also, like even like a family, like I don't live, like my parents. People back home who like live in different time zones and like trying to, like, accommodate, like spending time with them.

*P03: Family as a Competing Priority*

You see, like moms with family problems like their kids, and they're stressed out about that. I see that.

*P05: Family as a Competing Priority*

I have three little kids and a husband. So even if I've had a challenging day, I still have to kind of do my normal. But in general, I still have to Kind of perform my normal after school activities and dinner.

Participants also identified specific aspects of the Navy Nurse Corps culture as a barrier to fostering their well-being. In particular, Navy Nurse Corps officers identified the *Culture of Expected Perfectionism* and the *Mentality of Always On* as barriers.

P24: [*Culture of Expected Perfectionism*] I think that military life. The Navy will never love you as much as you love the Navy. The Navy will never give you as much as you give the Navy as officers and our enlisted as well. We give the prime of our lives. We give our healthy years. We give our young years. We give our energetic year. And that time is not time that we'll get back. I'm a bad nurse officer because I thankfully have been Successful so far can being exactly who I am, and I think a lot of the messages that we send to people is you must check these boxes exactly. And for some folks, that is such a stressor. I need the big command, I need the mid-size, I need the OCONUS I need the operational. You know, I shouldn't help my peers with their fitreps or their evals or their collaterals because I'm in competition with them. That is false. That is so false because the way that we create a stronger force is by building one another up and helping everybody function at their highest capacity. And sometimes your highest capacity is nothing because you have personal life stuff going on and that's OK. That expectation of perfection in the facade of being a, you know, a fully functional human being at all times is so toxic. And in the military environment, we're not just co-workers, we're friends. We're family. You know, this this is such an all-encompassing environment to expect people to have that level of togetherness is all, at all times. It's why we see these, that this horrible epidemic. Epidemic of suicide and horrible depressions debilitating.

P21: [*Culture of Expected Perfectionism*] I feel like some leaders are more accepting than others and make them going back to the specific command or leader. I do feel like sometimes there is a stigma and that were expected to be present and don't really show weakness. I believe sometimes and I feel like that's not fair because at the end, they're, we're still human. And we still get impacted by my life just as our civilian counterparts. And the expectation should not be that that does not apply to us. So, I do agree.

P24: [*Mentality of Always on*]  
But, you know, in the real world, when you're here and you're working in an MTF, I absolutely hate the idea that while you're in the Navy 24/7 and so you should be available ready to go 24/7. In times of crisis like pandemic. Yes, there are some extenuating circumstances or that can be true. I hate that always on mentality because when you have that, that is how you burn everybody just burn everybody out. You lose your strongest and best workers because they say, I don't need to do this. I'm marketable elsewhere. I can have quality of life elsewhere.

In addition, Navy Nurse Corps officers indicated that the pending thoughts of being ready for deployment was a barrier to fostering well-being.

P19: [*Wanting to Feel ready*] But we want to feel ready. We want to be ready for anything. I told my supervisor respectfully; I was concerned about my deploy

ability and that I wouldn't be ready for that if I didn't maintain my skill set. So that's what I think it makes it hard because I want to feel ready. I want to be prepared. And I don't want to be an inauthentic representation of my specialty. I feel that I am sometimes by meeting the Navy's objectives for me to work in these other roles.

P21: [*Not Feeling Prepared*] We actually did experience this recently. Due to the COVID response several nurses were deployed to a different state to, to be so responsive surge. And a lot of them came back and told us that they did not feel prepared for the, for the deployment, especially the critical care nurses, in that they did not see enough to help them get ready. And we're trying to mitigate that issue, but it is an issue. So, we've identified it. Yes. So, we basically just try to mentor them and make sure that they're ready. Actually, some nurses were actually sent back because they were deemed to be incompetent.

Participants reported that Permanent Change of Station (PCS) moves were a barrier to fostering their well-being because you are “uprooting every couple of years” and you have to find a “new everything.” Finding a new everything included social connections that are a key part of *Fostering Individual Well-Being*.

P24: But, but that just that uprooting every couple years. I think it's horribly detrimental. I think when you look at the folks who have done very well, they're able to kind of homestead a little bit more.

P05: It's hard moving every three years. Finding new everything. But then like finding a church, where six months in and still don't have a place yet. So, I haven't started volunteering, so I haven't got into some of that. Same with just learning the new kind of like what to do in the area. I think, just the starting over every time does, I think, make it hard just because it is like it's a stressful event. And then everything is new. And so, you're kind of like getting restarted. So, I think it is it's it is like hard on your well-being in general until and so you have to have some level of like perseverance to like get back to normal. And like this last one is one of those where I knew I wasn't getting back to Norm, you know. Back in like my normal stride of feeling well and normal and getting into the swing of things. Which is why I sought kind of like extra help at the time.

Navy Nurse Corps officers also revealed that their experience of being stationed at a joint command (a military installation that is utilized by two or more military services) was a barrier to fostering their well-being. Some participants indicated that working at a joint

command resulted in the loss of their Navy Nurse Corps identity or impacted the ability of new Navy Nurse Corps officer to develop a Navy Nurse Corps identity.

P23: [*A Loss of Your Navy Identity*] There is no sense of camaraderie. Just, just because there's nothing here. There's no traditions. There's nothing there's no Navy standards. You don't even call, you know, our service chiefs. I'm in a Navy term, you know what I mean? So, it's like there's no sense of it's a loss of your identity as a naval officer, especially if you've been to another command. And then you come here and you're like, what is happening here? You know what I mean? Or these new nurses that think this is how it is and a Navy command is not like this at all. And so, I think it's frustrating for people that have been in and have been to not a joint command and, and know how that how the Navy is, because there is a big sense of camaraderie. And I think that it's, it's just really disheartening here. And so, people just it's just so frustrating, I think, for everyone, no matter where you are in your nurse corps career. It's just hard because either don't know and you think this is the real thing or you do know. And you know, this isn't how it is. So, I think it's this place is hard to, hard to deal with. Very hard here.

Other participants detailed the impact on retention after being stationed at a joint command and not finding a sense of community.

P20: [*Roles and Expectations not Clearly Defined*] Yeah, like learning the Navy because it is a joint command and sometimes that roles and expectations are not clearly defined. So, I think that causes a lot of distress, you know, and it gets me upset when I hear nurses that want to get out just for being the first command, you know I feel, you know, we work with the army here and I feel like the Army doesn't want to treat us like we're Army, you know, and they don't. You know, because my leadership is Army and I feel like they don't, not appreciate. But they don't take into consideration that we're a different service sometimes. You know, and we have a way of doing things, you know. And they need to respect that. Yeah, this is totally different. I feel like Navy nurses, brand new shouldn't, come here. They should go to a port like Portsmouth or Balfour, you know, and then come here as their second tour later on know, because it's difficult.

P25: [*No Sense of Community*] I was stationed here (Walter Reed) As an ENS. There is not really a military sense of community except for your close friends or your peer group on your floor

Navy Nurse Corps officers also reported certain aspects of the work schedule were barriers to fostering their well-being. Participants identified that working 12-hour

shifts, coming in on off days, working night shift, and not having more control over their schedule (e.g., non-self-scheduling units) were examples of barriers related to the work schedule.

P11: [*Working 12-hour shift*] Like the 12-hour shifts make it hard. Like it occupies my whole day so often on my free time, days or like days that I have off, I need to do other like things like medical appointments, run errands. So, I feel like I don't get a lot of time to truly relax or like focus on my other responsibilities or because I am focusing on my other responsibilities because most of my time at work and then my days off like you do or involved in other things besides work.

P15: [*Coming in on Off Days*] Or like even if you're taking a lot of collaterals like you might be like doing your collaterals, like you never really get a true day off

P13: [*Working Nights*] Night shift. I'd say that's the big one. For some reason, my body just doesn't like night shift. I know previous times there was a night shift. If I didn't want to sleep the day away, but then I would wake up after only a couple of hours of sleep and feel groggy and feel tired. And then I get out of bed, moved to the couch, and then just feel like I'm not doing anything productive. That definitely makes it difficult.

P08: [*Working Nights*] Yeah, yeah. I'm a practicing Catholic, so I attend Mass Weekly generally, but night shift is hard. Like I, like I don't, I'm not good about it.

P15: [*Not Having Control Over Schedule*] I would make it a self-schedule, which I know like some units here are piloting where they make a minimum of like, oh, you pick one to two weekends a month and you like submit the ones you would like. And then based off of like all the submissions of these people like to work, they work around it. And I would just give people time to take like birthdays off request holidays more easily instead of just the premade schedule for everyone where there's no input from us at all, like what would help us to be, I guess, like better prepared physically, mentally and to work.

P01: [*Working as Charge Nurse*] As the new charge nurse that, I've had nurses refusing patients and things that. I've like gone home and I'm like, Oh, my God, I don't I don't want to come back.

P08: [*Working as Charge Nurse*] And then like charge nursing has been tough at times, especially my first started, because we were, we had a high census. And you're managing you know, you're trying to like control, your control, what's happening on the floor to the best of your ability. And there's certain things you

just cannot control. Like you? Well, to some extent, you are responsible for, you know, 18 patients.

P11: [*Not Getting Enough Sleep*] I think that sometimes, like especially when I work back-to-back shifts, I never get enough sleep. So, by the second or third one, I'm like, really tired, which for me I hate feeling like I feel like I need a lot of sleep to feel happy and good.

P07: [*Not Getting Enough Sleep*] Fatigue. (laughter) It's just. It's a lot of you know work is not easy. But it's just, not just, being tired, honestly.

**Summary: Barriers of Fostering Individual Well-Being**

In summary, Navy Nurse Corps officers identified several barriers to fostering their well-being that included disruptive behaviors in the workplace, frequent leadership turnover, competing priorities and aspects of the Navy Nurse Corps culture. A summary of all the barriers identified by the participants is provided in Table 62.

Table 62. Barriers of Fostering Individual Well-being

Category	Subcategory
Aspects of patient Care	Recognizing one’s own vulnerability and mortality Taking care of more than the Patient Jack of all trades Moral conflict with patient care
Experiencing Disruptive Behaviors in The Workplace	Bullying Lateral Violence Disrespect
Frequent Leadership Turnover	
Competing Priorities	Nursing clinical responsibilities Navy Officer training and physical fitness requirements Collateral Duties Family Personal time
Navy Nurse Corps Culture	Expected Perfectionism Mentality of Always On.
Pending Thoughts of Being Ready for Deployment	
PCS Moves	
Being Stationed at a Joint Base	
Scheduling	Not having control over your schedule

	12-hour shifts Rotating shifts Night shifts
Working as Charge Nurse	
Not getting enough sleep	

**SUMMARY**

In this study, Navy Nurse Corps officers defined well-being in a complex way that encompasses an interconnection of eight dimensions. They reported that in addressing well-being there needs to be individualized actions taken addressing all dimensions with organizational support to ensure the highest level of individual well-being. In addition, this study presents a substantive theory, *Fostering Individual Well-Being* (Figure 5.), providing a guide for individual Navy Nurse Corps officers and leaders in their efforts to enhance Navy Nurse Corps officer well-being in support of military readiness. Participates also provided an in-depth description of multiple facilitators and barriers to them enacting practices to foster their well-being.

# Fostering Individual Well-Being

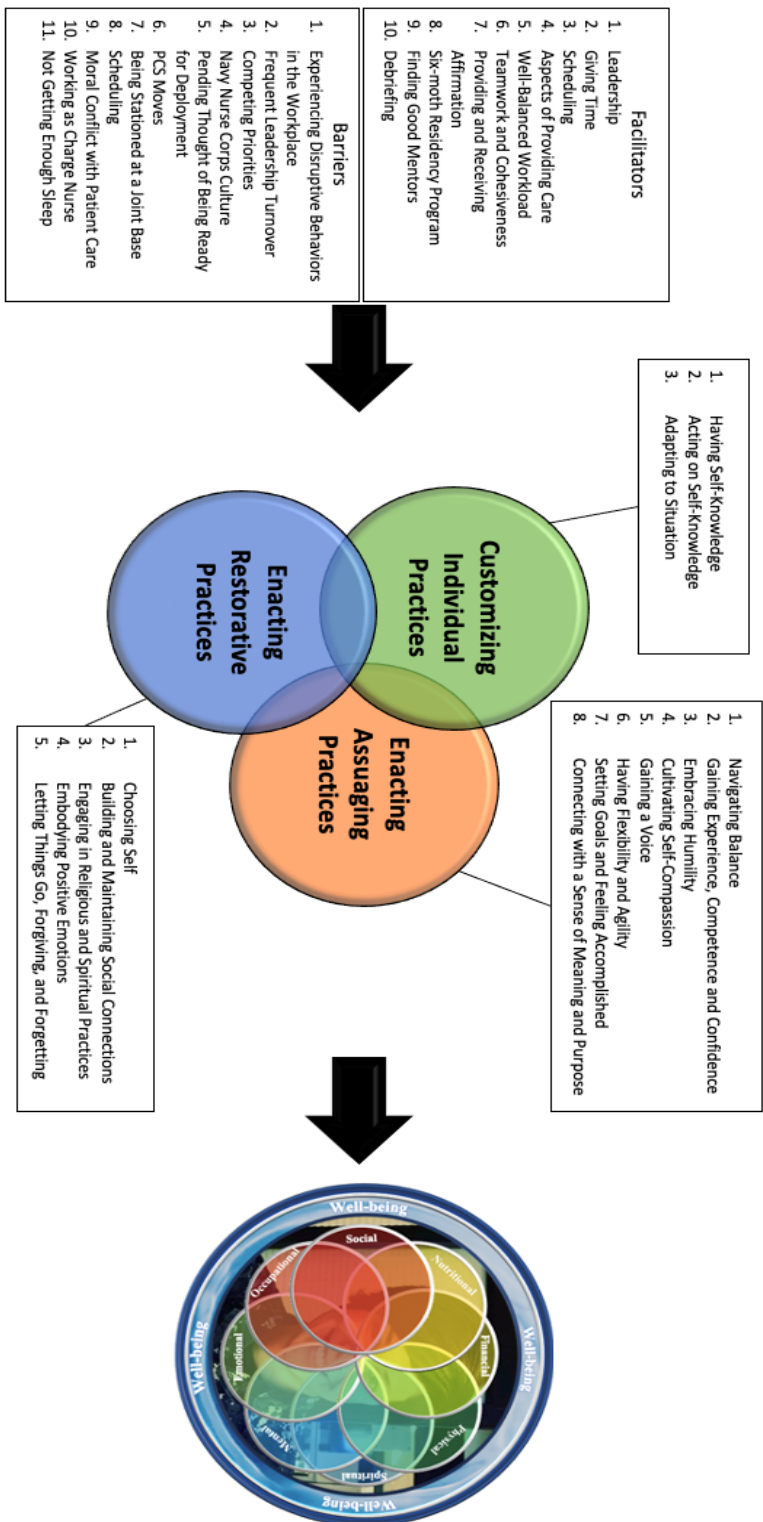


Figure 5. Fostering Individual Well-Being

## **CHAPTER 5: Discussion**

### **INTRODUCTION**

This study on military nurse well-being was a constructivist grounded theory study that explored the fundamental understanding of Navy Nurse Corps officers' well-being, including how it is defined, experienced, fostered, facilitated, and hindered. This understanding is essential to implementing efforts to enhance well-being of Navy Nurse Corps officers. Enhanced well-being supports a highly skilled workforce, contributing to meeting health organizations' mission of providing high-quality and safe care to the ill and injured (141). Identifying processes to enhance well-being within a population first requires understanding how well-being is defined within a particular population.

### **WELL-BEING DEFINED**

Currently, there is no consensus around a single global definition of well-being nor a definition of well-being for military nurses taking care of ill and injured individuals. According to Kiefer (84), improving well-being is dependent on encouraging individuals and groups to define well-being for themselves. Participants provided an in-depth description of what well-being meant to them that led to the construction of well-being defined by Navy Nurse Corps officers who recently provided care to individuals with a life-threatening illness or injury. The definition of well-being constructed in this current study is consistent with the finding in the literature related to the broad description of well-being. Well-being is a multidimensional concept, and the dimensions of well-being are not mutually exclusive but are rather inter-related components of a holistic whole (36; 147; 148). The definitions of well-being identified in the literature includes definitions

for a single dimension of well-being or a global perspective integrating a diverse collection of dimensions. Navy Nurse Corps officers provided a global perspective and definition of well-being that included eight separate dimensions. However, they also reported that what influences one dimension could influence the others due to the dimensions' interconnectedness. This knowledge further supports the need for a comprehensive understanding and conceptualization of well-being within military nurses rather than a single positive indicator of well-being such as resilience or a single negative indicator of well-being such as burnout.

### **THE SUBSTANTIVE THEORY**

The core aim of constructivist grounded theory is to construct a theory specific to a particular phenomenon and context grounded in the data (21). A substantive grounded theory focuses on phenomena within a specific context and should be distinguished from formal or grand theories that relate to broader, cross-disciplinary contexts (28). The results of this study provide an explanation of the perspective of Navy Nurse Corps officers who provide care to individuals with a life-threatening illness or injury and the process for how they foster their well-being. The theory, *Fostering Individual Well-Being*, encompasses three main categories - *Customizing Individual Practices*, *Enacting Assuaging Practices*, and *Enacting Restorative Practices*. Together these three main categories represent the collective actions and behaviors that Navy Nurse Corps officers engage in to foster their well-being inside and outside the workplace.

The theory and conclusions resulting from the analysis of the empirical data adds to and expands on the body of qualitative and quantitative research into the phenomenon of well-being. Although several theories within the literature explored well-being, there were no identified grounded theories capturing the experience of fostering military nurses' well-being. Therefore, the theory resulting from this study is unique because it captures actions and behaviors enacted by Navy Nurse Corps officers in efforts to foster one's well-being, and it has practical application to practice.

A grounded theory should predict and provide an explanation of behaviors, provide theoretical advancement in the discipline, provide practical application, and provide a guide for future research on a particular area of behavior (57). This substantive grounded theory offers interpretations of Navy Nurse Corps Officers' experiences providing care to individuals with a life-threatening illness or injury and their actions to foster their well-being. The practical application of this study can be used by leadership and Navy Nurse Corps officers to improve Navy Nurse Corps officers' experiences and enhance the fostering of individual well-being. The interpretation of this study allows for the integration of the theory into practice within Military Treatment Facilities. It also provides a guide for future research in other environments such as the operational settings and other populations such as Army and Air Force Nurse Corps officers.

#### **COMPARISON TO OTHER STUDIES**

This new substantive theory constructed in this study, *Fostering Individual Well-Being*, can be added to the known theories of well-being (Table 63). The fifteen defining properties (subcategories) of the three main categories (*Cultivating Individual Practices*,

*Enacting Assuaging Practices, and Enacting Restorative Practices*) share some similarities with concepts within known well-being theories.

Table 63. Theoretical Models of Well-being and Fostering Individual Well-Being

<i>Ideal Mental Health</i> Jahoda, 1958	<i>Lifetrack Model of Positive Mental Health</i> Ishizuka, 1988	<i>Scale of Psychological Well-being</i> Ryff, 1989	<i>Human Flourishing Theory</i> Seligman, 2011	<i>European Social Survey Huppert &amp; So, 2013</i>	<i>Fostering Individual Well-Being</i>
<ol style="list-style-type: none"> <li>1. Positive attitude towards Self</li> <li>2. Personal growth, development, and self-actualization</li> <li>3. Integration or synthesis of psychological function that helps resist stress</li> <li>4. Autonomy</li> <li>5. Accurate perception of reality</li> <li>6. Environmental mastery</li> </ol>	<ol style="list-style-type: none"> <li>1. The search for Self</li> <li>2. The need for intimacy</li> <li>3. The quest for achievement</li> </ol>	<ol style="list-style-type: none"> <li>1. Self-acceptance</li> <li>2. Positive relationships with others</li> <li>3. Autonomy</li> <li>4. Environmental mastery or competence</li> <li>5. Purpose in life</li> <li>6. A sense of personal growth</li> </ol>	<ol style="list-style-type: none"> <li>1. Positive emotion</li> <li>2. Engagement</li> <li>3. Positive Relationships</li> <li>4. Meaning</li> <li>5. Accomplishment</li> </ol>	<ol style="list-style-type: none"> <li>1. Competence</li> <li>2. Emotional stability</li> <li>3. Engagement</li> <li>4. Meaning</li> <li>5. Optimism</li> <li>6. Positive Emotion</li> <li>7. Positive Relationships</li> <li>8. Resilience</li> <li>9. Self-esteem</li> <li>10. Vitality</li> </ol>	<p><b>Customizing Individual Practices</b></p> <ol style="list-style-type: none"> <li>1. Having Self-Knowledge</li> <li>2. Acting on Self-Knowledge</li> <li>3. Adapting to Situation</li> </ol> <p><b>Enacting Assuaging Practices</b></p> <ol style="list-style-type: none"> <li>1. Navigating Balance</li> <li>2. Gaining Experience and Confidence</li> <li>3. Embracing Humility</li> <li>4. Cultivating Self-Compassion</li> <li>5. Gaining a Voice</li> <li>6. Having Flexibility and Agility</li> <li>7. Setting Goals and Feeling Accomplished</li> <li>8. Connecting with a Sense of Meaning and Purpose</li> </ol> <p><b>Enacting Restorative Practices</b></p> <ol style="list-style-type: none"> <li>1. Choosing Self</li> <li>2. Building and Maintaining Connectedness</li> <li>3. Engaging in Religious and Spiritual Practices</li> <li>4. Embodying Positive Emotions</li> <li>5. Letting Things Go, Forgiving, and forgetting</li> </ol>

One of the most salient of the fifteen subcategories, *Building and Maintaining Social Connections*, has noted parallels to the majority of the well-being theories.

Researchers have concluded that positive relationships with others may be the most critical source of life satisfaction and emotional well-being across individuals of all ages and cultures (139; 154). Navy Nurse Corps officers are deeply embedded in many

networks that can support fostering well-being within the workplace – these include networks with fellow Navy Nurse Corps officers, leadership, other healthcare disciplines, patients, and patient's families. Further, participants reported that they receive valuable social support through established relationships outside of the workplace setting with individuals such as partners, spouses, friends, children, parents, and roommates.

The importance of building and maintaining relationships identified in this current theory is consistent with well-known well-being theories. Positive relationships are central in nearly all the known theories of well-being (69; 71; 148; 154). Additionally, current research indicates that social connectedness correlates with well-being (156). Participants in the current study frequently identified *Building and Maintaining Social Connections* as the first of all the strategies they used after leaving the workplace setting to foster their well-being by reaching out to family and friends for support and encouragement. Also, positive connections in the workplace setting described by participants as *Relying on Cohesiveness and Teamwork on Unit* were essential parts of fostering well-being.

These results are consistent with previous research findings indicating that social connections and support within the workplace enhance nurse well-being (77). Moreover, supportive relationships have been linked to a reduction in anxiety and depression during stressful times (46) and increased happiness, positive emotions, and physical well-being (79). These findings corroborate the results of this current study that *Building and Maintaining Social Connections* within and outside the workplace setting support Navy Nurse Corps officers in fostering well-being. At times, the social connections within the

workplace lead to *Connecting with a Sense of Meaning and Purpose*, another subcategory of, *Fostering Individual Well-Being*.

*Connecting with a Sense of Meaning and Purpose* was a subcategory identified by participants as essential to *Fostering Individual Well-being*. As a concept, purpose in life, originates from Frankl's work, perceiving meaning as a motivating and vitalizing force in human life (50). According to Frankl (50), meaning and purpose are used synonymously. Frequently, research indicates that the most common sources of meaning are relationships and the types of activities individuals engage in (160). Participants in the current study identified purpose and meaning in providing care to individuals with a life-threatening illness or injury. There is also evidence that individuals who have a sense of high meaning and purpose care more about helping and benefitting others (105). Thus, it appears to go both ways: better interactions and relationships foster meaning and purpose; likewise, meaning and purpose create better interactions and relationships. This subcategory shares similarity with several of the concepts in the known well-being theories.

The identification of purpose and meaning in life as a measurable concept of well-being is consistent with three of the discussed well-being theories: (1) *Scale of Psychological Well-being* (148), purpose in life; (2) *Human Flourishing Theory* (154), meaning; and (3) *European Social Survey* (69), meaning. Ryff's *Scale of Psychological Well-being* (149) identifies someone scoring high in purpose in life as "Has goals in life and a sense of directedness; feels there is meaning to present and past life; and holds beliefs that give life" (p. 12). Seligman's *Human Flourishing Theory* (154) defines a "meaningful life" as "belonging to and serving something that you believe is bigger than

the self" (p. 368). Participants in the current study indicated that they were motivated to become a Navy Nurse Corps officer to be part of something bigger than themselves and recognized serving others as beneficial to their well-being. The *European Social Survey* assesses meaning by asking whether someone "feels that what they do in...life is valuable and worthwhile" (p. 843). Several of the participants found meaning and purpose in the work they completed as a Navy Nurse Corps officer.

Although, some participants indicated that when they transitioned into the Service Chief/Unit Manager position, they lost sight of the purpose they had identified with when engaged in providing patient care. Those individuals expressed that this loss of purpose negatively impacted their well-being, and they were anxious to identify the purpose and meaning in their new role. Research shows that people who are searching for meaning are a little more likely to be anxious and unhappy (159). Participants who had settled into the role of a Service Chief were able to identify that they found meaning and purpose in the aspects of their job that enabled them to connect with, support, and mentor junior Navy Nurse Corps officers and Hospital Corpsmen. This finding again emphasizes the connection between the two subcategories *Building and Maintaining Social Connections* and *Connecting with a Sense of Meaning and Purpose* in the current study. Findings from this study also highlight unique subcategories that are absent in the known theories of well-being.

One of the most salient subcategories identified by Navy Nurse Corps officers as beneficial in fostering their well-being that is absent in the known well-being theories is *Choosing Self*. *Choosing Self* refers to an individual taking time from the day to engage in actions or behaviors to provide self-care. According to the World Health Organization

(169), self-care is defined as "what people do for themselves to establish and maintain health, and to prevent and deal with illness." Although self-care is absent in the known theories of well-being, there have been decades of research on self-care within the healthcare professions.

Several conceptual models that emphasize self-care and health promotion in the prevention of burnout can be found in the medical, nursing, and allied health literature (24; 39; 82; 86; 87). This body of knowledge is consistent with the current study's findings, which indicated that engaging in self-care practices is beneficial to Navy Nurse Corps officers fostering their well-being. In addition, self-care has been shown to prevent negative psychological effects of nursing such as burnout and empower staff to prioritize their health and well-being and that of the healthcare team (94). This supports the participants' claim that Navy Nurse Corps leaders role modeling self-care behaviors are beneficial to fostering well-being. Not only should nurse leaders act as role models for self-care, opportunities to encourage self-care activities such as physical activity, healthy eating, and stress reduction techniques should be supported (142).

Unfortunately, what has also been noted in the literature is that nurses tend to prioritize the care of others over self-care. The American Nurses Association's (ANA) Health Risk Appraisal found that 68% of the nurses surveyed said they put their patients' health, safety, and well-being before their own (6). Self-care should not be seen as an indulgence but instead as a commitment to professionalism. In addition, self-care should be encouraged and recommended more by the organization. Ideally, self-care opportunities can be delivered, supported, and embedded within the organization. Examples of these strategies include wellness and meditation rooms, moments of

mindfulness, and exercise classes. Participants described initiatives such as these conceptually beneficial yet rarely practiced due to perceived barriers. In order for such initiatives to be of any benefit, barriers to their use must be mitigated, and access sustained. Therefore, the implementation of such initiatives requires simultaneously strategizing to control barriers to utilizing the initiatives. Moreover, recovery efforts to foster well-being in the moment, described as *Finding Solace in Pause* by participants, can be accomplished by breaks at work and further supported outside the workplace with sleep, relaxation, and physical exercise. *Navigating Balance*, another subcategory of *Fostering Well-Being*, is critical for incorporating *Choosing Self* practices.

*Navigating Balance* is another unique subcategory or defining property. There were noted similarities with *Navigating Balance* and literature prevalent in nursing science. An increasing culture of acceptance to undertaking work-related activities outside of the clinical environment and more often at home seems to be forming (128; 134). It has been reported that additional hours spent working at home, electronically accessing and tending to emails, and viewing and documenting in medical records, appear to increase burnout (43; 146). This, in turn, is impacting negatively on burnout by creating substantial tension between personal and professional life (128; 134).

This encroachment of work responsibilities into personal time at home identifies the negative impact of taking work home in addition to working an entire workday in the workplace setting and supports this study's findings that *Leaving Work at Work* and *Protecting Personal Time* are beneficial in fostering well-being. Navy Nurse Corps officers identified several additional tasks that encroached into their personal time, such as addressing emails, completing required training, and working on collateral duty

requirements. Leadership and organizations can support Navy Nurse Corps officers in their efforts to enact *Navigating Balance* within and outside the workplace by implementing scheduled administration days, which will allow them to complete training and collateral duty during working hours. In addition, leadership and organizations can decrease hours spent in the workplace setting to compensate for work-related responsibilities conducted at home.

Another unique subcategory is *Cultivating Self-Compassion*. Self-compassion has been linked with evidence of beneficial intervention outcomes. Gilbert (53) suggests that self-compassion enhances well-being because it helps individuals feel cared for, connected, and emotionally calm. Furthermore, self-compassion transforms suffering due to failure, mistakes, or general life happenings in a way that enhances well-being, resilience, and coping with complex thoughts and emotions (126). Navy Nurse Corps officers reported feeling tremendous pressure to exhibit faultless performance, meticulous attention to detail, and high competency levels in their roles as a clinician and Naval officer. *Cultivating Self-Compassion* was identified as a strategy that participants used to combat the effects of this pressure and establish an understanding that they are only human, and everyone makes mistakes. Self-compassionate individuals can offer themselves warmth and non-judgmental understanding rather than demeaning or berating themselves with self-criticism at the face of imperfection; instead of feeling isolated at the face of adversity or difficult circumstances, self-compassionate individuals understand that life is filled with struggles and that mistakes are inevitable (127).

Additionally, self-compassion has been demonstrated to moderate how people react to distressing events (47). Precisely, research has indicated that higher self-

compassion predicts lower reports of sadness and embarrassment in the face of real, remembered, and imagined life events (93). Studies have also shown that self-compassion buffers against anxiety in self-evaluative situations, and a higher self-compassion scale are negatively associated with self-criticism, depression, anxiety, rumination, thought suppression, and neurotic perfectionism (125). Similarly, high scores are positively associated with life satisfaction, social connectedness, and emotional intelligence (52).

These self-compassion features may be essential for Navy Nurse Corps officers who perceive the Navy Nurse Corps to contain a Culture of *Expected Perfectionism* and work in emotionally charged and often difficult circumstances. Additionally, these findings within the self-compassion literature are consistent with the current research findings, which indicate *Cultivating Self-Compassion* in Navy Nurse Corps officers may significantly buffer them against adversity in the workplace and support *Fostering Individual Well-Being*. Equally crucial to the activities and practices that participants engage in to foster well-being are the indicated facilitators and barriers to fostering well-being.

#### **FACILITATORS AND BARRIERS**

The most salient facilitator identified by participants was leadership. Specifically, Navy Nurse Corps officers identified characteristics and behaviors of leadership that supported *Fostering Individual Well-Being*. Research indicated that nurses' perception of their supervisors' leadership styles has a considerable influence on their working environment and lives (3), health (49; 150), and well-being (123). Participants in the

current study perceived that having leaders who were supportive, approachable, and took an interest in their staff facilitated *Fostering Individual Well-Being*. Furthermore, participants indicated that leadership presence in the workplace facilitated staff well-being. Bogue and Cater (15) indicated the importance of leadership presence and recommended that leaders adapt their work hours to optimize interaction with staff, perhaps varying one's hours to overlap with all unit staff.

Navy Nurse Corps officers also reported that providing care to individuals with life-threatening illness or injury was often seen as a facilitator to *Fostering Individual Well-Being*. They described caring for individuals with life-threatening illness or injury as an honor, privilege, and rewarding and specified that it provided a sense of purpose and meaning. Participants reported that aspects of patient care helped foster their well-being, such as *Serving Those who Serve, Witnessing Positive Outcomes of Efforts, Being Present, and Caring*. In addition to being identified as a facilitator, Navy Nurse Corps officers equivalently identified aspects of care that were barriers to fostering well-being.

Participants reported forming bonds with their patients and patient family members. This social connection was indicated as a facilitator when participants progressed and recovered from their illness or injury. However, when there was a concern regarding the prognosis of the patient's condition, the concern became a source of distress and identified as a barrier. Another aspect of patient care identified as a barrier to fostering well-being was experiencing moral conflict with providing care as a form of moral adversity. Moral adversity may result in moral distress and has been explored extensively in nursing research.

Moral adversity in nursing care has been identified as a prevalent concern. Some of the participants in this study identified experiences of moral adversity in the workplace setting. The results of a study by Hariharan et al. (59) indicated that more than 35% of nurses faced moral adversity every week, and 11% reported facing it daily. Rushton et al. (145) indicated that more than 96% of study participants reported experiencing ethically distressing symptoms in clinical practice. More recently, there has been a shift to explore the positive outcome of morally distressing situations in the workplace, such as moral resilience, which has been identified as a potential pathway to enhancing nurse well-being (62; 144; 145; 171).

Another barrier to *Fostering Individual Well-Being* identified by participants was experiencing disruptive behavior in the workplace. Bullying was the highest reported disruptive behavior reported by Navy Nurse Corps officers. Bullying has been identified as a form of horizontal violence. Horizontal violence is an overarching term used to refer to repeated behaviors over time that intimidate or demean another individual (38). Horizontal violence is prevalent in the nursing workplace. Studies have estimated that 44% to 85% of nurses are victims of horizontal violence and up to 93% of nurses report witnessing horizontal violence in the workplace (73; 138). A survey of nurses in the United States identified 82.0% of nurse respondents (n = 950) reported experiencing or witnessing at least one horizontal violence behavior daily or weekly (38). The majority of participants in the current study reported experiencing or witnessing horizontal violence in the workplace setting. Consistent with the current study findings, a study exploring the occurrence of horizontal violence within the military nursing workplace at three medical

centers identified that 89% of respondents experienced or witnessed horizontal violence (65).

Workplace bullying and other horizontal violence behaviors have been linked to decreased nurses' productivity, satisfaction, retention, and impact safe patient care (13). Victims of horizontal violence reported a decrease in the sense of overall well-being and physical health (23). The current study identified that bullying behavior on one unit resulted in suicide ideation of the nurses experiencing bullying. This finding corroborates the findings that bullying negatively impacts nurses' well-being and should be a high priority for leadership. Participants also indicated that leadership addressing disruptive behavior in the workplace facilitated well-being. An important expectation for nurse leaders is to be attentive to staff communication and behaviors on and off their units as bullying and other disruptive behaviors can occur between units and floors, causing less participation and productivity. Frequent, non-threatening contact, such as an open-door policy, may provide employees opportunities to share issues arising on and between the units with their nurse leaders.

Nurse leaders have the opportunity to facilitate Navy Nurse Corps well-being. The evidence generated in this study related to facilitators and barriers provides guidance for leaders and organizations to partner with Navy Nurse Corps officers in *Fostering Individual Well-Being*. The findings of this study exploring military nurse well-being provide a foundation for change. The findings provide evidence to equip Navy Nurse Corps officers, leaders, and organizations to design and implement solutions to foster well-being. Well-being is individualized. However, *Fostering Individual Well-Being* requires individual attention in partnership with the team, leadership, and organizational

commitment and solutions. The development and sustainment of healthy work environments should be an organizational and leadership mission along with a focus on mitigating and removing barriers while implementing and supporting facilitators of *Fostering Individual Well-Being*. In addition, moving forward, individuals and Navy Nurse Corps officers as a whole need to work together towards shifting the perceived culture of *Expected Perfectionism* and *Always on Mentality* that have been identified as barriers to well-being. The shift should include a culture of positive and realistic expectations while maintaining a culture of excellence.

#### **ISSUES OF TRUSTWORTHINESS**

In addition to data collection, analysis, and reporting, rigor is of utmost importance in qualitative studies, as it promotes credibility and trustworthiness of the research results (19; 21). Trustworthiness features consist of any effort by the researcher to address the more traditional quantitative issues of validity and reliability. In seeking to establish a qualitative study's trustworthiness, Lincoln and Guba (98) use the terms credibility, dependability, confirmability, and transferability, arguing that the trustworthiness of qualitative research should be addressed differently from quantitative research.

#### **Credibility**

The criterion of credibility suggests whether the findings are accurate and credible from the standpoint of the researcher, the participants, and the readers. This criterion becomes a key component of a trustworthy qualitative research design (104). According to Charmaz (21), grounded theory studies should be evaluated, first, for its credibility,

which refers to the rigor in which empirical data collected by the researcher supports the concepts, categories, arguments, and analyses. Credibility was achieved with the use of the interrelated process of data collection and analysis that continued until each category was saturated, thereby continually verifying the data and the findings. To further enhance this study's credibility, data was gathered from multiple sources yielding a fuller and richer picture of the phenomenon under review. In addition, key points were validated through paraphrasing and summarizing participants' descriptions throughout and at the end of the interview to ensure their intended meaning was accurately captured and reported.

### **Dependability**

Reliability in the traditional sense refers to the extent that other similar studies can replicate research findings. Qualitative research usually does not cover enough of an expanse of subjects and experiences to provide a reasonable degree of reliability. Lincoln and Guba (98) argued that the more important question is whether the findings are consistent and dependable with the data collection. Towards this end, inter-rater reliability (119) was established by engaging with the University faculty methodology expert throughout the entire coding and analysis process. An audit trail was also maintained (97) that chronicled the evolution of their thinking and the documented rationale for all the choices and decisions made during the research process. The computer software NVivo 12 was used throughout data collection, which also facilitated maintaining an audit trail.

### **Confirmability**

The concept of confirmability corresponds to the notion of objectivity in quantitative research. The implication is that the findings are the result of the research rather than an outcome of the biases and subjectivity of the researcher. To achieve this end, a researcher needs to identify and uncover the decision trail for the reader and public judgment (98). Confirmability was addressed by making the researcher's bias transparent in chapter one and making the data collection and analysis process explicit and detailed in chapter three. Furthermore, credibility was established through an audit trail, as described in establishing the dependability of the inquiry.

### **Transferability**

Although generalizability is not the intended goal of this study, what was addressed was the issue of transferability (98). That is the way in which the reader determines whether and to what extent this particular phenomenon in this particular context can transfer to another particular context. For qualitative research to be considered trustworthy and sound, transferability is an important consideration. As such, a thorough description was provided of the research context, the processes that were applied, and the substantive theory that was constructed to facilitate transferability.

### **STRENGTHS**

This study was a constructivist grounded theory that contributes new knowledge to military nursing about Navy Nurse Corps officers' well-being. The methods were a strength in that they allowed the exploration of how well-being is defined and experienced from the population's perspective. The inclusion of a diverse sample in this study contributed to its strengths, especially capturing Navy Nurse Corps officers'

perspectives at different levels of experience in both their role as a clinician and a Navy officer. This theory is relevant to Navy Nurse Corps officers stationed at a large joint environment MTF. However, this research's findings are likely to be relevant across broader settings due to the transient nature of the Navy Nurse Corps population and the broad non-deployed and deployed settings participants have experienced as Navy Nurse Corp officers.

### **LIMITATIONS**

There are several limitations to the study, including recruitment from a single site or one MTF. Unfortunately, this was unavoidable due to the COVID-19 restrictions and guidelines. However, several participants brought with them the experience of serving at other MTFs and the deployed setting. The study also captured a broad sample demographic to include Navy Nurse Corps officers who have completed one or more tours at an MTF other than WRNMMC. This increased the amount of information, which may demonstrate commonalities to provide a general base for understanding the processes involved in the experience of providing care to patients with life-threatening illness or injury and the process for fostering individual well-being in the larger population of Navy Nurse Corps officers.

Another limitation was related to barriers to prolonged immersion in the field due to the COVID-19 restrictions and guidelines. These barriers resulted in deviation from the traditional iterative data collection and analysis process of grounded theory. To mitigate this challenge, the iterative process was followed using an accepted non-traditional process of conducted interviews in rounds (21) for a total of five rounds.

During rounds of interviews, field notes were taken before, during, and after each interview to allow new or emergent ideas to be explored in the following interviews.

Researcher bias effect presented another potential limitation. In the current research study, the researcher conducted all interviews with participants and was the primary investigator for protocol development and the interpretation analysis process. However, several strategies were implemented to reduce researcher bias. Weekly meetings with University faculty with expertise in qualitative methodology were ongoing to provide their expert input and perspective throughout the data collection and analysis phases. In addition, debriefing with University faculty, experts in areas related to the research topic, and peers assisted in the coding and interpretation of data.

## **IMPLICATIONS**

This study has highlighted several key areas that multiple stakeholders should address at varying levels within the nursing profession and the Navy Nurse Corps. A substantive theory such as the one constructed in this study can serve as a guide for Navy Nurse Corps officers and leaders to enhance well-being and has the potential to increase the understanding of well-being and how well-being is fostered. The evidence from this study can guide the development of a new Navy Nurse Corps officer assessment as they transition from the academic environment into the practice setting. For example, the evidence can guide the development of an individual structured interview process for new Navy Nurse Corps officers entering a nurse residency program. The structured interview can inform the development of an individualized plan focused on fostering the nurse's well-being throughout the nurse residency program. The evidence can also guide the

development of an exit interview to identify readiness and potential ongoing needs as nurses continue the transition into their new role as a Navy Nurse Corps officer.

This same approach could be applied to Navy Nurse Corps officers who transition from one specialty to another or into a new role (e.g., Service Chief/Division Officer/Unit Manager) by conducting an interview prior to the transition. For example, nurses transitioning from med-surge to critical care could complete an interview assessment. Information from the assessment can help leadership and the Navy Nurse Corps officer implement strategies that best support *Fostering Individual Well-Being* during the transition to the new environment. The evidence can also serve as a guide to incorporate the assessment of overall well-being needs with yearly evaluations conducted by unit leadership. Such yearly assessments can identify support needed on an individual level, but it can also provide information for potential unit level changes needed to best promote *Fostering Individual Well-Being* in the workplace setting.

The evidence generated from this study can also be utilized to develop a self-assessment tool that will benefit Navy Nurse Corps officers in the following ways: (1) establish and enhance self-knowledge related to practices that work for them to foster well-being, and (2) identify potential individual areas of need related to well-being. The identified facilitators and barriers to fostering well-being can provide direction for organizational change that fosters a healthy workplace environment. The findings of this study about Navy Nurse Corps officer's well-being may inform organizational and Navy Nurse Corps policy to promote organizational structure that facilitates *Fostering Individual Well-Being* and assists with mitigating identified barriers.

## RECOMMENDATIONS FOR FURTHER RESEARCH

The findings in this study lend support for opportunities for future research. The grounded theory approach generates a substantive theory that demonstrates what is happening in phenomena under investigation in a specific area or context. Subsequent grounded theory studies can build on the initial study to further refine and expand on the initial ‘grounded theory’ generated (132). Building on a ‘grounded theory’ provides the opportunity to advance a substantive theory to a formal theory. The constant comparative analysis of the grounded theory methodology can be utilized across substantive theories that investigated the same phenomena in different groups to advance the substantive theories to formal theory (57).

Recommendations for future research include studies conducted among additional groups of Navy Nurse Corps officers. It would be interesting to include Navy Nurse Corps officers stationed at varied duty stations and refine the concepts identified in this study's outcomes and further the transferability to a greater extent. In addition, future research should be conducted among groups of Nurse Corps officers that represent other armed services, including the Army and Air Force Nurse Corps officers. The value of exploration in additional groups within the Navy and the other services would be to compare experiences and further refine the substantive theory of *Fostering Individual Well-being* with the potential of advancing the substantive theories to a formal theory.

Another focus of future research was identified while conducting the semi-structured interviews with Navy Nurse Corps officers. Several participants reported that the Hospital Corpsman would benefit from the exploration of how they foster their well-being and the types of facilitators and barriers that they have faced. Navy Nurse Corps

officers were open to discussing their success and struggles, but they also showed concern for how Hospital Corpsmen were able to foster their well-being within the environment. Therefore, it would be interesting to replicate this study within the Navy Hospital Corps and address whether the process of *Fostering Individual Well-being* in Navy Nurse Corps officers is transferable to the Navy Hospital Corpsman population.

## **SUMMARY**

This constructivist grounded theory study explored the experiences of Navy Nurse Corps officers fostering their well-being. The core category, *Fostering Individual Well-being*, was theoretically saturated to better understand its relationship to Navy Nurse Corps officers providing care to individuals with life-threatening illness or injury. Study findings were compared to the extant literature on this topic. Well-being, as defined by the participants, expanded on well-being described in the literature; the definition identifies that well-being encompasses eight dimensions: physical, mental, emotional, spiritual, social, nutritional, financial, and occupational. However, the importance of this study rests on its significant contribution to the science through the construction of a theory on the process of fostering well-being in Navy Nurse Corps officers and perceived facilitators and barriers.

The care of patients with life-threatening illnesses or injuries is challenging for all nurses. However, being a Navy Nurse Corps officer, juggling multiple roles, and providing care to, at times, fellow service members can add unique challenges to the process of caring for these individuals. Daily life and death struggles experienced in the care of a young patient population, such as those cared for in an MTF, are difficult. The

patients and Navy Nurse Corps officers providing their care are often close in age. The lack of theoretical guidance on the process of fostering well-being for these Navy Nurse Corps officers and the organization can leave them vulnerable to burnout, compassion fatigue, PTSS, and moral distress that are extensively known to contribute to attrition, hinder well-being, and impact military readiness of the individual and Navy Nurse Corps.

Fostering well-being in nurses has been recognized as both a professional duty (5) and an organizational responsibility (123). This research directly supports the Navy Surgeon Generals' priority of "People." Furthermore, this study's results fill a critical gap in knowledge that directly impacts readiness, retention, and talent management of the Navy Nurse Corps. This study can be used in collaboration with other evidence to foster military nurse well-being and promote military readiness. A medically ready and knowledgeable healthcare team is required to meet the Defense Health Agency's (DHA) quadruple aims: (1) ensuring military medically ready force; (2) improving quality and healthcare outcomes; (3) provide patient/family-centered care; and (4) manage the cost of delivering care (116).

This study supports the DHA's quadruple aims and the Surgeon General's priority of "People" by providing an operational definition of well-being, a substantive theory to guide the Navy Nurse Corps officers in fostering well-being and identified barriers and facilitators to fostering well-being. This knowledge and guidance can be capitalized on to ensure a medically ready military force, a ready medical force, and improved quality and healthcare outcomes.

## REFERENCES

1. Achour M, Binti Abdul Ghani Azmi I, Bin Isahak M, Mohd Nor MR, Mohd Yusoff MYZ. 2019. Job Stress and Nurses Well-Being: Prayer and Age as Moderators. *Community Ment Health J* 55:1226-35
2. Al Thobaity A, Alshammari F. 2020. Nurses on the Frontline against the COVID-19 Pandemic: An Integrative Review. *Dubai Medical Journal* 3:87-92
3. Al-Sawai A. 2013. Leadership of healthcare professionals: where do we stand? *Oman Med J* 28:285-7
4. Allport GW. 1937. *Personality: a psychological interpretation*. holt
5. American Nurses Association. 2015. *Code of ethics for nurses with interpretive statements*. . Silver Spring, MD: Nursebooks.org
6. American Nurses Association. 2017. Executive Summary: American Nurses Association Health Risk Appraisal, nursingworld.org
7. American Psychological Association. 2020. *APA Dictionary of Psychology: well-being*. <https://dictionary.apa.org/well-being>
8. American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*. Arlington, VA: American Psychiatric Association
9. Association AP. 2020. *APA Dictionary of Psychology: Mental Health*. <https://dictionary.apa.org/mental-health>
10. Averill LA, Eubanks Fleming CJ, Holens PL, Larsen SE. 2015. Research on PTSD prevalence in OEF/OIF Veterans: expanding investigation of demographic variables. *European journal of psychotraumatology* 6:27322
11. Aycock N, Boyle D. 2009. Interventions to manage compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing* 13:183-91
12. Bazarko D, Cate RA, Azocar F, Kreitzer MJ. 2013. The Impact of an Innovative Mindfulness-Based Stress Reduction Program on the Health and Well-Being of Nurses Employed in a Corporate Setting. *Journal of workplace behavioral health* 28:107-33
13. Berry PA, Gillespie GL, Gates D, Schafer J. 2012. Novice nurse productivity following workplace bullying. *J Nurs Scholarsh* 44:80-7
14. Birks M, Mills J. 2015. *Grounded Theory A Practical Guide*. Thousand Oaks, California SAGE Publications Inc. . 198 pp.
15. Bogue RJ, Carter KF. 2019. A Model for Advancing Nurse Well-Being. *Nurse Leader* 17:526-30
16. Brennan EJ. 2017. Towards resilience and wellbeing in nurses. *Br J Nurs* 26:43-7
17. Carpenter DR. 2011. Grounded theory as method. In *Qualitative research in nursing: Advancing the humanistic perspective*, ed. HJ Streubert, DR

- Carpenter:123-37. Philadelphia, PA: Wolters Kluwer Health | Lippincott Williams & Wilkins. Number of 123-37 pp.
18. Center for Disease Control and Prevention C. 2018. *Well-being concept*. <https://www.cdc.gov/hrqol/wellbeing.htm>
  19. Charmaz K. 2006. *Constructing Grounded Theory*. pp 1-208. London: Sage Publications. 208 pp.
  20. Charmaz K. 2010. Disclosing illness and disability in the workplace. *Journal of International Education in Business* 3:6-9
  21. Charmaz K. 2014. *Constructing Grounded Theory*. pp 1-388. SAGE Publications
  22. Choe K, Kang Y, Park Y. 2015. Moral distress in critical care nurses: a phenomenological study. *J Adv Nurs* 71:1684-93
  23. Christie W, Jones S. 2013. "Lateral Violence in Nursing and the Theory of the Nurse as Wounded Healer". *The Online Journal of Issues in Nursing* 19
  24. Christopher JC, Maris JA. 2010. Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling & Psychotherapy Research* 10:114-25
  25. Cocker F, Joss N. 2016. Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review. *Int J Environ Res Public Health* 13
  26. Compton WC, Smith ML, Cornish KA, Qualls DL. 1996. Factor structure of mental health measures. *Journal of personality and social psychology* 71:406-13
  27. Connor KM, Davidson JRT. 2003. Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and anxiety*:76-82
  28. Corbin JM, Strauss A. 1990. Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology* 13:3-21
  29. Cragun JN, April MD, Thaxton RE. 2016. The Impact of Combat Deployment on Health Care Provider Burnout in a Military Emergency Department: A Cross-Sectional Professional Quality of Life Scale V Survey Study. *Mil Med* 181:730-4
  30. Crowe L. 2016. Identifying the risk of compassion fatigue, improving compassion satisfaction and building resilience in emergency medicine. *Emerg Med Australas* 28:106-8
  31. Csikszentmihalyi M. 1990. *Flow: The Psychology of Optimal Experience*. Harper & Row
  32. Davidson JE, Proudfoot J, Lee K, Zisook S. 2019. Nurse suicide in the United States: Analysis of the Center for Disease Control 2014 National Violent Death Reporting System dataset. *Archives of Psychiatric Nursing*
  33. DePew CL, Gordon M, Yoder LH, Goodwin CW. 1999. The relationship of burnout, stress, and hardiness in nurses in a military medical center: a replicated descriptive study. *The Journal of burn care & rehabilitation* 20:515-22; discussion 4
  34. Dewe PJ. 1987. Identifying strategies nurses use to cope with work stress. *J Adv Nurs* 12:489-97
  35. Diener E. 1984. Subjective well-being *Psychological Bulletin*:542-75

36. Diener E, Oishi S, Lucas RE. 2003. Personality, culture, and subjective well-being: emotional and cognitive evaluations of life. *Annual review of psychology* 54:403-25
37. Dodge R, Daly A, Huyton J, Sanders L. 2012. The challenge of defining wellbeing. *International Journal of Wellbeing* 2:222-35
38. Dumont C, Meisinger S, Whitacre MJ, Corbin G. 2012. Nursing2012. Horizontal violence survey report. *Nursing* 42:44-9
39. Dunn LB, Iglewicz A, Moutier C. 2008. A Conceptual Model of Medical Student Well-Being: Promoting Resilience and Preventing Burnout. *Academic Psychiatry*:44-53
40. Dyrbye LN, Shanafelt TD. 2011. Physician burnout: a potential threat to successful health care reform. *Jama* 305:2009-10
41. Dyrbye LN, Shanafelt TD, Sinsky CA, Cipriano PF, Bhatt J, et al. 2017. Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care. *NAM Perspectives* 7
42. Electronic Code of Federal Regulations. 2018. *Subpart A: Basic HHS Policy for Protection of Humana Reserach Subjects*. [https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46\\_1116](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46_1116)
43. Emold C, Schneider N, Meller I, Yagil Y. 2011. Communication skills, working environment and burnout among oncology nurses. *Eur J Oncol Nurs* 15:358-63
44. Fertleman C, Carroll W. 2013. Protecting students and promoting resilience. *BMJ (Clinical research ed.)* 347:f5266
45. Figley CR. 1995. *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner Mazel Publisher
46. Fleming R, Baum A, Gisriel MM, Gatchel RJ. 1982. Mediating influences of social support on stress at Three Mile Island. *J Human Stress* 8:14-22
47. Ford J, Klibert JJ, Tarantino N, Lamis DA. 2017. Savouring and Self-compassion as Protective Factors for Depression. *Stress Health* 33:119-28
48. Foxall MJ, Zimmerman L, Standley R, Bene B. 1990. A comparison of frequency and sources of nursing job stress perceived by intensive care, hospice and medical-surgical nurses. *J Adv Nurs* 15:577-84
49. Franke F, Felfe J, Pundt A. 2014. The Impact of Health-Oriented Leadership on Follower Health: Development and Test of a New Instrument Measuring Health-Promoting Leadership. *German Journal of Human Resource Management: Zeitschrift f&#252;r Personalforschung* 28:139-61
50. Frankle VE. 1963. *Man's serch for meaning*. NewYork: Washington Square Press
51. Freudenberger HJ. 1974. Staff Burn-out. *Journal of Social Issues* 30:159-65
52. Germer CK, Neff KD. 2013. Self-compassion in clinical practice. *J Clin Psychol* 69:856-67
53. Gilbert P. 2005. Compassion and cruelty: a biopsychosocial approach. In *Compassion: Conceptualisations, research and use in psychotherapy*, ed. P Gilbert:9-74. Loundon: Routledge. Number of 9-74 pp.

54. Glaser BG. 1998. *Doing Grounded Theory: Issues and Discussions*. Sociology Press
55. Glaser BG, Holton J. 2005. Basic Social Process. *Grounded Theory Review: An international journal* 04
56. Glaser BG, Strauss AL. 1967. *The discovery of grounded theory: Strategies for qualitative research*. Aldine Transaction. 271 pp.
57. Glaser BG, Strauss AL. 1999. *The Discovery of Grounded Theory*. New York: Routledge
58. Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB. 2016. Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS One* 11:e0159015
59. Hariharan S, Jonnalagadda R, Walrond E, Moseley H. 2006. Knowledge, attitudes and practice of healthcare ethics and law among doctors and nurses in Barbados. *BMC Med Ethics* 7:E7
60. Harris PE. 1989. The nurse stress index. *Work & Stress* 3:335-46
61. Harris RB. 1989. Reviewing nursing stress according to a proposed coping-adaptation framework. *ANS Adv Nurs Sci* 11:12-28
62. Heinze KE, Hanson G, Holtz H, Swoboda SM, Rushton CH. 2020. Measuring Health Care Interprofessionals' Moral Resilience: Validation of the Rushton Moral Resilience Scale. *J Palliat Med*
63. Hickling EJ, Gibbons S, Barnett SD, Watts D. 2011. The psychological impact of deployment on OEF/OIF healthcare providers. *Journal of traumatic stress* 24:726-34
64. Hooper C, Craig J, Janvrin DR, Wetsel MA, Reimels E. 2010. Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of emergency nursing: JEN : official publication of the Emergency Department Nurses Association* 36:420-7
65. Hopkinson SG, Dickinson CM, Dumayas JY, Jarzombek SL, Blackman VS. 2020. A multi-center study of horizontal violence in United States military nursing. *Nurse Educ Pract* 47:102838
66. Hu D, Kong Y, Li W, Han Q, Zhang X, et al. 2020. Frontline nurses' burnout, anxiety, depression, and fear statuses and their associated factors during the COVID-19 outbreak in Wuhan, China: A large-scale cross-sectional study. *EClinicalMedicine* 24:100424
67. Hunsaker S, Chen HC, Maughan D, Heaston S. 2015. Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing* 47:186-94
68. Huppert FA. 2009. Psychological Well-being: Evidence Regarding its Causes and Consequences. *Applied Psychology: Health and Well-Being* 1:137-64
69. Huppert FA, So TT. 2013. Flourishing Across Europe: Application of a New Conceptual Framework for Defining Well-Being. *Soc Indic Res* 110:837-61
70. IBM Corp. Released 2017. *IBP SPSS Statistics for Mac*. Armonk, NY: IBM Corp

71. Ishizuka Y. 1988. Lifetrack Therapy. *Psychiatric Journal of the University of Ottawa* 13:198-207
72. Jackson D, Firtko A, Edenborough M. 2007. Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *J Adv Nurs* 60:1-9
73. Jacobs D, Kyzer S. 2010. Upstate AHEC Lateral Violence among Nurses Project. *S C Nurse (1994)* 17:1, 3
74. Jacobson T, Navarrete C, Sharma SK, Sideri TC, Ibstedt S, et al. 2012. Arsenite interferes with protein folding and triggers formation of protein aggregates in yeast. *J Cell Sci* 125:5073-83
75. Jahoda M. 1958. Joint commission on mental health and illness monograph series:. In *Current concepts of positive mental health*, 1. Number of.
76. Janssen E, Van Strydonck I, Decuypere A, Decramer A, Audenaert M. 2020. How to foster nurses' well-being and performance in the face of work pressure? The role of mindfulness as personal resource. *J Adv Nurs* 76:3495-505
77. Jarden RJ, Jarden A, Weiland TJ, Taylor G, Brockenshire N, Gerdtz M. 2020. Registered Nurses' experiences of psychological well-being and ill-being in their first year of practice: A qualitative meta-synthesis. *J Adv Nurs*
78. Joinson C. 1992. Coping with compassion fatigue: Burn out and burn up-has caring for others made you too tired to care for yourself? *Nursing* 22:116-21
79. Joseph S. 2015. *Positive psychology in practice: Promoting human flourishing in work, health, education, and everyday life*. Hoboken, NJ: John Wiley & Sons
80. Kahneman D, Diener E. 1999. *Well-Being: Foundations of Hedonic Psychology*. New York, NY: Russell Sage Foundation
81. Kashdan TB, Biswas-Diener R, King LA. 2008. Reconsidering happiness: the costs of distinguishing between hedonics and eudaimonia. *The Journal of Positive Psychology* 3:219-33
82. Kearney MK, Weininger RB, Vachon ML, Harrison RL, Mount BM. 2009. Self-care of physicians caring for patients at the end of life: "Being connected... a key to my survival". *Jama* 301:1155-64, E1
83. Keyes CL, Shmotkin D, Ryff CD. 2002. Optimizing well-being: the empirical encounter of two traditions. *Journal of personality and social psychology* 82:1007-22
84. Kiefer RA. 2008. An integrative review of the concept of well-being. *Holist Nurs Pract* 22:244-52; quiz 53-4
85. Kolkow TT, Spira JL, Morse JS, Grieger TA. 2007. Post-traumatic stress disorder and depression in health care providers returning from deployment to Iraq and Afghanistan. *Military medicine* 172:451-5
86. Kravits K, McAllister-Black R, Grant M, Kirk C. 2010. Self-care strategies for nurses: A psycho-educational intervention for stress reduction and the prevention of burnout. *Appl Nurs Res* 23:130-8
87. Kumar GS. 2013. Yoga in promotion of health: translating evidence into practice at primary healthcare level in India. *J Family Med Prim Care* 2:301-2
88. Laffrey SC. 1986. Development of a health conception scale. *Res Nurs Health* 9:107-13

89. Lang GM, Patrician P, Steele N. 2012. Comparison of nurse burnout across Army hospital practice environments. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing* 44:274-83
90. Lang GM, Pfister EA, Siemens MJ. 2010. Nursing burnout: cross-sectional study at a large Army hospital. *Mil Med* 175:435-41
91. Lazarus RS. 1993. Coping theory and research: past, present, and future. *Psychosom Med* 55:234-47
92. Lazarus RS, Folkman S. 1984. *Stress, appraisal and coping*. New York: Springer
93. Leary MR, Tate EB, Adams CE, Allen AB, Hancock J. 2007. Self-compassion and reactions to unpleasant self-relevant events: the implications of treating oneself kindly. *J Pers Soc Psychol* 92:887-904
94. Lee JJ, Miller SE. 2018. A Self-Care Framework for Social Workers: Building a Strong Foundation for Practice. *Families in Society: The Journal of Contemporary Social Services* 94:96-103
95. Lee TS, Tzeng WC, Chiang HH. 2019. Impact of Coping Strategies on Nurses' Well-Being and Practice. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing* 51:195-204
96. Leners C, Sowers R, Griffin MT, Fitzpatrick JJ. 2014. Resilience and professional quality of life among military healthcare providers. *Issues in mental health nursing* 35:497-502
97. Lincoln YS, Guba EG. 1985. *Naturalistic inquiry*. Thousand Oaks, CA: SAGE
98. Lincoln YS, Guba EG. 2000. Paradigmatic controversies, contradictions, and emerging confluences. In *The handbook of qualitative research*, ed. NK Denzin, YS Lincoln:1065-122. Thousand Oaks, CA: SAGE Publications. Number of 1065-122 pp.
99. Linley PA, Maltby J, Wood AM, Osborne G, Hurling R. 2009. Measuring happiness: The higher order factor structure of subjective and psychological well-being measures. *Personality and Individual Differences* 47:878-84
100. Linton MJ, Dieppe P, Medina-Lara A. 2016. Review of 99 self-report measures for assessing well-being in adults: exploring dimensions of well-being and developments over time. *BMJ Open* 6:e010641
101. Lorber M, Treven S, Mumel D. 2020. Well-Being and Satisfaction of Nurses in Slovenian Hospitals: A Cross-Sectional Study. *Zdr Varst* 59:180-8
102. MacGregor AJ, Clouser MC, Mayo JA, Galarneau MR. 2017. Gender Differences in Posttraumatic Stress Disorder Among U.S. Navy Healthcare Personnel. *Journal of women's health (2002)* 26:338-44
103. Makary MA, Daniel M. 2016. Medical error-the third leading cause of death in the US. *BMJ* 353:i2139
104. Marshall C, Rossman GB. 2016. *Designing Qualitative Research*. Thousand Oaks, CA: SAGE Publications
105. Martela F, Ryan RM, Steger MF. 2017. Meaningfulness as Satisfaction of Autonomy, Competence, Relatedness, and Beneficence: Comparing the Four Satisfactions and Positive Affect as Predictors of Meaning in Life. *Journal of Happiness Studies* 19:1261-82

106. Martins Pereira S, Teixeira CM, Carvalho AS, Hernandez-Marrero P. 2016. Compared to Palliative Care, Working in Intensive Care More than Doubles the Chances of Burnout: Results from a Nationwide Comparative Study. *PloS one* 11:e0162340
107. Maslach C, Jackson SE. 1981. The measurement of experinced burnout. *Journal of Organizational Behavior* 2:99-113
108. Maslach C, Jackson SE, Leiter MP. 1996. *Maslach Burnout Inventory Manual*. Palo Alto, CA: Consulting Psychologists Press
109. Maslach C, Leiter MP, Schaufeli W. 2009. Measuring Burnout. In *The Oxford Handbook of Organizational Well-being*. Number of.
110. Maslach C, Schaufeli WB, Leiter MP. 2001. Job Burnout. *Annual Review of Psychology* 52:397-422
111. Maslow AH. 1954. *Motivation and personality*. Harpers
112. Masten AS, Obradovic J. 2006. Competence and resilience in development. *Ann N Y Acad Sci* 1094:13-27
113. McCann CM, Beddoe E, McCormick K, Huggard P, Kedge S, et al. 2013. Resilience in the health professions: A review of recent literature. *International Journal of Wellbeing* 3:60-81
114. Melnyk BM, Orsolini L, Tan A, Arslanian-Engoren C, Melkus GD, et al. 2018. A National Study Links Nurses' Physical and Mental Health to Medical Errors and Perceived Worksite Wellness. *J Occup Environ Med* 60:126-31
115. Meredith LS, Sherbourne CD, Gaillot SJ, Hansell L, Ritschard HV, et al. 2011. Promoting Psychological Resilience in the U.S. Military. *Rand health quarterly* 1:2
116. MHS. 2014. Secretary of defense Military Health System Review Final Report
117. Microsoft. 2020. *Microsoft Word*. Microsoft Corporation
118. Microsoft. 2021. *Microsoft Excel*. Mocosoft Corporation
119. Miles MB, Huberman AM, Saldana J. 2014. *Qualitative Data Analysis: A methods sourcebook*. Thousand Oaks, CA: SAGE. 331 pp.
120. Moher D, Liberati A, Tetzlaff J, Altman DG, Group P. 2009. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS Med* 6:e1000097
121. Morse JM. 2015. Analytic Strategies and Sample Size. *Qual Health Res* 25:1317-8
122. National Academy of Medicine. 2017. Action Collaboration on clinician well-being and resilience.
123. National Academy of Sciences Engineering and Medicine. 2019. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. Washington, DC: The National Academies Press
124. Neff KD. 2003. Self-compassion: an alternative conceptualization of a healthy attitude toward oneself. *Self Identity* 2:85-102
125. Neff KD. 2016. Erratum to: The Self-Compassion Scale is a Valid and Theoretically Coherent Measure of Self-Compassion. *Mindfulness* 7:1009-

126. Neff KD, Davidson O. 2016. Self-compassion: Embracing suffering with kindness. In *Mindfulness in Positive Psychology*, ed. I Ivtzan, T Lomas:37-50: Rutledge. Number of 37-50 pp.
127. Neff KD, Kirkpatrick KL, Rude SS. 2007. Self-compassion and adaptive psychological functioning. *Journal of Research in Personality* 41:139-54
128. Neumann JL, Mau LW, Virani S, Denzen EM, Boyle DA, et al. 2018. Burnout, Moral Distress, Work-Life Balance, and Career Satisfaction among Hematopoietic Cell Transplantation Professionals. *Biol Blood Marrow Transplant* 24:849-60
129. NVivo. *NVivo qualitative data analysis software*. QSR International PTY Ltd
130. NVivo. *NVivo qualitative transcription software*. QSR International Pty Ltd.
131. O'Connell CB. 2015. Gender and the experience of moral distress in critical care nurses. *Nurs Ethics* 22:32-42
132. Olshansky E. 2005. Feeling normal. Women's experiences of menopause after infertility. *MCN Am J Matern Child Nurs* 30:195-200
133. Owen RP, Wanzer L. 2014. Compassion fatigue in military healthcare teams. *Arch Psychiatr Nurs* 28:2-9
134. Perry B, Toffner G, Merrick T, Dalton J. 2011. An exploration of the experience of compassion fatigue in clinical oncology nurses. *Can Oncol Nurs J* 21:91-105
135. Pollard EL, Lee PD. 2003. *Social Indicators Research* 61:59-78
136. Potter P, Deshields T, Berger JA, Clarke M, Olsen S, Chen L. 2013. Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum* 40:180-7
137. Potter P, Deshields T, Divanbeigi J, Berger J, Cipriano D, et al. 2010. Compassion fatigue and burnout: prevalence among oncology nurses. *Clin J Oncol Nurs* 14:E56-62
138. Quine L. 2001. Workplace bullying in nurses. *J Health Psychol* 6:73-84
139. Reis HT, Gable SL. 2003. Toward a positive psychology of relationships. In *Flourishing: Positive psychology and the life well-lived.*, ed. LM Keys, J Haidt:129-59: American Psychological Association. Number of 129-59 pp.
140. Ritchie EC, Benedek D, Malone R, Carr-Malone R. 2006. Psychiatry and the military: an update. *Psychiatr Clin North Am* 29:695-707
141. Romppanen J, Haggman-Laitila A. 2017. Interventions for nurses' well-being at work: a quantitative systematic review. *J Adv Nurs* 73:1555-69
142. Ross A, Bevans M, Brooks AT, Gibbons S, Wallen GR. 2017. Nurses and Health-Promoting Behaviors: Knowledge May Not Translate Into Self-Care. *AORN J* 105:267-75
143. Rostami S, Esmaeali R, Jafari H, Cherati JY. 2017. Perception of futile care and caring behaviors of nurses in intensive care units. *Nurs Ethics*:969733017703694
144. Rushton CH. 2016. Moral Resilience: A Capacity for Navigating Moral Distress in Critical Care. *AACN Adv Crit Care* 27:111-9
145. Rushton CH, Swoboda SM, Reller N, Skarupski KA, Prizzi M, et al. 2021. Mindful Ethical Practice and Resilience Academy: Equipping Nurses to Address Ethical Challenges. *Am J Crit Care* 30:e1-e11

146. Russell K. 2016. Perceptions of Burnout, Its Prevention, and Its Effect on Patient Care as Described by Oncology Nurses in the Hospital Setting. *Oncol Nurs Forum* 43:103-9
147. Ryan RM, Deci EL. 2001. On happiness and human potentials: a review of research on hedonic and eudaimonic well-being. *Annual review of psychology* 52:141-66
148. Ryff CD. 1989. Happiness Is Everything, or Is It? Explorations on the Meaning of Psychological Well-Being. *Journal of Personality and Social Psychology* 57:1069-81
149. Ryff CD. 2014. Psychological well-being revisited: advances in the science and practice of eudaimonia. *Psychother Psychosom* 83:10-28
150. Sabbah I, Sabbah H, Sabbah S, Akoum H, Droubi N. 2012. Burnout among Lebanese nurses: Psychometric properties of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS). *Health* 04:644-52
151. Sargent P, Millegan J, Delaney E, Roesch S, Sanders M, et al. 2016. Health Care Provider Burnout in a United States Military Medical Center During a Period of War. *Mil Med* 181:136-42
152. Schernhammer E. 2005. Taking their own lives -- the high rate of physician suicide. *N Engl J Med* 352:2473-6
153. Seligman ME. 1998. The prediction and prevention of depression. In *The science of clinical psychology: Accomplishments and future directions* ed. RJ Routh, RJ DeRubeis:201-14: American Psychological Association. Number of 201-14 pp.
154. Seligman ME. 2011. *Flourish: a visionary new understanding of happiness and well-being*. New York, NY: Atria Paperback: A division of Simon & Schuster, Inc.
155. Seligman MEP, Csikszentmihalyi M. 2000. Positive psychology: An introduction. *American Psychologist* 55:5-14
156. Seppala E, Rossomando T, Doty JR. 2013. Social Connection and Compassion: Important Predictors of Health and Well-Being. *Social Research: An International Quarterly* 80:411-30
157. Shanafelt TD, Sloan JA, Habermann TM. 2003. The well-being of physicians. *The American Journal of Medicine* 114:513-9
158. Stamm BH. 2010. The Concise ProQOL Manual. In *ProQOL.org*. Pacatello, ID: ProQOL.org
159. Steger MF, Kashdan TB, Sullivan BA, Lorentz D. 2008. Understanding the search for meaning in life: personality, cognitive style, and the dynamic between seeking and experiencing meaning. *J Pers* 76:199-228
160. Steger MF, Shin JY, Shim Y, Fitch-Martin A. 2013. Is meaning in life a flagship indicator of well-being? In *The best within us: Positive psychology perspectives on eudaimonia.*, ed. AS Waterman:159-82: American Psychology Association. Number of 159-82 pp.
161. Stelnicki AM, Carleton RN, Reichert C. 2020. Nurses' Mental Health and Well-Being: COVID-19 Impacts. *Can J Nurs Res* 52:237-9
162. Traynor K. 2017. Coalition seeks solutions for clinician burnout. *Am J Health Syst Pharm* 74:1296-7

163. Varner DF, Foutch BK. 2014. Depression and burnout symptoms among Air Force family medicine providers. *JAAPA : official journal of the American Academy of Physician Assistants* 27:42-6
164. Wagnild G. 2009. A review of the Resilience Scale. *J Nurs Meas* 17:105-13
165. Walters TA, Matthews EP, Dailey JI. 2014. Burnout in Army health care providers. *Mil Med* 179:1006-12
166. Waterman AS. 2008. Reconsidering happiness: a eudaimonist's perspective. *The Journal of Positive Psychology* 3:234-52
167. Weidlich CP, Ugarriza DN. 2015. A pilot study examining the impact of care provider support program on resiliency, coping, and compassion fatigue in military health care providers. *Military medicine* 180:290-5
168. Whitehead PB, Herbertson RK, Hamric AB, Epstein EG, Fisher JM. 2015. Moral distress among healthcare professionals: report of an institution-wide survey. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing* 47:117-25
169. World Health Organization. 2021. *What do we mean by self-care?* <https://www.who.int/reproductivehealth/self-care-interventions/definitions/en/>
170. Yilmaz EB. 2017. Resilience as a strategy for struggling against challenges related to the nursing profession. *Chinese Nursing Research* 4:9-13
171. Young PD, Rushton CH. 2017. A concept analysis of moral resilience. *Nurs Outlook* 65:579-87

## Appendix A

### Literature Review Evidence Table

#### Overview of Studies on military healthcare professional well-being

Author/Title	N	Sample Setting	Design Purpose	Instruments	Results
Lang, G. M., Pfister, E. A., & Siemens, M. J. (2010).	Sample frame: 600 eligible  Participated 364 (60%)	<p>Nursing personnel was defined as registered nurses (RN), licensed practical nurse (LPN), certified nurse aid (CAN), and Army medics.</p> <p>On unit for six months, work full-time, in direct patient care.</p> <p>Most participants were RNs: Army nurse corps officers (<math>n = 123</math>), followed by civilian RNs (<math>n = 97</math>). Most of the Army participants had a bachelor's degree in nursing, worked on inpatient units, worked 12-hour shifts, worked overtime (&gt;80 hours per pay period), and routinely cared for Operation Iraqi Freedom/ Operation Enduring Freedom (OIF/OEF) patients. Most civilians worked the day shift, worked fewer than 12-hour shifts, worked less overtime, and had less than a bachelor's degree in nursing, and on average, older than their Army counterparts (<math>43 \pm 11</math> years vs. <math>30 \pm 8</math>).</p>	<p>Determine if there were differences in the level of burnout among Army nursing personnel and civilian nursing personnel assigned to a large U.S. Army teaching hospital.</p> <p>Cross-sectional Pencil and paper survey</p> <p>IRB approved study</p>	<p>Maslach Burnout Inventory for Human Services Survey (MBI-HSS):</p> <p>The MBI is a 22-item norm-referenced instrument that is used by researchers nationally and internationally. The instrument's 22 items reflect direct measures of emotional exhaustion (8 items), depersonalization (5 items), and reduced personal accomplishment (9 items). Each subscale stands alone, but together, they are used to categorize into low, medium, or high levels of burnout on the basis of an established normative range for health care workers.</p> <p>Note: The authors provided references and an in-depth discussion on validity and reliability as well as</p>	<p>Results:</p> <p>Both the civilian and active-duty Army groups scored moderately burned out. However, the army participants fared worse on both the emotional exhaustion and the depersonalization subscales (<math>25 \pm 12.84</math> vs. <math>19 \pm 12.32</math> <math>t=4.22</math>, <math>p&lt;0.001</math>) and (<math>8 \pm 6.61</math> vs. <math>5 \pm 5.38</math>, <math>t=4.27</math>, <math>p&lt;0.001</math>) respectfully. The reduced personal accomplishment was not noticeably different between groups.</p> <p>Although both groups were moderately burned out, ordinal logical regression findings suggest that belonging the army nursing group, working other than the day shift, working more than 8-hour shift and routinely providing care to soldiers who were injured in Iraq and Afghanistan</p>

				indicated which of the five scales used. The appropriate scale for the population was used.	were work demands associated with emotional exhaustion and depersonalization.  Limitations: The authors did not address limitations.
Sargent, P., Millegan, J., Delaney, E., Roesch, S., Sanders, M., Mak, H., . . . Webb-Murphy, J. (2016).	N=523 (52.3%)	Naval Medical Center San Diego  Slightly more than half of the respondents were male and over the age of 41. Almost three-quarters of our sample were married. In terms of military status, 58.5% of our sample was active duty, whereas 41.5% were civilian/contractor. Further, for those active-duty staff, 27.1% had never been deployed, 17.5% had been on one deployment, and 16.7% had been on two or more deployments. In addition, 81% of respondents were considered as staff provider, whereas 13.7% were a provider in training and 5.3% were considered others. Most of the respondents were physicians (49%), with dentists (15.9%) and other (10.1%) making up the next two most endorsed job titles.	Command cross-sectional initiative survey  IRB approval not addressed by the authors	Maslach Burnout Inventory  The MBI contains three sub-scales to examine different aspects of burnout including “emotional exhaustion (EE),” “depersonalization (DEP),” and “lack of personal accomplishment (PA).” According to the MBI manual, the 9-item EE subscale assesses feelings of being emotionally overextended by one’s work, the 5-item DEP subscale measures having an unfeeling and impersonal response toward recipients of one’s services, and the 8-item PA subscale assesses feelings of competence and successful achievement. The reliability coefficients for the subscales are 0.90 for EE,	Results: Overall this sample scores were a low category on emotional exhaustion and depersonalization scores and high category of personal accomplishment.  There was statistical significance for emotional exhaustion and: time on call Time on collateral duties, Directorate (medical and mental health).  There was statistical significance for depersonalization, which indicated a higher level for age ranges under 50 with the 25-30 age range having the highest and active duty with one deployment higher score over a civilian. The number of deployments was not a factor identified as being significant.

				0.79 for DEP, and 0.71 for PA.	<p>There was statistical difference reflecting that providers over the age of 50 and staff providers had higher personal achievement scores.</p> <p>Limitations: Cross-sectional design limits conclusions and causality of burnout</p> <p>Potential response bias, no information available for non-responders</p> <p>Did not evaluate provider burnout effects on patient outcomes</p> <p>Recommendations: there is still much to learn regarding the causes and consequences of burnout, specifically on patient care outcomes. Trends and evolving factors in military treatment facilities should be monitored to assess severity or resiliency.</p>
Varner, D. F., & Foutch, B. K. (2014).	<p>Sample Frame 726</p> <p>Response rate 21% N=150</p> <p>86 family medicine physicians</p>	<p>Participants were recruited from active-duty Air Force family medicine providers</p> <p>An electronic survey sent to 726 Air Force family medicine providers across the globe to include providers</p>	This study used a cross-sectional electronic survey design to measure and quantify the effects of socio-demographic factors on depression and	<p>Maslach Burnout Inventory (MBI)</p> <p>Patient Health Questionnaire 9 (PHQ-9) and demographics</p> <p>Note: the authors did not provide</p>	<p>Results: 84 % (126) of the respondents scored positive for some degree of depression symptoms. With an overall mean PHQ-9 score of 4.76, indicating an average reported</p>

	<p>61 family medicine physician assistance (PA)</p> <p>3 family medicine nurse practitioners (NP)</p>	located in austere deployed locations.	<p>burnout symptoms.</p> <p>IRB Exempt study</p>	<p>references for the tools they used or discuss validity and reliability other than stating both measurements used had been previously validated. However, they reported using the MBI-GS version, which was designed for use with occupational groups other than human services and education, including those working in jobs such as customer service, maintenance, manufacturing, management, and most other professions.</p>	<p>depression symptom in the minimum range.</p> <p>For the MBI measurement: emotional exhaustion mean score of 16.04, (2) depersonalization mean score of 12.67, (3) Professional satisfaction mean score was 26.85.</p> <p>The only statistically significant contributing factor was respondents over the age of 44 reported lower emotional exhaustion and depersonalization and higher professional satisfaction.</p> <p>Limitations: Cross-sectional design inherent inability to infer causality. Relatively low response rate. Single military service: Air force.</p> <p>Future research recommendations: Include more diverse population in regards to service and specialty — stigma and barriers to seeking mental health.</p>
Walters, T. A., Matthews, E. P., & Dailey, J. I. (2014).	Sample Frame 158 Active Health care providers	Participants were obtained from a convenience sample of all	Cross-sectional survey. The purpose was to collect data in	Maslach Burnout Inventory (MBI): validity	Results: MBI subscale Emotional exhaustion=

	<p>excluding nurses</p> <p>33% response rate 53 participant, predominantly male</p> <p>female 17 male 36</p>	<p>available combat medics, and physicians stationed at Fort Campbell, Kentucky.</p> <p>101<sup>st</sup> Airborne Division, deployed for at least one month to Iraq or Afghanistan</p>	<p>regard to Army Health care providers and the rate of burn out they experience in correlation to the total number of months deployed and numerous demographic factors.</p> <p>IRB approved Study</p>	<p>and reliability of instrument provided</p> <p>Cronbach's alpha score over 0.7 proving high internal consistency. The test-retest reliability significant beyond the alpha level of <math>P &lt; 0.001</math> for all sub-scales.</p> <p>Areas of Work life Survey (AWS)</p> <p>Note: The authors provided references for the tools they used and an in-depth discussion of the validity and reliability. However, they did not indicate what version of the MBI was used.</p>	<p>30.17 (greater than 27=high burnout): 69.8% scored high Depersonalization= 15.92 (greater than 10=high for burnout): 67.9% scored high Personal accomplishment =34.34 (34-39 average) 28.3 scored low</p> <p>A higher number of leave days was correlated with a higher level of emotional exhaustion and depolarization</p> <p>AWS scale demonstrated a dislike for the area of workload and fairness and a like of control, reward, community, and values in their work environment.</p> <p>No correlation to the number of months deployed was found.</p> <p>Limitations: Cross-sectional design. Low response rate Single service: Army Time passed since the last deployment not collected Inability to compare demographics of respondents and non-respondents</p>
Cragun, J. N., April, M. D., &	Sample frame 377	Convenience sample	Non-experimental	The Professional Quality of Life	Results There was not a correlation

<p>Thaxton, R. E. (2016).</p>	<p>Participants: 105 30 technicians (11 previously deployed); 42 nurses (20 previously deployed); 33 Physicians (16 previously deployed).</p>	<p>San Antonio Military Medical center, Department of Emergency Medicine</p>	<p>cross-sectional survey</p> <p>Establish the impact of combat deployment on compassion fatigue among military health care providers.</p> <p>IRB approved study</p>	<p>(ProQoL) instrument is a 30-item questionnaire that evaluates three components of professional quality of life.</p> <p>The alpha reliability scores in prior research were as follows: Compassion satisfaction, <math>r = .87</math>; burnout, <math>r = .72</math>; compassion fatigue, <math>r = .80</math></p>	<p>between deployment history or profession. Results trended towards higher secondary traumatic stress and burnout scores and decreased compassion satisfaction with those with deployment history but not statistically significant; potential the sample is not large enough.</p> <p>Limitations No demographic data were collected Convenience sample at a single MTF The number and lengths of deployments were not collected. Future research will need to be done to clarify the impact of additional factors on compassion fatigue among military health care providers experiencing combat deployment to include demographic, providers specialty, resiliency training and assignment to designated trauma and critical care centers.</p>
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					The authors did not interrupt their ProQOL scores.
Weidlich, C. P., & Ugarriza, D. N. (2015).	93 enrolled in the study  28 (30%) completed the study.	A convenience sample of military and civilian RNs, LPNs, medics	The purpose of this pilot study was to collect data on the levels of resiliency, coping, and compassion fatigue in a population of military and civilian registered nurses (RNs), licensed practical nurses (LPNs), and medics who treat wounded services members and whether these dynamics improve over time. Examine how CPSP training affects participants' resiliency, coping ability, and level of compassion fatigue in a sample of health care providers over time (30 days)	Connor Davidson Resilience Scale (CD-RISC)  Ways of Coping Questionnaire (WCQ)  Professional Quality of Life Scale (ProQOL)  The alpha reliability scores in prior research were as follows: Compassion satisfaction, $r = .87$ ; burnout, $r = .72$ ; compassion fatigue, $r = .80$	Results No statistical difference was found in the total WCQ score between before receiving training and 30 days after.  No statistical difference was found in the eight individual coping skills except for Positive Reappraisal ( $p=0.025$ ) between before training and 30 days after.  There was a statistically positive effect noted with the CPSP training and the burnout subscale of the ProQOL. The subscales of secondary traumatic stress and compassion satisfaction had no statistical difference between before and 30 days after training.  Limitations The small sample size for individuals that completed the study $n=28$ Conducted at one Army facility. Unrelated budget cuts and hiring freeze occurring at the location during

					the time of the study could have potentially affected the stress Levels.
Leners, C., Sowers, R., Quinn Griffin, M. T., & Fitzpatrick, J. J. (2014).	168 surveys completed, 71 by nurses, 42 by advanced practice nurses, and 47 by physicians. The total response rate was 19 Gender distribution was 46.4% ( $n = 78$ ) male and 53.6% ( $n = 90$ ) female. The age range was from 23–66+ years old. The following ranks of military officer were represented: Commander, Lieutenant Colonel, 33.3%, $n = 60$ ; Lieutenant Commander, Major, 26.2%, $n = 44$ ; Lieutenant, Captain, 21.4%, $n = 36$ ; Colonel, Captain, 11.9%, $n = 20$ ; Lieutenant Junior grade, 2nd Lieutenant, 4.8%, $n = 8$ ; and Ensign, 1st Lieutenant, 2.4%, $n = 4$ . All branches of the service were represented.	Convenience Sample	The purpose of this study is to examine the relationship between resilience and professional quality of life and to explore differences among providers who had been deployed and those who had never been deployed.	The Resilience Scale (RS), a 25-item questionnaire developed by Wagnild (2009), was used to measure resilience. The RS is scored on a positively worded 7-point scale (1 = disagree, 7 = agree); scores range from 25 to 175, with higher scores indicating higher levels of resilience. The resilience scale has been widely used, and has been shown to be valid and reliable; reliabilities range from .75 to .95 In the present study the Cronbach alpha reliability was .95.  The Professional Quality of Life (ProQoL) instrument is a 30-item questionnaire that evaluates three components of professional quality of life.  The alpha reliability scores in prior research were as follows: Compassion	The mean score on the resilience scale was 147.93 ( $SD = 18.92$ ; range: 41–175). The scores on the Professional Quality of Life subscales were: Compassion Satisfaction: Mean = 41.80 ( $SD = 5.40$ ; range: 23–50); Burnout: Mean = 20.45 ( $SD = 4.90$ ; range: 10–34); and Compassion Fatigue/Secondary Trauma: Mean = 19.28 ( $SD = 5.66$ ; range: 10–42).  There were statistically significant relationships between resilience and compassion satisfaction ( $r = .45, p < .001$ .); resilience and burnout ( $r = -.37, p < .001$ ); and resilience and compassion fatigue/secondary trauma ( $r = -.29, p < .001$ ).

				<p>satisfaction, <math>r = .87</math>; burnout, <math>r = .72</math>; compassion fatigue, <math>r = .80</math></p> <p>In the present study the reliabilities were: compassion satisfaction, <math>r = .90</math>; burnout, <math>r = .77</math>; and compassion fatigue, <math>r = .85</math>.</p>	
<p>Kolkow, T. T., Spira, J. L., Morse, J. S., &amp; Grieger, T. A. (2007).</p>	<p>N=102</p>	<p>One hundred two responses were received from personnel recently deployed to a combat area (36% response rate among 278 personnel who had recently deployed to combat areas, based on hospital personnel records)</p>	<p>An anonymous cross-sectional survey was administered to previously deployed workers at a military hospital to examine risk factors for post-traumatic stress disorder (PTSD), depression, and mental health care use among health care workers deployed to combat settings.</p> <p>IRB approved study</p>	<p>The presence of probable PTSD was assessed with the 17-item PTSD Checklist (PCL).</p> <p>Probable depression was assessed using the Patient Health Questionnaire depression scale.</p> <p>Respondents were asked to describe how frequently they engaged in combat or were fired upon by enemy forces or observed or cared for wounded or dead opposition forces, wounded or dead friendly forces, or wounded or dead civilians. Respondents were also asked how often during deployment, they experienced physical danger, fear of death, or fear of exposure to chemical or</p>	<p>Results: Nine percent (<math>n=9</math>) met the criteria for PTSD, and 5% (<math>n=5</math>) met the criteria for depression. Direct and perceived threats of personal harm were risk factors for PTSD; exposure to wounded or dead patients did not increase risk. Those who met the criteria for PTSD were more likely to seek mental health care after but not before their deployment. Of the demographic characteristics non-Caucasian race was the only demographic factor associated with increased risk of probable PTSD (OR, 9.24; 95% CI, 1.46–58.40; Wald <math>\chi^2 = 5.59</math>, <math>df = 1</math>, <math>p = 0.018</math>) and depression (OR, 11.95; 95% CI, 1.02–139.57;</p>

				<p>biological weapons. Response choices for exposures and threat perceptions were "not applicable," "never," "once," "more than once," and "frequently." Those who responded "frequently" were compared with those who endorsed lower levels of exposure or threat perception.</p> <p>Respondents were asked to report how many times they had seen a psychiatrist, psychologist, or social worker during the following periods of time: "before enlistment or commissioning," "in the year before deployment," "during deployment," and "since returning from deployment." Respondents who reported six or more visits during each period were considered to be in ongoing mental health treatment.</p>	<p>Wald <math>\chi^2 = 3.91</math>, <math>df = 1</math>, <math>p = 0.048</math>). Age, race, gender, and education level were not associated with increased risk of subclinical PTSD.</p> <p>Those reporting frequent personal engagement in direct combat or being fired upon by opposition forces were 17.02 times more likely to meet the criteria for probable PTSD.</p> <p>those reporting a frequent concern regarding being in danger were at 8.87 times greater risk of meeting the criteria for probable PTSD</p> <p>Limitations: This study is limited by the relatively small sample size and sampling technique. Because personal experiences during deployment are diverse, a generalization of these findings to other groups of deployed health care workers should be performed with caution. Participation in this study was voluntary, and there is no way to determine</p>
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					<p>bias regarding those who chose not to participate. Actual rates of probable PTSD and depression might, therefore, be higher or lower than those reported here. There might also be some distortion of experiences and perceptions because of recall bias. Because clinical interviews were not performed, the rates described may not represent actual rates of illness.</p> <p>Conclusions: For health care workers returning from a warfare environment, the threat of personal harm may be the most predictive factor in determining those with subsequent PTSD.</p>
MacGregor, A. J., Dougherty, A. L., Mayo, J. A., Han, P. P., & Galarneau, M. R. (2015).	The sample consisted of 8,064 Navy personnel: 6,109 with one deployment (2,503 health care personnel and 3,606 non-health care personnel), 1,660 personnel with two deployments (768 health care personnel and 892 non-health care	U.S. Navy personnel were identified from electronic deployment records maintained by the Defense Manpower Data Center (DMDC). For inclusion, personnel must have had one, two, or three deployments to OEF/OIF between September 2001 and November 2008, and have completed a post-	Compare the rates of post-traumatic stress disorder (PTSD) among Navy health care personnel with non-health care personnel following single and repeated combat deployments.	New-onset PTSD was defined as presence of the 309.81 code from the "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Self-reported combat exposure was abstracted from the PDHA	Health care personnel had higher PTSD rates and an increasing trend in PTSD rates across repeated deployments. After adjusting for combat exposure and other covariates, health care compared with non-health care personnel were more likely to be diagnosed with PTSD after one

	personnel), and 295 personnel with three deployments (145 health care personnel and 150 non-healthcare personnel)	deployment health assessment (PDHA) within 60 days of their most recent deployment end-date			(odds ratio [OR] 2.02; 95% confidence interval [CI] 1.45–2.80), two (OR 2.27; 95% CI 1.26–4.08), and three deployments (OR 4.37; 95% CI 1.25–15.28). Exposure to wounded/dead friendly forces was associated with higher PTSD rates in health care personnel (OR 1.53; 95% CI 1.13–2.07). Health care personnel occupy a unique and essential role in current wartime operations, and are a high-risk group for PTSD.
Jacobson, I. G., Horton, J. L., Leardmann, C. A., Ryan, M. A., Boyko, E. J., Wells, T. S., . . . Smith, T. C. (2012). 25(6), 616-623. doi:10.1002/jts.21753	The study included members of the first and second panels who completed a baseline and at least one follow-up questionnaire ( <i>n</i> = 80,524). Of the 80,524 participants with at least one follow-up assessment, 4,285 were in the Marine Corps and ineligible because Navy personnel assume all health care positions for this service branch, 3,197 were missing demographic or covariate		Participants were drawn from the Millennium Cohort Study, a large, prospective cohort aimed at evaluating the effects of military service on short- and long-term health outcomes. Participants are surveyed every three years after initial enrollment.	PTSD Checklist-Civilian Version (PCL-C) is a 17-item screening tool for PTSD  The Patient Health Questionnaire (PHQ) screening tool was used to assess depression, measured by nine items from the PHQ (PHQ-9)	The rates of new positive screens for PTSD or depression were similar for those in health care occupations (4.7% and 4.3%) compared with those in other occupations (4.6% and 3.9%) for the first and second follow-up, respectively. Among military personnel deployed with combat experience, health care professionals did not have increased odds for new-onset PTSD or depression over time. Among deployed health care

	<p>data, 3,849 were missing PTSD or depression outcome data, and 4,085 screened positive for either PTSD or depression at baseline, leaving 65,108 individuals for descriptive analysis.</p>			<p>professionals, combat experience significantly increased the odds: adjusted odds ratio = 2.01; 95% confidence interval [1.06, 3.83] for new-onset PTSD or depression. These results suggest that combat experience, not features specific to being a health care professional, was the key exposure explaining the development of these outcomes.</p>
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## Appendix B

### IRB Approval



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

4301 JONES BRIDGE ROAD  
BETHESDA, MARYLAND  
20814-4799  
www.usuhs.edu



January 23, 2020

#### MEMORANDUM FOR MARGUERITE MARYANNE ENGLER, PhD., GRADUATE SCHOOL OF NURSING

SUBJECT: Uniformed Services University (USU) Human Research Protections Program (HRPP) Determination of Exempt Research Involving Human Subjects, Category 2 for Protocol DBS.2020.056 (Ref # 921632)

Protocol DBS.2020.056 (Ref # 921632), entitled "*The Process of Managing Psychological Well-being in Military Nurses Caring for Individuals with Life-threatening Illness or Injury: Dissertation Proposal*" was reviewed by the Uniformed Services University's Human Research Protections Program (HRPP) Office and determined to be considered exempt research involving human subjects, category 2 (32 CFR 219.104(d)(2)) because the research involves the use of surveys for the collection of data that if identifiable outside of the research study would not put subjects at risk. As such, this protocol does not require Institutional Review Board (IRB) review.

The primary focus of this study will be on the social process of military nurses navigating workplace adversity and the psychological effects of providing care to individuals with a life-threatening illness or injury. Navy Nurse Corps Officers who provide care for individuals with life-threatening illness or injury will be recruited from Walter Reed National Military Medical Center and Naval Medical Center Portsmouth to participate in semi-structured interviews and complete a demographic questionnaire, the Well-Being Index (WBI), the Connor-Davidson Resilience Scale (CD-RISC) and the Rushton Moral Resilience Scale (RMRS)

As a reminder, it is your responsibility to ensure all applicable protocol related approvals have been obtained prior to initiating study activities.

Should your project data sources, personnel, or methodology change, please contact this office before you begin any new phase of your work so that we may review it with you. Otherwise, we cannot ensure you will be in compliance with all applicable human subject research regulations. The IRB/HRPPO staff is a key resource that is available to assist you to ensure you are in compliance with applicable human research regulations.

If you have questions regarding this action, or questions of a more general nature concerning human participation in research, please contact Elizabeth Thammasuvimol at 301-295-0704 or [elizabeth.thammasuvimol.ch@usuhs.edu](mailto:elizabeth.thammasuvimol.ch@usuhs.edu).

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Petrice Longenecker, MA, PhD, CIP  
Human Protections Administrator  
Exemption Determination Official

*Learning to Care for Those in Harm's  
Way*

## Appendix C

### **Consent to Participate in Research**

The following will be read by or to prospective participants, and any questions will be addressed prior to asking for verbal consent to participate in the study. A copy will be provided to the participant.

#### **1. Protocol Title**

The Process of Managing Well-being in Military Nurses Caring for Individuals With Life-Threatening Illness or Injury.

#### **2. What is the Purpose and Duration of this research, and who will take part?**

You are being asked to take part in this research study because you are an active duty Nurse Corps Officer in the US military, and you have provided care for individuals with life-threatening illness or injury. The purpose of this research study is to learn about the social process of military nurses navigating workplace adversity and the psychological effects of providing care to individuals with a life-threatening illness or injury in the military treatment facility setting. The duration of participation for the first interview is 60-90 minutes. The duration of a possible follow up conversation will be 15-30 minutes.

#### **3. Screening Process to qualify for participation in this study?**

Before you can take part in this study, you will need to provide some information so that the research team can confirm that you qualify for the study. Please answer the following questions:

Are you an active-duty Nurse Corps officer in the US military?

Are you currently stationed at Naval Medical Center Portsmouth or Walter Reed National Military Medical Center?

Do you have a minimum of six months experience as a nurse?

Have you provided care to individuals with life-threatening illness or injury in the past 12 months?

#### **4. What will happen if you decide to be in this research?**

This study is being conducted by a Ph.D. student from the Graduate School of Nursing at the Uniformed Services University. If you agree to participate in this research, we will set up a date and time to conduct an approximately 60-90 minute interview in person, by phone or teleconference. There will be two interviewers, one who will ask you questions

and another who will take notes. For in-person interviews, you will be asked to complete a demographic questionnaire, a 9-item Well-being questionnaire, a 25-item resilience questionnaire, and a 17-item moral resilience scale before the interview. During the interview process, we will also ask about your perceptions and experience with providing care to individuals with life-threatening illness or injury and your well-being. We will also ask whether you agree to a follow-up conversation to confirm that our results reflect your experiences. In order to set up this conversation, we will ask for your telephone number to set up a date and time for the in-person, phone call, or teleconference.

**5. What are the risks or discomforts from being in this research?**

Although efforts are made to protect your research study records, there is always a risk that someone could get access to the personal information researchers have stored about you.

**6. What are the possible benefits from this research?**

There are no direct benefits to you for taking part in the study. However, others may benefit in the future from the information learned during this study.

**7. What are the alternatives to taking part in this research?**

Choosing not to take part in this research study is an option.

**8. Is there compensation for your participation in this research?**

You will not receive any compensation for participating in this study.

**9. Are there costs for participating in this research?**

No, there are no costs to you for taking part in this research.

**10. Who is conducting this research?**

Faculty and Ph.D. a student from the Graduate School of Nursing at the Uniformed Services University are conducting this research as part of the requirements for a

**Principal Investigator:** Marguerite M. Engler, PhD, RN, FAHA, Dissertation Chair  
**Associate Investigator:** Shawna Grover, PhD student

**11. Location of the Research?**

The research will be conducted in one of three methods per your preference: (1) in person at a mutually agreed upon private location, (2) by telephone, or (3) or

teleconference?

**12. Who will see my information (privacy), and how will it be protected (confidentiality)?**

Records of your participation in this research study may only be disclosed in accordance with state and federal law, including the Federal Privacy Act, 5 U.S.C.552a, and its implementing regulations. DD Form 2005, Privacy Act Statement - Military Health Records, contains the Privacy Act Statement for the records. A copy of DD Form 2005 can be given to you upon request, or you can read online at:

<http://www.dtic.mil/whs/directives/infomgt/forms/efoms/dd2005.pdf>.

Procedures to protect the confidentiality of the data in this study include but are not limited to: Minimal identifying information will be collected for the purpose of making contact. The minimal personal identifying information will be collected and kept separately from the data collection information. All study information will be kept in locked investigator's office. Files will be stored in a locked cabinet. The computer where data may be stored is password and personal id card protected. All audio recordings of the interviews will be stored on a tape recorder (for interviews conducted in person or by telephone) stored in a locked cabinet or an electronic file (for interviews conducted by teleconference) saved on a password and id -protected computer. All audio recordings will be destroyed three years after the completion of the study.

Researchers will make every effort to protect your privacy and confidentiality; however, there are risks of breach of information security and information loss.

**13. What happens if I withdraw from this research?**

You may withdraw your consent at any time and stop participating in this research study without any adverse consequences. Should you choose to withdraw, any collected participant data will be destroyed and not included in the data analysis.

**14. Voluntary Participation**

The decision to take part in this research study is completely voluntary on your part. You will be informed if significant new findings develop during the course of this research study that may relate to your decision to continue participation.

**15. Contact Information**

The Associate Investigator or a member of the research staff will be available to answer any questions throughout this study.

Associate Investigator: Shawna Grover  
Phone:901-605-2506  
Email Address: shawna.grover@usuhs.edu

**Institutional Review Board (IRB) Office**

If you have any questions about your rights as a research participant or if you have concerns or complaints about the research study, please contact the IRB Office at:

Uniformed Services University of the Health Sciences  
4301 Jones Bridge Road  
Room A2051  
Bethesda, MD 20814  
Phone: 301-319-4730 (direct); 301-295-3303 (main VPR office)

IF THERE IS ANY PORTION OF THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, ASK THE INVESTIGATOR BEFORE PROVIDING YOUR VERBAL CONSENT.

By providing verbal consent, you give your permission for information gained from your participation in this research study to be published in the literature, discussed for educational purposes, and used generally to further science. You will not be personally identified; all information will be presented as anonymous data.

Do you give verbal consent to participate in this study?

## Appendix D

### Demographic Questionnaire

A 24-item investigator-developed demographic questionnaire will be used to assess demographic data. Questions will include the following:

1. Have you been a military nurse for a minimum of six months?
  - a. Yes
  - b. No
2. Have you provided care to a patient with a life-threatening illness or injury in the past 12 months?
  - a. Yes
  - b. No
3. What type of inpatient nursing unit do you work on:
  - a. adult med-surg
  - b. General pediatrics
  - c. Adult oncology
  - d. Pediatric oncology
  - e. Adult critical care
  - f. Pediatric critical care
  - g. ED
  - h. PACU
  - i. In-patient behavioral health
  - j. other
4. How many hours a week do you typically work? \_\_\_\_\_
5. Do you ever work overtime?
  - a. Yes
  - b. No
6. If yes, how frequently do you work overtime (every week, once a month)? \_\_\_\_\_
7. How many years have you been in the military? \_\_\_\_\_
8. Are you prior-enlisted?
  - a. Yes
  - b. No
9. If you are prior-enlisted, what did you do while you were enlisted?  
\_\_\_\_\_
10. What is your rank? \_\_\_\_\_
11. What is your highest education level?
  - a. Bachelors
  - b. Masters
  - c. PhD
  - d. other
12. What certifications do you hold?  
\_\_\_\_\_

13. How many times have you been deployed in your current role? \_\_\_\_\_
14. Did you select the unit you are working on or was it based on needs of the organization?
- Selected the unit
  - Based on the needs of the organization
15. How many years have you worked in your current specialty? \_\_\_\_\_
16. Have you had any formal resilience training?
- Yes
  - No
17. Have you had any informal resilience training?
- Yes
  - No
18. Have you had any formal palliative care training?
- Yes
  - No
19. Have you had any informal palliative care training?
- Yes
  - No
20. Do you intend to separate from the military after current commitment?
- Yes
  - No
21. Based on your answer to number 17, was this your intention at the beginning of your commitment?
- Yes
  - No
22. What is your age? \_\_\_\_\_
23. Please circle your racial identity.
- Caucasian
  - Black/African American
  - Latino or Hispanic
  - Native American
  - Native Hawaiian or Pacific Islander
  - Asian
  - Two or more
  - Other/Unknown
  - Prefer not to say
24. What is the sex you were assigned at birth?
- Male
  - Female
25. What is your relationship status?
- Single
  - Divorced
  - Widowed
  - In a committed relationship
  - Married

26. If you are married, is your spouse a current or former military member?
- a. Yes, current
  - b. Yes, former
  - c. No
27. Do you have children living with you at home?
- a. Yes
  - b. No

## Appendix E

### Semi-Structured Interview Guide

Thank you so much for being willing to meet with me today. We are going to talk about your experiences providing nursing care to patients with life-threatening injuries and/or illnesses and your well-being. Questions will be asked in no particular order, and there are no right or wrong answers to my questions. We are going to talk about your feelings and opinions, and we will stop at any time if you feel uncomfortable and do not wish to continue.

In order to help protect your confidentiality, because we will audio record the interview, I won't be using your name during the interview. In addition, to protect the confidentiality of others, please do not use the real names of other individuals whom you may discuss. As an active-duty service member, you are held to the Uniform Code of Military Justice (UCMJ) and I am required to report any violations such as but not limited to drunken or reckless operation of vehicle, aircraft, or vessel, drunk on duty, wrongful use, or possession, etc., of controlled substances. Therefore, for your protection please do not disclose any violations during the interview process.

Are you feeling comfortable with our arrangements for privacy? Do you have any questions about anything before we begin? Is it OK to start the questions? If so, I will begin recording now.

#### 1. Opening Questions:

- i. Please describe the nature of your role as an active-duty Navy nurse?
- ii. Please describe for me what a typical day of providing care for individuals with life-threatening illness or injury is like for you?

#### 2. Intermediate Questions:

- i. What comes to mind when I say "well-being"?
- ii. Please describe in as many details as possible what well-being means to you?  
How would you define well-being?
- iii. What does someone with high "well-being" look like to you? What does someone with low "well-being" look like to you?
- iv. What do you do to manage your well-being?
- v. Please describe for me things you do after a difficult or challenging day at work caring for individuals with life-threatening illness or injury.
- vi. How much do you think about work when you are not here?
- vii. How does work affect how you feel when you are away from work?
- viii. Tell me what kinds of things you do to keep yourself feeling healthy or feeling good? What types of things do you think are important to keep yourself feeling healthy or feeling good?
- ix. Please describe what helps you manage your well-being?
- x. Please describe what helps make managing your well-being difficult?

- xi. Can you recall any changes have you made during your nursing career to improve your well-being?

**3. Follow-up questions:**

- i. Please expand on \_\_\_\_\_ (that point)?
- ii. You mentioned that...how did you feel about it?

**4. Probing Questions:**

- i. What are other examples of ...?
- ii. Tell me more about...?

**5. Interpreting Questions:**

- i. You mean that...?
- ii. Is it correct that you feel that...?

**6. Ending Questions:**

- i. What do you think are the most important ways to manage how a difficult day of providing care for individuals with life threatening-illness or injury may affect you?
- ii. After having the experience of providing care to individuals with life-threatening illness or injury, what advice or tips would you give to an active-duty Navy nurse who has not provided care to an individual with a life-threatening illness or injury to protect their own well-being?
- iii. Is there anything else you would like to discuss that I have not asked about, or you think we addressed too briefly?
- iv. Is there anything else you think is important for me to know when thinking about your well-being related to the work you do?

THANK YOU SO MUCH FOR YOUR PARTICIPATION

## Appendix F

### Institutional Resources



4494 North Palmer Road  
Bethesda, MD 20889  
USA

#### **Adult Outpatient Behavioral Health**

##### **Location**

Building 19 Floor 6  
America Building

##### **Contact Us**

For New & Follow Appointments only call (301) 295-0500.  
To reach the Front Desk or a Provider call (301) 295-0015/0790

##### **Military OneSource**

Phone: 800-342-9647

<https://www.militaryonesource.mil>